Psychological Sequelae of Torture and Organised Violence Suffered by Refugees from Iraq

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Trauma-related factors compared with social factors in exile

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Background

Refugees who have suffered traumatic events present complex therapeutic challenges to health professionals. There is little research into post-exile factors that may be amenable to change, and therefore reduce morbidity. We examined the importance of social factors in exile and of trauma factors in producing the different elements of psychological sequelae of severe trauma.

Method

Eighty-four male Iraqi refugees were interviewed. Adverse events and level of social support were measured. Various measures of psychological morbidity were applied, all of which have been used in previous trauma research.

Results

Social factors in exile, particularly the level of 'affective' social support, proved important in determining the severity of both post-traumatic stress disorder and depressive reactions, particularly when combined with a severe level of trauma/torture. Poor social support is a stronger predictor of depressive morbidity than trauma factors.

Conclusions

Some of the most important factors in producing psychological morbidity in refugees may be alleviated by planned, integrated rehabilitation programmes and attention to social support and family reunion.

Refugees may suffer systematic physical and psychological torture. There is often a history of years of discrimination, persecution and harassment, perhaps enforced exile or a period of hiding. Once in exile, there are social factors which may contribute to further psychological problems. The psychological impact of war trauma, torture and organised violence is wide-ranging and complex (Mollica et al, 1987; Turner & Gorst-Unsworth, 1990; Basoglu et al, 1994). However, there are few accounts of how stressors associated with flight and exile interact with the original trauma. A study of British hostages in Kuwait and Iraq during the Gulf War found that problems with finance, accommodation and work, after return home, were important causes of distress (Easton & Turner, 1991). In Nicaraguan war-wounded men, economic factors, work prospects and a sense of identification with wider social ideals was found to be
important in the overall well-being of survivors (Hume & Summerfield, 1994). In Turkish refugees, strong political commitment and prior knowledge of and preparedness for torture had a protective effect in the development of psychopathology (Basoglu et al, 1994). Hauff & Vaglum (1995), in a systematic study of Vietnamese refugees in Norway, found that significant predictors of psychiatric morbidity included gender, younger age, previous education, extreme trauma, absence of a close confidant in exile, negative life events since trauma, and separation from close family.

METHOD

A four-dimensional model of the reaction to torture has been put forward to provide a framework for further research and treatment of survivors of torture (Turner & Gorst-Unsworth, 1990): (a) incomplete emotional and cognitive proceeding (of central important in post-traumatic stress disorder (PTSD) as outlined in DSM-IV (American Psychiatric Association, 1994)); (b) depressive reactions (thought to relate to life events); (c) somatic symptoms (not always related to physical injury); and (d) the existential dilemma (a collection of profound attitudinal changes which may endure for many years and interfere with close relationships).

The Medical Foundation for the Care of Victims of Torture (MFCVT) is an independent charity in London, offering medical, psychological and social help to refugees from over 30 countries. Referrals come from immigration solicitors, general practitioners (GPs), refugee community groups, hospital doctors, or by self-referral. Since its inception in 1986, the organisation has seen a steady arrival of asylum seekers from Iraq, but referrals increased during the Gulf War.

Sample

One hundred and fifty consecutive referrals of Iraqi males were identified, who were between 18 and 59 years old and had arrived in the UK between 1990 and 1993. The group varied in their levels of trauma, social support and ongoing social stressors. Some were completely isolated from family and friends at the time of the assessment. Because of the mobile and unstable nature of the population as described previously, only 84 subjects (56%) from the original sample could be traced, despite attempts to contact any known GPs or solicitors as to their current addresses. Of these 84, all completed the full assessment procedure. Most interviews were carried out in Arabic with the aid of an interpreter experienced in such interviewing. A small number were conducted in Kurdish and two in English. Social and trauma history was gathered by E.G. and all psychiatric assessments carried out by C.G.-U.

Interview schedules and outcome measures

Detailed history of background, political activity, and nature of trauma was obtained using the Survivor of Torture Assessment Record (STAR; Van Velsen et al, 1996) and the Harvard Trauma Questionnaire (Mollica et al, 1992). These questionnaires were specifically designed for use in refugee populations and include events not covered by more widely known instruments such as the Life Events Schedule (Paykel et al, 1984). Two measures of social support were chosen for their applicability to refugee populations: the Rand Social Activities Questionnaire (Donald et al, 1978), and the
Duke-UNC Functional Support Questionnaire (Broadhead et al, 1988). The Rand Social Activities Questionnaire enquires about specific social activities at the time of interview, such as visits to friends, attendance of clubs/church and telephone contacts, yielding a score of between one and 60. The Duke-UNC instrument measures two components, 'confidant support' (the opportunity to talk to others about personal problems) and 'affective support' (the provision of close intimate support with an affective component, i.e. unlike that provided by a professional confidant).

The following measures of psychological morbidity were used: the Present State Examination (PSE; Wing et al, 1974); DSM-III-R criteria (American Psychiatric Association, 1987) for PTSD and major depression (part of STAR); and the Harvard Trauma Questionnaire symptom list (Mollica et al, 1992). Results were analysed using the Statistical Package for the Social Sciences (SPSS, 1988).

RESULTS

Description of the sample

All 84 men who completed the procedure were Iraqi, 45% being of Kurdish origin and 55% Shia. Ages ranged from 18 to 59 years (mean 39). All of the sample were separated involuntarily from some members of their close family; 10% of married subjects were separated from their wives and 11% from one or more of their children. Over two-thirds had completed some form of tertiary education, including university. This suggests that those reaching the UK are a highly selected sample in terms of educational background. Only two were illiterate, but less than half (46%) could speak good English at the time of assessment; 29% had no or very limited English and 25% were able to communicate on a basic level.

Torture experience

Fifty-five (65%) of the sample had suffered systematic torture during a period of detention. The remainder were either detained without formal torture, or experienced other traumatic events. The sample as a whole had high levels of political commitment; 73% were active supporters or members of political groups and 10% were leaders of such groups. All respondents who reported torture described multiple torture methods being employed (see Table 1). However, torture was by no means the only form of traumatic event experienced. Survivors described imprisonments, enforced combat, witnessing chemical attacks on civilians, scenes of violent death, massacre and execution of relatives. The Harvard questionnaire scores 'closeness to death' (which has been reported to be associated with development of PTSD), and gives a quantitative score of traumatic events.

Social problems in exile

Fifty-five (65%) of the sample were living in council property, and 25 (30%) were renting from a private landlord. Four were either homeless or living in bed-and-breakfast or hostel accommodation. Thirty-three (39%) said they were dissatisfied with their living conditions (see Table 1). From the Rand Social Activities Questionnaire and the Duke-UNC Functional Social Support Questionnaire, most survivors reported low levels of social activity (mean=22, possible scores range from 1 to 70+), but a wide range of level of social support (confidant support mean=17, range 5-25; affective support mean=10, range 3-15).
Psychological morbidity

At the time of interview, PSE score, index of definition score from CATEGO, DSM-III-R score for PTSD and for major depression (i.e. number of symptoms, irrespective of whether full criteria were met) and Harvard symptom score were obtained. Categorical results (yes/no) were also obtained for DSM-III-R diagnoses of PTSD and major depression. In addition, the STAR schedule contains the Attitudinal Change Questionnaire, giving information relating to more subtle and pervasive change in attitudes to important aspects of life such as religion, politics and family.

A total of 45 respondents fulfilled criteria for caseness in either the PSE-Catego assessment or by DSM-III-R diagnosis. The PSE proved more sensitive in picking up morbidity (only five cases fulfilled sufficient criteria for DSM-III-R diagnosis of major depression, but 37 cases of depression were obtained with PSE). Most PSE cases were 'neurotic depression' (ICD-9; World Health Organization, 1975) and therefore represent a less severely affected group.

An interesting finding from the PSE was the high prevalence of obsessional symptoms, although no case fulfilled criteria for obsessional-compulsive disorder. Seventeen cases (20%) admitted to one or more obsessional symptom on direct questioning, mainly checking and repeating behaviour in relation to security (e.g. checking locks, gas taps, etc.).

Relationship of psychological morbidity to trauma and social factors

Overall psychological morbidity

Relationships were investigated between PSE index of definition score and the various trauma and social factors. Associations were found between high score and low level of affective support in exile (Pearson's $r=0.40$, $P<0.001$), separation from children ($t=3.59$, 26 d.f., $P=0.001$), lack of contact with political organisations in exile ($t=2.95$, 82 d.f., $P=0.004$), low confidant support ($r=0.37$, $P<0.01$) and low number of social activities ($r=0.35$, $P<0.01$). It is notable that no significant associations were found between trauma factors (e.g. severity, type, time since event) and overall morbidity as defined by PSE index of definition score.

Multiple stepwise regressions were performed, with all social factors and trauma factors entered as predictor variables. This revealed that 25% of the variance in index of definition score could be accounted for by two variables - low affective support (19%) and lack of contact with political organisations in exile (a further 6%).

The presence of obsessional symptoms correlated with low number of social activities as measured on the Rand questionnaire (Pearson's $r=0.41$, $P<0.001$) and with difficulties on initial entry to the UK, such as detention at port of entry ($r=0.35$, $P<0.01$) but did not correlate significantly with severity of trauma.

Incomplete emotional processing (PSTD reactions)

A DSM-111-R diagnosis of PTSD was associated with sexual torture ($\chi^2=14.02$, $P=0.0001$). PTSD avoidance symptoms were associated with low affective support
(r=0.39, \(P<0.001\)), lack of contact with political organisation (t=4.12, 71 d.f., \(P=0.0001\)), and low confidant support (r=0.30, \(P<0.01\)). Avoidance symptoms were not specifically associated with sexual torture, which differs from the findings of previous

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<th>Table 1  Summary of results</th>
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<td><strong>Variable</strong></td>
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| Physical tortures
  Beating | 52 | 62 |
  Whipping | 51 | 61 |
  Falaka \(^1\) | 41 | 49 |
  Suspension | 36 | 43 |
  Standing for long periods | 34 | 40 |
  Tying/binding/manacles | 34 | 40 |
  Water hosing | 21 | 25 |
  Immersion/attempsed drowning | 19 | 23 |
  Electric shock | 18 | 21 |
  Burning/chemicals | 15 | 18 |
  Sexual assault | 12 | 14 |
  Medical (drug/dental) | 8 | 10 |
  Loss of consciousness at any time | 44 | 52 |
Psychological tortures
  Sensory deprivation | 56 | 67 |
  Listen to watch others’ torture | 55 | 66 |
  Verbal threats of death or mutilation | 48 | 57 |
  Threats involving others (family etc.) | 45 | 54 |
  Sleep deprivation | 43 | 51 |
  Solitary confinement | 41 | 49 |
  Noise | 40 | 48 |
  Deprivation of food | 32 | 38 |
  Deprivation of toilets/privacy | 26 | 31 |
  Deprivation of fluids | 25 | 30 |
  Mock execution | 19 | 23 |
Social difficulties in exile
  Lack of employment | 82 | 97 |
  Physical ill health | 65 | 77 |
  Financial problems | 57 | 68 |
  Isolation/loneliness | 54 | 64 |
  Awaiting Home Office decision | 24 | 29 |
  Verbal racial abuse | 17 | 20 |
  Physical racial abuse | 6 | 7 |
Attitudinal change
  Political commitment
    Increased | 22 | 26 |
    Decreased | 18 | 21 |
    No change | 45 | 53 |
Religious commitment
- Increased: 3, 4
- Decreased: 14, 17
- No change: 65, 77

Family life
- Higher priority: 54, 64
- Lower priority: 9, 11
- No change: 21, 25

Close relationships
- Now closer: 50, 60
- More distant: 17, 20
- No change: 17, 20

Feel different from non-traumatised others: 66, 79
Feel misunderstood by professionals: 48, 57

1. Beating the soles of feet with batons.

studies of torture survivors (Ramsay et al, 1993; Van Velsen et al, 1996). There were no significant associations between 'closeness to death' and morbidity, which differs from studies in the disaster literature (Weisaeth, 1989; Rosser et al, 1991; Green, 1994). Twenty per cent of the variance in PTSD score was accounted for by two of the variables - sexual torture (15%) and lack of affective support (5%).

Depressive reactions

DSM-III-R diagnosis of major depression was associated with physical racial attacks in exile ($\chi^2=8.65, P=0.003$). Higher symptom score for major depression was associated with low affective support ($r=0.40, P<0.001$), low confidant support ($r=0.38, P<0.001$), number of physical tortures ($r=0.30, P<0.01$), lack of contact with political organisation ($r=3.91, 80$ d.f., $P=0.0001$) and low number of social activities ($r=0.26, P<0.01$). Three factors accounted for 22% of the variance in DSM-III-R diagnosis of depression - physical racial attacks in exile (9%), lack of affective support (7%) and reported financial problems (6%). In relation to symptom score for major 'depression', the following three factors accounted for 23% of the variance - low affective support (15%), number of physical tortures (4%) and history of mock execution (4%).

Attitudinal change - the existential dilemma

Many attitudinal changes were reported in survivors (Table 1). Survivors were more likely to increase their political commitment if they were in touch with a political organisation in exile ($\chi^2=18.27, P=0.0001$). A feeling that 'professionals do not understand' is associated with dissatisfaction with housing ($\chi^2=9.94, P=0.006$).

DISCUSSION

This study examined a cross-sectional sample of Iraqi men in terms of trauma history and prevalence of psychological morbidity. Unfortunately, there were no details of psychological health prior to arrival, or of professional intervention in the period of
exile. However, it is the authors' impression that language and access problems limited any professional treatment that could have been offered.

**Overall morbidity**

The sample demonstrated considerable psychological morbidity. Risk factors are multiple and, in particular, social stressors and social support are of paramount importance. Using the PSE, 45 (54%) of the sample met the criteria for caseness. This is higher than Hauff & Vaglam's (1995) population of Vietnamese refugees in Norway. This may be explained by a combination of more severe trauma in the Iraqi group, coupled with a lack of any integrated rehabilitation programme and greater social deprivation of UK refugees in comparison to those in Norway.

**PTSD reactions**

Case-level PTSD was found in only 16 (10.7%) of the subjects. It could be assumed that the torture and systematic persecution suffered by this sample of Iraqi men would produce more severe psychiatric morbidity. Epidemiological studies of high-risk individuals give an overall range for PTSD prevalence of 3-58% (Yehuda & McFarlane, 1995) and Vietnam veterans have a lifetime prevalence of PTSD of 30% (Kulka et al., 1990). The relatively low PTSD prevalence found in the present study may suggest that trauma is not the most important factor, or that cultural differences lead to a reluctance in the Iraqi group to admit to psychological symptoms compared to the 'psychologically sophisticated' group of American ex-combatants.

Previous studies have suggested that the categorical thresholds for diagnosis of PTSD in torture survivors are inappropriate, particularly in relation to avoidance symptoms (Ramsay et al., 1993). Three or more avoidance symptoms are required for the diagnosis of PTSD but in a refugee survivor of torture few situations arise that resemble the original trauma, and furthermore, early avoidance responses are deliberately broken down by torturers to increase impact (Turner & Gorst-Unworth, 1990). If only two avoidance symptoms were needed, then in the present sample 15 (18%) of the subjects would be classified as suffering from PTSD.

**Depressive reactions**

Case-level DSM-III-R major depression existed in five subjects at the time of the study. However, PSE assessment revealed depression in 44% of the sample. In their study of Vietnamese refugees in Norway, Hauff & Vaglum (1995) found depression in 14% of the males from PSE assessment. The much higher rate of depression in the Iraqi men may relate to cultural effects, severity of trauma, or severity of social adversity in exile. It seems that the Vietnamese refugees suffered less systematic torture than the Iraqi group. Also, Norway's refugee resettlement programme is far more developed than that in the UK and is aimed at reducing social stressors.

**Risk factors in relation to the four-dimensional model**

PTSD symptoms (incomplete emotional processing) were associated with severe physical torture, particularly sexual torture, combined with a lack of affective social support. The prevalence of obsessional symptoms (20%) is an interesting finding. These
could be interpreted as variants of the hypervigilance symptoms of PTSD, but may warrant further study.

Depressive features were more likely when lack of social support and activities is combined with racial attacks, isolation from political organisations and a history of severe physical tortures. The trauma experience is less clearly associated with depressive reactions than with PTSD reactions. Poor social support appears to be a much stronger predictor of depression in the long term than severity of trauma. This finding is in keeping with established knowledge regarding life events and social stressors (Brown & Harris, 1978; Dalgard et al., 1995) and with recent studies of torture survivors (Van Velsen et al., 1996) and of Vietnam veterans (Boscarino, 1995).

Attitudinal change (the existential dilemma) was widely reported in the study group, and the extent of change correlated not with severity of trauma but with various social factors such as isolation, racial attacks and dissatisfaction with housing. In a previous pilot study of attitudinal change in survivors of torture, low expectation of torture and high religious commitment were associated with overall attitude change (Gorst-Unsworth et al., 1993). Further exploration of these issues and their relationship to outcome is needed.

**Implications for treatment and resource planning**

When faced with a survivor of such massive and complex experiences, many are overcome by therapeutic nihilism or assume that the only alternative is years of specialised psychotherapy centred around the traumatic events. This study suggests that many of the most important factors in continuing morbidity can be modified in the country of exile. This finding has implications for resource planning.

The importance of affective support may indicate that more effort should be directed towards family reunion where the survivor is separated from close relatives. Confidant support may he provided by either refugee workers who understand the cultural aspects and context of the trauma, or by a professional with the aid of a trained interpreter. Contact with political organisations is important to a group of highly committed individuals who may find life in exile somewhat meaningless without shared ideals and aims.

The multifactorial nature of risk factors in the psychological health of refugees points to the need for integrated rehabilitation efforts, with professional help alongside vigorous attempts to improve social environment and provide appropriate social activities and support. Affective support, however, can only he provided by families and friends, and may rely on Government policy (e.g. regarding rights to family reunion) more than professional input.

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CLINICAL IMPLICATIONS

- Refugees may have suffered varied and multiple traumatic events and social losses leading to complex needs in exile.
- The traumatic events may not be as important as the social problems of exile, in terms of psychiatric morbidity.
- Lack of social support, particularly of the 'affective' type, is associated with high morbidity.

LIMITATIONS

- The sample may represent a selected group as only 56% could be traced for interview.
- No information on previous psychiatric history or premorbid personality was obtained.
- Treatment effects were not taken into account in this study.

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