

## MENTAL HEALTH ON COLLECTIVE TRAUMA AND TERROR ON YAZIDI IN IRAQ

Prof. Dr. Jan Ilhan Kizilhan\*<sup>1,2</sup>

<sup>1</sup>Institute for Psychotherapy and Psychotraumatology, University of Duhok, Zakho Street, Duhok, Iraq.

<sup>2</sup>State University Baden-Württemberg, Friedrich-Ebert-Strasse 30, D-78054 Villingen-Schwenningen, Germany.

Received date: 01 October 2019

Revised date: 22 October 2019

Accepted date: 12 November 2019

\*Corresponding Author: Prof. Dr. Jan Ilhan Kizilhan

Institute for Psychotherapy and Psychotraumatology, University of Duhok, Zakho Street, Duhok, Iraq.

### ABSTRACT

In August 2014, when troops of the self-proclaimed “Islamic State” conquered areas of northern Iraq, they turned on the long-established religious minorities in the area with tremendous brutality, especially towards the Yazidis. Huge numbers of men were executed, thousands upon thousands of women and children were abducted and wilfully subjected to sexual violence. The religious minority was to be eliminated and the will of the victims broken. Thousands were forced to convert and, in keeping with patriarchal traditions, the women were told by the terrorists that they were now “dishonoured” and “couldn’t go back in any case”. When treating traumatised survivors of war, like the Yazidi, the therapist must take into consideration cultural and socio-political aspects, individual and collective burdens (e.g. war in homeland over many generations, gender-specific and societal disadvantages and imprisonment of family members or their disappearance), their perception of illness, how they deal with their illness and how they form relationships. In addition to an acceptance of cognitive behavioural therapy, there are language barriers and individual and psycho-social stress factors. The following contribution discusses the interaction of cultural and psycho-social factors in persons from other cultures who are undergoing cognitive behavioural therapy and makes recommendations based on this.

**KEYWORDS:** Refugees, trauma, yazidi, war, culture, perception of illness.

### INTRODUCTION

The Yazidis are a Kurdish minority group, distinguished in terms of religion rather than through ethnic or linguistic differences. The majority of Kurds were forced to convert to Islam<sup>[1]</sup> however, the Yazidis, who resisted this, regard themselves as followers of the oldest religion in the world. Yazidis live predominantly in present-day northern Iraq, with their total population worldwide being estimated at 800,000 to one Million (Kreyenbroek. 2009).

Since the attack by the so called ‘Islamic State’ (ISIS) at the beginning of August 2014, more than 9000 Yazidis have been killed and thousands of families have been held hostage in their villages and murdered if they refused conversion to Islam, and over 6000 young girls have been abducted, raped, sold in Arab markets, enslaved, or killed (Guest, 1998; Ceri et al. 2016).

There have been few epidemiological studies published on the psychological disorders of the Yazidi genocide. Ceri and colleagues (2016) interviewed children and adolescents approximately 2 years after the genocide in a

refugee camp in Turkey and concluded that 43% of the survivors showed moderate to severe posttraumatic stress reactions (Ceri et al. 2016). Posttraumatic stress reactions of children and young adolescents were associated with parental loss, exposure to violence, and, most importantly, the feeling that their life was perpetually in danger. More women than men suffered from PTSD, and more women than men with PTSD or depression reported having experienced rape or witnessed the death of a spouse or child (Tekin et al. 2016; United Nations Human Rights Office of the High Commissioner, 2016).

The medical and psychological treatment of traumatised refugees presents therapists with enormous difficulties (Schouler-Ocak, 2015). In addition to the problem of language, these include culture-specific perceptions of illness and how the patients describe it, their relationship to the therapist, how they structure their reporting of events, political constellations and sex-specific aspects etc., all of which go to make the examination, diagnostics and the treatment more difficult (Kizilhan, 2016).

In addition to their traumatic experiences it can be assumed that the Yazidi refugees have an increased mental burden as a result of additional stress factors during their flight and their adaption to migration (Pagotto, Mendlowicz & Coutinho, 2015; Mohammadi, 2016) and for several generations a the Yazidis have suffered repressive measures in their homeland on account of their ethnicity or religion (Kizilhan, 2016; Maercker, 2009).

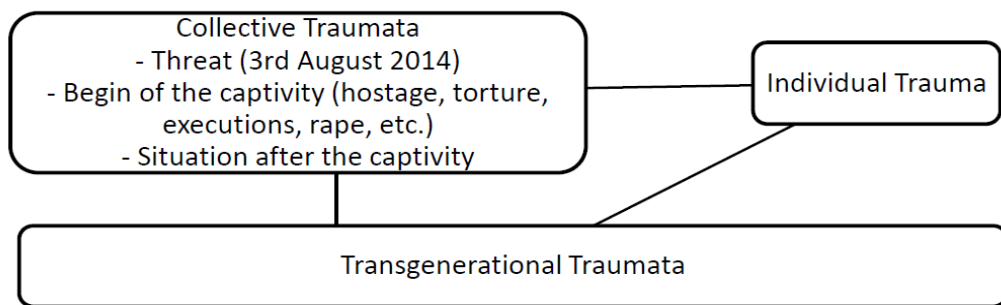
They have different conceptions of health and illness (Hinton & Kirmayer, 2016). Their ideas of dealing with traumatic experiences are influenced by their respective cultures and their traditional medicine (Kirmayer & Ryder, 2016; Kizilhan & Noll-Hussong, 2017). The therapist must therefore reflect all the more about his or her western constructs, adapt them and must integrate alternative concepts when encountering traumatised individuals from other cultures (Kirmayer & Ryder, 2016; (Hinton & Kirmayer, 2016).

**Transgenerational traumata and the consequences for the current traumatisation**

Together with their current traumatisation, the genocide of the ISIS brings back to mind the genocide and

massacre of their ancestors (Kizilhan & Noll-Hussong, 2017). They experience a double or multiple traumatisation and come to the conclusion that they cannot defend themselves and that they will, again and again, be victims of Islamic terror (Gedai, Kizilhan & Noll-Hussong, 2015). The distance to Islam has become significantly greater. Out of fear of their Moslem fellow-countrymen they keep quiet and say nothing, yet they have lost their trust, because once more, in the name of Islam, they are being subjected to a collective massacre just as they were in the 18th or 19th century (Kizilhan, 2017; Hinton & Kirmayer, 2016).

We can see similar types of behaviour as with those persons who experienced the Holocaust (Lazar, Litvak-Hirsch & Chaitin, 2006). They are unsure, tense, are worried that their children cannot survive and have feelings of being powerless and helpless (Hassan, Ventvoegel & Jeffee-Bahloul, 2016). They experience their individual traumata, are collectively traumatised on 3rd August 2014, and remember the transgenerational traumata of their ancestors.



(Yazidi: since 800 years 74 Genocide)

**Fig. 1: Three types of trauma.**

We can observe three types of trauma with the Yazidi. Through narrative, the genocides, connected with fear and insecurity, have been passed on from one generation to another via stories, songs and prayers. The concept “Ferman” stands for genocide. Memories of historical genocides are evoked as soon as a Yezidi hears the word “Ferman”. It was with this background that the Yezidi experienced the genocide at the hands of the IS which began on 3rd August 2014 as a continuation of the traumatisation of their collective (Gedau, Kizilhan & Noll-Hussong, 2017).

These collective experiences are part of the collective memory of the Yezidi, yet – as bad as they may be – during the therapy they can probably “help” a person come to terms better with his or her individual traumata by providing resilience strengthening. In treating the survivors of terror, resilience strengthening is of great significance (Gedau, Kizilhan & Noll-Hussong, 2017; Clay, 2016).

**Preconditions for the treatment**

The diagnostics of mental disorders and the diagnostics of post-traumatic stress disorders orient towards the criteria of ICD-10 and DSM-V. This assumes comparable burdens and reactions in all people who have lived through a traumatic event. However, this is not confirmed by clinical experience or by the findings of transcultural psychiatry (Schouler-Ocak, 2015).

In principle, the concept of post-traumatic stress disorder (PTSD) and cognitive behavioural 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 (Kira, 2010).

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 (Lersner & Kizilhan, 2017).

Even the working out of cognitions, emotions, the definition of the self, individual and collective identity and the way the problems are presented (for example, when taking the case history, some groups of patients only report pains in their body) can make treatment difficult because there is often no match with the known diagnostic criteria (Summerfield, 2001). Therapists often report that, when taking the initial case history, patients from a traditional oriental community first of all talk in great detail about their ancestors' problems and only later (perhaps) connect this to their traumatisation. This can lead to a lack of understanding and impatience on the part of the therapist (Schauer, Neuner & Elbert, 2011; Droidek, 2010). Meine Studie zur Medication im Iraq angeben.

### **PTSD, Pain Medication and Addiction of Refugees in Iraq Behavioural Case History**

The psychotherapeutic interview is of central importance to the treatment of mental illnesses. Patients from other cultures come to the first meeting perhaps with different expectations than those of indigenous patients (Ford, Courtois & van der Hart O, 2005). It is essential to recognise these and -within the realms of what is possible- to focus on them in order to create a good starting point for the treatment (Neuner, Schauer & Klaschik, 2004). There can be misunderstandings, for instance, when the relatives accompanying the patient want to be present at the initial interview. In this case Lersner und Kizilhan (2017) recommend having everybody in the treatment room and doing the first session with the whole family, even if this setting is unusual (Lersner und Kizilhan, 2017). At this point we must remember that socio-centric-orientated people experience life as part of a social system. They think, feel and act within this system. Everyday reality is in the family and is always linked to the "others"; the "collective thought" outweighs and influences their thoughts and actions. Concepts relating to the "ego" are not individualist as in western thinking (Droidek, 2010; Kirmayer, 1996).

When recording their case history, people from oriental-patriarchal communities do not relate events in a chronological or individual way regarding a particular focal incident. They always link these to the collective, that is, they refer to their ancestors, to their family, to clan structures etc. (Pennebaker, 1997). This can lead to a stress situation for the therapist, since he or she is used to a linear story line, with a beginning and an end, and the patient has not finished within the time allocated for the therapy. Pushing the patient to "get to the point" can be understood by him or her as an insult or rejection. This can put a strain on the patient-therapist relationship

right from the start. In such cases it is advisable to allocate a double session for the biographical history (Kirmayer, 1996; Pennebaker, 1997).

### **Forming Relationships**

As a result of their traditional upbringing and socialisation, the members of a traditional family regard the relationship to other people is very significant (Neuner, Schauer & Klaschik, 2004). This also applies to their relationship to the doctor or therapist administering treatment, since many patients have already (Slobodin & De Jong, 2015) sought help from traditional healers in their homeland who are able to communicate effectively (Kirmayer & Sartorius, 2007; Buhmann, 2014)). With traumatised people in particular, the therapist's qualities such as understanding, patience, respect, politeness, attentiveness, friendliness and openness are often more highly regarded than specialist knowledge (Droidek, 2010; Lersner & Kizilhan, 2017).

A relationship based on trust, which above all means accepting the patient's problems, is especially important. In the case of patients from family-oriented communities, the doctor (the clinical psychologist is also regarded as a "doctor") is traditionally seen as a fatherly friend of the family (Machleidt & Gül, 2010). He is a figure of authority who deals with the patient and his family in an active, knowledgeable and advisory capacity. He has to accept this cultural transmission so as not to cause considerable insecurity in the patient. Female therapists also enjoy great authority and male patients allow these women to treat them. Both male and female therapists are highly regarded in traditional communities and in everyday conversations you often hear the phrase "First God, then the doctor" (Machleidt & Gül, 2010). Men and women have no problems about undergoing a physical examination by either male or female doctors. In the case of severely traumatised patients due to sexual violence for instance, it is advisable to ask, prior to treatment, if they will accept treatment from a male therapist (Kizilhan & Noll-Hussong, 2017). In such cases a feeling of shame and transference phenomena play an important role and this should be taken into consideration (Wilson, Drozdek, & Turkovic, 2006). Unlike when dealing with indigenous patients, where it is very important to mobilise their own potential, the patients mentioned above have to be offered more help by the person in authority and, in fact, they expect this (Kinzie, 2006). This means, however, that the therapist has to develop an awareness of his or her own cultural dependence. From this position he or she should be in a position to diffuse his (counter)-transferences towards the patients. He must diffuse all his individual and social prejudices and stereotypes which are present in the shape of collective transferences before they begin to have a destructive effect on the treatment (Wenk-Ansohn & Gurriss N, 2006; Ford, Courtois & van der Hart O, 2005). Only then is it possible for the patient to be willing to change his behaviour on a mental and physical level.

Disorders and burdens are not individualised and pathologised a priori but are linked to the social environment. The individual's history is seen in the context of his family and his community within a cultural socio-political context. This applies in particular to politically-motivated experiences of violence, since these people become the victims of violence on account of their belonging to a social or political group (Wenk-Ansohn & Gurriss, 2006). Together with an appreciation of the migration experience as a necessary developmental process, this is the basis for a productive trauma therapy for migrants from family-oriented communities.

If the family and the role of each member of the extended family are included as a factor, this can lead to a better appreciation of any possible family conflicts and dependence on relationships. In cases of sexual violence, outside or within the family, the strong solidarity of the family with a traumatised patient can, in certain circumstances, prevent an improvement and even make the symptoms worse (Schauer, Neuner & Elbert, 2011, Droidek, 2010).

Whereas the contact to a different culture as a result of migration does have an influence on the explanation models of illness and health, it does not essentially influence attribution patterns. As we know from studies on migration, groups abroad tend to intensify their values and attitude systems (Pagotto, Mendlowicz & Coutinho, 2015). On the other hand attribution patterns which have been experienced positively are adopted and are integrated into their own concept of illness.

While for instance western societies regard mental problems as acquired and should therefore be actively processed, traditional societies see mental illness as the consequence of fate. They do not see any reason to actively work to bring about any change in behaviour, for example. Patients expect the therapist to have a solution and that with the support of the family and their community they can cure the mental illness, for example with rituals (Ford, Courtois & van der Hart O, 2005). The idea that the trauma, with its various symptoms, can be sufficiently treated with medication alone also poses a further challenge to the treatment (Wilson, Drozdek, & Turkovic, 2006). They hope that the "doctor" has a medicine which will "erase" their traumatic experience and its symptoms as well as the hurt and humiliation and that they will be able to feel as they did before. Owing to the great expectations of a treatment with medication, many traumatised people take a lot of medication, on or without a doctor's advice, and this increases the danger of addiction (Schouler-Ocak, 2015; Wilson, Drozdek, & Turkovic, 2006).

### **Diagnostics**

Irrespective of any cultural aspects and ethnic affiliation, the crucial factor for both diagnostics and treatment is that the therapist and patient understand the 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 were able to explain their illness (Schouler-Ocak, Kizilhan, 2017). The therapist's explanations must be adapted to the patient's level of education and cultural background. 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 behaviour, thinking and emotions (Kirmayer & Looper, 2007; Kizilhan, 2017).

The attitudes, evaluations and convictions of the patients in respect of trauma are to be ascertained in relation to their cultural imprint and generation differences by way of a cognition analysis. In this respect, such resources as solidarity, family loyalty and support via social networks together with more traditional procedures for alleviating pain help patients to cope in emergency situations (Hofstede, 2004).

Motivation analysis refers to the willingness of the patients to change something themselves and to want to do so. Active things such as sport and physiotherapy are accepted less by patients from family-oriented communities (Kirmayer & Ryder, 2016; Kizilhan, 2017). This can lead to a misinterpretation of their compliance. 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 are 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 questionnaire instruments and behaviour analyses (Kira, 2011). This, however, presents an especially difficult problem with patients who have a low level of formal education. This emphasises the need for a very detailed recording of the biographical trauma 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 possible.

### **Treatment**

As a rule, cognitive behavioural therapy in traumatised patients assumes that when a situation of sufficient stability has been reached, it is necessary to confront the patient with the trauma event. This can be seen as a

problem for some people from traditional cultures (Hassan, Ventvoegel & Jeffee-Bahloul, 2016). Even if we assume that a confrontation will have a fundamentally positive effect on the trauma therapy, 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 speak about the critical events in his life and to focus on the therapy (Butler, Lee & Gross, 2007).

The traditional exposure therapy is not always effective with victims of political oppression and with those with complex and cumulative traumatisations, like the Yazidi (Kizilhan & Noll-Hussong, 2017). It can even be counterproductive and can reduce compliance and increase the drop-out rate. Not with all, but with some patients it is reported that suppression and avoidance is a better coping strategy in this case (Schauer, Neuner & Elbert, 2011). In some cultures this is regarded as a successful coping mechanism. That applies especially to collective communities in which social harmony has top priority. Here, especially, 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. These patients tend to avoid any discussion of stress (Wenk-Ansohn & Gurriss, 2011).

An intercultural-proven helpful method is the combination of narration and exposure therapy such as in Narrative Exposure Therapy and Culture-Sensitive Narrative Trauma Therapy (Schauer, Neuner & Elbert, 2011; Kirmayer, 1996).

A different understanding of health and illness, traditional medical care in the homeland and the role of the individual and the collective can play a major role in the diagnostics and treatment of people from other cultures with mental reactions to extreme stress (Wenk-Ansohn & Gurriss, 2011). Therefore, people from traditional-rural regions as a rule are 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 (Pagotto, Mendlowicz & Coutinho, 2015).

### Case Casuistry Casuistry

*Sari is 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 again and again, 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. Two of her sisters are still in the hands of the IS. She does not know where her mother is at the moment. She goes on, “when the IS came to our village, my mother told me that we Yazidi were facing another disaster just as we had done 73 times before in our history”. Sari reports stories of previous massacres and that she has learned never to trust Muslims, to be polite to them but always distanced, since her ancestors suffered greatly at their hands. She is suffering from post-traumatic stress disorders and has dissociative cramp spasms nearly every day.*

As to how far psychotherapeutic trauma work is possible seems to depend on how that society deals with sexuality. In this context patients very often report great insecurity if not a complete taboo. High moral ideas and restrictions, especially with 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. The rape of a young woman can be evaluated by the collective as disgraceful and the victim can be ostracised. The role of the perpetrator is also regarded as a violation of the norm but in the collective it is only of secondary importance. It is not uncommon that unmarried young women who have been raped want to have their hymen re-created so that, in the event of marriage, they can appear as “virgins” and not be ostracised by their society (United Nations Human Rights Office of the High Commissioner, 2016).

Family-oriented societies often broach the subject of traumatic experiences via *expressions of pain* (Kirmayer & Sartorius, 2007). From a psychodynamic perspective, somatisation offers people with severe traumatic experiences a chance to shift ostracism, social hurt, feelings of guilt and inferiority from the conscious experience to a 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 (Cetorelli, Burnham & Shabila, 2017).

In individual psychotherapy, the following culture-specific components can be helpful when encountering

people with PTSD from other cultures. The various steps do not always have to be in this sequence but can be adapted individually (Cetorelli, Burnham & Shabila, 2017; Gedau, Kizilhan & Noll-Hussong, 2017).

### SUMMARY AND CONCLUSION

An individual and culture-sensitive treatment which takes the relationship structure between the refugee and therapist into consideration is especially important, whereby traumatologists and doctors co-operate with other professional groups (sport therapists, physiotherapists, creative therapists etc.) and look at the patient's state of the art cultural imprint.

If language, cultural and migration-specific aspects are included in the consultation, treatment and social support of refugees with 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 migrants with PTSD 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 behavioural trauma therapy methods. Individual therapy is also about concentrating on people from different cultures, with a different concept of illness and how to deal with it. This requires being willing to reflect and possessing a critical attitude to one's own work whilst at the same time remaining impartial and open to the patients' concerns. Transcultural competence is need and means that it is necessary to reflect on one's own culture in order to understand other cultures. In addition, the therapist must have the ability to change perspective, must deal in an unbiased way with people from different cultures, must employ curiosity and enquiry, flexibility and a variety of methods and must deal with mistrust and distance caused by the traumatic incidents which the refugees have experienced.

When dealing with Yazidi refugees with PTSD it is necessary to consider cultural, historical (trauma) and socio-political aspects, the perception of illness and dealing with it and the way in which a relationship can be formed with the patient. In addition, alternative therapy approaches are important, involving an interdisciplinary and culture-sensitive focus in the psychiatrists and psychotherapists, as is close co-operation with other professional groups and the patient's state-of-the-art cultural imprint.

### ACKNOWLEDGEMENTS

The authors have no conflicts of interest to declare.

### AUTHOR

Prof. Dr. Jan Ilhan Kizilhan is a psychologist, psychotherapist and orientalist. His expertise is in psychotraumatology, social medicine, culture sensitive psychiatry and psychotherapy, forensic and ethnological studies.

Prof. Dr. Jan Ilhan Kizilhan, psychologist, psychotherapist and trauma expert is Director of the Institute for Transcultural Health Science at State University Baden-Württemberg, Dean of the Institute for Psychotherapy and Psychotraumatology at the University Duhok/Northern Iraq.

### REFERENCES

1. Buhmann, C.B., Traumatized refugees: morbidity, treatment and predictors of outcome. *Danish medical journal*, 2014; 61: 48-71.
2. Butler, E.A., Lee, T.L., Gross, J.J., Emotion regulation and culture: Are the social consequences of emotion suppression culture-specific. *Emotion*, 2007; 7: 30-48.
3. Ceri, V., Özlü-Erkilic, Z., Özer, Ü., Yalcin, M., Popov, C., Akkaya-Kalayci, T., Psychiatric symptoms and disorders among Yazidi children and adolescents immediately after forced migration following ISIS attacks. *Neuropsychiatrie*, 2016; 30(3): 145-50.
4. 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. *Conflict and health*, 2017; 11; 4.
5. Clay, A., Treating Yazidi rape survivors. *APA*, 2016; 47(8).
6. Droidek, B., How Do We Salve Our Wounds? Intercultural Perspectives an Individual and Collective Strategies of Making Peace With Own Past. *Traumatology*, 2010; 16(4): 5-16.
7. Ford, J.D., Courtois, C., van der Hart, O., Nijenhuis, E., Steele, K., Treatment of complex post-traumatic self-dysregulation. *Journal of Traumatic Stress*, 2005; 18: 467-477.
8. Gedau, I., Kizilhan, J.I., Noll-Hussong, M., PTSD and related disorders among female Yazidi refugees following ISIS attacks – a case series and mini-review. *Front. Psychiatry*, 2017; doi:10.3389/fpsy.2017.00282.
9. Guest, J.S., *The Yezidis. A Study in Survival*. New York: Routledge and Kegan Paul, 1998.
10. Hassan, G., Ventvoegel, P., Jeffee-Bahloul, H., et al., Mental health and psychosocial wellbeing of Syrians affected by armed conflict. *Epidemiology and Psychiatric Sciences*, 2016; 25(2): 129-141.

11. Hinton, D., Kirmayer, L.J., The flexibility hypothesis of healing. *Culture, Medicine and Psychiatry*, 2016; doi:10.1007/s11013-016-9493-8.
12. Hofstede, G., *Culture's Consequences*, 2004. Thousand Oaks: Sage Publications, 2004.
13. Kinzie, D. J., Immigrants and refugees: the psychiatric perspective. *Transcultural psychiatry*, 2006; 43: 577-91.
14. Kira, I.A., Etiology and Treatment of Post-Cumulative Traumatic Stress Disorders in Different Cultures. *Traumatology*, 2010; 16(4): 128-141.
15. Kirmayer, L. J. Landscapes of memory: Trauma, narrative and dissociation. In P. Antze & M. Lambek (Eds.), *Tense past: Cultural essays on memory and trauma*, London: Routledge, 1996; 173-198.
16. Kirmayer, L. J., & Looper, K. J., Somatoform disorders. In M. Hersen, S. Turner, & D. Beidel (Eds.), *Adult psychopathology*, New York: Wiley, 2007; 420-475.
17. Kirmayer, L. J., & Sartorius, N., Cultural models and somatic syndromes. *Psychosomatic Medicine*, 2007; 69(9): 832-840.
18. Kirmayer, L.J., Ryder, A., Culture and psychopathology. *Current Opinion in Psychology*, 2016; 8: 143-148.
19. Kizilhan, J.I., Patient from Middle East and the Impact of Culture on Psychological Pain-Treatment. *Fibrom Open Access*, 2017; 2(1).
20. Kizilhan, J.I., The Yazidi—Religion, Culture and Trauma. *Advances in Anthropology*, 2017; 7: 333-339. <https://doi.org/10.4236/aa.2017.74019>.
21. Kizilhan, J.I., Null-Hussong, M., Individual, collective, and transgenerational traumatization in the Yazidi. *BMC, Psychiatry*, 2017; 15: 198, doi.org/10.1186/s12916-017-0965-7.
22. Kreyenbroek, P.G., Yezidism in Europe: Different Generations Speak about their Religion. In *Collaboration with Z. Kartal, Kh. Omarkhali, and Kh. Jindy Rashow*. Wiesbaden: Otto Harrassowitz, 2009.
23. Lazar, A., Litvak-Hirsch, T., Chaitin, J., Between Culture and Family: Jewish-Israeli Young Adults' Relation to the Holocaust as a Cultural Trauma. *Traumatology*, 2008; 14: 93.
24. Lersner, U., Kizilhan, J.I., *Kultursensitive Psychotherapie (Cultursensitive Psychotherapy)*, Göttingen: Hogrefe, 2017.
25. Machleidt, W., Gül, K., Kulturelle und transkulturelle Psychotherapie – Tiefenpsychologische Behandlung (Cultural and transcultural Psychotherapy – psychoanalytic treatment). In Machleidt, W. und Heinz, A. (Ed.), *Praxis der interkulturellen Psychiatrie und Psychotherapie, (Practice of the intercultural Psychiatry and Psychotherapy)*. München: Elsevier, 2010; 401-413.
26. Maercker, A., Psychologische Modelle. In A. Maercker (Hg.), *Posttraumatische Belastungsstörungen (Psychological Models)*. In A. Maercker (Ed.) *Posttraumatic Stress Disorders* Heidelberg: Springer Medizin, 2009; 33-50.
27. Mohammadi, D., Help for Yazidi survivors of sexual violence. *Lancet Psychiatry*, 2016; 3(5): 409-410.
28. 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. *Journal of consulting and clinical psychology*, 2004; 72(4): 579-587.
29. Pagotto, L.F., Mendlowicz, M.V., Coutinho, E.S., Figueira, I., et al., The impact of posttraumatic symptoms and comorbid mental disorders on the health-related quality of life in treatment-seeking PTSD patients. *Compr Psychiatry*, 2015; 58: 68-73.
30. Pennebaker, J.W., Writing About Emotional Experiences as a Therapeutic Process. *Psychological Science*, 1997; 8(3): 162-166.
31. Schauer, M., Neuner, F., Elbert, T., *Narrative Exposure Therapy. A short-term treatment for traumatic stress disorders* (2nd, rev. and exp. edition). Cambridge: Hogrefe, 2011.
32. Schouler-Ocak, M., *Trauma and Migration. Cultural Factors in the Diagnosis and Treatment of Traumatized Immigrants*, Berlin: Springer, 2015.
33. Slobodin, O., De Jong, T.J., Mental health interventions for traumatized asylum seekers and refugees: What do we know about their efficacy? *The International journal of social psychiatry*, 2015; 61: 17-26.
34. Summerfield, D., The Invention of Post-Traumatic Stress Disorder and the Social Usefulness of a Psychiatric Category. *British Medical Journal*, 2001; 322: 95-98.
35. Tekin, A., Karadag, H., Suleymanoglu et al., Prevalence and gender differences in symptomatology of posttraumatic stress disorder and depression among Iraqi Yazidis displaced into Turkey. *European journal of psychotraumatology*, 2016; 7: 28556.
36. United Nations Human Rights Office of the High Commissioner, UN Commission of Inquiry on Syria: ISIS is committing genocide against the Yazidis, 2016. <http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=20113&LangID=E>. Accessed 10 Oct 2017.
37. Wenk-Ansohn, A., Gurriss, N., Intercultural encounters in counselling and psychotherapy--communication with the help of interpreters. *Torture: quarterly journal on rehabilitation of torture victims and prevention of torture*, 2011; 21: 182-5.
38. Wilson, J.P., Drozdek, B., Turkovic, S., Posttraumatic shame and guilt. *Trauma, violence & abuse*, 2006; 7: 122-41.