Best, promising and emerging practices in the treatment of trauma:

What can we apply in our work with torture survivors?

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"To study psychological trauma is to come face to face both with human vulnerability in the natural world and with the capacity for evil in human nature. The study of psychological trauma means bearing witness to horrible events."

Judith Herman, Trauma and Recovery (1992, p. 7)

In 1997, the National Institute of Mental Health convened a working group to address the mental health consequences of torture and other related traumas. Their approach was to review related traumatic stress research and practice areas.[1] Specific studies focusing on the treatment of torture survivors was then a small body of literature. More than eleven years later, in 2008, an international conference was co-sponsored by the Rehabilitation and Research Centre for Torture Victims and the Centre for Transcultural Psychiatry in Copenhagen, Denmark. A Special Report, *Rehabilitating Torture Survivors*, summarized the conference presentations by invited experts.[2] Notably, the status of rigorous scientific studies of interventions utilized[2] by torture rehabilitation centers continue to be lacking in the literature.

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Many torture treatment centers annually provide services to survivors from more than 50 countries who are presenting with diverse cultural and linguistic backgrounds, thus posing obvious research challenges. Studies focusing on refugee camp populations or in-country nationals share similar backgrounds and also post-conflict, highly stressful living conditions. Refugees may or may not have a torture experience. It is an important consideration for researchers that the research may contribute to a survivor feeling like a research object, much like the object of torture they were, a passive rather than active participant. Torture survivors often feel disempowered by the experience of torture where they were under the control of the perpetrator. Research that empowers the survivor as a participant who is contributing to a body of knowledge that will help others seems particularly important to emphasize. Additionally, there are many confounding factors in trauma research, such as multiple traumas, previous mental health conditions, lengths of time since the trauma, and the difficulty in conducting controlled studies that make reliable conclusions.

The Complexity of Studying Psychological Healing

Many of the early accounts written about the treatment of torture survivors are clinical narrative accounts of case examples, lessons learned by clinicians. They are classic ac-

counts of the development of working with trauma survivors suffering from PTSD.[3] An instructive example of the importance of considering different factors, such as culture, in developing and studying treatment outcomes can be made by comparing two articles, Group Treatment of Exiled Survivors of Torture by Fischman and Ross[4] and Individual and *Group Treatment and Self and Other Representations Predicting Posttraumatic Recovery Among Former Political Prisoners* by Salo, et al.[5]

The 1990 publication is a description by two therapists of a group therapy process with Central and South American refugees with a focus on torture related symptoms of PTSD. The authors describe assessment interviews to select a homogeneous membership based on torture and subsequent symptoms. Six male and two female group members, all survivors of torture, completed a six month, once a week group therapy intervention at a hospital-based community mental health center. The first sessions focused on building group cohesion through trust building that stressed confidentiality and privacy. Thematic concerns were identified and addressed, including, but not limited to: psychoeducation about posttraumatic stress disorder, the strategies of the use of torture, identifying distressing triggers in their current environment and techniques to better manage symptoms. Additionally, "group members prepare[d] individual written testimonies of their experiences of torture and then organize[d] them into a collective document" (p. 57).[5] The authors believed that the collective testimony process, better understanding the strategy of torture and its psychological consequences, provided an important "sociopolitical context" for the group members. Based on the authors' clinical impressions, reports from group members at follow-up sessions, and then informal telephone follow-ups, the group therapy intervention provided the survivors with a "new perspective" that allowed them to understand their symptoms in a sociopolitical context and to feel "less alone and less disturbed" (p. 57).[5]

The 2008 publication compares individual therapy (19 participants), group therapy (20 participants), and a control group (76 members) of Palestinian former political prisoners at a community mental health clinic in Gaza. PTSD was measured using the Harvard Trauma Questionnaire and trauma events were documented using a check list of 30 commonly used interrogating techniques. Post traumatic growth measures were also collected but will not be discussed here due to the nature of the comparison being offered. The individual therapies were conducted by trained, degreed trauma specialists who utilized several psychotherapeutic techniques, including, but not limited to: systematic desensitization, coping skills training, affect regulation, and addressing family and social problems in the context of the therapy. Four male and one female BA level counselors led groups with five members each. The groups focused on creating mutual support by providing psychoeducation, sharing and validating each member's personal account of trauma, and creating social interaction. Additionally, the group addressed socioeconomic problem solving. The authors report that PTSD symptoms decreased for those who participated in the individual therapy and that no decrease was measured in the group therapy and the control group over a one year period. The authors state, "Our results caution the use of group therapy" (p.57).[5]

The 1990 study found group therapy to be a useful intervention with torture survivors from Central and South America; the 2008 study did not find improvement with Palestinian former political prisoners. These

examples provide different results and also utilized different methodologies of assessing, reporting, and conducting the group interventions. Can both be accurate? What are the critical differences? Both sets of authors are respected in the field of torture treatment. Is it culture? Is it living in exile versus being in the country of origin and trauma? Was it components in the treatment design? Was it the therapist's educational and experience level? Currently there is a focus on evidence-based practices which measure improvement. We must remember, however, that the lessons learned with clinical experience contribute to our body of knowledge as well.

After reviewing the selected literature (64 articles) on torture and other related traumas, multiple categories of interventions for discussion emerged: psychotherapy and psychiatric medication; Cognitive Behavioral Therapy (CBT); family interventions; psychosocial community interventions; oral history/testimony/psycho-legal work; other therapeutic techniques; and therapeutic considerations and cautions. This paper will discuss the literature within the context of these categories, provide a review of current literature, and make a determination as to its best, promising, or emerging practice status, specifically for treatment of survivors of torture.

Psychotherapy and Psychiatric Medication

Models of care and treatment issues are the primary focus of this category. Studies generally had small samples and mostly without control groups. Other write-ups were case analyses outlining the course of treatment with one torture survivor. Multidisciplinary care of torture survivors was generally promoted and reflected a bio-psycho-social model. The role of culture was mentioned in most studies noting that culture mediates how survivors may interpret, express, and cope with the trauma. Treatment models included individual psychotherapy, group therapy, and intergenerational groups and integrated cognitive-behavioral, insight-oriented, and short-term therapy strategies. Several of the reported interventions were in conjunction with psychiatric medication and care.

There was a general consensus in several articles that multidisciplinary care which included access to care in all domains of health was an important part of caring for torture survivors. Although clinicians often promote treatment that includes psychotherapy and psychiatric medication, there is no empirical research as to its efficacy in the treatment of trauma to consider it more than a "*Promising Practice*." Clinical experience is often anecdotal and the need for data that provides an evidence-based conclusion is needed and recommended.

A subset of these articles looked at specific psychological functions of torture survivors in the context of psychotherapy. One article by Kanninen et. al.[6] examined attachment patterns and the development of alliance with the therapist and noted that the interpersonal nature of torture results in extra difficulties in developing a trusting relationship. In another paper by Kanninen et. al.,[7] the authors suggested that understanding the survivor's appraisal of their trauma will help the therapist understand their coping processes and that facilitating a reappraisal can assist in improving coping strategies. These studies, however, may not be generalizable as they had small sample sizes and the subjects were all Palestinian male former political prisoners.

Cognitive Behavioral Therapies (CBT)

The largest percentage (30%) of articles fall into this category of intervention with sub-categories of study populations: general PTSD populations; female rape victims;

adults who were child sexual abuse victims; child sexual abuse victims; and refugees. Although trauma victims share many commonalities, especially of possible resulting symptoms, they also have unique contextual characteristics which are important to understand.

In the general PTSD studies, most were randomized trials with control groups of wait-listed participants or participants receiving care as usual. These trials looked at different CBT strategies with PTSD patients. Generally, CBT interventions, such as exposure and cognitive restructuring were compared with relaxation and eye movement desensitization and reprocessing (EMDR) with consistent finding of a CBT strategy being the most effective therapeutic condition, even when as in one study it was conducted via videoconference.[8] A multi-site study of female rape victims[9] treated chronic PTSD with random assignment to prolonged exposure, prolonged exposure plus cognitive restructuring, or wait list found that prolonged exposure alone reduced PTSD in the sample when compared to the other two groups. A randomized trial of CBT for chronic PTSD in women survivors of childhood sexual abuse was compared to a problem-solving therapy and to a wait-list.[10] CBT participants were more likely to no longer meet the criteria for PTSD than the other two groups with a sustained symptom reduction on follow up. A meta-analysis of research comparing the use of psychotherapy in treating PTSD with Trauma-focused CBT (TF-CBT), EMDR, stress management (SM) was conducted by Bisson and Andrew in 2007.[11] Combining the data from thirty-three studies, they found that TF-CBT, EMDR, and SM all were effective in reducing the severity of PTSD symptoms. Other forms of psychotherapy were not found to be effective.

Despite the success reported in case studies and in controlled studies, EMDR remains controversial among clinicians, with strong proponents and equally strong critics. There is consensus, however, that the use of EMDR in the context of a therapeutic alliance, following the full protocol which utilizes other cognitive techniques can be helpful in the treatment of PTSD. What component of EMDR effects improvement is an ongoing point of clinical discussion.[2,12,13] Additionally, the scientific rigor and populations studied is variable.

Judith Cohen and Anthony Mannarino at Allegheny Hospital in Pennsylvania and Esther Debliner and colleagues at the Center for Child Support in New Jersey have advanced the study of CBT's use with sexually abused children. Their efforts have resulted in Trauma-informed Cognitive Behavioral Therapy (TF-CBT) as an evidenced-based practice. Findings in randomly assigned treatment studies found TF-CBT more effective than non-directive supportive therapy or treatment with medication. Non-perpetrator parent(s) are part of the treatment plan as well, thus adding a family therapy component. Documentation of CBT used with refugee groups living in the United States,[14-16] the United Kingdom,[17] and in camps in Uganda[18] all improved functioning with the reduction in PTSD symptoms. Sensitivity to torture and war trauma events as catastrophic and cultural adaptation was stressed by each study, along with the importance of training interpreters to assist in the therapy. Additionally, sample sizes were small, so the results are to be considered as promising. The various modules frequently used in CBT include: psychoeducation; relaxation training; cognitive restructuring and affect modulation; and narrative construction. These components are often an integral part of treatment that torture survivors receive at

specialized treatment centers over a period of time, but not in a time-limited structured (4-16 weeks) intervention.

Disrupted sleep patterns are common to trauma survivors who are often plagued by nightmares with content of the traumatic event. Management of nightmares is often part of PTSD treatment. Imagery Rehearsal Therapy (IRT) has been successfully shown to resolve nightmares in a crime victim population. IRT is a four session up to eight hours intervention which includes an educational, cognitive restructuring element that emphasizes the nightmare as a learned behavior. Treatment emphasizes changing the nightmare into a new dream by rehearsing new imagery. It is a staged approach to decreasing nightmares. Authors cite the limited generalizability to other populations such as war veterans, refugees, and disaster survivors.

The body of empirical evidence in well-designed and executed studies conducted with diverse trauma populations is sufficient to consider CBT-guided treatment as a "*Best Practice.*" This suggests a strong probability that a trauma-informed CBT-guided treatment that is flexible to the unpredictable stressors, cultural diversity, and varying worldviews of torture survivors being treated in settings located in host countries is an effective treatment approach. There is again the need and recommendation for sensitively designed research with torture survivors to contribute to the growing base of evidence-based studies on the use of CBT-guided treatment.

Family Interventions

Many torture survivors enter the United States as individuals and apply for political asylum. Upon being granted asylum, the survivor starts the lengthy process of family reunification. Refugees are often resettled with family members. Families can be an important factor in facilitating mental health services. Multiple family groups were conducted with refugees from Bosnia-Herzegovina in the community as an alternative to agency delivered services. One-hundred and ninety-seven adults and their families were randomly assigned to the intervention group or a control group which met with an interviewer to complete measures. The multiple family groups brought families together for conversation and information and potential referral to appropriate services.[19] This method was found to provide support and increased access to needed services. Other family approaches were reviewed in an article by Froma Walsh[20] with a focus on family resiliency by promoting greater understanding of a family's belief systems, organizational patterns, and communication processes. This framework provides the structure to assist families as they encounter challenges and distressing events in their life cycle such as losses, illness, traumatic events with a focus on family strengths and how they can meet these challenges effectively. Strength-based interventions are an important part of trauma work that promotes wellness.

Promoting the practice of cultural and religious rituals by displaced families promotes the maintenance of their beliefs and traditions and helps maintain an emotional connection to "home." Case studies were used by Woodcock[21] to illustrate how incorporating the use of ritual into the therapeutic work can help families transport their culture into their new home and provide a familiar system of strength and support. Family practice of rituals may also lead to community celebrations.

Taking into consideration the strong role of family in most cultures and the impact torture has not only on the survivor, but also his family, these studies are important, but do not reach the needed rigor to be considered more than an "Emerging Practice." It

is important to consider the circumstances of torture survivors: are they resettled as a refugee with their family, or are they an individual asylum seeker who is seeking refuge alone and entering the long and arduous process of asylum and reunification. Family interventions are not always possible with torture survivors.

Psychosocial Community Interventions

Several studies conducted in post-violence countries addressed the needs of survivors of political violence and torture with community interventions. The cited programs included: internally displaced refugee mothers with young children in Bosnia who were provided psychosocial support groups and medical care;[22] discussion groups to address community psychosocial problems in the Peruvian Andes;[23] community workshops on personal and interpersonal empowerment in Namibia;[24] and facilitated community reflection groups in Guatemala.[25] The studies all reported achieving successful outcomes that focused on rebuilding trust and social support networks through education and discussion at the community level.

Psychosocial interventions as cited in the literature have been projects that have been unable to demonstrate more than clinical anecdotal information. While these projects suggest potential for psychosocial community interventions, it is an "*Emerging Practice*" for consideration.

Testimony Therapy, Oral History, and Psycho-legal Work

Case study reports about the use of testimony as therapy with Aurohuaca Indians in Colombia;[26] and with former political prisoners in Chile;[27] and an oral history group with Cambodian women living in Chicago[28] document successful interventions which broaden the context of healing. The subjective, private pain from torture was described as transformed into objective, political statements which provided the context for creating meaning in the survivor's life. The therapist as listener bears witness and is responsible for facilitating an authentic account of what happened to the survivor in a responsible and therapeutic manner. Anthropologist Kelly McKinney[29] objects to the stance that trauma victims need to tell their story in order to heal. McKinney states that psychological, cultural, and political beliefs are not universal and cautions about assuming the rehabilitative aspects of narrative.

Authors with a more geo-political perspective assess political activism as therapeutic and included testimony as part of historical construction in Peru[30] and legal action against police torture in India.[31] The victim is empowered with the support of legal advocates and therapists as they navigate legal arenas in an effort to expose the injustice, be heard in a court of law, and seek reparations. Justice is viewed as the therapeutic agent.

While interesting and suggestive of potential, the papers that describe the use of narrative within the context of testimony, oral history, or psycho-legal collaborations are projects that are anecdotal and therefore an "*Emerging Practice*."

Other Therapeutic Techniques

Within the context of trauma treatment, clinicians often find therapeutic techniques that are effective with some of their clients. These reports tend to be case studies or studies with small samples in a clinical setting. The International Rehabilitation and Research Centre for Torture Victims in Copenhagen addressed pain among torture survivors by combining physiotherapy (massage, exercise, and balance training) within a multidisciplinary treatment approach and demonstrated a significant decrease in mus-

culoskeletal pain.[32] A refugee clinic that is part of a Family and Community Medicine Program in Arizona reported in case studies the successful use of hypnotic ego-strengthening with an interactive metaphorical story telling approach that indirectly promotes improved self-efficacy. The authors caution that metaphors must be culturally meaningful.[33,34] Thought Field Therapy (TFT – mechanical stimulation of energy meridian points combined with bilateral optical cortical stimulation) was reported to have improved emotional suffering from trauma symptoms in 105 ethnic Albanians from Kosovo in 2000.[35] The authors recommend that more studies should be done using TFT with trauma victims.

While these papers share successful lessons learned at sites where skilled clinicians implemented treatment interventions that they clinically observe and report improvement, they lack scientific rigor to consider them more than "*Emerging Practices*." See Table 1 on next page.

Therapeutic Considerations & Cautions

Several general cautions appear throughout the literature regarding psychological treatment of survivors of war, political violence, and torture. Culture, religion, and gender ideologies are important considerations in treatment. The therapist is an important agent of assistance no matter what the intervention.

The studies reviewed on the psychological treatment of trauma covered a broad range of trauma populations. The evidence-based studies with control groups were not conducted with a torture survivor population. There are significant challenges for conducting research with torture survivors living in exile (diversity of languages and cultures seen at torture treatment programs) and with displaced refugees (acuteness of trauma and access). Most of the torture survivor studies are Promising and Emerging Practices that have utilized pre- and post-measures after treatment without a control group and case study reports. PTSD as a shared diagnosis is not enough to generalize best practices from a general American population to a culturally, religiously, and ethnically diverse refugee population. The scope of empirical evidence that has been well-designed and implemented studies of the use of CBT-guided treatments merits being a Best Practice. The obvious caveat is the need to modify and adapt CBT components to be appropriate for use with the culturally diverse torture survivor population. There is much to be learned and considered from the review of the literature on the treatment of trauma. As ethical and responsible clinicians we have the responsibility to remain versed in the latest treatment studies and thoughtfully consider them as we meet torture survivors in our treatment settings.

Learning Points

Post-traumatic stress disorder (PTSD) as a shared diagnosis is not enough to generalize best practices from a general American population to a culturally, religiously, and ethnically diverse refugee population.

The scope of empirical evidence that has been well-designed and implemented studies of the use of CBT-guided treatments merits being a Best Practice. The obvious caveat is the need to modify and adapt CBT components to be appropriate for use with the culturally diverse torture survivor population.

There is much to be learned and considered from the review of the literature on the treatment of trauma.As ethical and responsible clinicians we have the responsibility to remain versed in the latest treatment studies and thoughtfully consider them as we meet torture survivors in our treatment settings.

Table 1. *Treatment of Trauma*

	Article	Type of Practice
1	The Mental Health Consequences of Torture. Gerrity E, Keane TM, Tuma F. Editors Kluwer Press: Plenum Publishers;2001.	n/a
2	Sjölund BH, Kastrup M, Montgomery E, Persson AL. Rehabilitating torture survivors. J Rehabil Med 2009;41(9):689-96.	n/a
Complexity of Studying Psychological Healing		
3	Fischman Y, Ross J. Group treatment of exiled survivors of torture. Am J Orthopsychiat 1990;60(1):135-142.	n/a
4	Haley S. When the patient reports atrocities. Archiv Gen Psychiat 1974;30(2):191-196.	Emerging
5	Salo J, Punamaki R, Qouta S, El Sarraj E. Individual and group treatment and self and other representations predicting posttraumatic recovery among former political prisoners. Traumatology 2008;14(2):45-61.	Best
Psychotherapy and Psychiatric Medication		
6	Berliner P, Mikkelsen EN, Bovbjerg A, Wiking M. Psychotherapy treatment of torture survivors. The Int J Psychosoc Rehabil 2004;8:85-96.	Promising
7	Holmqvist R, Andersen K, Anjum T, Alinder B. Change in self-image and PTSD symptoms in short-term therapies with traumatized refugees. Psychoanal Psychother 2006;20(4):251-65.	Promising
8	Kanninen K, Salo J, Punamaki R. Attachment patterns and working alliance in trauma therapy for victims of political violence. Psychother Res 2000;10(4):435-49.	Promising
9	Kanninen K, Punamaki R, Qouta S. The relation of appraisal, coping efforts, and acuteness of trauma to PTSD symptoms among former political prisoners. J Trauma Stress 2002;15(3):245-53.	Promising
10	Kastrup M, Genefke IK, Lunde I, Ortmann J. Coping with the exposure to torture. Contemporary Family Therapy. 1988;10(4):280-7.	Emerging
11	Kidron CA. Surviving a distant past: a case study of the cultural construction of trauma descendant identity. Ethos. 2004;31(4):513-44.	Emerging
12	Kinzie JD. Psychotherapy for massively traumatized refugees: the therapist variable. Am J Psychother. 2001;55(4):475-90.	Emerging
13	Mollica RF, Wyshak G, Lavelle J, Truong T, Tor S, Yang T. Assessing symptom change in southeast Asian refugee survivors of mass violence and torture. Am J Psychiatry. 1990;147(1):83-8.	Promising
14	Momartin S, Coello M. Self-harming behaviour and dissociation in complex PTSD. Torture. 2006;16(1):20-9.	Emerging
15	Peltzer K. An integrative model for ethnocultural counseling and psychotherapy of victims of organized violence. Journal of Psychotherapy Integration. 2001;11(2):241-62.	Promising
16	Stultz J. Integrating exposure therapy and analytic therapy in trauma treatment. Am J Orthopsychiatry. 2006;76(4):482-8.	Promising

	Article	Type of Practice
Cognitive Behavioral Therapies		
17	Bisson J, Andrew M. Psychological treatment of post-traumatic stress disorder (PTSD). Cochrane Database Syst Rev 2007, Issue 3. Art. No.: CD003388. DOI: 10.1002/14651858.CD003388.pub3.	Review
18	Coalson B. Nightmare help: treatment of trauma survivors with PTSD. Psychotherapy Theory, Research, Practice, Training. 1995;32(3):381-8.	Emerging
19	Cohen JA, Mannarino AP. Interventions for sexually abused children: initial treatment outcome findings. Child Maltreat. 1998;3(17):17-26.	Best
20	Cohen JA, Mannarino AP, Perel JM, Staron V. A pilot study of modified cognitive-behavioral therapy for childhood traumatic grief (CBT-CTG). J Am Acad Child Adolesc Psychiatry. 2006;45(12):1465-73.	Promising
21	Cohen JA, Mannarino AP, Perel JM, Staron V. A pilot randomized controlled trial of combined trauma-focused CBT and sertraline for childhood PTSD symptoms. J Am Acad Child Adolesc Psychiatry. 2007;46(7):811-9.	Best
22	Deblinger E, Steer RA, Lippmann J. A two-year follow-up study of cognitive behavioral therapy for sexually abused children suffering post-traumatic stress symptoms. Child Abuse & Neglect. 1999;23(12):1371-78.	Best
23	Foa EB, Hembree EA, Cahill SP, Rauch SAM, Riggs DS, Feeny NC, Yadin E. Randomized trial of prolonged exposure for posttraumatic stress disorder with and without cognitive restructuring: outcome at academic and community clinics. J Consult Clin Psychol 2005;73(5):953-64.	Best
24	Germain V, Marchand A, Bouchard S, Drouin M, Guay S. Effectiveness of cognitive behavioural therapy administered by videoconference for posttraumatic stress disorder. Cogn Behav Ther 2009;38(1):42-53.	Promising
25	Hinton DE, Pham T, Tran M, Safren SA, Otto MW, Pollack MH. CBT for Vietnamese refugees with treatment-resistant PTSD and panic attacks: a pilot study. J Trauma Stress 2004;17(5):429-33.	Best
26	Hunot V, Churchill R, Teixeira V, Silva de Lima M. Psychological therapies for generalized anxiety disorder. Cochrane Database Syst Rev 2007, Issue 1. Art. No.: CD001848. DOI: 10.1002/14651858.CD001848.pub4.	Promising
27	Ilic A. EMDR in the treatment of posttraumatic stress disorder with prisoners of war. In: Torture in war: consequences and rehabilitation of victims – Yugoslav experience. Špiric Z, Knezevic G, Jovic V, Opacic G, editors Belgrade: IAN;2004. p.281-291.	Review
28	Krakow B, Johnston L, Melendrez D, Hollifield M, Warner T, Chavez-Kennedy D. An open-label trial of evidence-based cognitive behavior therapy for nightmares and insomnia in crime victims with PTSD. Am J Psychiatry. 2001;158;2043-7.	Emerging
29	Krakow B, Zadra A. Clinical management of chronic nightmares: imagery rehearsal therapy. Behav Sleep Med. 2006;4(1):45-70.	Emerging
30	Macdonald G, Higgins JPT, Ramchandani P. Cognitive-behavioural interventions for children who have been sexually abused. Cochrane Database Syst Rev 2006, Issue 4. Art. No.: CD001930. DOI: 10.1002/14651858.CD001930.pub2.	Best
31	Marks I, Lovell K, Noshirvani H, Livanou M, Thrasher S. Treatment of posttraumatic stress disorder by exposure and/or cognitive restructuring. Arch Gen Psychiatry. 1998;55;317-25.	Promising

Article		Type of Practice
32	McDonagh A, Friedman M, McHugo G, Ford J, Sengupta A, Mueser K, Demment CC, Fournier D, Schnurr PP. Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse. J Consult Clin Psychol 2005;73(3):515-24.	Best
33	Neuner F, Schauer M, Klaschik C, Karunakara U, Elbert T. A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. J Consult Clin Psychol 2004;72(4):579-87.	Best
34	Regel S, Berliner P. Current perspectives on assessment and therapy with survivors of torture: the use of a cognitive behavioural approach. Eur J Psychother and Couns 2007;9(3):289-99.	Emerging
35	Schulz PM, Huber LC, Resick PA. Practical adaptations of cognitive behavioral processing therapy with Bosnian refugees: implications for adapting practice to a multicultural clientele. Cogn Behav Pract 2006.13:310-21.	Promising
36	Schulz PM, Marovic-Johnson D, Huber LC. Cognitive-behavioral treatment of rape- and war-related posttraumatic stress disorder with a female, Bosnian refugee. Clin Case Stud 2006;5:191-208.	Promising
37	Schulz PM, Resick PA, Huber LC, Griffin, MG. The effectiveness of cognitive processing therapy for PTSD with refugees in a community setting. Cognitive and Behavioral Practice. 2006.13:322-31.	Promising
38	Sikes C, Sikes V. EMDR: Why the controversy? Traumatology 2003; 9(3):169-181.	Promising
39	Stultz J. Integrating exposure therapy and analytic therapy in trauma treatment. Am J Orthopsychiat 2006;76(4):482-8.	Promising
40	Tarrier N, Pilgrim H, Sommerfield C, Faragher B, Reynolds M, Graham E, Barrowclough C. A randomized trial of cognitive therapy and imaginal exposure in the treatment of chronic posttraumatic stress disorder. J Consult Clin Psychol. 1999;67(1):13-8.	Promising
41	Taylor S, Thordarson DS, Maxfield L, Fedoroff IC, Lovell K, Ogrodniczuk J. Comparative efficacy, speed, and adverse effects of three PTSD treatments: exposure therapy, EMDR, and relaxation training. J Consult Clin Psychol. 2003;71(2):330-8.	Promising
42	Wittmann L, Schredl M, Kramer M. Dreaming in posttraumatic stress disorder: a critical review of phenomenology, psychophysiology and treatment. Psychother Psychosom. 2007;76(1):25-39.	Emerging
Family Interventions		
43	Walsh F. A family resilience framework: innovative practice applications. Fam Relat 2002;51(2):130-7.	Emerging
44	Weine S, Kulauzovic Y, Klebic A, Besic S, Mujagic A, Muzurovic J, Spahovic D, Sclove S, Pavkovic I, Feetham S, Rolland J. Evaluating a multiple-family group access intervention for refugees with PTSD. J Marital Fam Ther 2008;34(2):149-64.	Best
45	Woodcock J. Healing rituals with families in exile. Am J Fam Ther 1995;17(4):397-409.	Emerging
Psychosocial Community Interventions		
46	Berliner P, Mikkelsen EN, Bovbjerg A, Wiking M. Psychotherapy treatment of torture survivors. Int J Psychosoc Rehabil 2004;8:85-96.	Promising

Highly Recommended Readings

- Berliner P, Mikkelsen EN, Bovbjerg A, Wiking M. Psychotherapy treatment of torture survivors. Int J Psychosoc Rehabil 2004;8:85-96.
- Fabri MR. Reconstructing safety: Adjustments to the frame in the treatment of survivors of political torture. Prof Psychol-Res PR 2001;32(5): 452-457.
- Hinton DE, Pham T, Tran M, Safren SA, Otto MW, Pollack MH. CBT for Vietnamese refugees with treatment-resistant PTSD and panic attacks: a pilot study. J Trauma Stress 2004;17(5):429-33.
- Kinzie JD. Psychotherapy for massively traumatized refugees: the therapist variable. Am J Psychother 2001;55(4):475-90.
- Neuner F, Schauer M, Klaschik C, Karunakara U, Elbert T. A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. J Consult Clin Psychol 2004;72(4):579-87.

References

1. Gerrity E, Keane TM, Tuma F, eds. The mental health consequences of torture. New York: Plenum Publishers, 2001.
2. Sjölund BH, Kastrup M, Montgomery E et al. Rehabilitating torture survivors. J Rehabil Med 2009;41:689-96.
3. Haley S. When the patient reports atrocities. Archiv Gen Psychiatry 1974;30:191-6.
4. Fischman Y, Ross J. Group treatment of exiled survivors of torture. Am J Orthopsychiatry 1990;60:135-42.
5. Salo J, Punamaki R, Qouta S et al. Individual and group treatment and self and other representations predicting posttraumatic recovery among former political prisoners. Traumatology 2008;14:45-61.
6. Kanninen K, Salo J, Punamaki R. Attachment patterns and working alliance in trauma therapy for victims of political violence. Psychother Res 2000;10:435-49.
7. Kanninen K, Punamaki R, Qouta S. The relation of appraisal, coping efforts, and acuteness of trauma to PTSD symptoms among former political prisoners. J Trauma Stress 2002;15:245-53.
8. Germain V, Marchand A, Bouchard S et al. Effectiveness of cognitive behavioural therapy administered by videoconference for posttraumatic stress disorder. Cogn Behav Ther 2009;38(1):42-53.
9. Foa EB, Hembree EA, Cahill SP et al. Randomized trial of prolonged exposure for posttraumatic stress disorder with and without cognitive restructuring: outcome at academic and community clinics. J Consult Clin Psychol 2005;73:953-64.
10. McDonagh A, Friedman M, McHugo G et al. Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse. J Consult Clin Psychol 2005;73:515-24.
11. Bisson J, Andrew M. Psychological treatment of post-traumatic stress disorder (PTSD). Cochrane Database Syst Rev 2007, Issue 3. Art. No.: CD003388. DOI: 10.1002/14651858. CD003388.pub3.
12. Ilic A. EMDR in the treatment of posttraumatic stress disorder with prisoners of war. In: Špiric Z, Knezevic G, Jovic V et al, eds. Torture in war: consequences and rehabilitation of victims – Yugoslav experience. Belgrade: IAN, 2004:281-91.
13. Sikes C, Sikes V. EMDR: why the controversy? Traumatology 2003;9:169-81.
14. Stultz J. Integrating exposure therapy and analytic therapy in trauma treatment. Am J Orthopsychiatry 2006;76:482-8.
15. Schulz PM, Marovic-Johnson D, Huber LC. Cognitive-behavioral treatment of rape- and war-related posttraumatic stress disorder with a female, Bosnian refugee. Clin Case Stud 2006;5:191-208.
16. Hinton DE, Pham T, Tran M et al. CBT for Vietnamese refugees with treatment-resistant PTSD and panic attacks: a pilot study. J Trauma Stress 2004;17:429-33.
17. Regel S, Berliner P. Current perspectives on assessment and therapy with survivors of torture: the use of a cognitive behavioural approach. Eur J Psychother and Couns 2007;9:289-99.
18. Neuner F, Schauer M, Klaschik C et al. A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. J Consult Clin Psychol 2004;72:579-87.
19. Weine S, Kulauzovic Y, Klebic A et al. Evaluating a multiple-family group access intervention for refugees with PTSD. J Marital Fam Ther 2008;34:149-64.
20. Walsh F. A family resilience framework: innovative practice applications. Fam Relat 2002;51:130-7.
21. Woodcock J. Healing rituals with families in exile. Am J Fam Ther 1995;17:397-409.
22. Dybdahl R. Children and mothers in war: an outcome study of a psychosocial intervention program. Child Dev 2001;72:1214-30.
23. Snider L, Cabrejos C, Marquina EH et al. Psychosocial assessment for victims of violence in

Peru: the importance of local participation. J Biosoc Sci 2004;36:389-400.
24. Curling P. The effectiveness of empowerment workshops with torture survivors. Torture 2005;15(1):9-15.
25. Berliner P, Dominguez M, Kjaerulf F et al. What can be learned from "crazy" psychologists? A community approach to psychosocial support in post-conflict Guatemala. Intervention (Amstelveen) 2006;4(1):67-73.
26. Agger I, Jensen SB. Testimony as ritual and evidence in psychotherapy for political refugees. J Trauma Stress 1990;3:115-30.
27. Van Dijk JA, Schoutrop MJA, Spinhoven P. Testimony therapy: treatment method for traumatized victims of organized violence. Am J Psychother 2003;57:361-73.
28. Herbst PKR. From helpless victim to empowered survivor. Women Ther 1992;13(1):141-54.
29. McKinney K. "Breaking the conspiracy of silence": testimony, traumatic memory, and psychotherapy with survivors of political violence. Ethos 2007;35:265-99.
30. Laplante LJ. Women as political participants: psychosocial postconflict recovery in Peru. Peace and Conflict: J Peace Psychol 2007;13:313-31.
31. Agger I, Ansari F, Suresh S et al. Justice as a healing factor: psycho-legal counseling for torture survivors in an Indian context. Peace and Conflict: J Peace Psychol 2008;14:315-33.
32. Danneskiold-Samsøe B, Bartels EM, Genefke I. Treatment of torture victims – a longitudinal clinical study. Torture 2007;17:11-7.
33. Edmunds D, Gafner G. Touching trauma: combining hypnotic ego strengthening and zero balancing. Contemp Hypn 2003;20:215-20.
34. Gafner G, Benson S. Indirect ego-strengthening in treating PTSD in immigrants from Central America. Contemp Hypn 2001;18:135-44.
35. Johnson C, Shala M, Sejdijaj X et al. Thought field therapy – soothing the bad moments of Kosovo. J Clin Psychol 2001;57:1237-40.