

Control-Focused Behavioral Treatment: A brief intervention for survivors of war and torture

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Abstract

This article briefly reviews the evolution and evidence-base of Control-Focused Behavioral Treatment (CFBT), largely self-help-based treatment that involves no cognitive interventions, focuses solely on reducing avoidance behaviors through self-exposure to anxiety-evoking trauma cues, and, unlike other interventions, aims to enhance sense of control over traumatic stressors, rather than anxiety reduction. As such, it is radically different from other interventions in both theory and practice. Our studies have shown improvement rates of 80%-85% with a single treatment session in earthquake survivors. When administered in an average of 6 sessions in war and torture survivors, it achieved 82% reduction in posttraumatic stress symptoms (PTSD), leaving 97% of the cases nearly asymptomatic or with only mild PTSD symptoms. Meta-analytical comparisons suggest that such improvement rates are substantially higher than those achieved by other evidence-based treatments.

Introduction

Trauma events affecting large numbers of people, such as natural disasters, political violence, and torture lead to a serious mental health problem around the world. Effective dealing with this problem requires a mental healthcare model based on treatments that

are theoretically sound, proven to be effective, brief, easy to train therapists in their delivery, practicable in different cultures, and suitable for dissemination through media other than professional therapists, such as lay people, self-help tools, and mass media. Current evidence-based trauma treatments do not meet more than two or three of these requirements. The last requirement is particularly important, considering that most survivors do not have access to specialized treatment services and resources are not available to disseminate treatment to large survivor populations around the world.

Among the currently available evidence-based treatments, Cognitive-Behavioral Treatment (CBT) and its variants are the most widely used interventions in care of trauma survivors. The usefulness of CBT in psychological trauma is limited for several reasons. First, it involves a combination of different interventions, the relative efficacies of which are uncertain. There is evidence to suggest that cognitive interventions (Cahill, Rauch, & Riggs et al., 2005; Foa, Hembree; Marks, Lovell, Noshirvani, & Livanou, M., 1998; Paunovic and Öst, 2001) or anxiety management techniques (Foa, Dancu, Hembree, Jaycox, & Meadows et al., 1999; Foa, Rothbaum, Riggs, & Murdock, 1991) do not confer additional improvement when used in combination with exposure, sug-

gesting that the latter is the critical element of the treatment. There is further evidence from our own studies (reviewed later in this article) showing that cognitive interventions are not an essential component of treatment. Second, CBT is aimed at anxiety reduction and thus not suitable for ongoing trauma situations where anxiety is a natural response to continuing realistic threats to safety. Third, there is no convincing evidence regarding its cross-cultural practicability. Most importantly, it is not suitable for dissemination as an entirely self-help treatment without the need for a therapist.

Cognizant of such limitations of CBT, we initiated a series of studies in the 1990s to develop Control-Focused Behavioral Treatment (CFBT) as an alternative intervention that meets all requirements for post-disaster usefulness noted above. The reader is referred to our 2011 book (Başoğlu and Şalcioğlu, 2011) for a detailed presentation of its evolution, theoretical framework, and evidence base. In this article I present only a summary of this work and the findings from a yet unpublished study that examined the efficacy of CFBT in asylum-seekers in Turkey exposed to war and torture trauma.

Control-Focused Behavioral Treatment

CFBT is based on learning theory of anxiety, which posits that exposure to unpredictable and uncontrollable stressors is the primary mediating process in traumatic stress (Mineka and Zinbarg, 2006). Its development can be traced back to our work in the early 1990's when we examined the parallels between animal responses to inescapable shocks and human responses to torture and presented a learning theory formulation of torture trauma (Başoğlu & Mineka, 1992). Over the years we conducted a series of studies to examine the role of unpredict-

able and uncontrollable stressors in human responses to war and torture trauma. These studies revealed ample evidence showing that loss of control over threats to safety or helplessness anxiety is indeed strongly associated with traumatic stress. Such evidence implied that traumatic stress can be reversed by interventions that enhance sense of control (or resilience against) traumatic stressors. It was indeed this hypothesis that eventually led to the development of CFBT. The treatment was first tested with earthquake survivors in two uncontrolled (Başoğlu, Livanou, & Şalcioğlu, 2003; Başoğlu, Livanou, Şalcioğlu, & Kalender, 2003) and two randomized controlled (Başoğlu, Şalcioğlu, & Livanou, 2007; Başoğlu, Şalcioğlu, Livanou, Kalender, & Acar, 2005) studies and found to be highly effective, even when delivered in a single session.

CFBT is a relatively simple intervention with a sole focus on anxiety-evoking trauma cues and behavioral avoidance. It is designed to enhance sense of control over distress, anxiety, or fear associated with traumatic stressors, including memories of trauma. This is achieved by encouraging the person not to avoid anxiety- or fear-evoking situations. Anxiety and avoidance are common features of traumatic stress and are particularly intense when there is a continuing (real or perceived) threat to safety. In the case of earthquakes, for example, the initial devastating shock is often followed by hundreds of aftershocks that pose further danger. Similarly, torture survivors may face (or perceive) risk of further arrest and torture. In such situations sleeping difficulty, extreme alertness, and startle reactions in response to sudden movements and sounds are quite common. Many survivors fear and avoid various situations that signal further threat. For example, earthquake survivors often avoid going into their houses or

other concrete buildings even when it is safe to do so, stay alone at home, sleep alone or in the dark, take a shower, get undressed when going to bed, or any other situation where they think they may be caught helpless during an earthquake. Torture survivors avoid military or police officers on the street, people in positions of authority, interviews that resemble interrogation, medical examinations involving instruments, or any other situation or activity that reminds them of their torture. Trauma survivors also avoid situations that bring back distressing memories of the original trauma. Such avoidance can generalize to a wide range of situations and activities, leading to significant disruption in social, work, and family functioning. Generalized fear and avoidance may lead to feelings of total helplessness, loss of control over life, and eventually hopelessness and depression (Başoğlu and Şalcioğlu, 2011).

Briefly, CFBT involves the following procedures: 1) identify trauma cues or reminders that trigger anxiety, fear, or distress; 2) explain the treatment rationale (i.e., confront your anxiety, fear, or distress until you gain control over it); 3) give self-exposure instructions (i.e., do not avoid situations that evoke anxiety, fear, or distress); and 4) monitor progress. It is fundamentally different from CBT and other exposure-based treatments in its underlying theory, aims, presumed mechanisms of action, and treatment techniques and procedures. Most importantly, it is not based on habituation paradigm. The primary aim is to increase anxiety tolerance or sense of control over anxiety (hence resilience against anxiety), rather than anxiety reduction. Although anxiety diminishes with increased sense of control in most cases, improvement occurs even without substantial reduction in anxiety. This implies that patients are not required to conduct extensive exposure until complete habituation occurs. Exposure until

anxiety tolerance or control develops is sufficient. A focus on resilience-building rather than anxiety reduction makes the treatment suitable for environments involving ongoing threats to safety, where anxiety reduction is neither possible nor desirable. Second, it focuses solely on avoidance (behavioral or cognitive) and distress induced by trauma cues and does not involve any other techniques or procedures commonly used with CBT, such as cognitive restructuring and imaginal exposure. This makes it relatively easier to administer and train therapists in its delivery. Third, the therapeutic benefits of CFBT arise mainly from self-exposure to anxiety cues in the person's natural environment. In most cases the therapist's role is limited to explanation of the treatment rationale, giving self-exposure instructions, and monitoring progress. As such, it is more suitable as a self-help intervention than other treatments. Finally, a behavioral focus without elaborate cognitive interventions makes it easier to administer in different cultural settings and with people of lower socio-educational status. This aspect of treatment confers a distinct advantage in work with refugees where treatment needs to be delivered through interpreters.

A study of Control-Focused Behavioral Treatment of war and torture survivors

As noted earlier, CFBT was first tested with earthquake survivors in the early 2000s and then with asylum-seekers in Istanbul in more recent years. The latter study was conducted to examine the minimum number of treatment sessions needed to achieve significant clinical improvement. It involved 80 asylum-seekers referred to the project by various refugee care agencies in Istanbul. Of these, 20 were lost to the study for various reasons (mostly unrelated to treatment response), so the results were based on 60 cases. The

study was conducted as part of routine care of asylum-seekers referred to the project. Among all referrals, cases with Posttraumatic Stress Disorder (PTSD) were consecutively included in the study. Only psychotic cases were excluded.

Of the 60 study completers, 47% were from Democratic Republic of Congo, 18% from other African countries, 27% from Iraq, and 8% from other Middle Eastern and Asian countries.

The most commonly reported trauma experiences were witnessing war atrocities, exposure to bombings, sexual violence including gang rape (37%), and torture (32%). In most tortured cases, torture had been perpetrated by non-state actors (e.g., rebel groups, paramilitaries, etc.). Fifty-seven percent of the cases were female, and the mean age was 25 (SD 10). Forty-seven percent were illiterate, or literate with no schooling, or had only primary school education. None of the study participants were on any medication for traumatic stress problems and no psychotropic drugs were used in treatment.

The study did not include a control group, but the non-specific effects of therapist contact and pre-treatment assessment were examined in a subset of 25 cases by using a single-case multiple baseline experimental design. This included two baseline assessments conducted three weeks apart with no treatment in the interim period. Treatment was initiated after the second baseline assessment. The mean scores of the Clinician-Administered PTSD Scale (CAPS) – a measure of PTSD symptoms (Blake, Weathers, Nagy, Kaloupek, Charney, & Keane, 1990) – showed no reduction at the second baseline, meaning that therapist contact had no effect on PTSD symptoms. This suggests that the improvement in PTSD symptoms at post-treatment can be attributed to the specific effects of treatment.

Because the main aim of this study was to examine the minimum number of treatment sessions required for significant clinical improvement, treatment duration was flexible and involved a maximum of 12 sessions. Treatment was terminated (and follow-up phase initiated) when a rating of *'much / very much improved'* was obtained on Patient's Global Improvement (PGI), a 1-7 scale used to assess overall clinical improvement (1 = very much improved, 2 = much improved, 3 = slightly improved, 4 = no change, 5 = slightly worse, 6 = much worse, 7 = very much worse). Our studies have shown that this is valid and reliable measure of overall clinical improvement. As it reflects patients' own assessment of improvement, it is free from assessor bias. Depression was assessed by using Beck Depression Inventory (BDI; Beck, Rial, & Rickels, 1974). Treatment effects on PTSD and depression are shown in Figure 1 and Figure 2, respectively.

The results are shown together with the results of two randomized controlled studies of single-session CFBT in earthquake survivors (Başoğlu et al. 2005; Başoğlu et al, 2007) to demonstrate how the outcomes of a single treatment session compare with those of full-course CFBT. Study 1 (31 CFBT cases vs 28 waitlist controls) involved a single session of self-exposure instructions with no further therapist contact until post-treatment assessment at week 6, whereas Study 2 (16 CFBT cases vs 15 waitlist controls) involved one session of therapist-administered exposure to earthquake tremors in an earthquake simulator (45 minutes) followed by self-exposure instructions. Post-treatment assessment was conducted at week 6 in Study 1, at week 8 in Study 2 and at week 7 in Study 3. Figure 1 shows outcome separately for asylum-seekers with and without torture experience (difference non-significant). Figure 2, on the other hand shows outcome in pooled subgroups

Figure 1 - Comparison of war and torture survivors with earthquake survivors in response to treatment (mean total CAPS score)

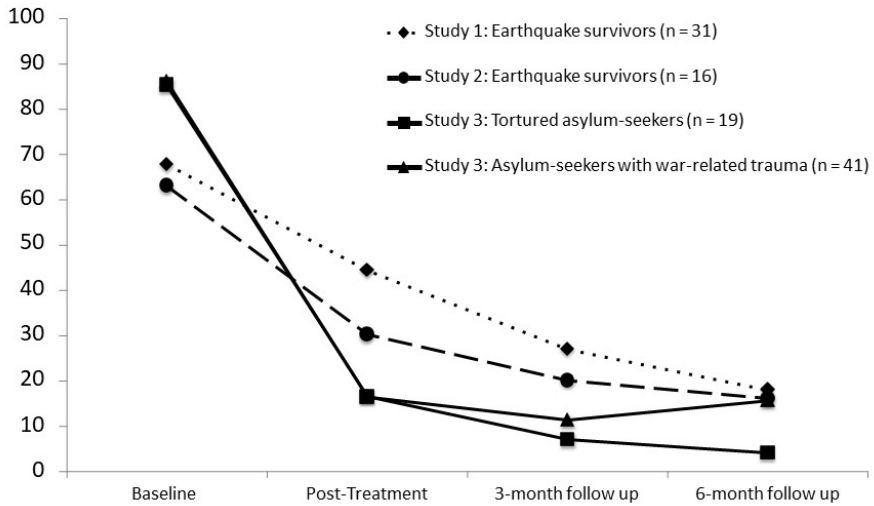
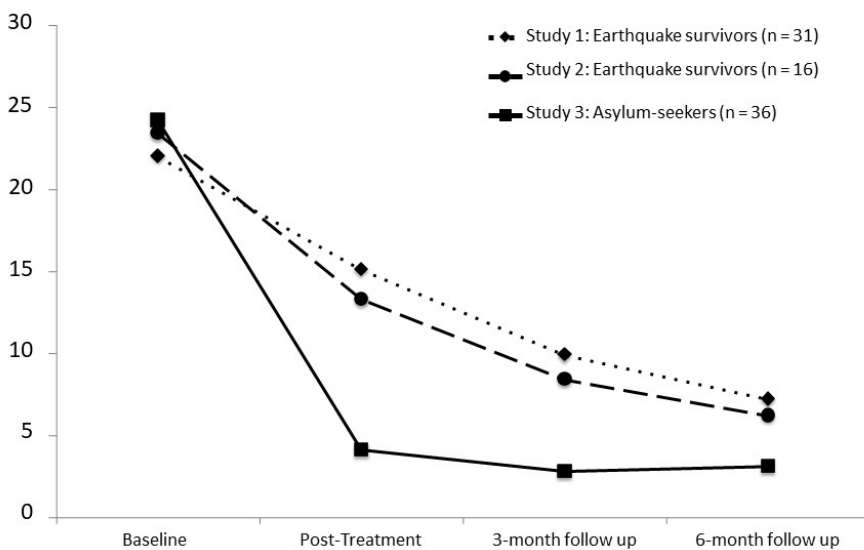


Figure 2: Comparison of war and torture survivors with earthquake survivors in response to treatment (mean Beck Depression Inventory score)



(which also showed no significant difference). Also, depression was assessed in only 36 refugees due to unavailability of BDI in some languages.

In study 1 and Study 2 the waitlist control group cases were crossed over after post-treatment assessment to receive active treatment following the same study design. In both studies the two groups were pooled together to examine the long-term global improvement rates in larger samples. Global improvement rates in Study 1 were 80% at 3-month follow-up, 85% at 6-month follow-up, and 83% at 1-2-year follow-up. The respective figures were 72%, 80%, and 80% in Study 2. The improvement rates at 6-month follow-up in the two studies correspond to within-group effect sizes of 1.6 and 3.5, respectively (mean 2.55).

In study 3 the mean number of sessions required for much / very much improvement in the sample was 6, which corresponded to the 7th week in treatment. The maximum number of sessions required for improvement was 4 in 20% of the cases, and 6 in 55% of the cases. Of the 60 cases, 56 (93%) met the criterion of much / very much improved at some point during treatment, which corresponded to 82% reduction in PTSD symptoms (81% in tortured cases and 82% in non-tortured cases). Although four cases rated themselves as 'slightly improved,' their PTSD symptoms showed mean 71% improvement. The CAPS score at post-treatment was under 20 in 70% of the cases (indicating near-complete recovery), between 20 and 39 (mild / sub-threshold PTSD) in 27%, and between 40-59 (moderately severe PTSD) in only 2 (3%) cases. Thus, 97% of the cases were either nearly asymptomatic or had only mild PTSD symptoms at the end of treatment. This outcome measure based on CAPS score is used in clinical studies to assess the end-state functioning achieved by treatment. It correlates highly with recov-

ery from the disabling effects of trauma on social, occupational, and family functioning.

The mean pre-treatment CAPS score among the asylum-seekers was 85, which indicates *extremely severe* PTSD, compared with 68 in Study 1 and 63 in Study 2, both of which fall into the category of *severe* PTSD. Despite such high levels of illness severity, the asylum-seekers showed greater improvement in both PTSD and depression than did earthquake survivors at post-treatment. This finding probably reflects the fact that the treatment was delivered to earthquake survivors in a single session, whereas the refugees received full-course CFBT. Note, however, that the improvement trends in the three groups converge at 6-month follow-up. This suggests that improvement with a single treatment session is slower but runs a steady course over 6 months, reaching the same level of improvement achieved by full-course treatment. This finding implies that CFBT can be administered on a largely self-help basis in war and torture survivors. Because Study 3 aimed at examining the optimum number of treatment sessions required for much / very much improvement, treatment had to be continued until such improvement occurred. It could have been discontinued earlier, as soon as the survivors showed sufficient reduction in avoidance behaviors (e.g., by 20%), thereby reaching a stage in treatment beyond which they might have been capable of conducting exposure on their own. Viewed together with the outcomes of a single-session CFBT in earthquake trauma, this possibility raises the prospect of a treatment even briefer than 6 sessions, possibly involving 1 to 3 sessions. Furthermore, CFBT could be helpful in reducing traumatic stress in some cases even when delivered on a solely self-help basis (e.g., through self-help tools). There is indeed preliminary evidence from a pilot study (Başoğlu,

Şalcıoğlu, & Livanou, 2009) with earthquake survivors showing that treatment delivered by a structured self-help manual can achieve a similar improvement rate as therapist-delivered treatment. This hypothesis is well worth testing in future research with war and torture survivors.

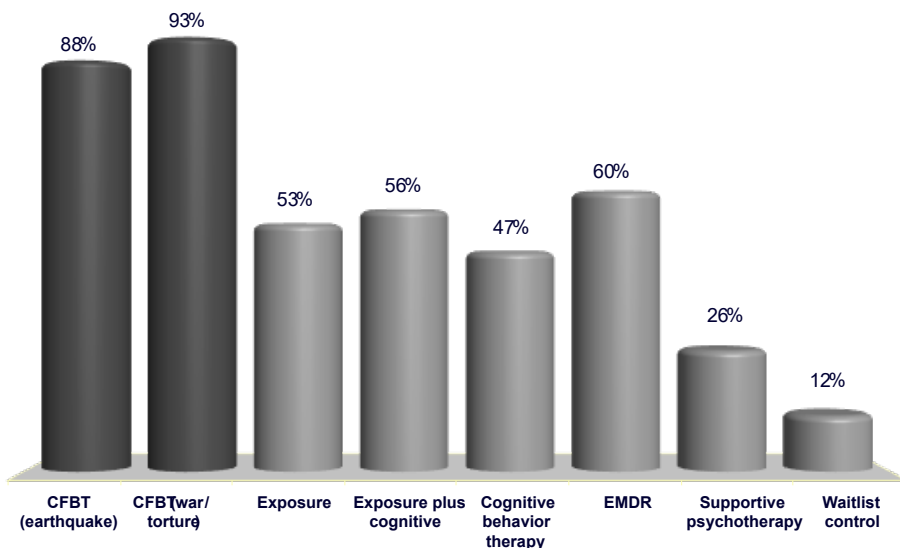
Comparison of CFBT with other evidence-based treatments

Although comparative studies of CFBT relative to other evidence-based treatments are not available, there is some indirect evidence to suggest that CFBT is superior to other treatments in efficacy. Figure 3 shows a comparison of CFBT (separately for earthquake and war / torture trauma) with other evidence-based treatments in terms of percentage of overall clinical improvement (or responder status). The improvement rate with CFBT in the first group is based on a total of 331 cases from our four treatment studies with earthquake survivors cited earlier, whereas

the improvement rate in the second group is based on 60 treatment completers in Study 3.

Figure 3 shows that the global improvement rates in our studies are substantially higher than those reported in studies of other treatments. Data on the latter treatments were drawn from a meta-analytical study (Bradley, Greene, Russ, Dutra, & Westen, 2005) of 26 studies (total of 1,535 cases) published between 1980 and 2003. As meta-analyses of treatment studies rarely report global improvement rates, I was able to find only one such study for comparison of treatment outcomes. Considering that more recent meta-analyses, such as that of Cusack, Jonas, Forneris, Wines, Sonis, et al. (2016) based on 31 studies conducted between 1980 and 2014, have not found greater between-group effect sizes for these treatments (mean treatment effect sizes across all treatments in Bradley et al and Cusack et al studies 1.32 and 1.26, respectively), the effectiveness of these treatments do not seem to have increased over time with the

**Figure 3 - Comparison of trauma treatments:
Percentage of overall improvement
(treatment completers)**



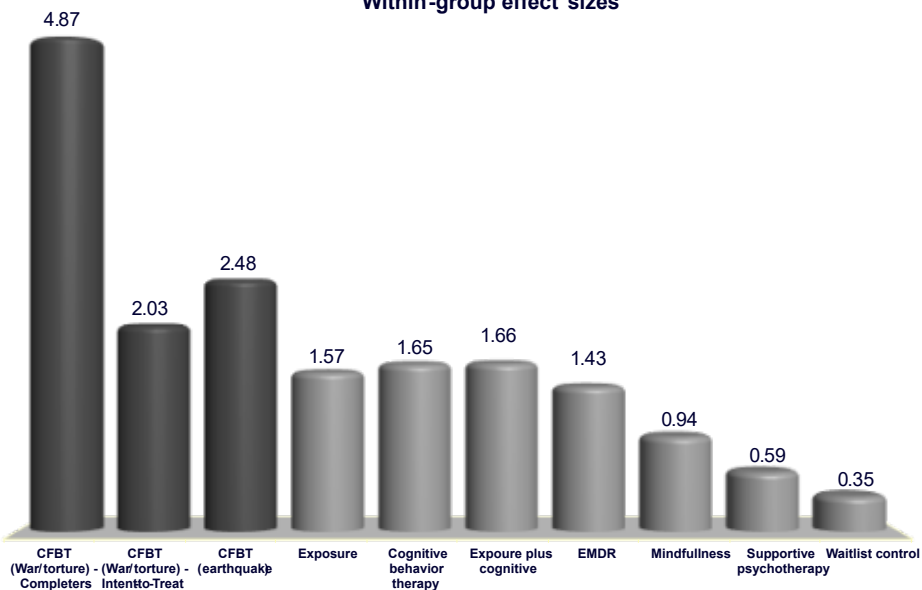
inclusion of more recent studies. Thus, to the extent that the studies included in these meta-analytical analyses reflect current practice of these treatments, CFBT appears to have a distinct superiority over them.

Comparison of between-group effect sizes across treatments is another useful way of comparing different treatments in effectiveness. However, this was only possible using within-group effect size for comparison here, because the pooled sample of 331 cases from our four studies of earthquake survivors included two uncontrolled trials of CFBT (Başoğlu, Livanou, & Şalcıoğlu, 2003; Başoğlu, Livanou, Şalcıoğlu, & Kalender, 2003). Again, such data were available only in the Bradley et al study. Figure 4 shows a comparison of treatments in within-group effect sizes. Information of mindfulness-based treatments was obtained from a metaanalytical study of Boyd, Lanius, & McKinnon (2108) involving treatments such as meditation-relaxation in child survivors of tsunami, mindfulness-based stress reduction, mindfulness-based cognitive therapy or mind-

fulness-based exposure therapy in war veterans, and mindfulness-based stress reduction in childhood sexual abuse.

All within-group effect sizes in Figure 4 were based on Intent-to-Treat analyses, except for the first one (4.87 in war and torture survivors), which is based on completers analysis. This effect size is therefore not comparable with those of other treatments. This information is nonetheless included in the figure to give the reader an idea about the magnitude of pre- to post-treatment change in PTSD symptoms (i.e., treatment efficacy) when survivors complete the treatment process. This finding reflects the substantial reduction in PTSD symptoms (81%-82%), while also explaining the high rate of global improvement (93%) as perceived by the study participants themselves. When the 20 non-completers are included in the analyses the effect size drops to 2.03, which is still substantially greater than the respective figures for other treatments. It is also worth noting here that an effect size of 2.48 in earthquake survivors is achieved by 1

**Figure 4 - Comparison of trauma treatments:
Within-group effect sizes**



or 2 sessions of CFBT (total session time of 1-2 hours), in comparison with an average of 15.6 total session time in other treatments.

A similar comparison of CFBT with other evidence-based treatments in asylum seekers or refugees was not possible because most studies do not report global improvement rates (or within-group effect sizes), as noted earlier. However, the results of some studies can be meaningful in this respect. A recent systematic review and meta-analysis (Turrini, Purgato, Acarturk, Anttila, Au, et al, 2019) of 26 studies involving a total of 1959 participants concluded that “while CBT was effective in decreasing PTSD and anxiety symptoms, EMDR was effective in terms of depressive symptoms only, and NET failed to show a significant effect.” The reported post-treatment between-group effect sizes were 0.71 (1.08 at follow-up) for PTSD symptoms, 1.02 (1.08 at follow-up) for depression, and 1.05 (1.28 at follow-up) for anxiety symptoms. Furthermore, only four studies assessed functioning and quality of life and found no difference between treatments and control conditions (effect size 0.17 for functional disability and 0.23 for quality of life at follow-up). These findings suggest that the so-called trauma-focused treatments do not perform better in asylum-seekers or refugees than in other trauma populations. Although such treatment effects can be statistically significant or effect sizes can be construed as large, there is still substantial room for improvement. Relatively low improvement rates around 50% points to only partial improvement and substantial residual psychopathology implying a serious risk of loss of treatment gains in the long-term.

It is worth illustrating the nature of this problem by examining the results of two studies of Narrative Exposure Therapy (NET), a variant of cognitive-behavioral treatment that has gained popularity in treatment of war and

torture survivors in recent years. In a controlled study of NET versus Treatment As Usual in asylum-seekers and refugees in Norway, Stenmark, Catani, Neuner, Elbert, and Holen (2013) reported highly significant treatment effects on PTSD and depression symptoms in the asylum-seeker group with between-group effect sizes of 0.58 and 0.59, respectively. Consistent with such relatively modest effect sizes, 54.5% of the active treatment cases among treatment completers still met the diagnosis of PTSD at 1-month follow-up. Similarly, of the 27 cases with Major Depression before treatment, 16 (59%) still met the diagnosis at the same assessment point. In another study of NET (Hansen, Hansen-Nord, Smeir, Engelkes-Heby, & Modvig, 2017) of 110 asylum-seekers and refugees conducted by the Danish Institute Against Torture (DIGNITY) in various North African and Middle Eastern countries, treatment reduced PTSD, anxiety, and depression scores only by 43.7%, 42%, and 28.7%, respectively, with similarly low improvement rates in pain (34.6%) and disability (39%). The authors concluded that these results “strongly suggest that short-term NET therapy can significantly reduce the mental health symptom load of survivors of war and torture.” Some of these results might be statistically significant but the extent of clinical improvement observed unfortunately leaves much to be desired. Clearly, there is still much room for improvement in the efficacy of treatments commonly used with war and torture survivors.

Concluding comments

Our findings show that war or torture trauma, however severe its psychological effects might be, is as responsive to an effective treatment as earthquake trauma. Furthermore, substantial recovery in the asylum-seekers occurred despite their adverse life circumstances in

Turkey. Some were homeless and had no money to buy food. This shows that additional life stressors do not necessarily block response to a potentially effective treatment. Lack of compliance with treatment is the single most important cause of treatment failure with CFBT and difficult life circumstances can affect treatment outcome only to the extent they make treatment attendance or conduct of homework self-exposure exercises difficult. We were able to overcome such difficulties with minimal support (e.g., providing travel money for treatment attendance) during the course of treatment.

While the fact that our study with asylum seekers did not include a control group could be viewed as a limitation, this does not necessarily invalidate the results for several reasons. First, lack of significant recovery between two baseline assessments in a subset of 25 cases suggests that the improvement observed at posttreatment does not reflect the effect of non-specific factors, as noted earlier. Second, the results need to be viewed together with those of Study 1 and Study 2, which had already demonstrated the effectiveness of CFBT using a controlled design. Third, the remarkable extent of improvement in asylum seekers (81%–82% reduction in PTSD symptoms, 93% of cases much / very much improved and 97% nearly asymptomatic or with only mild PTSD symptoms at the end of treatment, and a within-group treatment effect size of 4.85 among treatment completers), which is far greater than those reported with other treatments in the general trauma literature, is highly unlikely to reflect the effect of non-specific factors.

Over the last three decades I have argued for the need for an evidence-based approach to rehabilitation of survivors of torture. Such approach involves treatment research. I remember the strong negative reactions I had received

from some circles in the human rights and torture rehabilitation communities in response to a 1988 editorial (Başoğlu and Marks, 1988) pointing to the need for research in the field. Scientific research with survivors of torture was perceived almost as a blasphemy by some. In further publications (Başoğlu, 2006; Başoğlu and Şalcioğlu, 2011) in subsequent years I had pointed to the need for outcome evaluation studies to demonstrate the usefulness of torture rehabilitation programs. My 2006 British Medical Journal editorial (Başoğlu, 2006) triggered strong responses from many colleagues from around the world, leading to a heated debate (published online by the British Medical Journal, 2006) on issues such as whether there can be a “quick fix” or “standard therapy” for torture survivors (e.g., see Jaranson, 2007). In writing this article I could not help thinking that we have come a long way since then. Indeed, since the early 2000s some randomized controlled studies involving war and torture survivors have appeared in the literature, some conducted by torture rehabilitation centers, suggesting promising progress in this respect. These studies examined the effectiveness of various treatments, including CBT, EMDR, NET, and Interpersonal Psychotherapy, among others.

Having said this, I will once again have to play my usual Devil’s Advocate role and argue that there is still a long way to go. Most importantly, none of the above treatments are based on sound and empirically validated theory. It is therefore not surprising that they have only partial effects. In addition, how they exert their therapeutic effects and whether they have different mechanisms of action are important questions that have not received sufficient attention. Our research over the years has arguably shed some light on mechanisms of traumatic stress and improvement (the reader is referred to Başoğlu and Şalcioğlu, 2011 for

a detailed review of evidence). Nevertheless, a general tendency in the field of psychological trauma to give more weight to cognitive approaches in treatment still perseveres. That being the case, proponents of CBT or its many variants need to address some important questions raised by our studies. If cognitive and other anxiety-reducing interventions are essential in treatment, how can an intervention focusing solely on avoidance behaviors, using only live exposure, and aiming for enhancement of sense of control rather than anxiety reduction achieve such remarkable improvement, even when delivered in a single session in some trauma survivors? What do these findings imply for other psychotherapies, particularly for CBT and its variants, that involve systematic cognitive interventions? Furthermore, are these treatments suitable for cost-effective dissemination on a self-help basis to large survivor populations around the world without access to effective psychological care? I realize that these can be discomfiting questions for some, particularly those firmly entrenched in the idea that torture is a difficult trauma to treat and therefore requires lengthy psychological rehabilitation programs. Nevertheless, these questions will inevitably need to be properly considered and addressed to open the way to further progress in the field.

On a final note, I will take the opportunity to correct a common misconception that I have been advocating CBT for use in torture survivors throughout my career. First, I should note that my orientation in psychotherapy has been behavioral, not cognitive-behavioral, since the early 1970s. In the 1990s and early 2000s, I did some case studies of CBT in torture survivors (Başoğlu and Aker, 1996; Başoğlu, Ekblad, Bäärnhielm, & Livanou 2004) but having realized the limitations of both cognitive and traditional (habituation-based) behavior therapy, I abandoned

them in the early 2000s and developed CFBT. In our early articles on treatment of earthquake trauma cited in this article, we referred to the intervention as “modified behavioral treatment.” After having deliberated for some years over the question whether it is a modified version of traditional behavioral treatment (BT) or a novel intervention in its own right (hence deserving a new name), we decided to call it CFBT for the first time in our 2011 book (Başoğlu and Şalcioğlu, 2011). This decision was based on the consideration that CFBT is radically different both in its theoretical framework and clinical practice from either BT or CBT, as discussed earlier. It is therefore important not to confuse CFBT with the latter treatments.

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References

- Başoğlu, M. (2006) Rehabilitation of traumatised refugees and survivors of torture – After almost two decades we still do not use evidence-based treatments. *British Medical Journal*, 333, 1230-1231. 10.1136/bmj.39036.739236.43
- Başoğlu, M. & Aker, T. (1996) Cognitive-behavioural treatment of torture survivors: A case study. *Torture*, 6, 61-65.
- Başoğlu, M., Ekblad, S., Bäärnhielm, S., & Livanou, M. (2004) Cognitive-behavioral treatment of tortured asylum seekers: A case study. *Journal of Anxiety Disorders*, 18 (3), 357-369. [https://doi.org/10.1016/S0887-6185\(02\)00248-7](https://doi.org/10.1016/S0887-6185(02)00248-7)
- Başoğlu M., & Marks, I. M. (1988) Torture. Research needed into how to help those who have been tortured. *British Medical Journal*, 297, 1423-4.
- Başoğlu, M., Livanou, M., & Şalcioğlu, E. (2003) A single session with an earthquake simulator for traumatic stress in earthquake survivors. *American Journal of Psychiatry*, 160, 788-790. <https://doi.org/10.1176/ajp.160.4.788>
- Başoğlu, M., Livanou, M., Şalcioğlu, E., & Kalender, D. (2003) A brief behavioural treatment of chronic posttraumatic stress disorder in

- earthquake survivors: Results from an open clinical trial. *Psychological Medicine*, 33, 647–654. [10.1017/S0033291703007360](https://doi.org/10.1017/S0033291703007360)
- Başoğlu, M., & Mineka, S. (1992) The role of uncontrollability and unpredictability of stress in the development of post-torture stress symptoms. In M. Başoğlu (Ed.), *Torture and its consequences: Current treatment approaches* (182–225). Cambridge: Cambridge University Press.
- Başoğlu, M., & Şalcioğlu, E. (2011). *A mental healthcare model for mass trauma survivors: Control-Focused Behavioral Treatment of earthquake, war, and torture trauma*. Cambridge: Cambridge University Press.
- Başoğlu, M., Şalcioğlu, E., & Livanou, M. (2007) A randomized controlled study of single-session behavioural treatment of earthquake-related posttraumatic stress disorder using an earthquake simulator. *Psychological Medicine*, 37, 203–213. <https://doi.org/10.1017/S0033291706009123>
- Başoğlu, M., Şalcioğlu, E., & Livanou, M. (2009) Single-case experimental studies of a self-help manual for traumatic stress in earthquake survivors. *Journal of Behaviour Therapy and Experimental Psychiatry*, 40, 50–58. <https://doi.org/10.1016/j.jbtep.2008.04.001>
- Başoğlu, M., Şalcioğlu, E., Livanou, M., Kalender, D., & Acar, G. (2005) Single-session behavioral treatment of earthquake-related posttraumatic stress disorder: A randomized waiting list controlled trial. *Journal of Traumatic Stress*, 18, 1–11. <https://doi.org/10.1002/jts.20011>
- Beck, A. T., Rial, W. Y., & Rickels, R. (1974) Short form of depression inventory: cross validation. *Psychological Reports*, 34, 1184–1186. <https://doi.org/10.1177/003329417403403s01>
- Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Charney, D. S., & Keane, T. M. (1990) *Clinician-Administered PTSD Scale (CAPS) – Current and Lifetime Diagnostic Version*. Boston: National Center for Posttraumatic Stress Disorder, Behavioral Science Division.
- Boyd, J. E., Lanius, R. A., & McKinnon, M. C. (2010) Mindfulness-based treatments for posttraumatic stress disorder: a review of the treatment literature and neurobiological evidence. *Journal of Psychiatry & Neuroscience*, 43 (1), 7–25. <https://doi.org/10.1503/jpn.170021>
- Bradley, R., Greene, J., Russ, E., Dutra, L. & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry*, 162, 214–227. <https://doi.org/10.1176/appi.ajp.162.2.214>
- British Medical Journal (2006) Rapid responses. <https://www.bmj.com/content/333/7581/1230/rapid-responses>. Accessed October 27, 2021.
- Cusack, K., Jonas, D. E., Forneris, C. A., Wines, C., Sonis, J., Middleton, J. C., Feltner, C., Brownley, K. A., Olmsted, K. R., Greenblatt, A., Weil, A., & Gaynes, B. N. (2016) Psychological treatments for adults with posttraumatic stress disorder: A systematic review and meta-analysis. *Clinical Psychology Review*, 43, 128–41. <https://doi.org/10.1016/j.cpr.2015.10.003>
- Foa, E. B., Dancu, C. V., Hembree, E. A., Jaycox, L. H., Meadows, E. A. & Street, G. P. (1999) A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal of Consulting and Clinical Psychology*, 67, 194–200. [10.1037/0022-006X.67.2.194](https://doi.org/10.1037/0022-006X.67.2.194)
- Foa, E. B., Hembree, E. A., Cahill, S. P., Rauch, S. A. M., Riggs, D. S., Feeny, N. C., & Yadin, E. (2005) Randomized trial of prolonged exposure for posttraumatic stress disorder with and without cognitive restructuring: Outcome at academic and community clinics. *Journal of Consulting and Clinical Psychology*, 73, 953–964. <https://doi.org/10.1037/0022-006X.73.5.953>
- Foa, E. B., Rothbaum, B. O., Riggs, D. S. & Murdock, T. (1991) Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counseling. *Journal of Consulting and Clinical Psychology*, 59, 715–723. <https://doi.org/10.1037/0022-006X.59.5.715>
- Hansen, A. K. V., Hansen-Nord, N. S., Smeir, I., Engelkes-Heby, L., & Modvig J. (2017) Impact of Narrative Exposure Therapy on torture survivors in the MENA region. *Torture*, 27 (3), 49–63. <https://doi.org/10.7146/torture.v27i3.103977>
- Jaranson, J. M. (2007) Standard therapy for all torture survivors: A reply to Metin Basoglu. *British Medical Journal*. <https://www.bmj.com/rapid-response/2011/11/01/standard-therapy-all-torture-survivors-reply-metin-basoglu>. Last accessed October 27, 2021).
- Marks, I. M., Lovell, K., Noshirvani, H., & Livanou, M. (1998). Treatment of posttraumatic stress disorder by exposure and/or cognitive restructuring – A controlled study. *Archives of General Psychiatry*, 55, 317–325. [10.1001/archpsyc.55.4.317](https://doi.org/10.1001/archpsyc.55.4.317)
- Mineka, S. & Zinbarg, R. (2006). A contemporary learning theory perspective on the etiology of anxiety disorders – It is not what you thought it was. *American Psychologist*, 61, 10–26. [10.1037/0003-066X.61.1.10](https://doi.org/10.1037/0003-066X.61.1.10)

- Paunovic, N., & Öst, L. G. (2001). Cognitive-behavior therapy vs exposure therapy in the treatment of PTSD in refugees. *Behaviour Research and Therapy*, 39, 1183-1197. 10.1016/S0005-7967(00)00093-0
- Stenmark, H., Catani, C., Neuner, F., Elbert, T., & Holen, A. (2013) Treating PTSD in refugees and asylum seekers within the general health care system. A randomized controlled multicenter study. *Behaviour Research and Therapy*, 51(10), 641-647. 10.1016/j.brat.2013.07.002
- Turrini, G., Purgato, M., Acarturk, M., Anttila, M., Au, T., Ballette, F., ...Barbui, C. (2019) Efficacy and acceptability of psychosocial interventions in asylum seekers and refugees: systematic review and meta-analysis. *Epidemiology and Psychiatric Sciences*, 28(4), 376-388. <https://doi.org/10.1017/S2045796019000027>