



# Factor structures of Complex Posttraumatic Stress Disorder and PTSD in a community sample of refugees from West Papua

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## ABSTRACT

**Objectives:** The intention to include a category of Complex Posttraumatic Stress Disorder (CPTSD) in ICD-11 has renewed interest in this construct. Although growing evidence from high income countries supports the construct validity of CPTSD, little parallel research has been undertaken across cultures. We tested theoretically supported CPTSD structures (a one-factor, six-factor, one-factor higher-order, and two-factor higher order structure) in a community sample of West Papuan refugees living in a remote town, Kiunga, in Papua New Guinea (PNG). **Procedures:** A community-wide survey was conducted (2016–2017; response rate 85.5%) amongst 486 West Papuans. Culturally adapted measures were applied to assess cumulative traumatic exposure, postmigration living difficulties (PMLDs), CPTSD symptoms, and functional impairment.

**Findings:** A six factor structure for CPTSD provided the best fit to the data, consistent with our past study amongst West Papuans.

**Conclusions:** The cross-cultural validity of our findings is supported by the isolation of West Papuan participants from services treating traumatic stress. To further support the universal applicability of CPTSD, our findings need to be confirmed amongst other refugee groups from diverse cultural backgrounds.

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## 1. Introduction

In recent years, there has been growing interest in the construct of Complex Posttraumatic Stress Disorder (CPTSD), a category that will be formally recognized in the forthcoming ICD-11 [1, 2]. The construct validity of CPTSD has received broad support from factor analytic studies undertaken across a range of trauma-affected populations [3–6]. An important question, however, is whether CPTSD can be identified across cultures, and if so, whether the proposed ICD-11 structure can be verified in those settings. In a previous study amongst West Papuan refugees, we were able to identify the six-symptom domains of CPTSD but not a unitary factor underlying the construct [7]. We extend this line of inquiry by examining the factorial structure of CPTSD in a larger population of West Papuans residing in a remote, rural area of Papua New Guinea (PNG).

Advocacy for the recognition of CPTSD [8] has drawn on the limitations of the PTSD category in capturing the full range of psychosocial responses of survivors of interpersonal abuses such as rape, sexual assault, political persecution and torture [9–12]. Although some of the relevant characteristics of complex PTSD (hostility, extreme isolation, paranoia)

were included in the ICD-10 category of Enduring Personality Change After Catastrophic Experiences (EPCACE), the diagnosis received little attention [13]. In addition, a Disorder of Extreme Stress Not Otherwise Specified (DESNOS) proposed for DSM-IV was excluded from the final version of the manual following field trials [14]. Nevertheless, DESNOS retained its currency in high income, Anglophone countries, particularly in clinical practice and research amongst survivors of childhood sexual abuse [15]. However, the few studies that investigated DESNOS amongst conflict-affected and refugee populations provided only limited support for the validity of the category in those populations [16, 17].

The recent formulation of CPTSD for inclusion in ICD-11 defines the disorder as a disturbance of self-organization (DSO) [2] comprising the subdomains of affective dysregulation, negative self-concept, and difficulties in interpersonal relationship [2]. CPTSD is defined as an extension of PTSD manifesting amongst survivors of prolonged or repeated abuse (sexual and gender-based violence, torture, kidnapping), or of extreme forms of violence such as combat, warfare, and terror attacks. Based on this definition, the three subdomains of PTSD (memory intrusions, avoidance and hyperarousal) need to be present to consider an additional diagnosis of CPTSD. In effect, this means that six symptom domains need to be present (three each for PTSD and DSO) to make a diagnosis of CPTSD. Studies examining CPTSD amongst civilian populations residing in high income countries (including survivors of extreme childhood adversity, terror attacks, and combat) have provided initial support for the underlying factorial structure of the category [18–20].

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Specifically, in two studies of survivors of early childhood sexual abuse, confirmatory factor analysis (CFA) identified a two-factor higher order model comprising the two core components of PTSD and DSO, each represented by their respective three symptom domains [4, 21].

To date, there are few studies examining the factorial structure of CPTSD across cultures. A study amongst an ethnically heterogeneous clinic sample of refugees settled in Switzerland supported a higher order factor structure comprising the two domains of PTSD and CPTSD [22]. In our previous study amongst West Papuan refugees resettled in shanty towns in Port Moresby, the capital of Papua New Guinea, we identified the specified ICD-11 PTSD structure but not the six-factor structure required for CPTSD. In a further analysis, however, we found support for both a single factor (CPTSD) and two-factor (PTSD and CPTSD) model, although the former provided the most parsimonious solution [7, 23]. Given that these findings provide only partial support for the factorial structure of CPTSD in this transcultural setting, we undertook the present study involving a larger sample of West Papuan refugees living in a rural environment.

In undertaking the study, we note the considerable heterogeneity in the outcome of factorial studies examining the structure of PTSD in high income countries. These studies have yielded a range of structures, typically comprising between four and six factors [24–26]. In the present analysis, we examine the ICD-11, DSM-IV and DSM-5 structures of PTSD to provide a yardstick to compare the relative strength of our CPTSD factorial solution, the chief aim of our inquiry. We also investigate the concurrent validity of CPTSD by assessing its association with characteristics known to be associated with the reaction, including high levels of exposure to the traumas of persecution and conflict [5], ongoing stressors that may contribute to perpetuating and exacerbating the disorder, and functional impairment [15].

West Papuans have experienced extensive traumas related to mass conflict and human rights violations during the course of the history of the Indonesian occupation that extends back to the invasion in 1962 [27]. In an attempt to suppress the indigenous independence movement, the Indonesian military has perpetrated widespread abuses including torture, disappearances, extra-judicial imprisonment, and mass displacement of populations [28]. Successive waves of refugees have crossed the border into neighbouring PNG, with the largest settlement being established near the border in the small town Kiunga. The location is characterized by extreme geographical isolation, insecurity (being close to the border), poor opportunities for education and employment, limited services, and extreme poverty.

Our aim was to examine epidemiological data obtained from the Kiunga West Papuan community to test theoretically relevant factorial models of CPTSD, that is, a one-factor, six-factor, one-factor higher-order, and two-factor higher order structure. We also tested PTSD structures based on DSM-IV and DSM-5 criteria to provide a broad yardstick to judge the relative strength of the CPTSD structures. As a test of concurrent validity, we examined whether the CPTSD structure that emerged was associated with high levels of trauma exposure, functional impairment and postmigration living difficulties (PMLDs).

## 2. Material and methods

### 2.1. Sample

The study was conducted between March and September 2016. We applied a census-based community-wide sampling framework in which we surveyed all dwellings in nine settlements in Kiunga, a town in the Western Province of PNG situated close to the West Papuan border. Census data collected by the PNG government detailing the whereabouts of all West Papuans living in the country provided the initial template for identifying the population in Kiunga. Available local informants (community leaders, officials in the local government, and workers in faith-based services) confirmed that virtually all West Papuans in the area resided in nine settlements of *Nemo Corner*, *Defence*

*Camp*, *Kungim*, *Michael Corner*, *Bun Settlement*, *Kumbit 1 and 2*, *Komoka Corner*, *Selamat Corner*, and *Waterfront*. Based on the census data, we were able to identify the actual houses in which West Papuans resided within these catchment areas. To ensure accuracy in identifying the population, we conducted a full door-to-door household survey of the designated villages to document the origins of all residents. Eligible participants included all adults (18 years and older) and adolescents (11–17 years) originating from West Papua or born to at least one parent from the territory. The present analysis is restricted to the adult sample.

We identified 817 persons of whom 260 were adolescents. We were unable to contact 115 adult West Papuans residents after five visits to the relevant dwelling. In all cases, these persons were absent because of temporary relocation to other parts of PNG. All adults contacted agreed to participate in the survey. Taking absent persons into account, the response rate was 85.8%.

### 2.2. Measures

#### 2.2.1. CPTSD

We measured CPTSD using the Refugee Mental Health Assessment Package (R-MHAP) [29] developed during a previous study in Port Moresby, the capital of PNG. Diagnoses are generated for both the Diagnostic and Statistical Manual (editions IV and 5) [30] and ICD (editions 10 and forthcoming 11) [2]. We applied the DSM-5 criteria for PTSD and the ICD-11 formulation for CPTSD. Participants were asked to respond to the full list of symptoms for all diagnostic categories without applying skip rules. We defined a traumatic event based on the DSM-5 criteria. In assessing further for CPTSD, we applied the ICD-11 trauma exposure criteria specified for that diagnosis.

Details of the qualitative and psychometric steps taken to develop, culturally adapt and test the R-MHAP have been provided previously [29] and will only be summarized here. Prior to our first study amongst West Papuans in Port Moresby, we pursued a systematic process of consultation with community members and PNG psychiatrists to assess the cultural and contextual relevance of the mental health constructs under study, noting that there is a high degree of commonality in the Melanesian culture between indigenous persons from PNG and West Papua. All psychiatrists consulted reported that they commonly make the seven mental health diagnoses included in the R-MHAP in their practices. A series of focus groups were held amongst West Papuan refugees ( $n = 40$ ) drawn from a wide range of socio-demographic backgrounds (ages, gender, education and roles in the community), first in Port Moresby and then Kiunga ( $n = 20$  in both) [29]. As expected, none of the participants was familiar with the formal nomenclature of the index mental disorder categories under study, although there was a high level of recognition of constituent symptoms and their significance as a source of distress.

Terms for symptoms of PTSD in the lingua franca, Bahasa Indonesian included “waspada” (hypervigilance), “menghindari” (avoidance), “kehilangan minat” (loss of interest), “dijaga” (startle response), “sakit hati” (anger and resentment), and “tidak percaya” (loss of trust). Similarly, CPTSD symptoms were recognized and named, for example, anger outbursts (“naik dadah”), self-blame (“meduduh diri”), detachment (“tersendiri”), and loss of interest (“kehilangan minat”). Qualitative and psychometric data concerning the reliability and validity of the R-MHAP diagnostic section have been reported previously [29, 31, 32].

In a concordance study with a subsample of respondents from the Port Moresby community, we compared overall caseness (that is, persons meeting criteria for one or more of the disorders measured) based on the R-MHAP with the corresponding diagnostic modules of the Structured Clinical Interview for DSM-IV/DSM-5 disorders applied in a blinded manner by a psychologist. The analysis produced a sound level of concordance, indicated by an Area Under the Curve (AUC) of 0.93, a sensitivity of 0.98, a specificity of 0.97, a positive predictive power of 0.95, and negative predictive power of 0.98 [29]. In addition, there was a high degree of stability of symptoms of all disorder categories over a six-month period of follow-up. Internal reliability was high

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