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'Torture Syndrome': In search of a unique traumatic symptomatology for tortured treatment-seeking refugees

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Abstract

Background: Torture has a high traumatizing potential and is a strong predictor of PTSD. Thus far, interventions have only had little effect on treatment-seeking individuals who experienced torture, and a torture-related symptomatology has yet to be recognized.

Aim: This study aims to identify a torture-specific symptomatology among torture survivors from a treatment-seeking, refugee and asylum-seeking background, in order to optimize future interventions for this patient population.

Methods: CAPS-5 and the depression dimension of BSI were used in order to separately analyze symptoms of PTSD and depression for torture survivors and non-tortured refugees.

Results: A specific torture related symptomatology was not found. Most symptoms were found to vary between moderate to severe for both groups.

Conclusion: The results indicate that both groups are likely to experience severe PTSD symptomatology. Possible explanations for the similarity in symptoms include post and pre-migration stressors that increased symptom severity for both groups. Further research is needed in order to determine whether there is in fact a specific torture related symptomatology.

Key words: refugees, torture, post-traumatic stress disorder, depression, migration stress.

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Introduction

Torture is defined as deliberative infliction of acute pain or suffering caused by one person on another (United Nations, 1984). Torture can have different objectives, such as to oppress political activists, punish enemies, cause mental-defeat or humiliation, and is generally divided into two main categories - physical and psychological (Quiroga & Jaranson, 2005; 2008). Physical methods of torture aim to cause severe physical harm and can be extremely brutal (Hárdi & Kroó, 2011). It may include beating, burning and electric shocks (Defrin, Lahav, & Solomon, 2017). Psychological methods of torture inflict mental pain, usually without physical evidence, aiming to cause mental defeat and neutralize resistance (Hárdi & Kroó, 2011; Reyes, 2007). Psychological torture may include sleep deprivation, isolation, humiliation, rape and other forms of sexual torture (Defrin, Lahav, & Solomon, 2017; Reyes, 2007). Ehlers, Clark and colleagues (1998) propose that the infliction of trauma by one person on another, compromises the psychological integrity of the victim, causing them to mentally 'give up'. This mental defeat is characterized by one's feeling loss of human character, and will or concern about oneself, or loss of inner resistance to the acts of the perpetrator (Ehlers, Maercker, & Boos, 2000). Torture has many long-lasting possible psychological effects, such as affective symptoms (anxiety, depression, irritability, social withdrawal), cognitive symptoms (confusion, memory impairments, lack of concentration) and neuro-vegetative symptoms (nightmares, sexual dysfunction; Quiroga & Jaranson, 2005; Reyes, Elhai, & Ford, 2008). Torture differs from other types of trauma due to its repetitive nature, and the fact that it is inflicted premeditatedly by another person (Quiroga & Jaranson, 2005).

Torture is highly common in countries where forced migrants originate from (Sigvardsdotter, Vaez, Hedman, & Saboonchi, 2016). In a review analyzing health outcomes among populations exposed to mass conflict and displacement, high prevalence of reported torture was found, estimated at 21% (Steel et al., 2009). Refugees who survived torture have higher prevalence of psychological problems compared to non-tortured refugees (Başoğlu et al., 1994b; Silove, Steel, McGorry, Miles, & Drobny, 2002).

Refugees also tend to suffer from other stressors after migration, which can worsen their psychological problems (Steel et al., 2009). These can relate to inadequate accommodation, separation from family, financial difficulties, residence status, and

discrimination (Bogic et al., 2012; Schick et al., 2018). A possible reason for this can be the absence of defensive factors in the host countries, such as social support, which was found to provide psychological 'protection' from traumatic stress of tortured displaced persons (Başoğlu et al., 1994a). The lack of support may worsen feelings of helplessness and hopelessness which may increase stress (Başoğlu & Paker, 1995; Schweitzer, Melville, Steel, & Lacherez, 2006).

Among displaced populations - refugees and asylum seekers - torture constitutes one of the strongest predictors of Post-Traumatic Stress (PTS) symptoms (Başoğlu, 2009; Ibrahim & Hassan, 2017; Le Morina, Schnyder, Schick, Bryant, & Nickerson, 2018; Silove et al., 2002; Steel et al., 2009). PTS symptoms are common among torture survivors in a prevalence of 14-92% (Johnson & Thompson, 2008; Moisander & Edston, 2003). Additionally, refugees and torture survivors show high comorbidity of Post-Traumatic Stress Disorder (PTSD) and depression (Belz, Belz, Özkan, & Graef-Calliess, 2017; Nickerson, Schick, Schnyder, Bryant, & Morina, 2017); Schubert, & Punamäki, 2011). Refugees tend to suffer from various Potentially Traumatizing Events (PTE), which were found to be related to severe and highly severe PTSD (Jongedijk, Eising, Van der Aa, Kleber, & Boelen, 2020). PTSD symptomatology includes re-experiences of the traumatic event (such as intrusive memories, flashbacks and traumatic nightmares), avoidance of traumatic related stimuli (thoughts and conversations or activities, places and people), alterations in cognitions and mood, and alteration in arousal and reactivity (American Psychiatric Association, 2013).

Experiencing a large amount of traumatic events, or different types of traumas, were found to be connected to severe and highly severe symptoms of PTSD and depression (Jakob, Lamp, Rauch, Smith, & Buchholz, 2017; Jongedijk, Van der Aa, Haagen, Boelen, & Kleber, 2019; Knipscheer, Sleijpen, Mooren, Ter Heide, & Van der Aa, 2015; Renshaw, 2011). Severely traumatized individuals also exhibit anxiety, depression and somatization symptoms (Jongedijk et al., 2020).

While many researchers searched for the psychological effects of torture, or a 'torture syndrome' (Başoğlu & Marks, 1988; Elsass, 1998), a quantitative differentiation of these symptoms from PTSD has yet to be validated (Quiroga & Jaranson, 2005). Yet, there are various references for symptoms that were found to be related to severe traumatic experiences (Amstadter & Vernon, 2006; Ehlers & Clark, 2000; Le et al., 2018; Wenzlaff & Wegner, 2000) which could possibly indicate that there is a more specific symptomatology

related to torture survivors, regarding the cognitive or psychological process that follows this type of trauma.

During torture, the torturer impairs the victim's sense of security, integrity and self-worth, leading to feelings of betrayal and humiliation (Silove et al., 2002). As extreme types of trauma have a negative effect on the victim's core cognitions, it can disrupt their sense of personality (Dekel, Peleg, & Solomon, 2013; Reyes, 2007). This leads to an alteration in cognitions and mood - negative cognitions such as fear, anger, guilt, shame regarding the self, others and the world (e.g. 'the world is not safe', 'I am not capable'; Ehlers & Clark, 2000).

Another symptom that was found to be related to torture is suppression, characterized in avoidance from emotions or thoughts (Rassin, 2005). While often being referred to as a coping mechanism that follows a severe traumatic experience, the suppression of trauma-related thoughts can be another possible psychological mechanism of torture survivors (Wenzlaff & Wegner, 2000). Avoidance can be harmful for survivors of severe trauma such as torture, as it creates a negative cycle which ultimately results in increased experiences of intrusive symptoms and PTSD symptoms (Amstadter & Vernon, 2006; Wenzlaff & Wegner, 2000). Moreover, high thought-suppression might actually be experienced as dissociation (Nickerson et al., 2016; Rassin, 2005). PTSD with high dissociations may lead to PTSD with dissociative subtype (PTSD-DS). Dissociative subtype of PTSD includes depersonalization and derealization (in addition to PTSD criteria; APA, 2013).

There are more than a thousand different possible presentations of PTSD, emphasizing the difficulty that lies in its treatment. According to PTSD criteria of DSM-5, individuals with the same diagnosis could report remarkably different symptoms (Galatzer-Levy & Bryant, 2013). A recent meta-analysis, examining 15 published studies of interventions (psychological, social and welfare) of torture survivors between 2014-2019, concluded that there is only a small, though significant, decrease of PTSD symptoms after interventions, and none at follow up (Hamid, Patel, & Williams, 2019). This shows, that interventions which intend to treat general trauma might not be effective enough to reduce symptoms following torture. Therefore, disclosing the symptomatology of torture survivors can be useful in identifying the core symptoms of their psychological problems. By prioritizing these symptoms over others, clinical interventions can be optimized.

This study aims to investigate and expand the current knowledge of the psychological impact of torture (physical and psychological) in treatment-seeking population with a refugee background. The main aim of this research is to identify a specific torture-related symptomatology in order to increase the effectiveness of therapy for this population. Namely, whether in a population of treatment-seeking refugees and asylum-seekers, a difference can be recognized between PTSD and depression symptoms of torture survivors, and non-tortured individuals. Moreover, this study will specifically examine whether there is a difference in the dissociative subtype of PTSD. As mentioned above, previous studies indicate that torture survivors, in comparison to non-tortured refugees, may experience more negative alterations in their cognitions and mood, avoidance of torture related memories, that could lead to dissociations. Thus, our hypothesis is that torture survivors will experience PTSD, PTSD-DS, and depression symptoms in significantly higher severity than non-tortured refugees.

Methods

Participants and procedure

Participants were refugees and asylum seekers who reported having experienced traumatic events, and were referred to treatment in foundation Centrum '45 - a Dutch national mental health care institute specialized in complex psycho-trauma for diagnostics and treatment of patients with psycho-trauma-related disorders.

Data were primarily collected for diagnostic purposes before the beginning of treatment as part of a routine diagnostic assessment procedure. The data were archived anonymously for scientific research purposes. Participants were informed that this data will be used for research purposes and were given the opportunity to have their data removed from the database. Upon consultation, the institutional review board of Leiden University stated that no review of the ethical merits of this study was needed, and obtaining informed consent was not requisite, as assessments were conducted primarily for diagnostic and secondarily for research purposes.

The sample included 379 participants, exclusion criteria included incomplete information regarding torture status. 132 (34.8%) of participants were excluded from this database on this basis. Thus, after the exclusion, the sample included 247 participants, of which was 68.8% male, the mean age was 41 years (SD=11.7). Participants originated from 51 different countries.

Instruments

Torture

Torture experiences were assessed through a dichotomous (yes/no) reporting of clinicians who conducted the diagnostic procedure, according to participants' reporting.

PTSD symptoms and Dissociative Subtype (PTSD-DS)

To assess the severity of PTSD symptomatology, participants were interviewed using the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5; Weathers, Blake, Schnurr, Kaloupek, Marx, & Keane, 2013). The CAPS-5 is a 30-item interview to assess PTSD symptoms according to the DSM-5 criteria. 2 items test trauma experience and duration of symptoms (criteria A, F), 20 items test PTSD symptoms (criteria B, C, D, E), 3 items test functional

impairment (criteria G), and 2 items assess dissociative subtype (PTSD-DS). Symptoms are rated on 5-point Likert scale ranging from 0 (absent) to 4 (extreme/incapacitating). A symptom is considered present when rated 2 or higher. By summing the 20 symptom severity scores (criteria B–E), a total PTSD symptom severity score may be computed when ranging between 0 and 80 with higher scores indicating higher PTSD symptom severity. In addition, a dissociative subtype severity score is computed to range between 0 and 8. There is no cut off point within CAPS-5. For this study, every symptom was evaluated independently for severity, including PTSD-DS items. The CAPS-5 shows good psychometric properties, and has manifested high internal consistency (Cronbach's $\alpha = .88$) and interrater reliability (ICC = .91; Weathers et al., 2017). CAPS-5 was tested for cross cultural validity, and found to be adequate for culturally diverse populations (Boeschoten et al., 2018; Hinton et al., 2006; Charney & Keane, 2007).

Depression

Severity of depression symptoms was assessed by the depression dimension of the Brief Symptom Inventory (BSI; Derogatis & Spencer, 1993), a self-report measure to test psychological distress. The BSI consists of 53-items, rated on a 5-point Likert scale ranging from 0 (not at all) to 4 (extremely). The BSI includes 9 symptom dimensions: somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism.

In this study only the depression dimension was used. The total score for depression was calculated by computing the scores of the corresponding items, the scores range between 0 to 24. The BSI shows good psychometric properties (Franke et al., 2017). The BSI shows good reliability, Cronbach's alphas ranging from .71 to .85, and test-retest correlations ranging from .68 to .91 (Derogatis & Spencer, 1993). Specifically, the depression dimension shows good reliability (Cronbach's $\alpha = .87$; Franke et al., 2017). BSI was tested for cross cultural validity, and found to be adequate for culturally diverse populations (Franke et al., 2017; Hoe & Brekke, 2008).

Data analysis

In the present study, differences between groups of torture survivors and non-torture refugees were compared for symptoms of CAPS-5_total and BSI_depression. To indicate the

differences between torture and non-torture survivors, a comparison of means of severity symptoms was done by a Multivariate Analyses of Variance (MANOVA) test.

Participants who did not provide enough information as for whether or not they are torture survivors, were excluded prior to the statistical analysis. Additionally, demographics, symptoms means and standard deviations (SD) were analyzed. MANOVA assumptions were also tested.

In order to test the differences in PTSD symptoms severity, a separate MANOVA analysis was done for each of the CAPS-5 criteria in relation to differences in mean scoring between two groups of the dependent variable (tortured and non-tortured). Each criterion incorporates several symptoms- Criterion B (Recurrent, involuntary, and intrusive distressing memories of the traumatic event) includes 5 symptoms; Criterion C (avoidance of stimuli associated with the traumatic event) includes 2 symptoms; Criterion D (Negative alterations in cognitions and mood associated with the traumatic event) includes 7 symptoms; Criterion E (Marked alterations in arousal and reactivity associated with the traumatic event) includes 6 symptoms. Moreover, in order to test the differences between groups in relation to PTSD-DS, a MANOVA was conducted for two variables which represent the Dissociative Subtype of PTSD according to CAPS-5. In order to further test the alterations in cognitions and mood, a MANOVA analysis was done for the depression dimension of the BSI (includes 5 symptoms), in relation to differences in mean scoring between tortured and non-tortured groups. To interpret the MANOVA analysis, the Pillai's trace test was used as it is robust for MANOVA assumption violations. All data were analyzed using SPSS Version 23 (IBM Corp. Released, 2018), and all tests performed with α set at 0.05.

Results

Descriptive analyses

Eligible data collected at study were available for 72 subjects who reported to have experienced torture and 175 subjects who did not experience torture, from ages 18-74. Table 1 presents demographic characteristics of the study groups.

Table 1

Demographic characteristics of the sample

| Characteristic | Groups | |
|----------------------|---------------------|--------------------------|
| | Torture (n = 72) | Non-Torture (n = 175) |
| Age, <i>M (SD)</i> | 42.8 (11.6) | 40.23 (11.7) |
| Gender, <i>n (%)</i> | | |
| Male | 67 (93.1) | 103 (58.9) |
| Female | 5 (6.9) | 72 (41.1) |

Differences between groups

According to our hypothesis, we expected to find more severe symptoms for torture survivors, than non-tortured refugees, in the following criteria: Intrusive symptoms; avoidance of or efforts to avoid distressing memories, thoughts or feelings about or closely associated with the traumatic event(s); alterations of cognitions and mood; alterations in arousal and reactivity; PTSD-DS; and depression.

Before the main analysis, means and SDs of all PTSD and depression symptoms were analyzed (see Table 2). Mean scores for both groups in most symptoms were between moderate (2) and severe (3), 19 for torture survivors and 18 for non-tortured group, out of 29 symptoms of PTSD and depression in total, with none PTSD-DS symptoms. Most symptoms in the criteria of intrusion symptoms, avoidance, alterations of cognitions and mood, alteration in arousal and reactivity and depression were above moderate. The total mean of the severity score of PTSD was 39 for non-tortured refugees and 42 for tortured

survivors. In addition, the mean total score of depression was 15 for the non-tortured group and 16 for tortured group.

Prior to the MANOVA analysis, assumption testing was done and there were violations since variables in this study are measured in an ordinal scale and the dependent variables are not distributed normally. This test, however, is robust to those (Norman, 2010). MANOVA analysis did not reveal any significant differences between the two groups in all PTSD criteria: Involuntary, and intrusive distressing memories of the traumatic event (CAPS-5, criterion B), Pillai's trace=.024, $F(5,239)=1.16$, $p=.334$; avoidance of stimuli associated with the traumatic event (CAPS-5, criterion C), Pillai's trace=.007, $F(2,244)=0.9$, $p=.407$; negative alterations in cognitions and mood associated with the traumatic event (CAPS-5, criterion D), Pillai's trace=.037, $F(7,238)=1.32$, $p=.241$; marked alterations in arousal and reactivity associated with the traumatic event between groups (CAPS-5, criterion E), Pillai's trace=.031, $F(6,238)=1.25$, $p=.281$. MANOVA analysis did not reveal any significant differences in PTSD-DS between the two groups, Pillai's trace=.001, $F(2,239)=1.32$, $p=.876$. Additionally, both groups also did not differ in reported depression symptoms (BSI), Pillai's trace=.031, $F(6,238)=1.26$, $p=.275$.

Table 2*Means and SD's of CAPS-5 and BSI-Depression*

| Characteristic | Groups | |
|--|-----------------|---------------------|
| | Torture (SD) | Non-Torture (SD) |
| Intrusion symptoms | | |
| Intrusive distressing memories of the traumatic event(s) | 2.89 (.68) | 2.78 (.84) |
| Recurrent distressing dreams that are related to the event(s) | 2.86 (.82) | 2.55 (1.13) |
| Dissociative reactions | 1.46 (1.37) | 1.19 (1.29) |
| Psychological distress at exposure to internal/external cues | 2.5 (.75) | 2.44 (1.01) |
| Marked physiological reactions to internal/external cues | 2.36 (1.02) | 2.25 (1.05) |
| Avoidance of stimuli associated with the traumatic event(s) | | |
| Avoidance of distressing memories/ thoughts/ feelings | 2.32 (1.11) | 2.37 (1.0) |
| Avoidance of external reminders that arouse distressing memories/thoughts/feelings | 1.88 (1.35) | 1.66 (1.92) |
| Alterations in cognitions and mood | | |
| Inability to remember an important aspect of the traumatic event(s) | .31 (.78) | .17 (.59) |
| Negative beliefs/ expectations about oneself, others, or the world | 2.29 (1.2) | 2.31 (1.26) |
| Distorted cognitions about the cause / consequences of the traumatic event(s) | 1.32 (1.41) | 1.45 (1.3) |
| Persistent negative emotional state | 2.88 (.64) | 2.68 (.92) |
| Markedly diminished interest or participation in significant activities | 2.51 (1.11) | 2.27 (1.28) |
| Feelings of detachment or estrangement from others. | 2.36 (1.19) | 2.06 (1.32) |
| Persistent inability to experience positive emotions | 2.51 (1.51) | 2.41 (1.29) |
| Alterations in arousal and reactivity | | |
| Irritable behavior and angry outbursts | 1.56 (1.26) | 1.51 (1.18) |
| Reckless or self-destructive behavior | .33 (.87) | .30 (.81) |
| Hypervigilance | 2.01 (1.21) | 1.89 (1.32) |
| Exaggerated startle response | 1.82 (1.20) | 1.58 (1.20) |
| Problems with concentration | 2.68 (.90) | 2.47 (1.04) |
| Sleep disturbance | 3.17 (.76) | 2.83 (1.09) |
| PTSD-DS | | |
| Depersonalization | .32 (.81) | .35 (.87) |
| Derealization | .35 (.87) | .34 (.81) |
| Depression | | |
| Thoughts of ending your life | 1.44 (1.56) | 1.21 (1.41) |
| Feeling lonely | 3.17 (1.17) | 2.48 (1.29) |
| Feeling blue | 3.22 (.96) | 3.07 (1.12) |
| Feeling no interest in things | 2.89 (1.13) | 2.70 (1.29) |
| Feeling hopeless about the future | 3.0 (1.35) | 2.85 (1.33) |
| Feeling of worthless | 2.39 (1.48) | 2.42 (1.45) |

Note: all symptoms relate with traumatic event(s)

Discussion

This study aimed to discern a specific traumatic symptomatology for torture survivors. This, was specifically examined in relation to symptoms of PTSD, PTSD with dissociative subtype and depression, in a patient population of refugees and asylum seekers in the Netherlands. According to our knowledge, this is the first study which compared the severity of PTSD and depression symptoms separately, between tortured and non-tortured refugees; whereas previous studies focused on differences in prevalence rates of PTSD and other psychological problems as result of torture.

Main findings

As opposed to our hypothesis, the results of this study did not indicate significant differences in symptom severity between tortured and non-tortured participants in all symptoms, in all criteria of the PTSD assessment (intrusions, avoidance, alterations in cognitions and mood, alterations in arousal and reactivity). In addition, no significant difference was found between the groups in the assessment of symptoms of PTSD with dissociative subtype and depression. Thus, we could not find a specific torture-PTSD symptomatology that would be significantly different than PTSD and depression symptoms following other types of trauma.

Interestingly, some shared characteristics were found among the population in question. Levels of severity were unexpectedly found to be between moderate and severe in both groups for most symptoms of PTSD and depression. These results suggest that in a population of treatment-seeking refugees and asylum-seekers, participants are very likely to experience high severity of symptoms of PTSD and depression, regardless of whether or not they experienced torture. This implies that a refugee or asylum-seeking background can be enough to predict high severity of PTSD and depression symptoms. A support for this can also be seen in previous studies (Belz et al., 2017; Ford, Grasso, Elhai, & Courtois 2015; Miller & Rasmussen, 2017).

The results of this study refute previous studies which showed that torture survivors report PTSD and depression significantly more than non-tortured refugees. These studies showed that torture survivors were more likely to experience physical and psychological

problems than non-tortured refugees (Jaranson et al., 2004; Steel et al., 2009). Specifically, torture survivors showed significantly higher rates and severity of PTSD and depression scores than those who experienced other traumas (Başoğlu et al., 1994a; 1994b; Silove et al., 2002). In addition, intrusive thoughts, dissociations (flashbacks), nightmares and avoidance were found to be related to torture, but not to other traumatic experiences during or after captivity (Başoğlu, 1994b).

Nevertheless, possible reinforcements for our hypothesis can be partially identified in some of these previous studies. Başoğlu and colleagues (1994b) found that the severity of torture survivors' symptoms was only moderate. Additionally, Silove and colleagues (2002) showed that the effect size of the difference in PTSD severity between torture survivors and non-torture group decreased when controlling the number of traumatic events participants were exposed to. This may indicate that the difference in symptom severity between torture survivors and non-tortured refugees could in fact be less significant in a refugee population - as was found in this study.

The difference in our findings from previous studies, for instance, those of Başoğlu and colleagues (1994b) and Silove and colleagues (2002), may derive from the fact that they have tested different populations; the former examined a population of political activists (Başoğlu et al., 1994b), and the latter examined a specific refugee population (Silove et al., 2002), whereas this study examined a wide population of treatment-seeking refugees originating from 51 countries.

Explanations and theoretical considerations

A few explanations are possible for the lack of differences found in the traumatic symptomatology between torture survivors and non-tortured refugees. Overall, as the study examined the severity of each PTSD and depression symptom separately, the results may be more susceptible to change. This could possibly account for the difference in results from other studies, which examined general prevalence of PTSD and depression. We further devise four possible explanations for these results.

First, many refugees and asylum-seekers experience multiple severe pre-migration traumatic events, which may induce high symptoms severity of PTSD and depression also for individuals who did not experience torture. Previous studies show that the accumulative number of traumatic events, rather than the type of trauma, predict the severity of PTSD

and depression (Knipscheer et al., 2015; Steel, 2009). Moreover, refugees are likely to experience potentially traumatic pre-migration events during their seek for refuge, which was found to predict PTSD symptomatology (Chen, Hall, Ling, & Renzaho, 2017; Schweitzer et al., 2006). The high severity of PTSD among refugees could lead to a kind of a 'ceiling effect', which erodes the differentiation between tortured and non-tortured participants. Therefore, the severity of PTSD and depression in our study may originate from multiple traumatic events that participants experienced, and not necessarily due to torture.

Second, the 'ceiling effect' of symptoms severity may also be seen in the effects of post-migration events, which may increase the susceptibility to PTSD and depression of refugees regardless of whether or not they experienced torture. It was shown that the combination of war trauma and post-migration stressors has a negative effect on psychological wellbeing (Miller & Rasmussen, 2017). In addition, resettlement-related-post-migration stressors (loneliness, discrimination, family conflicts, etc.) and employment problems are related to PTSD and severe mental illness (Chen et al., 2017). The severity of PTSD and depression was also found to be predicted by the lack of refugee status (Knipscheer et al., 2015). Therefore, it is plausible that these stressors contributed to the high severity of PTSD and depression symptoms reported by the participants in this study, thus revoking the differences between tortured and non-tortured refugees.

A third possible explanation suggests social support as a variant that may have affected the symptom severity of the participants in this study. The presence of social support, family members, and support from the community, significantly determinants mental health functions (Schweitzer et al., 2006). It may provide protection against PTSD following war trauma and torture (Başoğlu, 1994a; Gottvall, Vaez, & Saboonchi, 2019; Johnson & Thompson, 2008; Siriwardhana, Ali, Roberts, & Stewart, 2014), as it contributes to feelings of safety, belongingness, and social inclusion (Gifford, Correa, & Sampson, 2009). As many torture survivors develop deep distrust in others as a result of the torture they experienced (De C Williams & Van der Merwe, 2013; Silove, 1999), social support could be even more beneficial in helping them regain their trust in others (Gottvall, Vaez, & Saboonchi, 2019). Refugees resettling in the Netherlands have reported seeking social support from family, friends, organizations, and social media platforms, which have helped them feel more in control over their lives (Udwan, Leurs, & Alencar, 2020). Therefore, in this case, it may be that even if the torture survivors suffered from higher severity of symptoms,

the social support they received reduced their severity, leading it to match the severity of the non-tortured group.

Finally, post-traumatic-shame, or survivor-shame, could also explain the absence of differences between torture survivors and non-tortured refugees. Survivor-shame occurs among victims of traumatic events and is usually connected to the nature of the traumatic event itself (Taylor, 2015). Shame typically 'tries to hide itself' – people who feel ashamed usually avoid talking about it and try to conceal it (Sanchez, & Zahavi, 2018). Specifically, it was also shown that torture victims may not be able to communicate experiences they are deeply ashamed of (Vorbrüggen & Baer, 2007). In most cases, a long therapeutic relationship and fundamental trust are needed to break the silence (Oravec, Hardi, & Lajtai, 2004), as shame impacts negatively on the therapeutic alliance (Black, Curran, & Dyer, 2013; Taylor, 2015). Therefore, participants who experienced torture could be ashamed to share details regarding their torture-related experiences, which in turn could lead to inaccuracies in the manner symptoms are expressed. Thus, torture-survivors may report lower severity of symptoms than they have actually experienced during the psychological assessment period, which was when data were collected for this study.

Clinical implications

This study functions as a primary step for a better understanding of the specific symptomology of torture survivors. As the results of this research were insignificant, clinical implication should be drawn cautiously. Yet, the results of this study allow to suggest clinical implications that could benefit torture survivors, refugees, and asylum-seekers.

As the torture survivor group showed high symptom severity, torture experiences should be approached in treatment in order to reduce symptom severity for this population. Yet, since all participants in this study showed high severity of symptoms, we also see a benefit in interventions which are not oriented to a specific trauma - but to traumatic events in general, before and after their migration. The magnitude of the traumatic events should also be considered. Thus, an intervention such as Narrative Exposure Therapy (NET), which was found to be highly effective for the reduction of severe symptoms for the population of torture survivors, refugees and asylum-seekers, would be advised (Halvorsen & Stenmark, 2010; Neuner, Elbert, & Schauer, 2018).

In addition, as post-migrations stressors also take a psychological toll on refugees and asylum seekers, interventions could include preventive measures for many of the stressors they face, such as acculturation in the community that will decrease isolation and increase accumulation, assistance in employment seeking, and assistance in the prolonged process of obtaining a visa. Access to social services was found to be related to a reduction in PTSD symptoms, for torture survivors and asylum seekers, even if the support was not necessarily trauma-focused (Kashyap, Page, & Joscelyne, 2019).

Strengths and limitations

A number of limitations for this study should be acknowledged. First, the generalizability of the results is limited to treatment-seeking, traumatized refugee populations. Second, the diagnostic procedure was done according to western criteria and by a western clinician. Although these measures were tested for cross-cultural validity, the western diagnostic criteria might not apply in the same manner for individuals from non-western cultures, and to highly traumatized population (Campbell, 2007; Raghavan, Rosenfeld, & Rasmussen, 2015). Third, although women were found to be tortured as often as men (Jaranson et al., 2004), this was not reflected in the population of this study. Therefore, it would be beneficial to aim for a more balanced sample in terms of gender.

Some of the strengths of this study lies within the separate examination of PTSD and depression symptoms, which according to our knowledge was made for the first time. Through this, we could indicate the different severity, or absence, of symptoms for this study's population. Additionally, this study supports previous studies which report high traumatization of refugee population. Finally, the study represents a high variety in participants' origin countries, which contribute to the generalizability of the results.

Future research

Further research is needed to establish whether there is a specific torture-related symptomology. A few recommendations include the following: First, future assessment should distinguish between symptoms that originate from potentially traumatizing pre-migration and post-migration events, and control them in order to isolate and better understand the impact of torture. Second, to better assess the severity of symptoms, variables that could possibly effect results, such as shame and social support, should be

collected in the data. Additionally, studies should aim to tackle the shame of torture survivors by building a therapeutic alliance before the assessment. Additional studies should also take into account that assessment should be done with more caution and sensitivity in regard to cultural differences that may implicate the results. Finally, it would be advisable to use a larger sample, for a more comprehensive perspective.

Conclusion

The results of this study indicate that in a treatment-seeking refugee and asylum-seeking sample, experience of torture does not reflect in a different PTSD and depression symptomatology. Within this population, severe symptoms of PTSD and depression were reported regardless of whether or not torture has been experienced. As it was expected to find specific torture-symptomatology, possible explanations have been suggested for the opposing results. It is possible that in this sample, participants have experienced many potentially traumatic events, both before and after their migration, which have increased the severity of symptoms in both groups, thereby making it difficult to distinguish between the effects of tortured and non-tortured refugees. Additionally, social support was seen as an important factor to reduce PTSD symptoms, specifically among tortured survivors due to their past experiences. Eventually, this could have resulted in balanced severity levels in both groups. Finally, as torture victims may not be able to communicate experiences they are deeply ashamed of, this could have led them to report on a symptomatology less severe. In order to find torture-related symptomatology in refugee and asylum-seeking population, further studies should use a larger sample, and test the effects of pre and post-migration stressors as moderators in the association between symptom severity and torture.

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