
Classifying the Torture Experiences of Refugees Living in the United States

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Few research studies have systematically categorized the types of torture experienced around the world. The purpose of this study is to categorize the diverse traumatic events that are defined as torture, and determine how these torture types related to demographics and symptom presentation. Data for 325 individuals was obtained through a retrospective review of records from the Bellevue/New York University Program for Survivors of Torture. A factor analysis generated a model with five factors corresponding to witnessing torture of others, torture of family members, physical beating, rape/sexual assault, and deprivation/passive torture. These factors were significantly correlated with a number of demographic variables (sex, education, and region of origin). Post Traumatic Stress Disorder, anxiety, and depression symptoms were significantly correlated with the rape factor but no other factors were uniquely associated with psychological distress. The results offer insight into the nature of torture and differences in responses.

Keywords: *torture; refugee mental health; factor analysis*

Reports in the media of international human rights violations have become an all-too-frequent occurrence. In 1996, Amnesty International estimated that government-sanctioned torture was occurring in one third of all of the countries in the world (Thomsen, Eriksen, & Smidt-Nielsen, 2000). The World Medical Association provided a broad definition of torture, known as the Declaration of Tokyo, stating that torture is “the deliberate, systematic or wanton infliction of physical or mental suffering acting alone or on the

orders of any authority, to force a person to yield information, to make a confession, or for any other reason” (Gerrity, Keane, & Tuma, 2001, p. 6). This broad definition of torture encompasses numerous types of abuse, as evident from the growing literature describing the torture experiences of particular subgroups of refugees and asylum seekers (e.g., Basoglu, Ozmewn, Tademir, & Sahin, 1994; Mollica, Wyshak, de Marneffe, Khuon, & Lavelle, 1987; Tang & Fox, 2001).

Researchers interested in the effects of torture have typically differentiated between physical assault, psychological abuse, and war-related trauma, using these three categories to describe the torture experience (Shrestha et al., 1998; Weinstein, Dansky, & Iacopino, 1996). Types of physical assault include, but are not limited to beatings, sexual assault and rape, electric shock, burning, forced standing, hanging by the wrists, asphyxiation, not being allowed to use the bathroom or clean one’s body (i.e., hygiene deprivation), and exposure to bright light (Basoglu et al., 1994, Holtz, 1998, Thomsen et al., 2000, Weinstein et al., 1996). Psychological torture types, on the other hand, typically involve aversive experiences in which corporal pain is not directly inflicted on the victim. These trauma types may include threats of death or physical torture, being stripped naked and other forms of humiliation, extensive solitary confinement, being forced to witness violence (including toward one’s family members), and sensory deprivation (Basoglu et al., 1994; Holtz, 1998; Shrestha et al., 1998). War-related trauma differs from other forms of torture in that the individual is not necessarily the direct target of persecution nor is a confession or behavior change the goal of the assault, yet these individuals experience many of the same psychological repercussions as those who suffer physical and psychological abuses. The experiences encompassed by war-related trauma typically include a lack of food, water and shelter, experiencing the death or disappearance of close friends or family members, exposure to combat and dead bodies (Hinton, Ba, Peou, & Um, 2000; Weine et al., 1995).

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As evident from the varied descriptions of torture and war-related trauma, these broad and potentially overlapping categories encompass a wide range of different experiences, some of which may have unique physical and psychological consequences. In addition, many of the traumatic experiences refugees describe occur in both individual torture experiences as well as combat situations (e.g., rape and sexual assault, death or disappearance of friends and family members). Thus, these intuitively appealing categories of torture and war-related trauma may not offer the best description of torture experiences for researchers interested in studying the psychological effects of abuse. More sophisticated methods of classifying torture/refugee trauma might be useful in identifying specific physical and psychological consequences and guiding clinical interventions. Likewise, regional differences may exist in the types of torture used that have implications for later psychological adjustment.

Two notable studies have used a factor analytic approach to categorize torture experiences. Cunningham and Cunningham (1997) used a principal components factor analysis of reported traumas to assess the relationship between torture experiences and DSM-IV diagnoses. The 191 participants in their study had fled various countries in Asia, Europe, and Africa and were receiving services at a torture treatment center in Australia. They identified six factors but were unable to interpret some of these factors because of the lack of a clearly defined theme. The factors they did identify were labeled as follows: "common torture" (i.e., beating, isolation, threats, bondage), "torture of family members," "fear of death" (e.g., mock executions, near-drowning), and "passive torture" (e.g., being blindfolded, forced standing, and sleep and water deprivation). Two factors did not have any apparent similarities among the items and could not be interpreted. Although the researchers analyzed possible relationships between specific torture experiences and psychological distress, they did not report any relationships between these trauma factors and psychological symptoms.

More recently, Silove and colleagues (Silove, Steel, McGorry, Miles, & Drobny, 2002) studied traumatic experiences in 196 Tamil refugees from Sri Lanka using a principal components analysis of the Harvard Trauma Questionnaire (HTQ; Mollica, et al., 1992). The authors identified five distinct trauma factors that they labeled "torture" (which the authors did not further define), "persecution" (e.g., imprisonment, kidnapping, and forced separation), "suffocation and loss of consciousness," "exposure to violent death," and "war exposure." The authors noted that Post Traumatic Stress Disorder (PTSD) symptoms were significantly associated with the "persecution" and "torture" factor scores, suggesting that these types of experiences

are more likely to lead to PTSD symptoms. Unfortunately, this study focused solely on PTSD symptoms rather than analyzing a more broad range of possible psychological symptoms (e.g., depression, anxiety). Moreover, Silove et al., (2002) did not address the differences between their findings and those of Cunningham and Cunningham (1997). For example, Cunningham and Cunningham (1997) found a distinct “family torture” factor whereas Silove et al. (2002) included violence against family members as part of a larger “exposure to violent death” factor. Furthermore, Silove et al. described a “war exposure” factor (clearly relevant to their sample) but did not observe a “passive torture” factor that was observed by Cunningham and Cunningham. However, it is not clear whether these differences in factor structure reflect the nature of the two samples (Silove et al. included only Tamil refugees whereas Cunningham and Cunningham used a heterogeneous sample), the inclusion of different trauma items in their analysis (e.g., there were no deprivation items in the measure used by Silove et al., so no such factor could be found).

The present study sought to further the existing literature by addressing several shortcomings in the two past studies. By using a large, heterogeneous sample of refugees and asylum-seekers who had experienced torture and an extensive and widely-recognized classification system to categorize types of traumatic events (the Huridocs codes; Dueck et al., 1993), we attempted to better represent the different patterns of torture/trauma experiences in this population. In addition, we analyzed the relationship between the types of torture/trauma observed in our factor analysis and a broad range of psychological symptoms including anxiety, depression, and PTSD.

Method

Participants

Participants were obtained through a retrospective review of records from the Bellevue Hospital/New York University Program for Survivors of Torture (PSOT) in New York City. This program was established in 1995 to offer aid to immigrants, refugees, and asylum-seekers that had experienced torture and other types of severe trauma in their native countries. The program offers a variety of services, including medical interventions, group and individual psychotherapy, psychiatric care, English classes, social services, as well as aid in finding housing, employment, and legal matters. The program receives referrals from social service agencies, community organizations, hospitals, and clinics, as well as human-rights organizations

such as the Lawyers Committee for Human Rights and Physicians for Human Rights. This current sample includes all participants in the program who began receiving services between May 2000 and March 2003. Because the study was archival, participants did not provide informed consent although the study was approved by the New York University Institutional Review Board.

Procedures

A semi-structured interview was used to gather information from participants as they entered the PSOT. The intake interview elicited demographic information such as age, place of birth, religion, marital status, family members, asylum status, and level of education. The intake interview also included a narrative of the participant's history of torture, persecution, and other traumas, as well as specific inquiries about whether several types of traumas were experienced (e.g., separation from family members, witness to torture, arrest or detention). Each participant was administered two self-report symptom-rating scales, the HTQ (Mollica et al., 1992) and the Hopkins Symptom Checklist (HSCL-25; Mollica et al., 1987). Both the HTQ and the HSCL-25 are self-report rating scales for PTSD (the HTQ), depression, and anxiety (the HSCL-25) symptom severity that have been widely used in studies of refugee mental health (Hollifield et al., 2002). The intake assessments were conducted by PhD staff members at the PSOT or master's level graduate students. All interviewers were thoroughly trained in advance of conducting any intake interviews and received regular supervision by experienced clinical staff. If the interviewer and participant did not speak a common language, a faculty translator in the participant's native language was used. Translated versions of the HTQ and HSCL were used for participants who spoke French, Spanish, Bosnian, Fulani, and Tibetan. Translation/back-translation was used in adapting these measures for other languages, although validation data for these translated versions varied. The reliability of these translated measures is cited in a previous study (Keller et al., 2006). Individuals who spoke other languages used the instruments as translated by the interpreter. Although this method of translation did not account for standardization of cultural background of these individuals, the interpreted measures may still provide worthwhile information. Nonetheless, the data from the translated measures must be interpreted cautiously.

Data regarding types of torture and other traumatic experiences that were elicited during the intake evaluation were coded according to Huridocs format (Dueck, 1993). Some individual types of torture were subsequently collapsed into slightly broader categories when the frequency was sufficiently

low as to preclude meaningful analysis (i.e., $n < 10\%$ of the total sample). For example, receiving burns through cigarettes, boiling water, or chemicals were collapsed into the general category of burns. Similarly, slapping, punching, and kicking were collapsed into the category "assault with hand or foot." This process generated 20 trauma categories: burns, rape, other sexual assault, beating with an object, assault with hand/foot, unspecified beating, stress to the senses, harassment, family harassment, death threats, other threats, food and water deprivation, other deprivation, family tortured, witness to violence/torture against family, witness to violence/torture against others, seeing dead bodies, forced to work, living in hiding, and other physical discomfort (i.e., suspension, forced standing, and other forced postures). These categories represented dichotomous (yes/no) variables. Although all of these events are not necessarily torture (i.e., living in hiding), the remainder are typically encompassed by war-related trauma.

Statistical Analysis

Principal components factor analysis with Varimax rotation was used to identify which types of the 20 separate traumatic events experienced by this sample could be grouped together in meaningful categories. Because we had no a priori expectations as to the optimal factor structure, we opted to use an exploratory approach that would maximize the discrimination among factors. The appropriate factor solution was determined through an examination of eigenvalues, the scree plot, and factor loadings (discussed below). Individual trauma types with a factor loading of .40 or greater were considered significant items on each factor. Factor scores (the number of traumas in each factor experienced by an individual, without regard to factor weights) was then used to identify significant correlates. We used *t*-tests, ANOVA, and frequency analyses (Chi-Square test of association) to determine which socio-demographic (e.g., age, gender, region of origin) or clinical variables (depression, anxiety, and PTSD severity) were significantly associated with trauma types (i.e., factor scores).

Results

Sample Characteristics

During the 34-month study period, a total of 325 total patients between the ages of 18 and 72 ($M = 33.5$, $SD = 9.7$) completed intake assessment.

The sample has been described in detail elsewhere (Keller et al., 2006) and is only summarized in brief here. The sample contained 199 males (61.2%) and 126 females (38.8%). The largest proportion of subjects came from Africa (59.1%, primarily Sierra Leone, Guinea and other parts of West Africa) and Asia (26.5%, primarily Tibet). The sample was primarily Muslim (43.7%), Buddhist (22.8%), or Christian (27.7%). Most participants were currently married (56.0%) and the average number of dependents was 1.8 ($SD = 2.3$).

The most common types of torture reported were general harassment (reported by 291 of 325 participants, 89.5%), family harassment ($n = 276$, 84.9%), witness to violence or torture to others ($n = 276$, 78.5%), torture of family ($n = 255$, 68.0%), living in hiding ($n = 216$, 66.5%), seeing dead bodies ($n = 172$, 52.9%), and witnessing violence or torture to one's family ($n = 171$, 52.6%). The average number of torture/traumatic experiences coded for each participant was 7.4 ($SD = 2.2$, range: 1 to 13). The reported traumatic experiences by this sample are detailed in Table 1.

Factor Analysis

Principal components factor analysis generated eight factors with eigenvalues more than 1.0. However, some of these factors had zero or only one trauma type loading on the factor and an examination of the scree plot indicated that four, five, or six factor solutions would be more appropriate. A four-factor model offered clear delineations of the trauma types, but there was a great deal of variance that was unaccounted for (the model accounted for 36.9% of variance) and a number of traumas that did not load on any factor. A five-factor solution helped account for more variance than the previous model (an additional 6.2%), generated factors that each included multiple trauma types, and left only two trauma types with no significant loading. Adding a sixth factor account for more variance than the five-factor solution (5.8%) but produced a much less coherent model with no strong loadings on the sixth factor. As a result, a five-factor solution was deemed the best fitting model and is described below. This solution accounted for 43.11% of the total variance, with all factors having eigenvalues above 1.46. The loadings for each of the five factors are listed in Table 2.

The first factor in this solution was labeled the "witnessing trauma" factor, as the traumatic events with the highest loadings consist of experiences in which the participant saw someone else who had experienced torture and violence. The second factor was labeled the "family torture" factor, as the

Table 1
Types of Trauma

Trauma	<i>N</i>	%
Harassment	291	89.5
Family harassed	276	84.9
Witness violence/torture to others	255	78.5
Family tortured	221	68.0
Lived in hiding	216	66.5
Saw dead bodies	172	52.9
Witness violence/torture to family	171	52.6
Unspecified beating	145	44.6
Beating with object	112	34.5
Forced to work	110	33.8
Food/water deprivation	59	18.2
Rape	59	18.2
Death threat	53	16.3
Other physical assault besides beating	51	15.7
Threats (not involving death)	48	14.8
Beating with hand	43	13.2
Other sexual assault	35	10.8
Burns	30	9.2
Stress to senses	29	8.9

significant loadings included those traumas involving a family member (e.g., witness torture to family, family harassed). The third factor, labeled the “beating” factor, included a number of types of physical assault. The fourth factor was the “rape/sexual assault” factor (“other sexual assault” was included in this factor even though it did not reach the 0.40 criterion). The fifth factor included burns, deprivation, and threats, but was labeled “deprivation” because the two highest loadings were food/water deprivation and other forms of deprivation (e.g., deprivation of medical care and deprivation of hygiene or sanitation). Stress to the senses, which included blindfolding and exposure to loud noises or bright lights, and living in hiding did not load significantly on any of the five factors.

Analysis of Factor Differences

To explore differences between these groups of torture survivors, *t*-test statistics and ANOVA analyses were calculated for demographic variables and clinical variables. Four of the factors showed significant differences in

Table 2
Principal Component Analysis of Trauma Events

Variable	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
Witness violence to family	.497	.563			
Witness violence to others	.660				
Saw dead bodies	.749				
Forced to work	.475				.401
Harassment		.522			
Family harassed		.744			
Family tortured		.711			
Beating with object			.675		
Beating with hand			.582		
Unspecified beating			-.821		
Rape				-.658	
Other sex assault				.341	
Other physical assault				.544	
Death threats				-.404	
Threats					-.561
Burns					.439
Food/water deprivation					.469
Other deprivation					.465
Stress to senses	Did not load on any factor				
Lived in hiding	Did not load on any factor				

Note: Only factor loadings more than .40 are listed.

prevalence by gender. Women experienced significantly more traumas than men in the family torture category, $t(322) = 2.74$, $p = .01$, and the rape/sexual assault factor, $t(314) = 5.34$, $p < .0001$. Conversely, men experienced significantly more traumas in beating and deprivation factors than women, $t(316) = 4.74$, $p < .0001$ and $t(322) = 4.42$, $p < .0001$, respectively. There were no differences by gender in the frequency of witnessing torture. Married individuals also experienced significantly more traumas in the family torture factor than did unmarried individuals, $t(315) = -2.15$, $p = .011$; no other associations with marital status were observed. Level of education was negatively correlated with witnessing torture, $r = -.14$, $p = .011$, and family torture, $r = -.12$, $p = .034$; more educated participants reported fewer of these experiences than less educated participants. Number of dependents was significantly correlated with both witnessing torture, $r = .11$, $p = .042$, and family torture, $r = .13$, $p = .032$.

Regional differences were calculated by classifying individuals according to region of origin (Africa, Asia, South/Central America, and Europe). A one-way ANOVA with post hoc analysis (Tukey HSD, using $\alpha < 0.05$) indicated that African clients were overrepresented in the witness torture factor, $F(3, 311) = 10.11, p < .0001$. No other regional differences were observed. In addition, no significant differences in torture factors were found for religion, age of immigration, or age of first torture experience.

We examined scores on the PTSD symptom severity scale of the HTQ, as well as the depression and anxiety subscales of the HSCL to determine whether there was a differential psychological symptom response based on torture experiences. The only significant finding from these analyses was for the rape/sexual assault factor, which was significantly correlated with all three of these symptom distress measures. Specifically, scores on the rape/sexual assault factor (which also included death threats) were positively correlated with severity of anxiety symptoms, $r = .20, p = .0004$, depressive symptoms, $r = .16, p = .005$, and PTSD symptom severity, $r = .27, p < .0001$. None of the other factors were significantly correlated with any of these symptom scales. Moreover, there was no correlation between the number of torture/trauma types reported and severity of psychological symptoms. Considering the high rate of traumatic experiences reported by our sample (an average of 7.4 types of trauma per person), however, we examined the correlation between number of traumas and demographic variables. Number of torture experiences was significantly correlated with marital status ($r = .15, p = .049$). Additionally, a one-way ANOVA with post hoc analysis (Tukey HSD, using $\alpha < .05$) indicated that participants from Africa experienced significantly more trauma events than those from Asia, Eastern Europe, and South America, $F(3, 315) = 6.34, p < .0001$. No other demographic variables were significantly correlated with number of experienced traumas.

Discussion

The purpose of this study was to describe and categorize the different types of torture that are encountered in various regions of the world to identify patterns of torture experience. As expected, meaningful groupings emerged within the types of torture experienced by our sample, and these groupings (factors) were quite similar in many respects to the clinical distinctions that have often been drawn. Thus, the results of this study provide empirical support for a number of clinically useful distinctions, such as

between witnessing torture, physical assault, and sexual abuse. Moreover, these various patterns of torture experience appeared to have differential ramifications on the mental health functioning of survivors, with some experiences seeming more psychologically damaging than others.

The factor analysis offered a relatively clear five-factor solution, including witnessing torture, family torture, beating, rape/sexual assault, and deprivation. The trauma events within each factor appear similarly associated, despite a few aberrations. Notably, there are a few negative factor loadings of trauma events (e.g. rape and unspecified beating) that are puzzling, and likely reflect the response style of participants (i.e., participants who endorsed experiencing rape may have failed to endorse other types of sexual assault), focusing solely on the more severe assault within any given category. Additionally, death threats also loaded negatively on the rape/sexual assault factor along with rape, perhaps suggesting that sexual assault usually does not involve a feeling of closeness to death, whereas rape does. Nevertheless, the factors observed here appeared both intuitively meaningful and psychometrically robust, supporting the use of such delineations in subsequent research efforts.

In examining the correlates of these factors, a number of important findings emerged. For example, individuals who reported more of the experiences included in the rape/sexual assault factor also endorsed higher rates of psychological distress. Previous research on the impact of sexual assault supports this finding, noting that this type of trauma is particularly damaging psychologically. For example, in a large sample of U.S. women who had experienced a variety of traumas, Resnick, Kilpatrick, Dansky, Saunders, and Best (1993) found that “the highest rates of PTSD were associated with physical assault and rape” (p. 989). Breslau, Davis, Andreski, and Peterson (1991) also found that PTSD had a higher association with rape than with any other type of trauma. Considering that rape and death threats are both negatively loaded on this factor, the potential for death may contribute to the increased severity of psychological distress in rape. Whereas the other types of refugee trauma may be psychologically and physically damaging, encountering sexual assault during trauma (usually involving physical assault) is more likely to result in severe psychological distress.

Equally interesting is the lack of association between several of the factor scores and psychological distress. Many previous researchers have found that individuals who experience greater numbers of traumatic events have higher levels of psychological distress. Yet, the lack of association between several of the factors identified in this study suggests that the severity of individual traumas may be more important than the sheer

volume of different trauma types (despite the greater ease in quantifying types of trauma compared to severity). Without a much more thorough analysis of specific traumatic events than is possible in a broad-based survey such as this, important individual differences in the torture experience will undoubtedly be obscured. Nonetheless, a preliminary exploration of the nature of torture experiences at the macro level provides some guidance as to the nature of traumatic experiences and the effects of these events on mental health functioning.

The factor structure obtained in our sample is quite similar to those observed in two previous factor analyses (Cunningham & Cunningham, 1997; Silove et al., 2002). For example, the family torture factor found by Cunningham and Cunningham is virtually identical to the analogous factor we identified and the witness to torture and deprivation factors they observed were also quite similar. On the other hand, Silove et al. (2002) found an exposure to death factor that included both family and witnessing torture experiences, whereas these factors were distinct in our factor analysis. There were also some differences among the factors identified in these three studies, such as the presence of a sexual assault factor in our study that was not present in previous research.

We also observed a number of interesting demographic and regional differences in the types of torture experienced by our sample. For example, males endorsed significantly more types of physical beatings whereas women were more likely to endorse sexual assault and family-related traumas. Torturers may be more likely to use sexual assault with women as opposed to men, explaining part of the gender differences. Future research should examine why women experienced more family-related traumas. Individuals from Africa were also more likely to report witnessing torture experiences than were individuals from other regions, likely because of the frequent war-related violence that has plagued West Africa (where most of these individuals were from). Torture survivors from Africa and those who were married also experienced higher numbers of trauma experiences than those from other regions and those not married. Although Africans may experience more trauma events, this finding may also reflect the high proportion of participants from Africa included in this study. Married participants may experience more trauma events as a result of potentially greater family size for these individuals, increasing the likelihood that a family member would be subjected to torture. The findings regarding level of education, while significant, are somewhat harder to interpret, although they may reflect disadvantaged living conditions and cultural discrimination practices. For example, more educated individuals may live in more affluent

areas, where they may avoid war-torn living conditions. Additionally, individuals who were tortured may belong to an oppressed social group, who were offered less opportunity for education. Further research exploring this possible explanation is clearly necessary.

Despite the interesting findings reported here, a number of methodological limitations in this study may affect the results and their interpretation. Most importantly, traumatic events were solicited largely through open-ended questions rather than with a specific, validated checklist. Moreover, interviewers only coded up to five types of physical abuse (although many more types of torture experiences were coded in total), possibly underestimating the range of physical torture experiences that occurred. Although many individuals did not provide even five different types of torture experiences, others may have experienced many more that were not recorded. Thus, the data reported here may not accurately reflect of the actual frequency of some types of abuse. Additionally, relying on translated measures with limited validation measures might have misrepresented psychological symptoms reported by a minimal number of participants. Although translation/back-translation methods were often used, the validity of these measures may vary.

It is also unknown whether the sample in this study is representative of torture survivors all over the United States or even in New York City. It is also possible that these participants were more distressed or impaired than other torture survivors, accounting for why they were seeking services at the PSOT, perhaps skewing the sample toward greater impairment. Although individuals from Africa were found to experience more types of traumas than those from other regions, specifically more witness trauma types, these findings may overestimate actual experiences because of the large proportion Africans included in this study (59.1%). Additionally, traumas encountered only during or since the migration process were not included in this analysis, even though some of these experiences may have been severe (e.g., prison). Many refugees are separated from their families and lived in undesirable conditions on their arrival to the United States, and these experiences might negatively affect their psychological functioning. Further research might improve on our understanding of the impact of torture by better measuring post-migration experiences.

Another limitation in this study was the absence of data specifically addressing potential mediating or protective factors. Psychological response to a trauma no doubt differs depending on individual and situational characteristics. Past research has found that family support may act as a protective factor against developing severe psychological symptoms as a result of

torture (Basoglu et al., 1994). Research has also found that individuals who expected to be tortured experienced less severe PTSD symptoms than those who were not expecting torture, as the former group was psychologically prepared for the torture experience (Basoglu et al., 1997). Additional research focusing more specifically on the individual and social factors that might mediate psychological responses to torture is clearly needed.

Despite these limitations, the present study is the largest analysis of the torture experience in a diverse, relatively heterogeneous sample and the first to use the Huridocs coding system that is widely accepted by torture treatment programs. In addition, this study presents the first attempt to identify meaningful and distinct factors of torture survivors who differ in terms of their experiences. These findings have important implications for conceptualizing and treating torture survivors. The apparent finding that similarly high levels of distress was often independent of the number of traumas experienced (with the exception of the rape/sexual abuse factor) suggests that treatment providers should be vigilant to possible psychological distress even when the individual has not experienced any physical assault his or herself. Finally, our finding that sexual assault is related to increased psychological distress indicates the continued need for the allocation of resources for the prevention of torture.

The importance of understanding the torture experience, both from a survivor perspective (i.e., which types of events are more or less traumatic) as well as from a psychopathology perspective (i.e., are there specific traumatic events that have unique and identifiable repercussions) is becoming increasingly clear as the literature on torture and political trauma evolves. As research continues to examine the types of torture experienced in different parts of the world, efforts to establish preventative social policy may be improved. By identifying patterns of torture and response, more focused interventions may emerge that have stronger beneficial effects for those individuals who have survived these often-horrific experiences.

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