# The effectiveness of psychoanalytic psychotherapy in individuals diagnosed with PTSD due to torture and severe human right violations

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**Key points of interest**

- Despite its evident methodological limitations, the study is a contribution supporting the application of psychoanalytic psychotherapy to individuals diagnosed with PTSD as a result of torture and severe human rights violations.
- Psychoanalytic psychotherapy applied to PTSD patients can exert positive effects and such positive effects tend to increase with the continuity of therapy.

**Abstract**

*Introduction:* Various psychotherapies have been applied to individuals who have been subjected to torture and severe human rights violations. However, studies assessing the effectiveness of such therapies are limited. Psychoanalytic psychotherapy is said to be used frequently in practice for these patient groups. Yet, there are scarcely any studies assessing its efficacy. In this study, we aim to assess the effectiveness of psychoanalytic psychotherapy in patients with PTSD associated with torture and severe human rights violations.

*Methods:* 70 patients who were diagnosed with PTSD due to being tortured and severe human rights violations in accordance with DSM-IV-TR and who applied to the Human Rights Foundation of Turkey were given psychoanalytic psychotherapy. CGI-S and CGI-I scales were applied to the patients (in Months 1, 3, 6, 9, and 12); and the patients' continuity of therapy and the changes in their recovery during the one-year psychotherapy period were assessed.

*Results:* 38 (54.3%) of the patients were female. Their mean age was 37.7 years (*SD* = 12.25), while their mean baseline CGI-S score was 4.67. The drop-out rate was 34%. The mean length of treatment was 21.9 sessions (*SD* = 20.30). Mean scores for CGI-I scale were 3.46, 2.95, 2.23, 2.00, and 1.54 for months 1, 3, 6, 9 and 12 respectively. As the number of sessions increased, the final CGI-I scores of the patients improved significantly ($p < .001$) towards recovery. 75.4% of the patients benefited from the treatment in general according to their final CGI-I score.

*Conclusions:* Considering the limited literature in the field, this study has provided sig-

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nificant data on the effectiveness of the use of psychoanalytic psychotherapy in individuals diagnosed with PTSD related to torture and severe human rights violations, despite its limitations such as not involving a control group, not having been conducted blindly and randomized and being based on a single scale.

*Keywords:* torture, PTSD, post-traumatic stress disorder, psychotherapy, psychoanalytic therapy, effectiveness

## Introduction

156 countries signed the United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment and Punishment (United Nations General Assembly, 1984), yet, torture is still very common around the world. According to the Amnesty International Report 2014, torture and other forms of ill treatment have been documented in 141 countries (Amnesty International, 2014; Hamid et al., 2019). Turkey is one of the countries where torture and systemic violence are quite frequent, intense and perpetual (Human Rights Foundation of Turkey [HRFT], 1994; Human Rights Watch, 2005; Refugee Health Care Center, 1988; Yılmaz et al., 2015).

It has been reported that the lifetime prevalence of PTSD is up to 15 percent in population-based studies, and the prevalence in individuals who are at risk for trauma varies between 3 and 58 percent (DSM-IV; American Psychiatric Association [APA], 1994). Torture is a key risk factor (Steel et al., 2009), and torture survivors are more likely to report symptoms of PTSD, major depression, and elevated anxiety compared to the individuals who have been subjected to other forms of violence; and these symptoms often have severe consequences for daily functioning long after the events that precipitated them (Basoglu, 1993; Holtz, 1998; Weiss et al., 2016).

Studies on the efficacy of treatments in relation to the frequency and severity of torture are often limited. A review conducted in 2011 describes a limited range of interventions for torture survivors, tested in studies with significant limitations such as small sample sizes and unvalidated outcomes (Hamid et al., 2019; Jaranson & Quiroga 2011). In addition, Weiss et al. (2016) identified 88 studies including interventions against torture and systematic violence victims in their literature review, but there is no study from Turkey among them.

Several psychological treatment models including cognitive behavioral therapy, narrative exposure therapy, psychoeducation and supportive counselling have been proposed for improving PTSD symptoms in torture survivors. However, the effectiveness of the treatments was understudied. Additionally, the results of review studies which investigated the effect of psychological treatments (McFarlane & Kaplan, 2012; Weiss et al., 2016; Patel et al., 2016) were controversial. While McFarlane and Kaplan (2012) suggest that psychological treatments are largely effective in reducing psychological symptoms, Patel et al. (2016) found that the studies used psychological treatments had no immediate effect on PTSD symptoms.

It has been reported that studies on the treatment of torture-related PTSD have significant limitations and research is needed on the effectiveness of different intervention options that have not been studied so far (Hamid et al., 2019; Patel et al., 2016; Pérez-Sales, 2016; Weiss et al., 2016). On the other hand, very few studies assess the effectiveness of psychodynamic psychotherapies, psychoanalytic ones in particular, in either tortured individuals or, even in general, patients with PTSD even though psychodynamic therapies are among the therapies that are frequently used in the treatment practice for PTSD (Hamid et al.,

2019; Patel et al., 2016; Weiss et al., 2016; Fonagy, 2015; Leichsenring, 2014).

This study aims to assess the effectiveness of psychoanalytic psychotherapy primarily in the patients diagnosed with PTSD related to torture and severe violations of rights. Additionally, the study seeks to monitor the continuity of therapy in the first year and its relationship with general clinical change.

## Method

*Scope and subjects*

This study reports on the research findings of the Psychoanalytic Psychotherapy Programme of HRFT Istanbul.[1] The study sample consisted of 70 people who applied to the Istanbul Centre of HRFT and were admitted to the psychoanalytic psychotherapy programme between 2013-2017. Subjects were individuals diagnosed as (primarily) suffering from posttraumatic stress disorders according to DSM-IV-TR. These PTSD patients met the full criteria required for the diagnosis of PTSD and they were not subthreshold. 27 patients who were included in the program without a diagnosis of PTSD during that period, and 15 patients whose files could not be reached in the archive for various reasons were excluded from the study.

*Procedure*

*The process for determining torture, diagnosing and measuring*

Torture was determined according to the definition in UNCAT and by experienced medical doctors who received training according to the Istanbul Protocol -consultations and clinical team (medical doctors, psychiatrists, psychologists, social workers, forensic medicine doctors) meetings took place for evaluation when necessary.

Psychiatrists who have extensive experience in diagnosing PTSD have conducted the psychiatric assessments of the patients and diagnosed PTSD according to DSM-IV-TR criteria. They also filled out the sociodemographic and clinical data forms, and determined the rating scale scores (CGI-S prior to the therapy, and CGI-I at the 1st, 3rd, 6th, 9th, 12th months of the therapy). Diagnosis has been made with a half-structured process which is based on DSM-IV-TR. The same psychiatrist diagnosed and followed a given patient with CGI-S and CGI-I scale assessments (completely independent of the therapists). A total of three psychiatrists took part in the study. The rating scale scores and attrition up to the first year of therapy were analysed in the study.

*Therapies*

Therapeutic processes and therapists are completely outside the scope of the application of diagnosis, forms and application of scales (CGI-S, CGI-I). The therapies were conducted by 15 therapists who were trained in the psychoanalytic method and had experience of more than ten years. Almost all the therapists were analysts who were members of the International Psychoanalytic Association (IPA) or candidates undergoing their psychoanalytic training under the supervision of the IPA, and all the therapists either underwent or were undergoing personal analysis.

Therapies were designed exclusively according to analytical principles, hence case-specific and confidential. The psychotherapy process, on the other hand, was not designed to carry out a specific study, and individuals were pro-

1 The Psychoanalytic Psychotherapy Programme was awarded the IPA in the Community Awards in Humanitarian Organizations (first prize) by the International Psychoanalytic Association (IPA) in 2019.

vided psychoanalytic psychotherapy in a natural course by HRFT. The patients received psychoanalytic therapy on a once per week basis, without a set time-limit, in analysts'/candidates' private office; and the course of therapy was determined based on the necessities of the analytical space. HRFT carried out the treatment of patients free of charge, with the help of a budget formed through various funding and projects -that are run independently of the state. A payment was made to the therapists for the sessions from the HRFT treatment budget -the fees were relatively low compared to the average session prices in the market.

Some basic principles of the *HRFT Psychoanalytic Psychotherapy Program* and some core components of the therapy processes are presented in Table 1. For more details, you can also refer to our previous publications (Özyıldırım et al., 2017, Özyıldırım & Aslantaş Ertekin, 2021).

Approval for the study was obtained from the Ethics Committee of Istanbul Arel University (Istanbul, Turkey).

*Measures*

*Sociodemographic information form*

Includes information regarding patients, their stories and the assessment of the torture they have suffered. In this study, an exclusively arranged version of this form was used.

*Clinical information form*

This form, which was created by HRFT, includes detailed clinical history and evaluation of patients, physical and mental complaints and findings, diagnosis and improvements during the treatment. In this study, an exclusively arranged version of this form was used.

*Clinical Global Impression Scale (CGI)*

The Clinical Global Impression Scale (CGI) is a scale created to enable a brief, stand-alone assessment by the clinician regarding the severity of the illness prior to initiating a treatment and the clinician's view of the patient's general clinical course during the treatment process. The assessment process is performed by considering all the available information, including the patient's history, psychosocial circumstances, symptoms, the impact of behaviour and symptoms on the patient's functionality (Busner & Targum, 2007).

CGI consists of 3 subscales. A 7-point rating is used in the first two subscales which are severity of illness (CGI-S) and improvement (CGI-I). The third subscale, efficacy index, is created to assess the side effects of treatment. The assessment is based on the symptoms, behaviours, and functionality that have been observed and reported in the past seven days (Busner & Targum, 2007). Assessment of improvement (CGI-I) is done by considering the individual's condition prior to the treatment, by comparing it with the initial condition at the interviews after the initiation of the treatment. The initial rating for the severity of illness is the baseline for the assessment (Busner & Targum, 2007).

CGI helps to monitor the clinical progress in a short period of time and allows the clinician to determine whether the applied intervention is effective. The CGI scale is applicable for all research populations; and a useful measure that correlates with longer and more time-consuming assessment tools used for several psychiatric diagnoses (Busner & Targum, 2007). In this study, CGI-S and CGI-I scales were used. The HRFT Psychoanalytic Psychotherapy Programme is not focused on scientific research, but on the clinical picture and treatment of patients. Given this emphasis, CGI scale was preferred in this study for its quick and easy administration, and its correlation with specific rating scales on disorder severity and improvement of the sympyoms.

**Table 1**. Basic principles of the HRFT Psychoanalytic Psychotherapy Program and some core components of the therapy processes.

| A. Some of the basic principles of the HRFT Psychoanalytic Psychotherapy Program. |
|---|
| • The Program does not directly equate the traumatic event is with the traumatic effect, nor miss the fact that the traumatic is shaped within a *subjective realm* and a *psychic reality.* |
| • The therapists conduct the therapeutic processes with an analytical sensitivity to the subjective intrapsychological dynamics unique to each patient, rather than using a 'standardized' approach. |
| • The Program places emphasis on establishing *a sustainable and long-term setting and frame* for in-depth psychoanalytic therapy; and avoiding, to the extent that is possible, to justify ignoring the requirements of psychoanalytic work on the grounds that extraordinary conditions are present. |
| • Given that the therapists are also often exposed to the general social traumatic environment that creates torture, the Program pays attention to the analysis of the countertransference and the intersubjective effects of this *shared reality*. |
| • The Program was carried out with the general sensitivity of adopting a position involving social *recognition* and *witnessing* in the face of torture. |
| B. Some core components of the psychoanalytic psychotherapy processes. The therapists; |
| • Attempted to represent and symbolize traumatic intrapsychic hyperarousal and affective dysregulation. |
| • See the traumatic symptoms as temporary maintainers of a certain internal balance, not as problems that need quick relief. |
| • Try to transform the effect of torture on the internal object relations within the processes of transference and countertransference. |
| • Aim to analyze the internal conflicts, unconscious fantasies and defensive processes associated with torture. |
| • Aim to process the introjective and identificative processes related to torture, aggression and losses. |
| • Studied the effects of traumatic experiences on the patient's life and relationships and unconscious compulsive repetitions. |

*Statistical analysis*

Statistical analyses were performed using IBM SPSS 22.0. First, preliminary analysis of the data was done, and Kolmogorov-Smirnov Test was applied to examine normal distribution. The test results showed that the variables were not normally distributed, and non-parametric tests were used for the main statistical analysis. For the examination of difference between groups, the Mann-Whitney U Test was used for the groups with two categories, and the Kruskal-Wallis Test was used for those with more than two categories. Total points were obtained to perform a Spearman Rank Analysis to analyse the correlation between variables. The Chi-Square Test of Independence was used to determine the relationship between categorical variables. Friedman Test was performed for the effectiveness of treatment, and Wilcoxon Signed-Ranks Test was used to determine the difference in time measurements.

**Table 2.** Sociodemographic and Clinical Distribution of the Participants

| | n | % | Range | *M* | *SD* |
|---|---|---|---|---|---|
| N | 70 | 100 | | | |
| Age | 70 | 100 | 22-70 | 37,7 | 12,25 |
| Education (year) | 70 | 100 | 1-19 | 11,3 | 3,79 |
| Time between torture to therapy (month) | 70 | 100 | 3-447 | 78,7 | 110,36 |
| Gender | | | | | |
| Women | 38 | 54,3 | | | |
| Marital status | | | | | |
| Married | 44 | 62,9 | | | |
| Reason for application | | | | | |
| Torture | 58 | 82,9 | | | |
| Bomb attack | 7 | 10,0 | | | |
| Relative of deceased victim of torture | 5 | 7,1 | | | |
| Comorbidity | 36 | 51,4 | | | |
| Major Depressive Disorder | 27 | 38,5 | | | |
| Dysthymic disorder | 4 | 5,7 | | | |
| Other | 5 | 7,1 | | | |
| Psychopharmacotherapy | | | | | |
| Received | 14 | 20 | | | |
| Torture history (sub type) | 58 | 100 | | | |
| Threats/insults | 50 | 86,2 | | | |
| Coercive behaviours | 24 | 41,3 | | | |
| Physical interventions | 47 | 81,0 | | | |
| Positional tortures | 26 | 44,8 | | | |
| Physical/chemical factors | 15 | 25,8 | | | |
| Sexual assaults | 25 | 43,1 | | | |
| Restricting requirements | 21 | 36,2 | | | |

General classification of torture methods in the HRFT reports (taking into account the Istanbul Protocol): *Threats/insults*: insults, humiliations, various threats against oneself or his/her relatives... *Coercive behavior*: eyeballing, making a person witness torture, having a person to listen to a loud anthem, offering to be an agent, torturing in the presence of relatives, forcing obedience... *Physical interventions*: beating, bastinade, electrocution, squeezing testicles... *Positional tortures*: hangers, crucifixion, strappado... *Physical/chemical factors*: pressurized/cold water, exposure to chemicals, burning, asphyxiation... *Sexual assaults*: undressing, verbal/physical sexual abuse, anal cavity search/naked search, rape and rape threat... *Restricting requirements*: cell isolation, restriction of eating/drinking, prevention of urination/defecation, prevention of sleep...

**Table 3**. Participants' CGI-S and CGI-I scores

| CGI | *n* | *M* | *Mdn* | *SD* | Range |
|---|---|---|---|---|---|
| CGI-S | 70 | 4.67 | 4 | 1.18 | 2 -7 |
| CGI-I Month 1 | 61 | 3.46 | 3 | 0.62 | 2 – 5 |
| CGI-I Month 3 | 42 | 2.95 | 3 | 0.69 | 2 – 4 |
| CGI-I Month 6 | 35 | 2.23 | 2 | 0.77 | 1 – 4 |
| CGI-I Month 9 | 25 | 2.00 | 2 | 0.70 | 1 – 4 |
| CGI-I Month 12 | 24 | 1.54 | 1 | 0.72 | 1 - 4 |

CGI-S: Clinical Global Impressions-Severity, CGI-I: Clinical Global Impressions-Improvement
CGI-I: 1, *Very much improved*; 2, *Much improved*; 3, *Minimally improved*; 4, *No change*; 5, *Minimally worse*; 6, *Much worse*; 7, *Very much worse*.

## Results

*Sociodemographic and clinical data*

The sample comprised of 70 people who were diagnosed with post-traumatic stress disorders according to DSM-IV-R. The sample comprised of 58 people who had experienced torture (82.9%), 7 people who survived a suicide bombing attack (in Ankara) (10.0%) and 5 people who had lost a loved one as a result of torture and enforced disappearance by a paramilitary force (7.1%). About 90% of survivors had been tortured while in custody/prison for political reasons. Sociodemographic data of the patients are presented in Table 2.

*Participants' CGI-S and CGI-I Scores*

The CGI-S and CGI-I Scale scores of the patients are presented in Table 3. As age increases ($r$ = .24, $p$ = 0.04), CGI-S scores gets higher in married participants ($U$ = 292,500, $p$ = 0.02) and participants with comorbidity ($U$ = 401,500, $p$ = 0.01). No association was found between CGI-S and education, time between torture to psychotherapy and torture methods ($p$ >.05).

It has been observed that out of 61 patients who received CGI-I assessment at least once, 75.4% (46) of the patients benefited from the treatment in general according to their final CGI-I score (final CGI-I = 3, 19.7%; final CGI-I = 2, 31.1%; final CGI-I = 1, 24.6%). As the number of sessions increases, final CGI-I scores of the patients significantly improved ($r$ = -.76, $p$ = .00 ; $x^2$ (3, $n$ = 61) = 34.732, $p$ = .00) towards recovery.

*Continuity to psychotherapy*

Considering the one-year period, the mean length of therapy in the entire group was 21.9 (*SD* = 20.30) sessions and 5.66 (*SD*= 5.01) months. It was found that the total number of sessions was higher in women ($U$ = 436,000, $p$ = 0.04). On the other hand, there was no meaningful relation between the total number of sessions and variables such as age, marital status, torture method, presence of comorbidity, presence of concomitant psychopharmacotherapy, and CGI-S scores ($p$ >.05). As a criterion for premature discontinuation, if we take those who dropped out of therapy with no any CGI-I assessment (9 patients) and those who dropped out of therapy with no improvement in their CGI-I score -i.e. CGI-I scores of 4-7 (15 patients), the drop-out rate is 34% (24 patients).

**Table 4**. Distribution of Final CGI-I Scores of Patients who Received Only Psychotherapy (No Concomitant Pharmacotherapy)

| Number of sessions | *n* | *M* | *SD* | 4 | 3 | 2 | 1 |
|---|---|---|---|---|---|---|---|
| 0 – 3 | 8 | 3.38 | ,92 | 5 (62.5%) | 1 (12.5%) | 2 (25%) | - |
| 4 – 11 | 10 | 3.40 | ,52 | 4 (%40%) | 6 (60%) | - | - |
| 12 – 23 | 3 | 2.00 | ,00 | - | - | 3 (100%) | - |
| 24 – 35 | 4 | 1.50 | ,58 | - | - | 2 (50%) | 2 (50%) |
| 36 – 47 | 2 | 1.50 | ,71 | - | - | 1 (50%) | 1 (50%) |
| 48+ | 22 | 1.45 | ,51 | - | - | 10 (45.5%) | 12 (54.5%) |

*CGI-I scores of patients who received only psychotherapy*

Concomitant psychopharmacotherapy was applied in addition to psychotherapy in a total of 14 patients (20%). The majority of patients, who also received pharmacotherapy, are patients with comorbidities (12 out of 14 patients) ($p = 0.004$). In addition, when patients who received concomitant pharmacotherapy in addition to psychotherapy and those who received only psychotherapy are compared in terms of CGI-I scores, the former group showed significantly greater improvement ($p = 0.001$). Table 4 shows the final CGI-I scores of the patients who received only psychotherapy (56 patients), excluding the patients receiving concomitant pharmacotherapy. In the group that received only psychotherapy, it is observed that more patients' CGI-I scores tend to concentrate towards improvement as the continuity of therapy increases.

*Effect size*

As shown in Table 5, there is a statistically significant difference between the data obtained from the CGI-I scale at different months (CGI-I Month 1, CGI-I Month 3, CGI-I Month 6, CGI-I Month 9, CGI-I Month 12 $x2(4, n = 24) = 73.62, p < .001$). When the entire group and the group receiving only psychotherapy were assessed separately, a strong (Effect size $r = .62$, $r = .64$, respectively) and statistically significant ($p = .000$) change was identified in CGI-I scores between the first month and the first year. Accordingly, the change becomes more evident from the point forward the third month of the therapy (see Table 5).

## Discussion

*Limitations of the study*

Nevertheless, our study has several significant limitations including not involving a control group, not being blind and randomized, not employing an assessment scale specific to PTSD which is filled by patient, deciding the effectiveness based on a single indicator, not having manualized interventions, not measuring to what extent which symptom groups have changed throughout therapies, and not performing to end-of-treatment evaluations of the CGI-S scale and patient's condition of meeting the diagnostic criteria for PTSD. These significant and determinant limitations should certainly not be forgotten while considering the results of our study on effectiveness, which should also be evaluated considering aforementioned limitations.

**Table 5**. Wilcoxon Signed-Rank Test Results

| | *N* | CGI-I measure time | Mean Rank Positive Rank | Mean Rank Negative rank | *z* | *p* | Effect size *r* |
|---|---|---|---|---|---|---|---|
| All patients | 42 | CGI-I-1-3 | 25.00 | 12.50 | -4.158 | ,000 | .45 |
| | 35 | CGI-I-1-6 | ,00 | 15.50 | -4.932 | ,000 | .59 |
| | 25 | CGI-I-1-9 | ,00 | 12.00 | -4.283 | ,000 | .61 |
| | 24 | CGI-I-1-12 | ,00 | 12.00 | -4.323 | ,000 | .62 |
| PT only | 35 | CGI-I-1-3 | ,00 | 12.00 | -4.796 | ,000 | .57 |
| | 31 | CGI-I-1-6 | ,00 | 15.00 | -4.849 | ,000 | .62 |
| | 24 | CGI-I-1-9 | ,00 | 12.00 | -4.283 | ,000 | .62 |
| | 23 | CGI-I-1-12 | ,00 | 12.00 | -4.323 | ,000 | .64 |

*Note*: Bonferroni correction was conducted to avoid Type 1 Error ($p < .0125$). The effect size was calculated by dividing the absolute Standardised test statistic z value by the square root of N. Cohen's classification can be used as 0.1 = *small*, 0.3 = *moderate*, and 0.5 = *large* (Pallant, 2016). PT: Psychotherapy.

*Significance of the study*

Studies on the effectiveness of therapies in relation to the frequency and severity of torture are limited and controversial (Hamid et al., 2019; Jaranson & Quiroga, 2011; Patel et al., 2016; Pérez-Sales, 2016; Weiss et al., 2016). Given the scant literature, greater understanding of what works in treatment and rehabilitation for torture survivors is crucial in order to obtain maximum benefits from scarce resources. In the literature, it has been reported that, as in the specific case of torture, studies on the treatment of PTSD in general have also certain limitations such as limited effectiveness, loss of effectiveness in follow-up, high drop-out, and it has been stated that there is need for studies on intervention options different from those which had been thoroughly studied (CBT interventions in different forms, narrative exposure, testimony) so far (Hamid et al., 2019; Patel et al., 2016; Weiss et al., 2016).

On the other hand, although psychodynamic therapies are among the therapies that are frequently used in PTSD treatment practice (Schottenbauer et al., 2008), there are almost no studies evaluating the effectiveness of psychodynamic therapies, especially psychoanalytic psychotherapies, in tortured patients (Hamid et al., 2019; Patel et al., 2016; Weiss et al., 2016). For instance, no psychoanalytic psychotherapy practice has been found in those who have been subjected to torture or systematic violence in the two reviews that have been conducted in recent years and include RCT studies (Hamid et al., 2019; Patel et al., 2016). Weiss et al. (2016), on the other hand, state that a total of 102 intervention arms were tested in 88 studies related to torture and systematic violence, which they identified in their systematic review. Accordingly, most of these arms are CBT and psychosocial studies, while only three are psychodynamic. The authors commented that "the effectiveness of psychodynamic therapies was unclear; unclear was defined as a situation in which the coder was unable to determine, from the content of

the article, the results of the study regarding the symptom in question (PTSD in this particular case)" (Weiss et al., 2016). Besides, even when assuming that existing studies are "psychodynamic", their content is not very psychoanalytic, and their therapy methods are very different from each other. Also, the arm sample numbers for psychodynamic therapy in these studies are also very limited (Holmqvist et al., 2006, $n$ = 14; Nicholson & Kay, 1999, $n$ = 15). In this context our study is a contribution to the literature as it was carried out in Turkey -a country where torture is quite intense and prevalent, and it was investigated the effects of less studied psychoanalytic treatment option in the fields of torture and PTSD.

*Effectiveness of psychodynamic therapies*

The study of Nicholson and Kay (1999) was conducted with 15 Cambodian refugee women who migrated to the United States; with this group, Yalom Group Psychotherapy had been conducted in single group for 2 years. At the end of the study, it has been reported that there was a decline in depressive, anxiety and PTSD symptoms, as well as an increase in their self-esteem and functionality. However, reports of symptoms, diagnosis, and consequences were only anecdotal.

Holmqvist et al. (2006) found a considerable remission in PTSD symptoms and more moderate changes in self-image in their study which examines the changes in self-image and the change of PTSD symptoms with short-term therapy with 14 refugees who were victims of war and torture. The therapists of the research applied short-term psychodynamic psychotherapy.

In addition to abovementioned specific limitations, our study has some features that relatively overcomes such limitations of these existing studies that research the effectiveness of currently available psychodynamic psychotherapy on torture (e.g., higher number of patients, a relatively purer patient group, a more specific diagnosis group, clarity of the psychoanalytic content of psychotherapy and the clarity of the standards of the therapists' psychoanalytic psychotherapy formation, etc.).

Also, there are very few studies that evaluate the effectiveness of psychoanalytic psychotherapy on PTSD patients in general beyond torture as a specific notion. Different authors (Fonagy, 2015; Leichsenring et al., 2014) who regularly monitor and review the effectiveness of psychodynamic psychotherapies refer to a single study by Brom et al. while assessing the effectiveness of psychodynamic therapies in PTSD patients. According to Fonagy (2015),

> There is only one study of PDT [psychodynamic psychotherapies] as an approach to post-traumatic stress disorder (Brom et al., 1989), which shows a significant reduction of intrusion and avoidance compared to waitlist, to about the same extent as hypnotherapy and trauma desensitization. Systematic reviews found insufficient evidence in relation to PTSD to warrant comment, although strong theoretical and clinical arguments have been advanced for incorporating a psychodynamic approach into PTSD treatment programmes. ...The case is weakened, however, by the absence of evidence for PTSD and the evidence of absence of effect for obsessive-compulsive disorder. In general, the methodological weaknesses of earlier studies call meta-analytic findings into question. (p.140-141)

In this study conducted by Brom et al. (1989), a total of 29 patients were included in a short-term psychodynamic therapy, and the majority of these patients were those who lost a relative to a disease; clinically significant improvements could be observed in about 60% of these patients. Furthermore, more re-

cently, a study by Levi et al. (2015) has been reported which compares CBT with psychodynamic therapy for combat-related PTSD patients who were combat soldiers or other military personnel. A significant improvement on symptoms has been monitored as a result of both therapies; no difference has been found in terms of effectiveness measurements; at post-treatment, 45% of the psychodynamic patients remitted. In our study, it has been observed that 75.4% of the patients benefited from the treatment in general according to their final CGI-I score. For such studies, the differences among the patient groups, trauma types, the features of applied psychodynamic therapy, effectiveness measurements etc. do not make a detailed comparison feasible in terms of treatment results.

Finally, our study -despite its evident methodological limitations- represents a contribution to the literature mainly for two reasons. First, it was conducted in Turkey which is a country where torture is practiced intensely. Second, research data on the psychanalytic treatment for PTSD due to torture is sparse in the literature and has not been studied extensively. Well-structured further studies of psychoanalytic psychotherapy in patients with PTSD associated with torture and severe violence are required.

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