



Research Article

Transcultural aspects in the treatment of posttraumatic and situational distress among middle eastern refugees

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Abstract

The increasing size of displaced populations seeking protection in third countries, should be considered in public health and especially in Psychotherapy in that countries. Refugees from the Middle East, usually from collective cultures, require special skills and modifications in the treatment setting. The cultural formulation (CF) of illness and suffering, as described in the recent version of medical standard manuals, is part of this challenge. Besides bridging cultures, the specific nature of trauma, especially highly complex issues such as a genocidal environment, - in our case example - the both transgenerational and the immediate persecution experienced by the Yazidi ethnic and religious minority - the therapist must also consider aspects of distress caused by displacement and exile. The article discusses the needed adaptations in the therapeutic setting, using the case of a Yazidi woman surviving ISIS violence abduction. Within the framework of our treatment, she received cognitive behavioral therapy with individual and group therapies (multimodal interventions) over a period of 10 weeks. Besides establishing stability, safety and orientation and strengthening her self-consciousness, her traumatic experiences were considered from an individual, collective, socio - cultural and political point of view. Both the causes and maintaining conditions of the symptoms as well as the symptoms themselves are being worked on. The sensitive confrontation with the trauma was particularly helpful for the patient. In addition, she learned to participate actively in everyday life and in new social contacts again during therapy. She was able to overcome the passive - avoidant lifestyle since the traumatic event in a somewhat stable manner, although she will still need time to develop a stable perspective in the long term. She was offered the prospect of renewed follow-up treatment if necessary.

Introduction

In recent years, political upheavals, states of war and civil war, rising poverty and natural disasters in various countries of the world have led to an increased flight to Western countries, in addition to the many groups living as internally displaced persons. On the one hand, populations displaced in this way can suffer from unprocessed traumatic experiences, such as those resulting from war, flight, and displacement itself including uprooting experiences and insecure status [1-3]. Refugees and migrants, in general, are confronted in the host country with many aspects completely new norms and values, institutions and a foreign language, creating barriers in all areas of life including access to health care that would be necessary to promote recovery and healing. It is particularly difficult for people from communities who have been fleeing, at war, or in war-like situations for several generations [4,5] [4,5]. In

people with genocide and torture experience, even children and grandchildren can be affected by the psychological complaints of their ancestors [6].

The medical and psychological treatment of traumatized refugees from the middle east presents therapists with enormous difficulties [6,7]. In addition to the problem of languages, these include culture - specific perceptions of illness, as outlined for example in the cultural formulation concept in the recent DSM 5 update of the "Diagnostical and Statistical Manual" reference system [8,9]. Therapists also have to consider differences in how the patients describe their symptoms [10], their relationship to the therapist, how they structure their reporting of events, political constellations and sex-specific aspects, and other relevant aspects. All of which goes to make the examination, diagnostics and treatment more difficult [11]. For people from Middle Eastern



societies, the relationship between the physician and the therapist is especially important because of the meaning of the relationship in their traditional upbringing. Many patients will have previously sought help from traditional healers who have a special way of communicating. Qualities in the therapist such as understanding, patience, respect, politeness, attentiveness, friendliness and openness might thus value more highly than specialist knowledge [12,13].

The ethnic and religious background of the patients may be important for the therapy, as they may have been persecuted and oppressed for centuries, such as the Yazidi, Christians, or Ismaili in Iraq or Syria [12]. Women who have experienced sexual violence and have therefore been rejected by the community even though they have been victims or are persecuted because of their sexual orientation can play an important role in anamnesis, diagnosis and later treatment [14].

In addition to their traumatic experiences, it can be assumed that the refugees have an increased mental burden as a result of additional potentially traumatic or at least stress-inducing events during their flight and their adaptation to migration [15,16]. This might interact with the impact of repressive measures and persecution in their homeland because of their ethnicity or religion [11,17]. The feelings of concern about family members remaining in dangerous environments might further contribute to a persistent level of distress.

The therapist must consider the complex impact of these factors on the patient's specific cultures and their traditional medicine [18,19]. It should be considered in this context that the individual's personal "cultural background" might be shaped by different factors such as their specific religious subgroup, the local community reflecting geographical differences even between villages and social, occupational, or political identity and background factors. The therapist must therefore reflect all the more on his or her background factors, adapt them and must integrate alternative concepts when encountering traumatized individuals from such complex backgrounds in other cultures [5,18].

Psychotherapy with ethnic minority groups should always strive to take ethical principles into consideration in making decisions that affect patients. For example, the Beauchamp and Childress model (2009) is one of the most important systematic and well-argued models in the field of bioethics, which also has validity for psychotherapy [20].

The basic ethical principles in the Beauchamp and Childress model (2009) are autonomy, beneficence, non-maleficence and justice. Autonomy means the obligation to respect the decision-making abilities of individual persons. Beneficence refers to the obligation to perform and balance benefits and risks. Non-maleficence stands for the obligation to avoid causing damage. Fairness establishes obligations with regard to the distribution of benefits and risks [21].

These four principles can be applied in psychotherapy regardless of the personal philosophy, politics, religion, moral theory, or cultural concept of the individual. These basic

principles are not all-encompassing, but provide a transcultural framework and a common language for psychotherapy with ethnic minorities [5].

This also means, however, that the psychotherapist should have sufficient sensitivity and a minimum of cross-cultural competence to treat all people, regardless of their origin, with respect for their human dignity and in a fair manner that allows patients to benefit from treatment of the same quality [22,23].

Diagnosics

Irrespective of any cultural aspects and ethnic affiliation, the crucial factor for both diagnostics and treatment is that the therapist and patient find a shared understanding and model of the problem or illness and assess it correctly. In a comparative study with Turkish and German patients in a psychosomatic clinic, it was observed that significantly fewer ethnic Turkish patients compared with German patients were able to explain their illness [6,13]. The therapist's explanations must be adapted to the patient's level of education and cultural background, in a sometimes gradual process of developing a mutually acceptable health (and illness) belief model that can be shared by both. Other impedimentary reasons why patients do not understand the exact reason for their mental illness (e.g. physical pain due to inner psychological conflicts) and classify these in their concept of illness, is possibly due to multiple and several individual and collective burdens (e.g. war in their homeland over generations, sex-specific and social disadvantages, arrest or disappearance of family members, etc.). For example, ethnic and religious minorities in Iraq and Syria have been threatened by war and traumata for many generations and this has influenced the succeeding generations in their behavior, thinking, and emotions [11,19].

The attitudes, evaluations and convictions of the patients in respect of both individual, collective, and transgenerational trauma are to be ascertained in relation to their cultural imprint and generation differences by way of an analysis of health belief-related cognitions. In this respect, also resources such as solidarity, family loyalty and support via social networks together with more traditional procedures for alleviating pain should be considered in their capacity to alleviate the recovery process [24].

Motivation analysis refers to the willingness of the patients to change something themselves and to want to do so, which again is strongly influenced by cultural background. Activities such as sports and physiotherapy are accepted less by patients from family-oriented communities [11,18]. This can lead to a misinterpretation of the degree of patient compliance with recommended measures. Since these communities assume that in the case of physical and mental disorders the body should not move, the relationship between therapist and patient and above all the acceptance of the patient's complaint is important for the diagnosis and subsequent treatment. Only then will the person be willing to change the way he deals with his anxiety and, for example, learn to control it.

The analytical diagnosis of the problem should be expanded to include culture-sensitive questionnaire instruments and



behavior analyses [25]. This, however, presents an especially difficult problem with patients who have a low level of formal education. This emphasizes the need for a very detailed recording of the biographical trauma aspects and the social case history. Comorbidity should also be checked during diagnostics since very often it must be assumed that several mental and physical diagnoses are to be addressed.

Treatment

In principle, the concept of post-traumatic stress disorder (PTSD) and cognitive behavioral therapy are generally applicable to all ethnic groupings. However, the differing conceptions of health, illness and cultural-traditional medical treatment in dealing with traumatic experiences demand alternative approaches or additions [25] as also outlined by Hinton [26-28] and other authors who promote a cultural in addition to trauma-focused adaptation for example in transcultural use of cognitive behavioral therapy (CBT).

A basic pre-requisite is a secure environment in which the person does not feel threatened by persecution or any other danger or, in the case of refugees, does not have to fear that he will be deported to his homeland. Only when this safe environment has been established can the person speak about the critical events in his or her life and can accept the therapy and therapists [29].

Even the working out of cognitions, emotions, the definition of the self, individual and collective identity and the cultural formulation (CF), including the way the problems are presented (for example, when patients only report physical pain or complaints) can make treatment difficult because there is often no match with the known diagnostic criteria [30]. Therapists often report that, when taking the initial case history, patients from traditional society first talk in great detail about their ancestors' problems and only later (perhaps) connect this to their psychological suffering. This can lead to a lack of understanding and impatience on the part of the therapist [31,32]. As a rule, therapy in traumatized patients assumes that only when a situation of sufficient stability in both the general social situation and in the therapy setting has been reached, it is possible and usually necessary to confront the patient with a traumatic event [31].

Through careful confrontation with the trauma event, the patient should learn to integrate the trauma event, the fear level should decrease and previous emotions of agitation, flight and fear and the behavior should improve [12,31]. This can be seen as a problem for some people from traditional cultures because they do not understand what a psychotherapist can offer, feel ashamed to talk about intimate feelings, or fear they might be rejected by the Therapist and society. Even if we assume that a confrontation will have a fundamentally positive effect on mental health, it is important to establish the basic prerequisite of a secure environment in which the person does not feel threatened by persecution or any other danger and that he does not have to fear that he will be deported to his country of exile. This safe environment enables the person to speak about the critical events in his life and to focus on the therapy [33].

Consequently, the traditional, unmodified forms of exposure therapy [34] are not always effective with victims of political oppression and with patients with complex and cumulative traumatization [19]. It can even be counterproductive and can reduce compliance and increase the dropout rate. Not with all, but with some patients it is reported that suppression and avoidance might at times be better-coping strategies [31]. In some cultures, this is regarded as a successful coping mechanism. That applies especially to collective communities in which its members see social harmony as a priority. Here the cultural and social context determines and is responsible for, the healing process and attention is paid to the fact that the victim "does not lose face". This applies above all to politically-motivated violence. Therefore, people from traditional-rural regions are often steeped in a collective way of thinking in which personal desires, interests and the complaints of a single member are valued as secondary. Harmony and security in the family and peer group are considerably more important than individual autonomy. The individual sees himself as part of a mutually supportive group from which arise the appropriate tasks and obligations. Therefore, he has to make sure that this solidarity group, especially the core and extended family, does not come to any harm. As a result, personal feelings and complaints are not expressed, so as not to burden or cause any possible harm to the family [15].

Therefore these patients might also avoid any discussion of stress [35] experienced on an individual level.

It might be noted, that an intercultural-proven helpful method is in this context the combination of narration and exposure therapy such as in Narrative Exposure Therapy and Culture - Sensitive Narrative Trauma Therapy [31,36].

How far psychotherapeutic trauma work is possible seems also to depend on how society deals with sexuality. In this context patients very often report great insecurity if not a complete prohibition on any sharing of events or memories. High moral ideas and restrictions, especially in women, lead to great worry and anxiety since they are in danger of being ostracised by the collective. Feelings of shame play a special role in this, because in a "shame culture" it is not so much the incident and the committing of a possible violation of the norm which plays a part but the need to save one's face in front of the others [37].

Family - oriented societies in the Middle East therefore often broach the subject of traumatic experiences by way of expressions of pain [38]. From a psychodynamic perspective, this offers community members with severe traumatic experiences a chance to cope with ostracism, social hurt, feelings of guilt and inferiority by shifting the conscious experience and presentation from a more stigmatized to a socially more acceptable physical level. In this way, they retain their self-respect and at the same time hope that the doctor and some medicine can help them [39].

Case

In the article, we have included the therapeutic phases for the case of Yezidis who have emigrated to Germany.

We are working at the University of Duhok in the Kurdistan Region of Iraq to adopt Western psychotherapy in a culturally sensitive way and will publish the evaluation and guidelines at the end of 2003.

The participant was a 16-year-old Yazidi woman from Iraq, who was in IS terrorist organization captivity and raped and severely traumatized when being held hostage in Iraq in 2015. She was brought by a special program to Germany for treatment. Since then she has lived in Germany and continues psychotherapy and was medicated with Amitriptyline 50mg, Sertraline 75mg and time by time Promethazine 10mg.

The patient met the criteria for *Posttraumatic Stress Disorder, Major Depression and Somatoform Disorders*.

On the background of psychological stress: The young Yazidi woman was 16 years old and a Yazidi. She was taken prisoner by the IS along with her family. Her father and two brothers, together with other men, were executed before her very eyes. She, herself, was guarded, humiliated, beaten by IS fighters and repeatedly raped in Mosul. Every evening IS fighters and also civilian men from Syria, Saudi-Arabia and other Arab countries turned up, looked at the girls and bought them for themselves. She was bought by a Tunisian and taken to Syria. In Syria she was raped repeatedly over a longer period and then sold on. In total, she was sold twelve times to IS fighters in Iraq and Syria. Finally, after ten months as a hostage she managed to flee from Syria. She is suffering from post-traumatic stress spectrum symptoms and has dissociative muscle spasms nearly every day.

A group of psychotherapists, physicians, social workers and nurses were trained in transcultural psychotherapy, counseling and supervision by the first author and the team have been working and trained for seven years in working with refugees regarding understanding and processing illness, shame and gender based sexual violations, intercultural communication and competence.

On the background of CBT, in addition to detailed diagnostics, psychoeducation and stabilization techniques, the following phases were used to administer treatment:

Phase 1: The siege of Sinjar (Shingal) and the start of the terror (from 3rd August 2014)

Phase 2: Deportation, being held hostage (captivity), executions, rape, separation of parents and children, child soldiers etc.

Phase 3: Liberation

Phase 4: Life in refugee camps (up to 20,000 people can live in one refugee camp)

Phase 5 (living in Migration): Life migration (this is the most important phase in the healing of traumata)

Based on our practical experience with traumatised Yazidi women, it is not necessarily and not always the degree of seriousness of the first two trauma phases which are decisive

for their long-term "mental health" but rather the post - trauma care, in other words the treatment in the refugee camps or after fleeing to the host country.

A basic prerequisite in any case is a secure environment in which the person does not feel the threat of persecution or other dangers. It is only with this security that the woman is able to speak about the critical experiences in her life and to accept the therapy and the therapist.

The psychotherapist was trained in Cognitive Behavioral Therapy with an additional qualification in Trauma Therapy and trained by the author on Transcultural Psychotherapy and Psychotraumatology.

Psychotherapy with ethnic minority groups should always strive to take ethical principles into consideration in making decisions that affect patients. This also means, however, that the psychotherapist should have sufficient sensitivity and a minimum of cross - cultural competence to treat all people, regardless of their origin, with respect for their human dignity and in a fair manner that allows patients to benefit from treatment of the same quality [42].

Treatment and result

Besides the traumatic events that the young patient went through, her migration to Germany, the grief of her lost family members and old life and the destabilized community system have to be considered when planning her treatment. In refugees, psychosocial support and the building of a safe social environment are necessary to enable a psychotherapeutic trauma work.

Besides establishing stability, safety, orientation and strengthening her self-consciousness, her traumatic experiences were considered from an individual, collective, socio-cultural and political point of view [40].

After building a safe environment and establishing motivation for therapy through psychoeducation and a trustworthy therapeutic relationship, various culturally specific narrative PTSD elements were then applied to provide the framework for working through the traumatic experiences.

In addition to a detailed analysis of her trauma experiences, effects on the current experience and behavior and possible transference to the therapeutic relationship were analyzed. Because Therapy aims at supporting the patient to live satisfied despite the traumatic experience, learn how to accept and living with her symptoms through new skills instead of use escape strategies was discussed with the patient to clarify values and goals. Moreover, dysfunctional cognitions and emotions as well as symptom maintaining behaviors were analyzed through the psychoeducation and individual therapy. The goal was also to identify the dysfunctional cognitions, behavior and emotions and motivate to work to change this.

For trauma exposure we have chosen the narrative approach. The patient comes from a "narrative culture" that



has already heard about historical and collective through narratives, songs and prayer in her community. Therefore, in individual psychotherapy with the patient, the following steps were chosen for exposure:

- Narration of the pre-traumatic events
- Narration of the traumatic events
- Narration of the post-traumatic events (including the discussion of psychosocial burdens, coping with everyday life, plans for the future).

Intergenerational and collective traumas were also considered in the narration. The patient was able to talk about the historical and collective traumas of her community and had "practice" as she had already heard a lot from her family and community through narratives, music, songs and prayers. Through this she was also able to better understand her own trauma and the genocide of her people and see herself as a part of a whole. This also helped her to talk about her trauma in detail and to unburden herself.

Therapy could also start with the narration of the pre-traumatic events, followed by the narration of the traumatic events and the narration of the post-traumatic events. Further the narration of other events was supported to permit an integration of the old and new identity. In the following process a re-evaluation of the past, the traumatic experiences and the new conditions in the migration could be supported therapeutically leading to an emerging feeling of control over her own cognitions, emotions and behavior. The goal of this phase of finding meaning was to gain social recognition of the violence inflicted and the suffering endured [40] The patient consequently improved in all symptoms identified in evaluation.

Psychotherapists spoke the patient's native language. The team with occupational therapists, physiotherapists, psychiatrists and physicians are trained in the treatment of trauma patients from other cultures by the first author. Especially for patients with psychological pain from other cultures, like in this case, who prefer medication rather than exercise therapies, psychoeducation and cooperation between therapists and physiotherapists is important. This is also true for ergo - therapists who may prefer other forms of exercise that have no impact in these cultures. In this case, there were regular meetings to discuss and update the treatment plan.

While PTSD symptoms and severe flashback, intensions, sleep disturbances, apathy and negative mood, shame and physical pain occurred before treatment, a gradual decrease in the intensity of the symptoms was noted during treatment. Due to uncertain perspective of the Yazidis in Iraq, the missing person she was still dealing with the trauma events, but was able to go about her daily life in Germany and attend school again.

A number of recent studies have documented the severe mental health impact especially on women and even in those who had escaped to third countries [35] that underlines the need for adequate treatment strategies.

Summary and conclusion

An individual and culture - sensitive treatment which takes the relationship between the refugee and therapist into consideration is especially important and mental health experts need to closely co - operate with other professional groups (ergo therapists, physiotherapists, sport and exercise experts) and look at the patient's state of their individual cultural imprint.

If language, cultural and migration - specific aspects are included in the consultation, treatment and social support of refugees with trauma spectrum reactions, such as PTSD, it is possible to fundamentally improve their care and integration. Therefore, on the part of both the therapist and the health institutes, specific transcultural knowledge and the consideration of the social and political structures of the health institutes are necessary to be able to treat these patients early enough and adequately and, in this way for instance, to prevent a chronification of the illness. In addition to multicultural teams of therapists, it is above all necessary to make all staff aware of the need to take a transcultural, culture-sensitive perspective.

Treating refugees with trauma spectrum disorders is not about learning a new form of psychotherapy. It is about registering and learning skills of the culture-sensitive use of psychotherapeutic treatment in general and especially in cognitive behavioral trauma therapy methods as proposed and verified by Hinton [41]. Individualized therapy is also about concentrating on people from different cultures, with a different concept of illness and how to deal with it. This requires the willingness to reflect on priorities and possesses a critical attitude to one's own work whilst at the same time remaining impartial and open to the patients' concerns. Transcultural competence is needed in public health, especially taking into consideration the large groups of displaced persons and migrants in the present globalized setting. This means also that it is necessary to reflect on one's own culture in order to understand other cultures and include this aspect in the training of therapists [7]. In addition, the therapist must have the ability to be change perspective and focus and be able to deal in an unbiased way with people from different cultures. He or she should employ curiosity and enquiry, flexibility and experience in a variety of methods and finally must be able to deal with mistrust and distance resulting from the traumatic incidents, which the refugees might have experienced.

Patents

Author contributions: JIK has provided the framework and the case, Thomas Wenzel and Johanna Neumann have contributed in the writing and research.

References

1. Opaas M, Wentzel-Larsen T, Varvin S. The 10-year course of mental health, quality of life, and exile life functioning in trauma-tized refugees from treatment start. *PLoS One*. 2020 Dec 31;15(12):e0244730. doi: 10.1371/journal.pone.0244730. PMID: 33382807; PMCID: PMC7775068.
2. Sachs E, Rosenfeld B, Lhewa D, Rasmussen A, Keller A. Entering exile: trauma, mental health, and coping among Tibetan refugees arriving



- in Dharamsala, India. *J Trauma Stress*. 2008 Apr;21(2):199-208. doi: 10.1002/jts.20324. PMID: 18404641.
3. Summerfield D. War, exile, moral knowledge and the limits of psychiatric understanding: a clinical case study of a Bosnian refugee in London. *Int J Soc Psychiatry*. 2003 Dec;49(4):264-8. doi: 10.1177/0020764003494004. PMID: 14727693.
 4. Kizilhan JI, Noll-Hussong M, Wenzel T. Transgenerational Transmission of Trauma across Three Generations of Alevi Kurds. *Int J Environ Res Public Health*. 2021 Dec 22;19(1):81. doi: 10.3390/ijerph19010081. PMID: 35010342; PMCID: PMC8751140.
 5. Hinton DE, Kirmayer LJ. The Flexibility Hypothesis of Healing. *Cult Med Psychiatry*. 2017 Mar;41(1):3-34. doi: 10.1007/s11013-016-9493-8. PMID: 27142641.
 6. Schouler-Ocak, Trauma M, Migration: Cultural Factors in the Diagnosis and Treatment of Traumatized Immigrants; Springer, 2015; ISBN 9783319173351.
 7. Wenzel T, Droždek B, Chen AF, Kletecka-Pulker M. The significance of intercultural psychotherapy in further education and professional training. *Intercultural psychotherapy*; Springer. 2020; 59–80.
 8. Droždek B. Challenges in treatment of posttraumatic stress disorder in refugees: towards integration of evidence-based treatments with contextual and culture-sensitive perspectives. *Eur J Psychotraumatol*. 2015 Jan 7;6:24750. doi: 10.3402/ejpt.v6.24750. PMID: 25573504; PMCID: PMC4287632.
 9. Rohlf H, Knipscheer JW, Kleber RJ. Use of the cultural formulation with refugees. *Transcult Psychiatry*. 2009 Sep;46(3):487-505. doi: 10.1177/1363461509344306. PMID: 19837783.
 10. Zbidat A, Georgiadou E, Borho A, Erim Y, Morawa E. The Perceptions of Trauma, Complaints, Somatization, and Coping Strategies among Syrian Refugees in Germany-A Qualitative Study of an At-Risk Population. *Int J Environ Res Public Health*. 2020 Jan 21;17(3):693. doi: 10.3390/ijerph17030693. PMID: 31973104; PMCID: PMC7037213.
 11. Kizilhan JI. Kulturelle Deutungen des Schmerzes in familienorientierten Gesellschaften [Cultural interpretation of pain in family-oriented societies]. *Schmerz*. 2016 Aug;30(4):346-50. German. doi: 10.1007/s00482-016-0127-4. PMID: 27333767.
 12. Kizilhan JI, Friedl N, Steger F, Rüegg NL, Zaugg P, Moser CT, Hautzinger M. Trauma Workbook for Psychotherapy Students and Practitioners; Pabst Science Publishers: Lengerich. 2019; ISBN 978-3-95853-498-8.
 13. Gilson L, Alilio M, Heggenhougen K. Community satisfaction with primary health care services: an evaluation undertaken in the Morogoro region of Tanzania. *Soc Sci Med*. 1994 Sep;39(6):767-80. doi: 10.1016/0277-9536(94)90038-8. PMID: 7973873.
 14. 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 Aug;72(4):579-87. doi: 10.1037/0022-006X.72.4.579. PMID: 15301642.
 15. Pagotto LF, Mendlowicz MV, Coutinho ES, Figueira I, Luz MP, Araujo AX, Berger W. The impact of posttraumatic symptoms and comorbid mental disorders on the health-related quality of life in treatment-seeking PTSD patients. *Compr Psychiatry*. 2015 Apr;58:68-73. doi: 10.1016/j.comppsy.2015.01.002. Epub 2015 Jan 14. PMID: 25656798.
 16. Mohammadi D. Help for Yazidi survivors of sexual violence. *The Lancet Psychiatry* 2016; 3: 409-410, doi:10.1016/s2215-0366(16)30004-9.
 17. Maercker A. Psychologische Modelle. In *Posttraumatische Belastungsstörungen*, 3. Aufl. 2009; Maercker, A., Ed.; Springer Berlin Heidelberg: Berlin, Heidelberg, 2009; 33-49, ISBN 978-3-540-88488-0.
 18. Kirmayer LJ, Ryder AG. Culture and psychopathology. *Curr Opin Psychol*. 2016 Apr;8:143-148. doi: 10.1016/j.copsyc.2015.10.020. Epub 2015 Dec 17. PMID: 29506790.
 19. Kizilhan JI, Noll-Hussong M. Individual, collective, and transgenerational traumatization in the Yazidi. *BMC Med*. 2017 Dec 11;15(1):198. doi: 10.1186/s12916-017-0965-7. PMID: 29224572; PMCID: PMC5724300.
 20. Beauchamp TL, DeGrazia D. Principles and Principlism. In *Handbook of Bioethics: Taking Stock of the Field from a Philosophical Perspective*, 1st ed. 2004; Khushf G Ed. Springer Netherlands; Imprint Springer: Dordrecht, 2004; 5574, ISBN 9781402018701.
 21. Tom VA, Beauchamp L, James F. *Childress (2009) Principles of Biomedical Ethics*. 6. Auflage. *Ethik in der Medizin* 2010; 22:171–173.
 22. Ethical principles of psychologists and code of conduct. *Am Psychol*. 2002 Dec;57(12):1060-73. PMID: 12613157.
 23. Nordenfelt L. The varieties of dignity. *Health Care Anal*. 2004 Jun;12(2):69-81; discussion 83-89. doi: 10.1023/B:HCAN.0000041183.78435.4b. PMID: 15487812.
 24. Hofstede G. *Culture's consequences: Comparing values, behaviors, institutions and organizations across nations*, 2. Aufl., [Nachdr.]; Sage Publ: Thousand Oaks, Calif. 2011; ISBN 9780803973237.
 25. Kira IA. Etiology and treatment of post-cumulative traumatic stress disorders in different cultures. *Traumatology* 2010; 16:128-141. doi:10.1177/1534765610365914.
 26. Eskici HS, Hinton DE, Jalal B, Yurtbakan T, Acarturk C. Culturally adapted cognitive behavioral therapy for Syrian refugee women in Turkey: A randomized controlled trial. *Psychol Trauma*. 2021 Oct 7. doi: 10.1037/tra0001138. Epub ahead of print. PMID: 34618479.
 27. Kananian S, Ayoughi S, Farugie A, Hinton D, Stangier U. Transdiagnostic culturally adapted CBT with Farsi-speaking refugees: a pilot study. *Eur J Psychotraumatol*. 2017 Nov 7;8(sup2):1390362. doi: 10.1080/20008198.2017.1390362. PMID: 29163870; PMCID: PMC5687805.
 28. Hinton DE, Rivera EI, Hofmann SG, Barlow DH, Otto MW. Adapting CBT for traumatized refugees and ethnic minority patients: examples from culturally adapted CBT (CA-CBT). *Transcult Psychiatry*. 2012 Apr;49(2):340-65. doi: 10.1177/1363461512441595. PMID: 22508639.
 29. Lersner Uv, Kizilhan JI. *Kultursensitive Psychotherapie*; Hogrefe Verlag. 2017; ISBN 9783844427554.
 30. Summerfield D. The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *BMJ*. 2001 Jan 13;322(7278):95-98. doi: 10.1136/bmj.322.7278.95. PMID: 11154627; PMCID: PMC1119389.
 31. Schauer M, Schauer M, Neuner F, Elbert T. *Narrative Exposure Therapy: A Short-Term Treatment for Traumatic Stress Disorders*; Hogrefe Publishing. 2011; ISBN 9781616763886.
 32. Droždek B. How do we salve our wounds? Intercultural perspectives on individual and collective strategies of making peace with own past. *Traumatology*. 2010; 16: 5-16.
 33. Butler EA, Lee TL, Gross JJ. Emotion regulation and culture: are the social consequences of emotion suppression culture-specific? *Emotion*. 2007 Feb;7(1):30-48. doi: 10.1037/1528-3542.7.1.30. PMID: 17352561.
 34. Başoğlu M. Prevention of torture and care of survivors. An integrated approach. *JAMA*. 1993 Aug 4;270(5):606-11. PMID: 8331760.
 35. Wenk-Ansohn M, Gurriss N. Intercultural encounters in counselling and psychotherapy—communication with the help of interpreters. *Torture*. 2011;21(3):182-5. PMID: 22057106.
 36. Kirmayer L. Landscapes of memory. *Tense past: Cultural essays in trauma and memory* 1996; 172-198.
 37. United Nations Human Rights Office of the High Commissioner. UN Commission of Inquiry on Syria. UN Commission of Inquiry on Syria: ISIS is committing genocide against the Yazidis. Available online: <https://www.ohchr.org/en/press-releases/2016/06/un-commission-inquiry-syria-isis-committing-genocide-against-yazidis> (accessed on 3 May 2022).



38. Kirmayer LJ, Sartorius N. Cultural models and somatic syndromes. *Psychosom Med.* 2007 Dec;69(9):832-40. doi: 10.1097/PSY.0b013e-31815b002c. PMID: 18040090.
39. Cetorelli V, Burnham G, Shabila N. Prevalence of non-communicable diseases and access to health care and medications among Yazidis and other minority groups displaced by ISIS into the Kurdistan Region of Iraq. *Confl Health.* 2017 Apr 6;11:4. doi: 10.1186/s13031-017-0106-0. PMID: 28396693; PMCID: PMC5382370.
40. Kizilhan JI. Behandlung traumatisierter Frauen in Deutschland. *Forens Psychiatr Psychol Kriminol* 2017; 11:335-341, doi:10.1007/s11757-017-0444-1.
41. Hinton DE, Chhean D, Pich V, Safren SA, Hofmann SG, Pollack MH. A randomized controlled trial of cognitive-behavior therapy for Cambodian refugees with treatment-resistant PTSD and panic attacks: a cross-over design. *J Trauma Stress.* 2005 Dec;18(6):617-29. doi: 10.1002/jts.20070. PMID: 16382423.
42. Ethical principles of psychologists and code of conduct. *Am Psychol.* 2002 Dec;57(12):1060-73. PMID: 12613157.
43. Association AJoP. Ethical principles of psychologists and code of conduct. *Am Psychol.* 2002;12:1060-73.

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