Conceptualizing anxiety in torture survivors

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Not knowing what is coming next creates fear. (Watercolour by Latin American Artist).
Introduction

By Søren Bøjholm, MD, Chief Psychiatrist

The effects of the treatment of torture survivors at the Rehabilitation and Research Centre for Torture Survivors (RCT) are manifested in three major areas – psychological, somatic, and social.

Some words about PTSD

Discussion is still taking place concerning the existence of a tortue syndrome or whether the diagnosis Post Traumatic Stress Disorder, PTSD¹, can be applied to torture survivors.

Attempts to delineate a tortue syndrome have not been successful. The typical finding is a considerable overlapping of symptoms following very different traumatic experiences, rather than the existence of well-defined syndromes. Consequently, it appears that the response of the human organism to various stresses is confined to somewhat restricted psychological pathways.

Undoubtedly many symptoms presented by survivors are in agreement with the diagnostic criteria of PTSD, and a proportion of survivors may be diagnosed as suffering from PTSD. On the other hand, the current version of the PTSD has certain shortcomings. Its main imperfections are that:

- it excludes “changed identity or personality”
- it allows for a rather insufficient length of time from the trauma to the emergence of symptoms
- it does not cover the chronically traumatized individual.

Furthermore, PTSD reduces complex politico-historical problems to difficulties at the individual level, and it appears to be a diagnosis applicable exclusively to adults. The reports published on long-term torture sequelae provide sufficient evidence to conclude that a hypothesis of no correlation between torture and the postulated long-term consequences must be rejected, although there are methodological shortcomings².

Terminology

However, the terminology used in the various studies differs. In a critical review of the international literature on the somatic and mental effects of torture, Goldfield et al³, recommended the use of standardized diagnostic criteria in the evaluation of persons who have survived torture.

RCT was therefore urged in 1990 to establish an academic and multidisciplinary group – a consensus group – to come forward with a recommendation for a more uniform and defined terminology, applicable on an international scale and enabling more direct comparisons between studies.

Table 1a.

<table>
<thead>
<tr>
<th>Study No.*</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
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<tbody>
<tr>
<td>Self-isolation/social withdrawal</td>
<td>10</td>
<td>-</td>
<td>63</td>
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<tr>
<td>Emotional lability</td>
<td>-</td>
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<td>30</td>
<td>-</td>
<td>11</td>
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<tr>
<td>Depression</td>
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<td>71</td>
<td>66</td>
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<tr>
<td>Anxiety</td>
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<td>88</td>
<td>94</td>
<td>42</td>
<td>32</td>
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<tr>
<td>Irritability/aggressiveness</td>
<td>30</td>
<td>-</td>
<td>63</td>
<td>26</td>
<td>18</td>
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<tr>
<td>Lack of energy</td>
<td>14</td>
<td>41</td>
<td>23</td>
<td>30</td>
<td></td>
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<tr>
<td>Insomnia</td>
<td>47</td>
<td>68</td>
<td>83</td>
<td>60</td>
<td>50</td>
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<tr>
<td>Nightmares</td>
<td>-</td>
<td>34</td>
<td>78</td>
<td>63</td>
<td>41</td>
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<tr>
<td>Impaired memory and concentration</td>
<td>45</td>
<td>-</td>
<td>-</td>
<td>66</td>
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<tr>
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<td>-</td>
<td>29</td>
<td>46</td>
<td>-</td>
<td>39</td>
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<tr>
<td>Impaired concentration</td>
<td>-</td>
<td>32</td>
<td>60</td>
<td>-</td>
<td>43</td>
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<tr>
<td>Sexual dysfunction</td>
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<td>12</td>
<td>51</td>
<td>21</td>
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<tr>
<td>Number observed</td>
<td>135</td>
<td>42</td>
<td>53-98</td>
<td>38</td>
<td>44</td>
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In the light of the experiences of RCT during the last decade, and from an epidemiological survey (Table 1a + 1b)⁴, it was possible to arrange the most frequently occurring symptoms and signs in relation to torture into a limited number of principal terms. Having surveyed the international terminology, the consensus group found that a modification of selected mental symptoms in accordance with DSM-III-R¹ was an appropriate choice.

Table 2.

Main Groups of Psychological Symptoms (DSM-III-R).

<table>
<thead>
<tr>
<th>Term</th>
<th>Number</th>
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<tbody>
<tr>
<td>II Anxiety symptoms</td>
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<tr>
<td>IV Behavior</td>
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<tr>
<td>V Cognition</td>
<td></td>
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<td>VII Energy</td>
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<td>VIII Form and amount of thought/speech</td>
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<tr>
<td>IX Mood/affect disturbance</td>
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<tr>
<td>X Occupational and social impairment</td>
<td></td>
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<tr>
<td>XI Perceptual disturbance (including hallucinations)</td>
<td></td>
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<tr>
<td>XII Personality traits</td>
<td></td>
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<tr>
<td>XIII Physical signs and symptoms</td>
<td></td>
</tr>
<tr>
<td>XIV Sleep disturbance</td>
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</tbody>
</table>

The selection of the modified symptom-groups is listed in Table 2. Groups I, III, VI, and XV from the DSM-III-R symptom categories are omitted; all multiple occurrences of symptoms should be reduced to association solely with one group, and a few symptoms should preferably be omitted or transferred to more appropriate groups in relation to the traumatology of torture.

We at RCT agree with Alldi that:

Future research needs to include the conceptualization of the trauma of torture and its sequelae in broader terms, the application of standardized measurements to facilitate international comparisons and the testing of various approaches to intervention in an experimental design.

Most studies in this area have dealt with torture and its consequences. The next step in research will be to develop better treatment models. Treatment today is practised in different ways. We do not know which treatment composition is the most effective. Reports on outcome of treatment are uncontrolled and anecdotal.

The client

Clients are usually sceptical about the treatment, in particular when they are not familiar with westernized thinking. They may be reluctant to enter the psychotherapeutic process.

Obviously an exiled torture survivor must adapt to certain new cultural modes and practices, and at the same time he should be offered rehabilitation from the torture-induced trauma.

We believe at RCT that one of the prerequisites is for a client to take part in his new society, enabling him to make a free choice, e.g. that he may be able to decide again what he wants to do, and where and how he wants to live.

There are problems in evaluating psychotherapy in general, but evaluation of the treatment of the torture survivor is even more problematic. Our clients come from all over the world. However, during the last 3 years 80% of the clients at RCT come from the Middle East, mainly Muslims, but with different religious beliefs and political ideologies. We also receive clients from Poland, Chile and Vietnam. Common to all of them is the fact that they are living as refugees in a foreign country, in a culture quite different from their own. So a pertinent question would be, “To what culture do we rehabilitate our clients?”

The torture survivor has lived under inhuman and degrading circumstances during the period in which torture took place. After release, he often has to live underground until he succeeds in escaping from his home country. There have been losses of different kinds and at different levels.

After arriving in the new country, language and cultural barriers add to the natural reluctance of survivors to speak freely about their harrowing experiences. Survivors often feel ashamed of the way in which they succumbed to torture, and they are plagued by persistent fears of further attacks on themselves or their families by international agents of the regimes from which they have fled. Another difficulty is their fear of being stigmatized as psychiatric patients, a difficulty which increases their tendency to present somatic complaints that may mask psychiatric symptoms—a diagnostic problem that is magnified in a transcultural setting.

- Do the questions mean the same in different cultures?
- Does culture influence the client’s interview behaviour?

Many survivors—at least at their first contact with RCT—tend to use somatic expression for psychological discomfort, complaining of chronic diffuse headache or muscular tension, or being fearful of having a heart disease.

The reasons for this somatization may be twofold, related to culture and to torture. According to our experiences these complaints are regarded as psychosomatic, indicative of unresolved mental stress. There may be sleep disturbances, very often in connection with nightmares, in which torture experiences are repetitively relived. Many survivors allege impaired memory and difficulty in concentration. But in spite of this the experiences of torture are often remembered in the smallest detail. The feelings of guilt and shame are often linked with loss of self-esteem. Other features are sadness, worry, fatigue, emotional instability, suspiciousness, and social withdrawal. In this context, the symptom anxiety emerges.

The Anxiety

Anxiety is among the most evident of the survivors’ mental symptoms; its prevalence ranges from 24% to 94% of the population examined, although our experience at RCT would suggest the higher rate as more realistic.

Objectively the clients give the impression of being anxious, although they do not often talk about it. In our field of work, with people from various cultures, there are different ways of expressing emotion—also in the West people have difficulty in speaking about anxiety and other emotions. Culture affects the expression of emotion and the language of expression.

Moreover, unlike anxiety disorders described in DSM-III-R, the anxiety of the torture survivor is associated with conscious memories, tentatively but never really repressed, and so readily accessible to the professional outsider. Events from daily life are used in connection with the torture. After release these events will act as a stimulus triggering an anxiety or even a panic attack. The experience seems inexplicable, and therefore terrifying. In this way, through well-designed stimuli, the torture may continue even after release, so that the survivor is caught in a chronically alert state. The manifestation of anxiety in the survivor seems to be the same as anxiety in other people. Therefore it should be possible to apply rating scales such as those used for anxiety elsewhere.

When the person is released, he or she has thus been forced into the role of a victim. Long-term complaints indicate that after release these victims have to undergo a new adaptation in order to return to their former identity. However, it seems as if their capacity to use different coping strategies in a flexible way, depending on the situation, is restricted.
Trautman's description of the chronic anxiety syndrome in survivors from the concentration camps has much in common with our experiences concerning anxiety in torture survivors:

If they show anxiety and other manifestations today, we cannot blame such persistent symptoms on constitutional weakness or inherited disposition.

The goal of the seminar

The idea behind the seminar was to assemble experts from the fields of:

- Anxiety
- Coping, and
- Evaluation.

It was hoped that their treatment theories could be applied to the world of the torture survivor with the purpose of developing instruments of evaluation and methods of treatment.

The seminar was the first step in the development of methods for evaluation of the effect of psychotherapy as part of a rehabilitation programme for torture survivors.

This supplementum presents the contributions from the seminar. However, the contribution from Professor Leo Eitinger, Norway, has already been printed in a shorter version in TORTURE vol. 2,1 pp. 21-23 and is therefore not reprinted in this supplementum.

References

Qualitative methods in the evaluation of anxiety
Presentation of a research approach to torture survivors
By Peter Elsas, DMSc, Professor

Abstract
In the humanistic sciences qualitative methods and narratology are often presented as alternatives to the quantitative methods that dominate natural science and medicine. In psychotherapeutic research on anxiety disorders, both the quantitative and qualitative approaches are represented. The humanistic disciplines such as analytical psychology advocate qualitative research, while clinical, biological psychiatry prefers quantitative methods.

Deciding which of the two approaches is the more appropriate is more than a strategic decision, however confrontational the humanistic and natural sciences may be. One has to answer some fundamental theoretical questions about the conceptualization of anxiety and the goal of the therapy.

Does one conceptualize the anxiety syndrome within the framework of coping and appraisal or of ego strength and defence mechanism? Is the purpose of the therapy effectiveness or veridicality?

It is argued that the quantitative approach is more in line with the cognitive-behavioral viewpoint and that the qualitative methods are more appropriate for psychodynamic and analytical theories.

As a first stage of psychotherapeutic research with torture victims, the methods of narratology and qualitative methods are promoted with the orientation of a psychodynamic viewpoint, where the veridicality is preferred. A concrete example of the narratological method is presented with the preliminary results.

Science has to be interesting and stimulating. But the question is for whom. Are we doing research to promote our professional field, the work of anti-torture, for the general public? Are we "doing" science to give cues to the practitioner, so he might be a better therapist? Are we doing research for purely academic and theoretical reasons, or are we doing research for our own egoistic reasons, reasons which can not be justified?

None of these purposes and reasons can be separated from each other, and this might be one of the reasons why it is not possible to answer them in a simple way.

Science in practice
Among all these reasons for doing research, I would like to focus on the aspect of the application of science.

This is a relatively new field of research – trying to investigate and analyze how the practitioner uses his theoretical and academic knowledge in his daily work.

There is a dilemma between the scientific, academic research in psychotherapy and the practical, clinical work. The integration of science and practice comes to mean that practitioners are to be guided by the knowledge created by science. Practitioners are to be consumers of research so that they can apply the most up-to-date knowledge in their practice. But the relevance of academic research to practice is increasingly questioned. Studies have shown that practising therapists are producing very few publications and are not consumers of scientific journals with relevance for their field (Lazarus 1990, Strupp 1989). There is a big gap between formal knowledge and practical knowledge within the field of psychotherapy. The big booming field of psychotherapy, as reflected in the therapeutic supermarket, contrasts strongly with the decreasing status of academic psychology at the universities.

Psychology as a humanistic discipline at the universities is a disappearing world in many places, often trying to survive by transforming itself into other disciplines, such as the more cognitive discipline within computer and brain science and information technology, or the nearby disciplines such as anthropology and philosophy. The Department of Psychology at Massachusetts University has, for example, been changed to an institute of cognitive and brain science.

This crisis in academic psychology contrasts with the rapidly growing field of clinical psychology, outside the universities, as illustrated by the enormous number of psychotherapists.

This schism illustrates, among other things, the difficulty of combining science and practice in a happy marriage. And in doing research in psychotherapy, one of our main goals is to redefine the science-practice relationship and professional training.

Very interesting literature about "science in practice" has been appearing during the last years. Some of the titles in this new field show the attitude and problems of combining science with practice: Cognition in practice (Lave 1988), Narrative knowing and the human sciences (Polkinghorne 1988), The reflective practitioner: how professionals think in action (Shon 1983).

Their content is that so-called scientific knowledge is applied in practice in ways that are sometimes far from the
scientific conclusions. Medical doctors are diagnosing and treating in ways which are often not mentioned in medical textbooks, and many of the therapeutic inventions which therapists use in practice are not based on theory and their formal knowledge, learned in school and universities.

Confronted with psychotherapy, we have to consider seriously how to develop a scientific method that is interesting not only for the academic world but also for the working therapist.

**Qualitative methods**

As methods of combining practice and science, *qualitative methods* have emerged as a magic solution. In the borderland between science and practice, the concepts of *qualitative methods* and *narratology* have been almost political catchwords or slogans. If one wants to be a superstar at a congress of humanistic science, one should use the terms *qualitative methods* and *narratology* as often as possible.

Behind my ironic attitude, I believe that some methods place science closer to practice, and among them are qualitative methods.

My purpose is to introduce a qualitative method, but at the same time to be critical of its seductive frame. Qualitative methods are very old within the field of humanistic science of, for example, literature and history, but in the battlefield between human science and natural science they are promoted to being new methods.

The word *qualitative* comes from the Latin *qualis*, which means *how*. Qualitative analysis has as its goal to decide how something is constructed and how its connections and nature are.

The qualitative method tries to perceive basic structures, connections, and development trends in a relatively small material, which, in return, it studies very thoroughly. It may take the form of a series of penetrating interviews with a small number of patients, in which the person in charge of the study as an interviewer familiarizes himself with the patient’s perception of his disease and thus gets closer to understanding his situation; all in aid of being able better to understand and reflect.

The qualitative method has two separate elements: the description and the analysis. “The description is the account of what is there, reported spontaneously as it appears: the meaning, the experience, the connection. By contrast, the analysis is the differentiation of what is there: the demonstration of features, concepts and their connections in the description” (Jørgensen 1989:28).

The qualitative analysis of *soft data* differs from the empirical, quantitative analysis of *hard data*, by the fact that, among other things, the understanding of an experience and a connection does not necessarily mean that the interview is repeated on a larger number of patients. Instead of collecting a large material which can be analyzed statistically, it is sufficient to make a single, but very thorough, interview. It must be stressed that the method must live up to a demand of validity which makes sure that it is not just an artistic, journalistic method in which one records and reports subjective experiences. The qualitative method is a scientific method in which the researcher should be able to raise himself above time and place and say that his material throws light on a connection in a more general and universal sense. This means that the collected data should be part of an interconnected set of meanings and significances. Even if the method is a subjective method which is connected with the interviewer and his patient, it should be able to reach further out and still be valid. It is a condition, however, that the researcher has considered beforehand what he intends with the interview, and in which relationship the interviewed person takes part. The researcher must have some theoretical concepts, an idea of the connections, a model and a theory, which can be tested on the descriptions. The theory gets more nuances and is restructured as a result of the process of analysis (Jørgensen 1989: 33).

The validity can only be controlled by insisting on a description of a theory and of some concepts before the interview. Other research workers can thus see the conditions for the study, follow the process, and read how the data have been adapted to the theory.

What makes the qualitative method a science is the fulfilment of two conditions: 1. The condition concerned with inter-subjectivity, i.e. that it is possible to obtain a mutual understanding and agreement between the researcher and the interviewed person about the subject of the study, so that this mutual understanding can be presented for the readers in such a way that it can be understood and followed. 2. The condition concerned with validity, which requires that the collected data can be tested in relation to a theory and a system of concepts.

The method is thus the basis for reaching areas that are unreachable with the methods of natural science. Experiences, intuitive and wide coherences of, for instance, therapeutic character, can be included in the scientific working methods and thus enlarge and supplement the medical methods.

The qualitative method can be used by the reflective practitioner even on small samples. It may be an effective forerunner for a more detailed research project based on larger samples and on both quantitative and qualitative methods.

**Applicability – Description of an example of qualitative research**

Can we develop a conceptualization and measurement of anxiety which is of interest also for the practising therapist? To answer this question one has to turn to both the client and the therapist, and ask them what is important for them in the therapeutic process.

I work with the qualitative method because of my theoretical interest in compliance and congruency between client and therapist. I have a hypothesis that client and therapist have to be congruent in only few parts of the therapy; the therapeutic setting and some extra-therapeutic contexts. For example, the therapist and the client will conceptualize anxiety in very different ways and they will point to different ingredients in the therapy as being effective. But they will agree on formal aspects of the therapeutic setting, the importance of listening, empathy, transference testing, etc. I am interested in how
the two parties, the client and the therapist, verbalize the therapeutic process.

For my data-collection, I ask the therapist and the client to come to an interview lasting one hour. After a short introduction I say to them: "Please tell me about the therapy and the results of it. You have about 10 minutes. I am not going to ask you specific questions, but will help you if you have difficulties with talking. Tell me what you think is important". While they are speaking I write down every word.

I have used this method with different populations – general practitioners who are doing psychotherapy, and their patients, psychologists and their clients – and have just started a research project with tortured clients, interviewing torture survivors and their therapist.

After this unstructured opening, I ask more specific questions, e.g.: what has been helpful in the therapy, what has not been helpful, what happened to you in your daily life while you were having therapy, what part of it was influenced and provoked by what happened in the therapy, and what had extra-therapeutic reasons.

After this more structured part of the interview, I get even more restrictive and ask the client/therapist to fill out some rating scales.

Part of my data-analysis is semi-quantitative or pseudo-qualitative. I write down every word and sort them from the transcript in different categories. Some sentences are about the effect of therapy, others about the process, the psychodynamic themes, others about the setting and the transference. I have developed a scoring system, whereby every sentence is categorized. This categorization is a starting point for further analysis, in the field of discourse and content analysis.

Let me focus on some results of the first part of this analysis. First of all, the therapist and the client focus on and verbalize very different aspects of the therapy. The therapist focuses on the psychodynamic core of the client’s problem, but the client talks mostly about the setting, the test of the therapist, and other subjects with relationship to transference.

For example, the therapist would often tell in detail about what sort of problems they have been working with during therapy, they do that in a chronological order – first we worked with this and that, and after a while it turned out to be more important to work with another problem. The content of the problem is normally explained in detail and often verbalized in psychodynamic terms, using concepts of, for example, defence mechanism, ego-strength, problem- or emotional-based coping, etc.

The patients, in contrast to the therapists, seldom talk about the psychodynamic conflict and problem, but mostly about the therapeutic setting. For example, they underline the great importance of having a place and time every week where they can come and unburden themselves. Many of the clients mentioned experiences related to transference – "I was very lucky, because my therapist was very sympathetic, he was very good at listening and had a special skill in understanding my difficult situation". They mentioned the content of the therapeutic process very rarely – never in the same terms and always to a lesser extent than the therapist.

Hypothesis:

The context of the ritual is more important than its content

These results with general practitioners and their patients, and with skilled psychologists and their clients, gave me a hypothesis concerning therapy with torture survivors.

The torture victim and the therapist do not talk about anxiety in the same way: the client is more concerned about overt coping behaviour than the therapist, and is searching for techniques of primary reduction of anxiety symptoms, whereas the therapist focuses more on how to get a psychodynamic meaning and coherence out of the symptoms of anxiety.

The client gives more attention than the therapist to the setting of the therapy, and, for example, gives importance in the therapeutic process to the institution’s frame of the therapy, the place and the referral, etc. The therapist gives this contextual aspect an implicit meaning and will not always realize the importance of the client’s perception of it.

I underline this result to support a piece of anthropological knowledge which states that the ritual of healing is sometimes more important in itself than the content which is attached to it. A shaman and his client may well speak about different things and may have quite different experiences about what has taken place between them, but if healing is to take place, they will always agree on the limits of the ritual, the cultural setting of the ritual. For instance, an Arhuaco-Indian, whom I once interviewed after a healing ritual, said: "I did not understand what the mamu said, he was completely in his own world. But I know it was about the history of our society, and about what is important for our survival as Indians. He has probably explained how in the past our culture was overrun by the Spanish conquistadors. But what he really said, I did not understand; by his incomprensible talk he has tried to create disorder among the pictures which the conquistadors have made in my head" (Elssas 1992).

Perhaps the same conditions predominate in therapy. Here too it is not always so important that we talk exactly the same language and about the same phenomena, but we must agree about the character of the ritual. We must agree on the setting for the therapy, the time, the contract, the duty of discretion, that the therapist should listen empathically, that the patient comes out with the material, etc.

We all know that the setting of the therapy is important, but what it is, more exactly, still needs to be mapped out.

By inviting the patients to attend a short follow-up examination, in which they are asked to say what was of particular help to them, one gets to know what was the core of the healing ritual; what they think is essential – and this may not be what the therapist gives priority to.

However, it may be difficult to conclude that the setting of the therapy is more important than its content, because the one part, i.e. the setting and the context, has a mainly non-language character, while the content has a language character.

In cross-cultural connections, we may pay too much attention to cultural differences and language difficulties.
But by emphasizing the form of the ritual we try to identify some non-linguistic forms of healing. And just by going beyond the linguistic barrier, it may be easier for us to abstract from cultural differences and find something common to all mankind with a healing effect.

And a search for something universal may well be our finest task in our attempt to find a common understanding with refugees and torture victims.

Differences between ratings and descriptions of therapy outcome

Concerning the conceptualizing of anxiety; I do not think that we always have to be close to the formulations of the two parties – client and therapist. Sometimes theories are far removed from the ways in which the clients and therapist formulate the symptoms and dynamics. But my warning is that if we take a theoretical position, without knowing the formulations of the people in practice, we run the risk of separating science and practice even more than before.

This is perhaps especially important when we are working in a cross-cultural setting. If we just take over a rating scale without considering the context in which it was developed, we might find ourselves measuring something different from what we were supposed to.

Let me give you some examples of ratings of the results of therapy; all of them are from the studies of general practitioners and their clients.

The first illustrates how a patient can evaluate therapeutic results as bad, even when the therapist thought they were good.

One client told me: “It was a terrible experience. I can not recommend it to anybody. My therapist was very poorly skilled. He never gave me proper advice. Mostly he was silent, because he was too afraid of making a mistake. I was desperately in need of tranquilizers and I could not work for the first three weeks of the therapy – but even when I explained my difficulties to him, he would not prescribe anything for me. He was not interested in helping me and did not even allow me to move to another therapist. ... So little by little I began to realize that I could not depend on him, could not depend on anybody. I realized that the only person I could depend on was myself. So I have to live with my symptoms, nobody can help me, and I have to start working again and trying to survive on my own. I realized that the only one who could help me, was myself.”

This is an example of how a client rated the outcome of the therapy as very bad, though from the therapist’s point of view it was good.

Another client told me: “The therapy has been very important for me, and even though it is one and a half years since I stopped, I think about it almost every day. Very often small episodes from the sessions suddenly blow up in my mind and I feel happy. My therapist was very skilled and I learned a lot from him. He was a fantastic person and I was very happy that I had the chance of having therapy from him. If I get problems and if I get an attack of anxiety, I just have to think of him, and my anxiety will disappear.”

In this case the client rated the outcome as very good, but the therapist was not satisfied and said that there had been problems because of a strong positive transference which had almost stopped the patient from gaining insight.

An interesting result of my research is that many of the patients were unable to remember much from their therapy, particularly when the skilled therapist had evaluated it as a good therapeutic outcome. A positive therapeutic process, in which the patient gains a lot of insight, is accompanied by a normal process of forgetting, by which he will forget part of his psychological problems. It is as if the pathological defence mechanism of repression is changed during therapy into a normal process of forgetting.

Some of the torture survivors could not remember how long they had been having therapy, how often they met during a week, and surprisingly little about the content of the process. But they all evaluated the outcome as very good.

The goal of therapy: efficiency or veridicality

It is problematic to depend only on a quantitative rating, when one is evaluating therapeutic results. The criteria for a good or bad outcome of therapy depend on the theoretical frame.

The theoretical framework of the therapy decides, among other things, which methods we should work with and which rating we should use. As an introduction and in a superficial way, one could say that working within the cognitive and behavioral theories, one uses concepts of, for example, coping behaviour, rating scales, quantitative methods, and efficiency. Within the psychodynamic, psychoanalytical theory, one speaks of defense mechanisms, privileged access, narratology, qualitative methods, and veridicality.

Let me comment on the two terms efficiency and veridicality. One has to decide what the goal of the psychotherapy is. Is it the effectiveness, meaning that the client should be relieved of his symptoms, of his anxiety, so that he can get back to work and live a life without being bothered by his symptoms? Or is it insight into his situation, knowledge of his intra-psychic constellation? – according to the Hegelian traditions, insight and self-knowledge give one more freedom to decide one’s life.

Of course these two therapeutic goals cannot be separated, in a way that insight and self-knowledge can open up the possibility of a much better effectiveness. Effectiveness and veridicality are interwoven, and likewise I have to admit that coping and defense mechanisms are now incorporated in one complex theory, which Haan presented some years ago (1985). It has given the coping-mechanism a more psychodynamic frame, instead of the mechanistic outlook it had in the 1960s. In a way, the borders are becoming blurred between coping and defense, behavioral, cognitive theories and psychodynamic, psychoanalytical theories.

Sometimes one can talk too much about theories and concepts, and some of the very academic research at the universities is doing too much talking, with too little
connection to practice and data. - Knowledge gained, truth lost.

Within psychoanalysis, Eagle, who is himself a prominent psychoanalyst, says:

"My impression is that much current psychoanalytic theorizing is more saturated with jargon than earlier traditional psychoanalytic writing. Indeed, much current psychoanalytic literature includes formulations so vague and so jargon-filled that there is a serious question as to whether they have any clear empirical meaning. Often, the necessary initial step in the approach to this material is to unravel what is really being said and thereby recover whatever empirical content resides in these formulations. Is this to be viewed as progress?" (Eagle 1987: 180).

There is a risk of overdevelopment of theories and concepts, which in itself is not stimulating. Theories and concepts sometimes go into a closed system, with no inspiration to the outside world.

But with the use of the qualitative methods one has the possibility of opening up the research model. By going back to the patients and the therapist with the use of intensive interviewing, one might get new clues for the use of therapy.

**Conclusion**

Within the research of psychotherapy there is a problem of applying the results to the therapist's daily work. Most therapists do not find the research interesting and are not consumers of scientific journals. It is often difficult to get a therapist involved in a research project, because it has no direct interest for him. Science and practice have separated more and more from each other, especially in the field of psychotherapy.

With the work on torture victims, one might be initiating research which is not stimulating for the practitioner. The research might promote the work of anti-torture in a broader public context, but does the use of, for example, a rating scale of anxiety have interest for the therapist, and does it provide academic knowledge he can use in his daily practice?

With the use of the narrative method, the researcher gets closer to the formulations and interests of the therapist and client. The method is simple. Ask the parties, the client and the therapist, to tell about the therapy and the outcome. Ask them to tell you what they think is important for you to know. Write down every sentence and use it for qualitative analysis afterwards. It can be done by one of the colleagues in the clinic, not by the therapist himself.

The concept of anxiety is well developed, and theoretically well articulated. But in the cross-cultural setting and in the field of anti-torture research, one has to know the involved clients' own formulations. For example, coping behaviour may be formulated by the client within the context of shame and guilt, which is not according to how a therapist from the Western world conceptualize it.

My research with this method shows large differences between the client's and the therapist's formulations about the same therapeutic process. The therapist's narrations are in a chronological order, as he has been trained to do from his medical education, e.g. in writing up a history. The therapist focuses on a psychodynamic core, using concepts of coping, defences, anxiety, etc. The client does not focus on psychodynamics. For him the setting of the therapy is much more important, the context of the therapy, and the transference phenomenon. The therapist and the researcher have to respect this difference.

This approach is easy to adopt. Perhaps it will not turn into an article at the very beginning, but it has the possibility of establishing an atmosphere of inquiry – and the reflective practitioner is a very important starting point for doing proper research.

**References**


Measurement of Clinical Anxiety by Rating Scales: A review

By Per Bech, MD, DMSoc

Anxiety: Non-clinical versus clinical (disorders)

The nineteenth century was the century of anxiety. The first monograph on the concept of anxiety was published by the Danish philosopher Kierkegaard (1844). He emphasized the distinction between anxiety as a unique human element (a conditio sine qua non for being a man) and anxiety as a psychopathological, clinical phenomenon (disorder). The manifestation of anxiety clinically as well as non-clinically is a mixture of psychic and somatic phenomena. The differentiation between non-clinical and clinical anxiety is a matter of severity: clinical anxiety is often considered as an extreme variation of non-clinical anxiety.

At the end of the nineteenth century James (1884) and Lange (1885) formulated the James-Lange theory of anxiety emotions that the somatic symptoms always appear first and the psychic anxiety symptoms will appear second also in non-clinical states of anxiety.

In our century the two world wars gave further experiences of anxiety states, the post-traumatic anxiety states. Thus, Wimmer (1923) observed that in some soldiers participating in the First World War a state of post-traumatic anxiety neurosis had developed. In these cases the somatic manifestations of anxiety (e.g. palpitations, faintness, dizziness, trembling, hot or cold spells) had emerged immediately after the traumatic event, whereas the psychic manifestations of anxiety (e.g. worrying, neurasthenia, concentration difficulties and sleep disturbances) had emerged later and constituted the chronic symptomatology.

During the Second World War (Suchman, 1950) it was found by use of self-rating scales that soldiers who had been under fire experienced somatic anxiety symptoms where palpitations and sinking feelings in the stomach were among the indicators of mild to moderate states and vomiting and urinating were among the indicators of marked to extreme states of anxiety. This was one of the first scientific measurements of anxiety.

The spectrum of clinical anxiety:

Personality traits versus states

The term anxiety neurosis introduced by Freud (1894) referred both to the clinical states of anxiety (panic anxiety and generalized anxiety) and to a predisposed character neurosis. In one of the most comprehensive studies on the interaction between character neurosis and the clinical syndrome of anxiety neurosis Jacobsen (1965) showed that anxiety neurosis was correlated to personality traits with avoidance behaviour which he called eridophobia (phobic avoidance of situations including conflicts or aggression).

The Spielberger State-Trait Anxiety Inventory (STAI, Spielberger et al 1970) was originally developed with non-clinical undergraduate and high school students samples, but has been used extensively in clinical settings. However, the results with the STAI have been clinically inconclusive (Beck et al 1988, Loldrup et al 1991). The Eysenck dimension of neuroticism seems more valid that the Spielberger trait of anxiety in psychosomatic disorders (Loldrup et al 1991). Another frequently used self-rating scale for the measurement of trait anxiety is the Taylor Manifest Anxiety Scale (Taylor 1953) which is a sub scale derived from the Minnesota Multi-Phasic Personality Inventory (MMPI, Hathaway and McKinley 1951).

Measurement of anxiety syndromes by rating scales

The term anxiety neurosis has another implicit reference than the one referring to personality trait, name to severity. Neurosis when contrasted to psychosis means that the patient has a reasonable degree of insight. From a psychometric point of view this implies that self-rating scales are applicable, unlike psychosis where overvalued ideas or delusions might result in unreliable self-reports.

Most scales measuring anxiety syndromes are questionnaires or self-rating scales. Such scales can, of course, also be used as observer rating scales, i.e. scales administered by a psychiatrist, a psychologist or other skilled observers after an interview with the patient. Structured interviews are in principle orally administered questionnaires.

The third edition of Diagnostic and Statistical Manual for Mental Disorders (DSM-III, APA 1980) has had an unusual strong impact on the development on rating scales for anxiety. It seems therefore most appropriate to review the various anxiety scales with reference to DSM-II (APA 1968), DSM-III, DSM-III-R (APA 1987) and DSM-IV (APA 1991).

Rating scales for anxiety neurosis, panic disorders and generalized anxiety

DSM-II followed Freud (1894) in using anxiety neurosis as a meta concept including both panic disorder and generalized anxiety. With DSM-III panic disorder was separated from generalized anxiety. In DSM-III-R and
DSM-IV panic disorder as well as generalized anxiety are clearly distinct from phobia.

The two most frequently used rating scales for the measurement of anxiety neurosis (Table 1) are the Hamilton Anxiety Scale (HAM-A, Hamilton 1959, 1969) and the Hopkins Symptom Checklist (SCL-90, Guy 1976). The HAM-A is an observer scale and the SCL-90 is a self-rating scale (but can also be used as an observer scale). Both scales measure intensity of symptoms. In patients with both generalized anxiety and with attacks of anxiety (panic) the number and intensity of panic attacks are incalculated in the ratings. This seems not to cause problems even in patients where panic attacks are dominating (Bech et al 1992). A structured interview for the HAM-A has been developed by Williams (1990).

Table 1. Rating scales for anxiety neurosis, panic disorders and generalized anxiety.

<table>
<thead>
<tr>
<th>DSM diagnoses</th>
<th>Rating scales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety neurosis</td>
<td>Hamilton Anxiety Scale (HAM-A, Hamilton 1969)</td>
</tr>
<tr>
<td>(DSM-II)</td>
<td>Hopkins Symptoms Checklist (SCL-90, Guy 1976)</td>
</tr>
<tr>
<td></td>
<td>SCID-HAM-A (Williams, 1990)</td>
</tr>
<tr>
<td>Panic disorders</td>
<td>Modified Hopkins (Sheehan, 1983)</td>
</tr>
<tr>
<td>(DSM-III)</td>
<td>Modified HAM-A (Bech et al 1986)</td>
</tr>
<tr>
<td></td>
<td>Panic Attack Scale (Sheehan, 1983)</td>
</tr>
<tr>
<td></td>
<td>Panic Attack Diary (Sheehan 1983)</td>
</tr>
<tr>
<td>Generalized anxiety</td>
<td>Hopkins SCL-90 (Guy, 1976)</td>
</tr>
<tr>
<td>(DSM-III)</td>
<td>Modified HAM-A (Bech et al 1986)</td>
</tr>
<tr>
<td></td>
<td>Zung Self-Rated Anxiety Scale (Zung, 1971)</td>
</tr>
<tr>
<td></td>
<td>Beck Anxiety Inventory (Beck et al 1988)</td>
</tr>
</tbody>
</table>

However, when measuring anxiety in patients with DSM-III panic disorder it has been found most appropriate to modify both the SCL-90 and HAM-A. Thus, Sheehan (1983) has developed the Patient-Related Anxiety Scale to adequately cover the symptoms of panic disorder. A physician version of this scale has also been released (Sheehan, 1983). Actually, the physician version was found most valid in the Cross-National Panic Study (Albus et al 1990, Maier et al 1990). In such short-term trials with anti-anxiety drugs observer scales are more sensitive to measuring changes in anxiety neurosis. Thus, HAM-A was found superior to SCL-90 in this respect (Uhlenhuth et al 1982). These findings are similar to results with antidepressants where the Hamilton Depression Scale is more sensitive than self-rating scales like the Zung scale (Angst et al 1992) or the Beck Depression Inventory (Edwards et al 1984).

Table 1 shows that panic attacks should be measured globally, most appropriately both by the physicians (Panic Attack Scale) and by the patient (Panic Attack Diary), Sheehan (1983). These scales differentiate between spontaneous (unprovoked) attacks and situational attacks as well as anticipatory anxiety attacks. The number of the different attacks are then recorded as is the average duration (in minutes) and the average intensity (on a scale from 0 to 10).

A modified HAM-A to be used in panic disorders has been published by Bech et al (1986) in agreement with Hamilton. As a consequence, a modified HAM-A for measuring generalized anxiety has also been released (Bech et al 1986). As shown in Table 1 the SCL-90 can appropriately cover generalized anxiety. In a recent study the validity of SCL-90 in measuring generalized anxiety has been confirmed (Noyes et al 1992).

Factor analysis with the HAM-A both in anxiety neurosis (Hamilton 1969) and in panic disorders (Bech et al 1992) has identified two major factors, namely a factor of psychic anxiety and a factor of somatic anxiety. Of these factors the psychic anxiety factor seems most coherent when investigated by latent structure analysis (Maier et al 1988). In patients with generalized anxiety (Bjerrum et al 1992) the HAM-A factor of psychic anxiety obtained an acceptable Loewinger coefficient of homogeneity (0.46), the factor of somatic anxiety obtained an inadequate coefficient (0.29), while the full HAM-A obtained a just acceptable coefficient (0.35).

Factor analysis with SCL-90 in panic disorder (Bech et al 1992) has identified a general factor of discomfort (which was the original meaning of the scale, Parloff et al 1954), a factor of phobia, and a factor of generalized anxiety. Factor analysis of the SCL-90 in a heterogeneous sample of non-psychotic patients (Guy 1976) has identified factor of anxiety (SCL-11) and of phobia (SCL-9).

Table 1 shows the two other self-rating scales for measuring generalized anxiety, namely the Zung Self-rated Anxiety Scale (SAS, Zung, 1971) and the Beck Anxiety Inventory (BAI, Beck et al 1988). Both Zung and Beck have developed self-rating scales for measuring depression (Zung 1965, Beck et al 1961). As emphasized by Zung (1971) discriminant validity of depression versus anxiety scales is frequently a problem emerging in the later stages of the scale construction when attention has shifted from the individual item analysis to the total scale score. The correlation between the BAI and the Beck Depression Inventory is 0.48.

The components of generalized anxiety are according to DSM-III and DSM-IV psychic anxiety (anxious mood and psychic tension) and the following somatic components (motor tension, autonomic hyperactivity and hyperarousal). Table 2 shows the items distribution of the

Table 2. Item distributions (%) of rating scales measuring generalized anxiety.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxious mood</td>
<td>7%</td>
<td>18%</td>
<td>15%</td>
<td>24%</td>
<td>0%</td>
</tr>
<tr>
<td>Psychic tension</td>
<td>14%</td>
<td>9%</td>
<td>10%</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Motor tension</td>
<td>14%</td>
<td>9%</td>
<td>15%</td>
<td>11%</td>
<td>33%</td>
</tr>
<tr>
<td>Autonomic hyperactivity</td>
<td>43%</td>
<td>55%</td>
<td>45%</td>
<td>48%</td>
<td>66%</td>
</tr>
<tr>
<td>Hyperarousel</td>
<td>14%</td>
<td>9%</td>
<td>15%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Phobia</td>
<td>7%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Number of items</td>
<td>14</td>
<td>11</td>
<td>20</td>
<td>21</td>
<td>9</td>
</tr>
</tbody>
</table>
various scales for generalized anxiety. In the HAM-A one item measure phobia (7%), which is not included in the DSM-III concept of generalized anxiety. All the scales are weighted on the somatic components; the Beck Anxiety Inventory seems, however, most balanced in respect to psychic and somatic anxiety.

Rating scales for phobic states

In DSM-IV phobia is defined as anxiety about being in places or situations in which escape might be difficult (or embarrassing) or in which help may not be available in the event of suddenly developing fear. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; travelling in a bus, train or car. Social phobia is anxiety in situations involving public performances such as giving a speech, eating, writing etc. Simple (DSM-III) or specific phobia refers to fear cued by the presence of a specific object or situation (e.g., flying).

Based on the work summarized by Gelder and Marks (1966) several phobia scales have been developed. Of these the Fear Scale (Marks and Mathews, 1979) is the most widely used scale covering the DSM-II concept of phobic neurosis. This scale has been modified by Sheehan (1983) to correspond to DSM-III (Table 3). However, the SCL-9 subscale (Guy 1976) on phobia covers reasonably well the three components of phobias in DSM-III: agoraphobia, social phobia and simple phobia.

Table 3.

<table>
<thead>
<tr>
<th>DSM diagnoses</th>
<th>Rating scales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phobic neurosis (DSM-II)</td>
<td>Gelder-Marks Phobia Questionnaire (Gelder and Marks, 1966)</td>
</tr>
<tr>
<td></td>
<td>The Fear Questionnaire (Marks and Mathews, 1979)</td>
</tr>
<tr>
<td>Phobic disorders (DSM-III)</td>
<td>Marks and Sheehan Phobia Scale (Sheehan, 1983)</td>
</tr>
<tr>
<td></td>
<td>Hopkins subscale SCL-9 (Guy, 1976)</td>
</tr>
</tbody>
</table>

In ICD-10 (WHO, 1992) agoraphobia is accepted as a category independent of panic attacks. In DSM-IV there are categories of panic disorder without agoraphobia, panic disorder with agoraphobia and agoraphobia without history of panic disorder. In a meta-analysis of double-blind placebo-controlled trials of antidepressants and benzodiazepines for patients with panic disorders Wilkinson et al (1991) have included phobia as one of the outcome variables (the other being panic attacks, anxiety, depression, social functioning, physical symptoms and global clinical ratings). This emphasized that anxiety neurosis and phobic neurosis should be considered in their whole range in drug trials.

Rating scales for obsessive-compulsive states

Obsessive-compulsive neurosis (DSM-II) was originally, like anxiety neurosis, considered as a pathological extension (symptoms) of a basic obsessive personality trait (Reed 1985). In contrast, Rachmann and de Silva (1976) have, among others, advocated that clinical states of obsessions are an extreme variant of a normal psychological process involving intrusive thoughts. DSM-III used the terms obsessive-compulsive disorders, thereby excluding any link to a basic neurotic character type. In DSM-III obsessions and compulsions were considered as indicators of the same underlying dimension, but DSM-IV seems to consider obsessions and compulsions as separate dimensions.

The Leyton Obsessional Inventory has both trait and state items (Cooper 1970; Allan and Tune 1975). Empirical studies (Salkovskis, 1990) seem not to support a relationship between obsessional traits and the obsessive-compulsive syndrome.

The Maudsley Obsessive-Compulsive Inventory (Hodson and Rachmann, 1977) measures mainly compulsion. This scale has been modified by Sanavio and Vide (1985). The scale differentiates between checking behaviour, cleaning behaviour, doubting behaviour and behaviour of slowness.

One of the most frequently used observer scales within the frame of DSM-III is the Obsessive-Compulsive Subscale of the Comprehensive Psychopathological Rating Scale (Thoren et al 1980). A modification of this scale to correspond with the Hamilton Scales has been released (Bech 1992).

Another scale measuring the combined obsessive-compulsive states is the Hopkins SCL sub scale including 10 items (Guy 1976).

The most comprehensive scale which seems especially to cover the DSM-IV separation of obsessions and compulsions is the Yale-Brown Obsessive Compulsive Scale (Y-BOCS, Goodman et al 1989).

Table 4 shows a review of scales measuring obsessive-compulsive states.

Table 4.

<table>
<thead>
<tr>
<th>DSM diagnoses</th>
<th>Rating scales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obsessive-compulsive neurosis (DSM-II)</td>
<td>Leyton Obsessional Inventory (Cooper, 1970; Allan and Tune, 1975)</td>
</tr>
<tr>
<td></td>
<td>Maudsley Obsessive Compulsive Inventory (Hodson and Rachmann, 1977)</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder (DSM-III)</td>
<td>Obsessive-Compulsive Rating Scale (Thoren et al, 1980)</td>
</tr>
<tr>
<td></td>
<td>HopkinsObsessive-Compulsive Subscale (SCL-10, Guy 1976)</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder (DSM-IV)</td>
<td>Yale-Brown Obsessive-Compulsive Scale (Goodmann et al, 1989)</td>
</tr>
</tbody>
</table>

Rating scales for post traumatic stress disorders

Whereas panic disorder as well as generalized anxiety disorder according to DSM-III and DSM-IV are considered as primary disorders, post traumatic stress disorder is considered as a reaction to severe psychosocial stressors. In DSM-III-R the stressor is defined as an event "outside
the range of usual human experience”. In DSM-IV more specific descriptions of the nature of the allowable stressors have been suggested taking a subjective component into account, e.g. the person’s response of intense fear, helplessness or horror. In other words the severity of the anxiety or depression.

Already Wimmer (1923) showed that the acute stress reaction induces somatic anxiety symptoms and that the prolonged reaction includes psychic anxiety symptoms and depression. At the phenomenological level, therefore, measurements of post traumatic stress symptoms can be adequately covered by the self-rating scales for anxiety and depression. Thus, Horowitz et al (1980 a,b) used Hopkins SCL-90. Analogously the Hamilton scales for anxiety and depression can be considered as adequate observer scales.

However, specific scales for post traumatic stress disorder have been developed, among them the Impact of Events Scale (Horowitz et al, 1979). So far, no specific scale for post traumatic stress disorder has obtained status of international standard. Both DSM-III-R and DSM-IV require that a persistent avoidance of stimuli associated with the trauma should be taking into account.

When reviewing drug therapy of post traumatic stress disorder Davidson (1992) identified six goals for treatment:
1) reduction of phasic intrusive symptoms,
2) improvement of avoidance symptoms,
3) reduction of tonic hyperarousal,
4) relief of depression,
5) improvement of impulse regulation and
6) control of acute dissociative symptoms. Whereas the Impact of Events Scale measures intrusive as well as avoidance symptoms, and the SCL-90 or Hamilton Scales cover arousal, depression and impulse regulation. The acute dissociative symptoms are only insufficiently covered by these scales. It is, therefore, recommended to include the Dissociative Experience Scale (Bernstein and Putnam, 1986) when measuring the full range of post traumatic stress disorder. However, in many situations, especially when evaluating the prolonged stress disorder, the SCL-90 and the Hamilton Scales are sufficient.

An overview of the different scales in accordance with DSM-III-R and DSM-IV is shown in Table 5.

**Table 5. Rating scales for posttraumatic stress disorder.**

<table>
<thead>
<tr>
<th>DSM diagnoses</th>
<th>Rating scales</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSM-III-R Intrusive symptoms and avoidance behaviour</td>
<td>Impact of Events Scale (Horowitz et al, 1979)</td>
</tr>
<tr>
<td>Arousal</td>
<td>Hopkins Symptom Checklist (SCL-90, Guy 1976)</td>
</tr>
<tr>
<td></td>
<td>Hamilton Anxiety Scale (HAM-A, Hamilton 1969)</td>
</tr>
<tr>
<td>DSM-IV Severity (acute)</td>
<td>Dissociative Experience Scale (Bernstein and Putnam, 1986)</td>
</tr>
<tr>
<td></td>
<td>Hamilton Depression Scale (HAMD, Hamilton 1967; Bech et al 1986)</td>
</tr>
<tr>
<td>DSM-IV Severity (prolonged)</td>
<td>Hamilton Depression Scale (HAMD, Hamilton 1967; Bech et al 1986)</td>
</tr>
</tbody>
</table>

The Hamilton Depression Scale includes a factor of anxiety (psychic anxiety, somatic anxiety, agitation, hypochondriasis) and Hamilton (1989) emphasized that anxiety is an important factor in depression. According to DSM-III and DSM-IV mood disorders including major depression have been described without any anxiety symptoms.

One of the most frequently used self-rating scales for depression is the Beck Depression Inventory (Beck et al 1961) which like DSM-III and DSM-IV has no items covering anxiety. The relationship between the Beck Depression Inventory and the Hamilton Depression Scale in a population of depressed outpatients has been studied by Steer et al (1987). They found that both scales were needed to cover the factors of anxiety and depression.

The Hospital Anxiety-Depression Scale was developed by Zigmond and Snaith (1983) to screen for anxiety and depression secondary to medical disorders. The scale is a self-rating scale with fewer somatic items because in the medical setting such items can be difficult to interpret.

The Melancholia Scale (MES, Bech and Rafaelsen 1980, Bech 1981) was designed as a Hamilton scale with special focus on cognitive and motor symptoms of depression. A self-rating version of this scale has also been developed (Bech, 1992).

In patients with chronic idiopathic pain disorders the Melancholia Scale (MES) was found valid in predicting outcome of antidepressants (Loldrup et al 1991). The concept of “less than major depression” emerged in this study as an important condition from which 33% of these patients suffered. This confirmed the study by Paykel (1990) who found in the primary care setting that amitriptyline was superior to placebo in depressed patients with HAMD score of 13 or more (i.e. “less than” or “probable” major depression according to Research Diagnostic Criteria, RDC, Spitzer et al 1978). This has also been confirmed by Philipp et al (1992).

“Less than major depression” (i.e. a score of 13 to 17 on HAMD-D or between 10 and 14 on MES) equals a score between 15 and 20 on the Beck Depression Scale or a score between 15 and 20 on the Hamilton Anxiety Scale (HAM-A) as shown by Loldrup et al (1991). In this study the MES and the Beck Depression Inventory
were more homogenous than the Hamilton Anxiety Scale. Thus, depression seems to be the most valid dimension in mixed anxiety-depressive disorder.

In DSM-IV “less than major depression” has been included as a mood disorder referred to as minor depression disorder. This category, like mixed anxiety-depression disorder, has been considered because many individuals in primary care settings fall short of the DSM-III-R thresholds for major depression. In ICD-10 recurrent depressive disorder has also been sub-divided into mild, moderate and severe. Likewise, ICD-10 has under anxiety disorders included a category of mixed anxiety and depressive disorder.

Table 6 shows a review of scales to be considered for mixed anxiety-depressive disorder.

Table 6.
Rating scales for mixed anxiety-depressive disorder.

<table>
<thead>
<tr>
<th>DSM diagnoses</th>
<th>Rating scales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed anxiety-depressive disorder (DSM-IV)</td>
<td>Hospital Anxiety-Depression Scale (Zigmond and Smith, 1983)</td>
</tr>
<tr>
<td>Minor depressive disorder (DSM-IV) or “less than major depression”</td>
<td>Hamilton Depression Scale (score 13-17, Paykel, 1990)</td>
</tr>
<tr>
<td></td>
<td>Melancholia Scale (score 10-14, Loldrup et al, 1991)</td>
</tr>
<tr>
<td></td>
<td>Beck Depression Inventory (score 15-20, Loldrup et al, 1991)</td>
</tr>
<tr>
<td></td>
<td>Hamilton Anxiety Scale (score 15-20, Loldrup et al, 1991)</td>
</tr>
</tbody>
</table>

Rating scales for other “neurotic” target syndromes

The DSM-II categories of neurosis have in DSM-III and DSM-IV been separated into rather distinct (global or gestalt) syndromes such as panic, obsessions and compulsions. At the same time, however, syndromes defined by a group of symptoms with shared phenomenology have also emerged such as generalized anxiety disorder, minor depressive disorder and mixed anxiety-depressive disorder.

Among global syndromes not covered under the heading of anxiety disorders are outward attacks of aggression, suicidal impulses, self-mutilation, emotional instability, sleep and pain. As discussed elsewhere (Bech, 1992) these syndromes might most appropriately be measured by global scales such as Visual Analogue Scales. They are target symptoms rather than target syndromes. Among these target symptoms emotional instability might be considered as a neurotic symptoms in dementia (Nyth and Gottfries, 1990), self-mutilation as a pseudo-neurotic symptom in borderline disorders (ERAG, 1992) and outward attacks of aggression as a non-neurotic or psychotic symptom in schizophrenia and mania. Thus, pain, sleep and suicide symptoms remain, but they are often most appropriately considered as ingredients of the respective anxiety or mood disorders.

Conclusion

The anxiety disorders considered in this review have been discussed in relation to the historical development of DSM-II, DSM-III, DSM-III-R and DSM-IV, because the DSM has had a major impact on the rating scale approach to measure clinical anxiety, but the ICD-10 development in this field has also been considered. This scale approach to the specific anxiety disorders such as post traumatic stress disorder, phobia, generalized anxiety disorder, panic and obsessive-compulsive disorder has shown that they all should be measured in a diagram of anxiety and depression as shown in Table 7. It has been concluded that mixed anxiety-depressive disorder and minor or less than major mood disorder are a matter of severity on the abscissa in Table 7. From a treatment point of view the dimension of anxiety and depression in Table 7 is often more important than sub-diagnosing the individual categories. Thus, the term anti-anxiety and antidepressive drugs.

Table 7.

<table>
<thead>
<tr>
<th>Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phobic disorders</td>
</tr>
<tr>
<td>Generalized anxiety disorder</td>
</tr>
<tr>
<td>Panic disorder</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
</tr>
<tr>
<td>Mixed anxiety-depressive disorder</td>
</tr>
<tr>
<td>Less than major mood disorder</td>
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<tr>
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Depression (melancholia)

References


Cooper J (1970). The Leyton Obsessional Inventory. Psychol Med 1, 48-64.


James W (1884). What is an emotion? Mind 9, 188-205.


Lange C (1885). Om sindesbevægelser (Emotions). Jacob Lunds Forlag, Copenhagen.


The limitations of the anxiety concept in work with survivors of repressive violence

By Stuart Turner, MA MD MRCP MRCPsych

Abstract

In seeking to understand the way people react to grossly abnormal events such as torture and other forms of organised repressive violence, there are two contrasting approaches. The first is to examine the range of pathological symptoms and from them construct a syndrome. The alternative is to generate hypotheses based on understandings of normal behaviour and apply them to the condition of torture; this is an approach more typical of psychological practice. Both methodologies have drawbacks. In this paper, these different perspectives will be explored and in so doing the limitations of a vague anxiety concept will be exposed. There are few words with more meanings or levels of understanding. It can be seen in terms of a pathological state, a normal emotion, a theoretical construct within a range of mutually incompatible psychological theories or a description of a state of being. It will be suggested that it is too unclear a concept to have much value although specific aspects of anxiety may lead to testable and relevant ideas.

The anxiety concept

In psychiatric nosology, anxiety is both a symptom and a (categorical) syndrome. As a symptom, it is characterised by a sense of morbid fear or dread, associated with a range of typical physiological changes (fast heart beat, sweating, dry mouth etc.) and a wish to avoid or escape the situation. It is a feature of most psychiatric disorders, for example, phobic states, panic disorder, obsessive states, anorexia nervosa, depression, and psychosis. There is also a syndrome called generalised anxiety disorder in which the symptomatic anxiety is pervasive and not tied to a specific situation.

In addition, anxiety is applied not just to an individual's current state or to a period of illness, but also to an enduring personality trait. Some people are more or less anxious in their general disposition; they have a prevailing tendency to be more anxious or more robust.

In theoretical terms, anxiety has an important role as an explanatory concept in both psychoanalytic and behavioural theories. These use the term in superficially similar but fundamentally incompatible ways. In one case, it is based on a theoretical understanding of human development; in the other it rests upon classical conditioning and social learning theory.

Finally, anxiety has a more fundamental aspect, unrelated to any description of illness. It may have something to add to the descriptions of people's essential being or existence (note the references by Bødnholt to the "destruction of identity, the killing of a soul"). This existential aspect may have a critical role to play in understanding how people react to malicious violence such as torture.

This plethora of uses of the term inevitably weakens its heuristic value. Because anxiety covers such a range of phenomena, it is easy to lose focus. Neither is it simply a concern over definitions. There is a fundamental theoretical distinction between, on the one hand, attempting to understand and investigate the effects of trauma on normal psychological processes and, on the other hand, starting with descriptions of the pathological states and trying to make sense of a motley collection of symptoms (Goldfeld et al, 1988).

Simple and complex traumas

In investigating the nature of the psychological reaction to trauma, some common elements keep surfacing. The association between intrusive thinking and desire to avoid/emotional numbing has long been recognised in professional and lay literature. Moreover, some theoretical work (eg Horowitz, 1976; Rachman, 1980) has attempted to provide an explanation for these reactions, based on normal emotional processing. Indeed the primitive and stereotyped nature of Post-traumatic Stress Disorder (PTSD) as currently defined (American Psychiatric Association, 1987) almost certainly reflects a disturbance in a basic psychological process, caused by major trauma.

One of the main advantages of PTSD is its use of symptoms present across a range of post-trauma states. It is based on an understanding of what effect simple trauma has on individuals and is not merely a description of phenomena reported by survivors of violence to women (battered woman syndrome), combat (shell shock, war neurosis, combat stress etc) or torture (torture syndrome). In this way it is possible to identify themes which are common and to distinguish them from those elements where there are differences.

PTSD has significant limitations as well. One of the most obvious is its categorical nature. Does it really make sense to have a criterion beyond which there is a disorder (and should this not be an injury) when experience suggests that people present with a range of difficulties? Another is the tendency not to look beyond the syndrome to see the other ways in which people have reacted.
(adaptively as well as maladaptively) to their experiences. Finally, there may be differences in the pattern of reaction. In torture, the individual’s ability to avoid the impact of the assault may have been deliberately attacked by the perpetrator in order to have a maximum effect; this may weaken the avoidance reaction afterwards.

In the case of torture, the individual will certainly have been subjected to a trauma of a scale sufficient to produce a PTSD-type reaction. However, the trauma is often particularly complex, associated with malice and perverted intimacy, and followed by a wide range of consequential losses (health, family, work, safety, trust, and even, for asylum seekers, country, community and culture). Seen in this way, it is possible to start to draw out several other strands in the individual’s range of reactions.

A four-theme model applied to survivors of torture

Four common themes, which may be identified in survivors of torture, have already been proposed (Turner & Gorst-Unsworth, 1990 & 1992). These are based on a mixture of clinical experience and theoretical assumptions. It was intended that they should be amenable to testing.

In summary, these themes were:

(a) Incomplete emotional processing. Intended to be similar to PTSD, the theoretical approach would suggest a dimensional rather than a categorical reaction; for this reason a different name was selected. It was hypothesised that this reaction is primarily caused by the trauma itself and may be understood in terms of (more cognitive) theories of emotional processing or (more behavioural) theories of conditioning.

(b) Depressive reactions. It was proposed that the experience of torture and other repressive violence leads to a range of consequential losses, which in turn lead to a depressive reaction. These losses are likely to be greater in asylum seekers and refugees than people who are able to stay in their countries of origin. So depressive reactions may be more prominent in displaced people and they may show a high co-morbidity with PTSD (Van Velsen et al, 1992).

(c) Somatoform reactions. People subjected to physical pain and privation in order to achieve a psychological result (repression, submission, punishment etc.) have the opportunity to learn many patterns or associations between physical and psychological events. It is suggested that some of these may be adaptive during torture but maladaptive afterwards.

(d) The Existential Dilemma. Torture has effects not just on basic processes such as conditioned learning, it also seems to affect many aspects of a person’s notion of self and their position in the world. Alienation, personal change, inability to trust and survivor guilt, for example, have been described by survivors. The RCT symbol itself appears to be a person jaggedly ripped in two. These phenomena often go beyond a typical psychiatric nosology yet may be of the most importance in determining the shape of a person’s future life. It is suggested that being unprepared for torture or having a world political or religious view which does not encompass the evil of torture are likely to lead to the greatest effects. Torture and other repressive violence appears to have a fundamentally radicalizing effect, pushing people into repressed submission or into active opposition (Gorst-Unsworth et al, 1992).

Interestingly, in a recent survey of Gulf hostages (Easton & Turner, 1991), there appeared to be a distinction between alienation and attitude change on the one hand (associated with the horror of the experience) and psychological distress including intrusive thinking and avoidance on the other hand (associated with persisting social and financial worries). This sort of evidence tends to indicate that there are distinct themes within the generality of the trauma reaction, each with its own antecedents and pattern, which merit further investigation and elucidation.

Clinical implications

This approach also carries implications for treatment. There may be different approaches to people with different types of difficulty. Indeed it would be surprising if everyone reacted to such a complex type of trauma in the same way or stood to benefit from the same treatment approach. On the other hand, some common treatment approaches have been identified (eg Cienfuegos & Monelli, 1983; Turner, 1992). Without some commonality of approach, there can never be any systematic evaluation or comparison of different types of approach.

It also indicates some of the limitations of treatment. If the person has experienced the “killing of a soul”, how do we as professionals stand to help with this? Sometimes the opportunity to relate to another human being, or the opportunity to come to understand some of the experiences might help, but often there are others, for example religious, political or social elders, who may have a greater part to play.

Social context & culture

This leads on to another issue – the importance of the community in which torture is perpetrated. Usually, this is a process of repressing of whole groups of people in which some are directly attacked but all, indirectly, are potential victims. Not only have there been no substantial validation exercises for the categorical disorder, PTSD, on people from a broad range of cultures, its limitations as a reaction of people, individually, to a communal violence are immediately obvious. Further attention to the differences between people and between cultures are essential if this process of understanding is to proceed.

The anxiety concept

So anxiety needs to be broken down into more discrete elements to have any substantial value in understanding
the condition of torture survivors. It is a mere truism to assert that survivors of torture may suffer fear. To attempt any more detailed understanding requires such a process of qualification of the ambiguous concept of anxiety that it again becomes necessary to select another label for the concept under scrutiny.

In discussing anxiety in the context of torture, the first step should be to consider a theoretical approach in which a relationship between a (defined) anxiety and a lesser trauma is encapsulated. Then, this work may be applied to understanding survivors of torture. The need to make a qualitative distinction between a chronic generalised anxiety disorder following torture and a normal fear syndrome may disappear in this sort of analysis.

**Conclusion**

Anxiety may be an important concept to explore in research with torture survivors. In this paper, some of its limitations have been presented and an alternative approach suggested.

Torture is a complex phenomenon with a multitude of associated factors of psychological significance. Moving away from a position in which there is a single uniform syndrome and, instead, looking at different patterns of reaction has many advantages. The themes presented here may be insufficient or even incorrect but they are at least based on more precise theoretical positions and amenable to scientific investigation.

**References**


Bøjholm S. (1991): The effects of the treatment of torture survivors at the RCT. Please see this issue’s introduction.


Conceptualizing anxiety in torture survivors

An investigation of children of torture survivors

By Yvonne Krogh, MSc, clinical psychologist
& Edith Montgomery, Msc, clinical psychologist

At a scientific conference in London in May 1988 sponsored by the International Academy of Pediatric Transdisciplinary Education (IAPTE), the Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen organized a seminar on aid for children whose parents had been subjected to torture. Existing research results were discussed, and it was concluded that there was a need for an international study of the nature of the problems experienced by these children. An international project with the title, Children in Crisis was initiated with participation of psychologists, psychiatrists, and paediatricians from Argentina, Denmark, France, Greece, Pakistan, the Philippines, South Africa, and the U.S.A.

As a first step in this international project, a qualitative investigation was carried out at the RCT in Copenhagen during the period March to September 1989.

Prevalent research on children exposed to armed conflict addresses the impact of multiple traumatic experiences.

- Children who have themselves lived under concentration camp conditions (Kinzie et al. 1986, Sack et al. 1986, Kinzie et al. 1989), and
- Exhibit a number of mental symptoms sharing common emotional, psychosomatic, and behavioral features: fits of anxiety, depressive symptoms, sleep disturbances (e.g., nightmares); enuresis, stomach pain, headache; aggressive behaviour and concentration, learning and contact problems. First of all, these studies deal with the prevalence of mental symptoms in children having been exposed to organized violence. Attempts have been made to summarize such symptoms in a more comprehensive syndrome, the so called Post Traumatic Stress Syndrome (PTSD) (Eth & Pynoos 1985).

The objective of this study was to obtain deeper insight into the processes which control symptom development and the coping process:

- to investigate and describe the emotional, cognitive, psychosomatic, behavioral and somatic problems among children from families in which one or both parents have been subjected to torture,
- to describe and understand the dynamic processes behind the individual child’s reactions to traumatic experiences and to summarize this understanding in individual coping-components and main types of coping strategies.

The study comprised 11 children of adult RCT clients. The examinations took place between March 1989 and November 1989.

The children (8 girls and 3 boys), were from 5 to 13 years old and came from Chile, Uruguay, Turkey, Iraq and Afghanistan. In all five families one or both of the parents had been tortured, but none of the children. The children had experienced violent apprehension of their parents, separation from their parents, war, flight, etc.

The children were assessed by the following techniques:

- Open interview with the child
- Open and semi-structured interview with the parents
- Semi-structured interview, including Rutters scale (Rutter 1967), with the child’s teacher
- Home visit with observation and open interview
- Paediatric and functional neurologic examination
- Rheumatological examination
- Psychological examination, including, Draw-a-tree (Hammer 1980) and Rorschach tests and observation of play
- Body test (Bentzen et al. 1989)

Results

All the children appeared emotionally unbalanced. The psychological unbalance showed itself in such symptoms as:

- anxiety
- headache, stomach ache, pain in arms and legs,
- eating problems,
- tics
- sleep disturbances
- depressive tendencies
- learning and/or concentration difficulties
- family relation conflicts

The objective of this study was to obtain deeper insight into the processes which control symptom development and the coping process:
We have used the term *coping* (Lazarus & Folkman 1984) concerning the behaviour and intra-psychic processes which together constituted the child’s manner of dealing with the situations. By the term *coping-strategy*, we understand a specific, complex pattern of intra-psychic mechanisms and behavioral patterns, which are consistent and identifiable with regard to the goal-directedness and relevance. Coping is a goal-directed process and therefore can be assessed and classified according to its relevance in light of specific goals (e.g., survival or both survival and development). The coping process takes place as a dynamic interaction between the goal for the child’s coping (e.g., survival, development, freedom to act), the child’s individual psyche, the family dynamics, and external events.

The children seem to have developed four different main strategies for handling the problems:

1. Dominating attention and help seeking behaviour.
2. Eagerness to adapt by playing “the role of the nice girl”, showing respect of authority, perfectibility, obedience, politeness and inordinate solicitude.
3. Flight from reality through dreaming or romanticism.
4. Denial of problems and maybe isolation-seeking.

The coping process’s dynamic dependence upon the interaction between goals, personality, family dynamics, and external events is exemplified by the following case description.

**The story of Ali and his family**

Ali is a 12-year-old boy from Afghanistan. His dramatic story started when the war broke out when he was just 2 years old. His oldest little sister was born just after that and her whole life has thus been influenced by the war and its consequences. Ali was close to his father and already during his early childhood, he went with his father around the town with the father for the father’s work. What he did not know was that his father from the start of the war was politically involved in the Resistance Movement. When Ali was around 7 years old his father was brought to prison and tortured. Nobody told Ali why his father suddenly was gone and Ali told the author that he should not ask. He felt his mother’s anxiety and as he was the oldest child living at home, he had to take over some of the practical obligations of the father in the home. The situation did not get easier when Ali’s smallest sister was born during the time the father was imprisoned. The father was away for 6 months and after this time he had to hide himself in his home for around one year. During this period the military paid frequent “inspection visits” in the home to look for the father without finding him. Ali’s sisters were terrified during those visits that often took place during the night, which were very violent with screaming, threats and throwing around with things.

The family decided to escape as the situation got more and more tense. Still the children were not informed, they were told that they were going to visit friends of the family in a neighbouring country. However, Ali knew. He did not say anything, he knew that they were escaping from a dangerous situation and that the escape itself could be dangerous, especially if the little sisters started to cry on the way. He suppressed his own needs to the advantage of the family’s needs. He also knew, or rather thought he knew, that the family had to escape because of him, otherwise he would have been drafted to the army. So in this way, Ali took the full responsibility for the family’s situation.

On the way, the family experienced bombardments, fire and military encounters. After 25 days they arrived at a refugee camp in a neighbouring country. Here the children were told that the family had escaped and would not return to their home. They were not, however, told the reason for the escape. They stayed in the camp for 2½ years under very bad conditions before they were allowed to come to Denmark.

Ali has learned to suppress his own feelings and to take a big responsibility upon himself. This was necessary during the father’s imprisonment, during his hiding in the home and during the escape. Now his father, however, is back in the family and do not want Ali to be the man in the house. Because of the torture he has gone through, he is characterized by a great emotional instability with feelings of anxiety, depression and sometimes anger. He has headaches and difficulties in sleeping. Thus it is still very practical for the parents that Ali now and then take extra responsibility upon himself for the family, although they do not want it at all times.

The changing and ambivalent reactions towards Ali’s behaviour are very confusing for Ali and make it very difficult for him to revise his way of coping with the situation. Ali himself is anxious and afraid, he is sad and cries a lot, he has headaches, bad appetite, ticks and sometimes enuresis. He tries to isolate himself and withdraw from human contact. The family regard his behaviour as satisfying, Ali does not bother them, but minds his own business.

**Discussion**

The children seemed each, in relation to their circumstances in their home country, to react in an understandable and most often appropriate manner. The two active, extroverted coping strategies (“Eagerness to Acclimatize” and “Strength of Will and Fighting”) seem in the long run to give more advantages and fewer losses (in the sense of more or fewer psychological symptoms) than the more passive strategies “Isolation and Withdrawal” and “Mental Flight”). The active strategies seem thus to serve a more comprehensive coping objective (survival, development, and freedom to act) than the passive ones which primarily secured survival in the concrete, traumatic situations.

The coping strategy “Strength of Will and Fighting” represents the most active processing, and 2 of the 3 children who primarily used this strategy were free of psychological symptoms requiring treatment.

The coping strategy “Eagerness to Acclimatize” comprises both a critical will to acclimatize and a more un-critical attempt to put the past behind and become Danish. The children who were more critical in their interest in acclimatizing were similarly without psychological symptoms which required treatment.

However, none of the children had been able to revise their coping strategy after their life situation had changed radically (exile). Parallel to this, the coping of the family members at large remained unchanged due to loss of strength because of imprisonment, after-effects of torture, and escape.

One situation which seemed to have particular significance for the child’s reaction was the degree of openness in the family about the imprisonment, torture and escape. Two families had told their children about the background for the family’s escape, and these children seemed to be better able to deal with the situation and had fewer signs of emotional instability. However, the children were all born after the father’s imprisonment and torture.

The reason for the lack of openness from the parents can originally have been fear that the child might reveal in words or behaviour plans which must of necessity be kept secret. The parents might also have remained silent because the horrors they themselves had been through.
still were too painful for them to express in words. This could mean that the families which had been able to speak with their children about the experiences and answer the children’s questions are the families where the parents had come furthest in working through their torture experiences and perhaps therefore had a better possibility of supporting their children.

The two oldest boys in the investigation had as a main coping strategy “Isolation and Withdrawal” and both boys were characterized by depressive symptoms. This could be explained as a result of the fact, that identification with the imprisoned parent (most often the father) is made difficult, as he appears vulnerable in the child’s eyes. The imprisonment brings further confusion into the child’s picture of right and wrong and makes it difficult to identify with the parents’ moral values. This can lead to a poor social adaptation and a passive, withdrawn attitude. This consequence is particularly marked for the child of the same sex as the imprisoned parent. With regard to families suffering the consequences of torture, it is likely that the identification process is further disturbed by the fact that when the father returns home he suffers from psychological after-effects of the torture. This aspect should be analyzed more closely in future investigations.

Further investigations are also necessary to more closely elucidate how the family dynamics and the child’s choice and change of coping strategy are co-related, as well as which consequences this can have for the child’s development.

The consequences for the therapeutic approach are that one ought to deal with entire families affected by torture and not exclusively focus on the children or adult as individuals.

Acknowledgement

References

Anxiety and coping in torture survivors

By Susan Folkman, PhD

Introduction

It is a great privilege to participate in this conference on conceptualizing anxiety in torture survivors. The work of RCT is impressive in its commitment to survivors of torture, the scope of its activities, and the quality of those activities. I know that Professor Lazarus regrets not being able to attend. He spoke very highly to me of this group, and I know he will be keenly interested in the ideas that are discussed here.

The readings that were provided for this conference convey a very clear picture about the prevalence and intensity of anxiety among survivors of torture. Those who work with survivors report at least two major tasks regarding this anxiety. One task is to help survivors become less anxious through therapy. A second task is to provide survivors with information and skills that they need to function in their day-to-day lives. I am struck by how difficult these tasks are among survivors of torture, especially those who are also refugees. The process of dealing with the aftermath of torture through psychotherapy can take years. In the mean time, survivors need to be able to function so that they can find housing, learn a new language, and maintain relationships with families and possibly friends. It is toward this latter task – functioning in day-to-day-living – that I would like to direct my comments about anxiety and coping.

Conceptual Background

The relationship between anxiety and coping is dynamic and recursive; anxiety can influence coping, and coping in turn can influence anxiety. Thus, anxiety is both an antecedent and an outcome of coping. In this talk I shall be concerned primarily with anxiety as an antecedent of coping, and its effects on coping.

Let me take a few moments to provide a conceptual framework for my comments about coping. The term coping is widely used – almost as widely used as the term stress. Like the term stress, it has many different meanings. In our 1984 book, Stress, Appraisal, and Coping, Richard Lazarus and I defined coping as “Constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (p.141). This is the definition I shall use. Let me highlight two of its important features:

First, coping consists of thoughts and actions that the person uses to manage stressful demands. In the vernacular in the United States, and perhaps here, as well, to say someone is coping usually implies that individual is successfully mastering adversity. The definition of coping as successfully mastering adversity implies that people who do not fully master the problems with which they are contending are not effective copers. This definition does not take into account that many stressful events of conditions cannot be controlled or overcome. At best, some situations can be tolerated, minimized, or even simply survived, but not mastered. People who learn to tolerate situations that cannot be mastered may well be coping effectively, given the conditions with which they are coping. The definition of coping needs to be broad enough to include the efforts people make to tolerate or simply survive uncontrollable situations. I cannot think of any group to whom the restricted definition of coping as-mastery does more disservice than the survivors of torture.

Second, coping thoughts and actions changes as the person-environment relationship changes. Changes in the person-environment that are independent of the person. This feature has two important implications. First, coping is not a stable feature of personality. It is a changing process. Second, to understand coping, one must understand the context in which coping occurs and changes in that context over time.

Coping has two major functions: the regulation of emotion and the management of the problem that is causing distress. Coping that is directed at regulating emotion is called emotion-focused coping and includes strategies such as relaxation, escape-avoidance through the use of alcohol or drugs, seeking emotional social support, seeking reassurance through positive comparisons, and selectively attending to the potential benefits in a difficult situation. Coping that is directed at managing the problem causing distress is called problem-focused coping and includes strategies such as seeking information and advice, problem-solving, resolving conflicts, negotiating, and decision-making. Generally, problem-focused coping is relied on more in situations the individual appraises to be changeable or controllable, and emotion-focused coping is relied on more in situations that are appraised as unchangeable or uncontrollable, as having to be accepted.

Two other approaches to coping, the ego-psychology approach and the trait/disposition approach, have been widely used in both research and practice. While each of these other approaches has strengths, each also has weaknesses when it comes to understanding how people manage the stressful demands of living, including chronic stressful conditions, major life events, and ordinary daily hassles.
Ego psychologists often use the term coping to refer to mature ego mechanisms, such as altruism, sublimation, and suppression as opposed to less mature ego mechanisms such as repression and reaction-formation (e.g., Vaillant, 1977). The ego-psychotherapy model emphasizes the regulation of emotion, in particular anxiety. While this is important, the management of day-to-day stressful demands also demands problem-solving skills. Psychotherapy based on the ego-psychotherapy model is usually not brief and, as Dr. Vesti and Dr. Kastrup (1992) point out, insight therapy is sometimes contraindicated in survivors of torture. With respect to research, the assessment of ego mechanisms usually requires clinical training and depends heavily on inference. Inter-rater reliability is difficult to achieve. Further, the rating of a given mechanism sometimes requires knowledge of the individual’s life context and his or her general functioning, which means that the rating becomes confounded with outcomes (e.g., Vaillant, 1977).

Personality psychologists use the term coping to describe a generalized trait or disposition for processing and responding to stressful information of circumstances. Usually the trait or disposition is unidimensional on a continuum of approach and avoidance. Examples include Byrne’s (1969) repression-sensitization measure of Miller’s (1987) concept of monitoring-blunting. Here the emphasis is on stable aspects of personality that predict how an individual copes with a wide range of stressful situations. Assessment is usually by relatively simple paper and pencil measures, which is an advantage for research. However, the personality model tends to oversimplify the very complex processes that people use to manage stressful demands. People do more than fight or flee, approach or avoid. They use a wide range of cognitions and behaviours that is inadequately described by a unidimensional conceptualization. Further, trait measures tend not to predict actual coping behaviour in specific stressful situations.

Effective Coping

Researchers and clinicians alike are concerned with criteria for evaluating coping. How do we know when coping is adaptive or maladaptive, effective or ineffective? This is not an easy question, but it is important to address, however tentatively. There are two major models for evaluating coping. I have labelled these the outcome model and the goodness-of-fit model (Folkman 1991). Those who use an outcome model focus on a particular outcome, say depression symptoms, anxiety, or a behaviour such as performance in an exam. Effective coping is coping that results in a desired outcome such as reduced depression or anxiety, or a good exam grade, whereas ineffective coping results in an undesired outcome such as no change or increased depression or anxiety, or a poor exam grade. This model can be difficult to use if multiple outcomes are involved. Among survivors of torture, for example, two important outcomes are reduction of anxiety symptoms and increased skills for living in a new country. It may be that improvement in one outcome may occur simultaneously with lack of improvement or even worsening in the other. My colleagues and I were confronted with this dilemma in a study of mistakes made by residents (physicians-in-training) in large training hospitals. We found that residents who accepted responsibility for their mistakes made constructive changes in their practice while simultaneously being more distressed (Wu et al. 1991). We decided that the outcome of constructive change in practice was more important than reducing distress, and therefore we labelled coping that led to constructive changes in practice as effective, even if distress increased. But sometimes it is difficult to decide which outcome is more important.

The goodness-of-fit model focuses on the coping process itself. Goodness-of-fit refers to two fits: 1) the fit between the person’s appraisal of what is happening and what is actually happening; and 2) the fit between the opportunities for coping (control) and the use of problem-focused and emotion-focused coping.

The fit between the person’s appraisal of what is happening and what is actually happening has to do with the veridicality of the individual’s appraisal. To the extent that the person’s appraisal of what is happening is distorted, the coping strategies that follow are likely to be ineffective and even harmful. For example, appraising a situation as benign when in fact there is danger can lead to an absence of protective coping. In contrast, appraising a situation as dangerous when in fact it is benign can lead to protective coping and failure to engage in a positive transaction. Finally, appraising a situation as controllable when in fact it is not can lead to futile efforts to change the situation, whereas appraising a situation as uncontrollable when in fact it is controllable can lead to inappropriate passive coping.

The second fit has to do with using the appropriate kinds of coping. In general, problem-focused coping is called for when there are opportunities for changing a situation, whereas emotion-focused coping is called for a situation must be accepted. A person may accurately appraise a situation, but for some reason, in the case of torture survivors perhaps having to do with loss of confidence in one’s ability to carry out the requisite coping activity, not engage in the appropriate type of coping. The outcome model and the goodness-of-fit model are not necessarily mutually exclusive. Presumably coping in which the fits are good between appraisal and reality and appraisal and coping should result in desired outcomes. The goodness-of-fit model can also be used as a diagnostic tool in relation to the outcome model. In the case of survivors of torture, for example, the reduction of anxiety may be an important goal, and the extent to which there is goodness-of-fit in appraisal and coping may provide important insights into what constitutes coping that leads to reduction in anxiety. The decision as to which model to use to evaluate coping, or whether to use both, has to be made by the researcher or clinician.

Anxiety and coping in torture survivors

The extensive literature on the effects of anxiety on cognition has highlighted two mechanisms through which
anxiety can impede coping. The first is motivational: attention is redirected from a task at hand to a more pressing emergency. The second is cognitive: Anxiety-related thoughts impede functioning because they are irrelevant to or counterproductive for performance (for a brief review see Folkman & Lazarus, 1988). These two mechanisms are well documented and familiar, I am sure, to this group. Using the cognitively oriented theory of coping that I described briefly, I would like to focus on this second mechanism – anxiety related thoughts that impede functioning – in the context of torture survivors.

Cognitions underlying anxiety
Lazarus’s (1991a, 1991b, 1991c) cognitive-motivational theory of emotion is helpful in understanding the role of cognition in anxiety. According to this theory, every emotion contains a specific kind of cognition, a core appraisal. Appraisals refer to the individual’s evaluation of a specific person-environment transaction in terms of its significance to the individual’s personal goals and stakes. In its most global sense, appraisal determines whether a transaction is irrelevant, benign, harmful or threatening or challenging.

Appraisals are shaped by the individual’s beliefs about the way the world works. These beliefs are usually shared, at least to a certain extent, by others in the individual’s reference groups. The distinction between beliefs and appraisal is important: Beliefs refer to knowledge, to an understanding of how things are, whereas appraisals refer to the personal significance of that knowledge in a given person-environment transaction. Beliefs themselves do not cause anxiety; it is the significance of those beliefs for an individual’s well-being that cause anxiety. Knowledge that some ex-patriots turn their compatriots into authorities has to do with an understanding of how the world works. For a business person living in San Francisco this knowledge is not personally significant. The business person might be upset by this knowledge, but not personally threatened. For a torture survivor in a new country meeting compatriots, this knowledge has intense personal significance and he or she is highly likely to feel personally threatened. For the business person in San Francisco, the knowledge remains relatively “cool”, while for the torture survivor this knowledge becomes “hot”, emotionally laden. Appraisal is the process through which knowledge is transformed from cool to hot (see Lazarus & Smith, 1988, for further discussion of this issue).

The clinical observations and empirical data included in the papers for this meeting point to changes in beliefs about the world that seem almost universal among torture survivors. Contingencies that had been accepted prior to torture – understandings of basic cause effect relationships – no longer apply. The world is believed to be basically dangerous, and it is unpredictable and uncontrollable. The lack of trust and low-self esteem that characterize torture survivors are logical sequela to the altered belief system.

In some instances, especially in the case of refugees who are at risk of being betrayed by fellow ex-patriots, beliefs that the world is dangerous, unpredictable, and uncontrollable may be realistic and lead to realistic appraisals of danger and adaptive, vigilant coping. This effect is consistent with the idea of anxiety as a signal of danger that promotes survival. However, in other instances, especially in the events that the survivor experiences in day-to-day living in a neutral country, beliefs that the world is dangerous, unpredictable, and uncontrollable are likely to be maladaptive because they lead to unrealistic appraisals and hence ineffective, inappropriate coping. The coping strategies that flow from these appraisals, such as aggression or flight, may well be appropriate to the appraisals, but they will not be appropriate to what is really going on.

Generalized versus situational expectancies of control
A specific class of beliefs, expectancies of personal control, are central to psychological well-being. Personal control expectancies are associated with the individual’s sense of being able to change, predict, understand, or accept person-environment transactions (Potocki & Everley, 1989). Expectancies of personal control seem to be profoundly altered, indeed obliterated, by torture.

The significance of personal control for well-being is one reason why the term victim is so odious to the people to whom it is applied: it implies helplessness, passivity, and lack of control. We may have sympathy and compassion for victims, but being a victim does not evoke respect. Simply labelling people survivors rather than victims changes perceptions. At the very least, a survivor is someone who deserves respect. In the United States, for example, one of the earliest campaigns of AIDS activists was to encourage the media not to refer to people with AIDS as victims. The preferred term was person with AIDS. Even the term patient, which can imply helplessness, is considered anathema in most settings except, perhaps, hospitals or doctors’ offices.

Expectancies about control have been defined at two levels of abstraction: generalized expectancies of control are beliefs that are a part of personality; situational expectancies of control are beliefs about control in a specific person-environment transaction. Generalized expectancies of control concern the extent to which individuals assume they can control outcomes of importance. The best known formulation is Rotter’s (1966) concept of internal versus external locus of control. An internal locus of control refers to the conviction that events are contingent upon one’s own behaviour, and an external locus of control refers to the conviction that events are not contingent upon one’s behaviour but upon luck, chance, fate or powerful others. Situational expectancies of control refer to individuals’ judgements about the extent to which they can control the outcome of a specific person-environment transaction.

According to the social learning theory within which Rotter formulated the concept of internal-external locus of control, generalized expectancies influence situational beliefs about control primarily in ambiguous conditions, where information is scant and little is known about contingencies. In conditions where information is available and contingencies are at least somewhat known, generalized expectancies give way to situational expectancies (Rotter, 1975). For example, I might generally believe that I can control outcomes of importance, but in the
specific situation of awaiting news of a biopsy, I know that there is nothing I can do to influence the outcome. Conversely, I might generally believe that I am unable to control outcomes of importance, but I might believe I have control over a specific outcome of importance, as in determining which of two apartments to rent. There is both ambiguity and clarity in most real life situations, the proportion of each varying from situation to situation and from person to person. For survivors of torture, ambiguity is likely to be omnipresent, regardless of the amount of situational information that is available. The readings provided for this conference suggest survivors really do not know whom they can trust, or what is really going on in interactions they have with others. Thus, every situation has an ambiguous underside. For survivors, generalized expectancies are therefore likely to play an important role in shaping situational appraisals of danger, threat, and harm.

Control expectancies, coping, and distress
As I mentioned earlier, the relative use of problem-focused coping and emotion-focused coping vary as a function of appraised control. Appraised control also leads to diminished distress through its effects on problem-focused coping.

For example, we studied changes in depression symptoms over one year in a cohort of HIV+ and HIV- gay men in San Francisco. We found that control led to active problem-focused forms of coping, which in turn led to reduced depression symptoms (Folkman et al, 1991). Control did not directly affect changes in depression symptoms. These findings were consistent with findings from a study of community residents in which we found that changes in emotion in a stressful encounter were mediated by control and its effects on coping (Folkman et al, 1986).

People tend to rely on emotion-focused coping in situations they appraise as uncontrollable. In general, emotion-focused coping does not reduce distress and in fact, most often is associated with increases in distress. The exception is positive-reappraisal, which involved looking for positive meaning in difficult circumstances (e.g., "I am a stronger person for having gone through this"). Frankl’s (1963) account of the search for meaning in the concentration camps is an excellent example of this form of coping and its importance for survival in extreme conditions. Fairbank et al (1991) found that repatriated former prisoners of war who focused on the positive were better adjusted than their counterparts who used other forms of emotion-focused coping including self-isolation, wishful thinking, self-blame, and social support.

Coping can also influence personal control expectancies. This effect is of particular significance when dealing with individuals whose sense of control over their lives has been seriously diminished. Problem-focused coping that leads to successful outcomes has the potential for increasing the individual’s sense of mastery and efficacy. This idea is used in education programs that build self-esteem in young children. Problems are presented in a way that allows the child to find solutions and feel efficacious. This feeling is positively reinforcing and helps increase the child’s sense of mastery, which in turn increases the child’s confidence about solving new, perhaps more difficult problems.

It is more difficult for coping to increase expectancies of personal when individuals are coping with situations over which they have no control. In such situations, what is important is for the individual to use emotion-focused coping that involves cognitive restructuring to let go of goals that are not attainable and to identify new goals that are attainable (Folkman & Chesney, in press). For example, an individual with advanced HIV disease may decide that there is nothing he can do to control the progression of the disease, but that he can control how he will use the one hour a day when he feels well. The idea that it is good for mental health to change only what is potentially changeable, and to accept what cannot be changed has been around a long time. It is known i 12-step programs as the Serenity Prayer. What is different in what I am saying is that yielding of control over outcomes that cannot be controlled is a necessary, but not sufficient condition for a good mental health outcome; in addition, the individual must identify an outcome (or goal), no matter how seemingly trivial, that can be controlled.

Implications for intervention
The ideas about coping that were developed and examined in empirical research during the 1980s helped increase our understanding of the coping process. This research, however, did not address a key question, namely, does coping cause outcomes? Even the longitudinal studies that we conducted could not adequately address this question because of the lack of controls that inevitably inhere in naturalistic research. The acid test has to be an experimental design in which we attempt to change coping, and then determine whether changes in coping account for changes in an outcome of importance. In addition, in recent years a number of people have asked me about applying the principles of coping effectiveness to interventions to help people get along in daily life.

The need for coping interventions is particularly compelling in San Francisco, where it is estimated that up to 50% of the gay men are infected with HIV. My colleague, Margaret Chesney, and I decided to develop a coping intervention based on coping theory to help men who were HIV+ to manage the chronic stress posed by this infection as well as the demands of day-to-day stressful events, some of which are related to HIV disease, others of which are not. With our colleagues Leon McKusick, PhD, Gail Ironson, MD, PhD, and David Johnson, MA, we developed a program called Coping Effectiveness Training (Folkman et al, in press). The program is based on and uses established cognitive-behavioral principles in an 8-week, group format setting. A pilot study indicated the program showed promise for helping men who were HIV+ cope with the background stress of being infected with HIV as well as the foreground stresses of day-to-day living.

Beginning this fall (1991), Dr. Chesney and I will compare Coping Effectiveness Training with a social support program and a no-treatment control. In the program we will teach men who are HIV+ specific appraisal and
coping skills, using the goodness-of-fit paradigm. Sessions are devoted to teaching individuals to appraise the controllable and uncontrollable aspects of situation and to fit the appropriate kind of coping to the situation; problem-focused coping skills including decision-making and negotiating; emotion-focused coping skills including relaxation, distancing, and the use of humour; and skills for obtaining information, tangible, and emotional social support.

Implications for Research
We have been asked to consider a research agenda concerning anxiety for RCT. The meeting will undoubtedly spawn a number of intriguing questions that can be explored systematically in research. Here I shall mention just two such questions, based on the ideas I have discussed.

A major question that arises from this discussion concerns the correlation between generalized and situational expectancies of control in torture survivors. To what extent can torture survivors have situational expectancies of control that are not consistent with their generalized expectancies of control? At the very simplest level, this question could be addressed in a cross-sectional study with a 2 x 2 design (High/Low generalized control expectancy vs High/Low situational control expectancy). However, it may be difficult to find people high on either generalized or situational control expectancies, in which case, variation would have to be examined within the lower ranges of control expectancies. A question that follows inevitably from the first concerns the extent to which situational expectancies of control can be influenced through therapy. And if so, do changes in expectancies of situational control affect symptoms of anxiety, independent of generalized expectancies of control? The test of this question would require first developing a treatment protocol based on the control-expectancy ideas discussed earlier. The treatment’s efficacy would need to be examined in a controlled intervention study. Ideally, a design would call for a wait-list control, and a comparison group using one of the standard therapeutic approaches, maybe Supportive Therapy.

Conclusion
It is important to keep potential limitations of the ideas I have discussed with respect to torture Survivors. First, I focused on just one dimension of problems caused by anxiety in survivors of torture – its effect on coping – and within this dimension, I focused on the importance of beliefs about control. By limiting the discussion in this manner, I risk not taking into account other aspects of the torture survivors’ psychological economy that may need to be taken into account in investigating their anxiety. Second, the theory and research I described has been developed primarily in the United States, Canada, the United Kingdom, and Europe. Further, most of the work has been conducted with white, middle-class people experiencing the minor and major events of ordinary life. This, there is a question about the generalizability of this work to torture survivors who are largely from non-European countries, who have been through an extreme situation, and who as a result have had their belief systems profoundly and systematically altered.

As pointed out in the readings for this conference, anxiety in survivors of torture can be considered from a number of different perspectives. I have chosen a cognitive approach based on the hunch that much of the anxiety experienced by survivors arises from cognitions and beliefs that have been distorted as a result of torture. These distortions lead to inappropriate appraisals of (most) day-to-day transactions, which in turn lead to inappropriate ways of coping. The outcomes of these transactions are likely to be problematic because realistic social and environmental demands are not effectively managed. Poor outcomes to the transactions are likely to reinforce anxiety. The recursive process will continue, and anxiety is likely to continue unless the underlying cognitions are modified so that realistic appraisals and appropriate coping can take place.

The key question is how to modify the underlying cognitions. I suggested a cognitive-behavioral therapy to increase the individual’s sense of situational control, while other therapy, such as insight therapy, might help deal with other anxiety-related issues. These ideas need to be evaluated both clinically and empirically. Ideally, this approach would help diminish anxiety, but even if it does not achieve this goal, it might help survivors of torture manage their daily lives even while they remain anxious.

References
Miller SM (1987). Monitoring and blunting: Validation of a ques-
Rotter JB (1975). Some problems and misconceptions related to the construct of internal versus external control of reinforcement. Journal of Consulting and Clinical psychology. 43, 56-.
Anxiety disorders in torture survivors

By Şahika Yöksel, MD, Professor

The symptoms, course and treatment of the clinical pictures that develop after physical and psychological torture are current issues of discussion. The identification of a well-defined torture syndrome is not only important for the rehabilitation of torture survivors, but also carries significant implications for legal issues concerning torture, such as compensation for the victims, and allowing refuge for asylum seekers (Rasmussen 1990, Ström 1968).

The diagnostic categories attributed to these clinical pictures that are observed after torture have only recently become topics of discussion. Consequently, there are only few controlled studies on the subject. Post-traumatic stress disorder (PTSD) was introduced into the psychiatric classification system with the advent of DSM-III (1980). PTSD is defined as a disorder that may appear due to various causes, one of which is torture. The symptoms of PTSD and whether it constitutes a clinical entity by itself has been a subject of controversy. There have also been objections against including torture as a specific form of trauma in medical classification. These objections can be grouped as arguments against reduction/medicalization of an essentially social-political problem (Turner, Gorst-Unsworth 1989) and those pertaining to the inadequacy of the diagnostic criteria of PTSD within a given framework (Allodi, Cowgill 1982). In the DSM-III-R, the diagnostic criteria for PTSD resulting from torture and the definition of its psychological consequences has not been completed yet.

Introducing a separate torture syndrome of torture-related PTSD is also debated. Jones and Barlow (1990) reviewed the etiological models of PTSD and proposed a model based on a recent conception of the process and origins of anxiety and panic. This model includes a consideration of the role of biological and psychological vulnerabilities, negative life events, alarm, perceptions of control, social support, and coping strategies.

Does PTSD characteristically develop after being exposed to torture? Epidemiologic studies of this syndrome in the general population are rare. Helzer et al (1987) reported that the prevalence of a history of PTSD was 1% in the general population, approximately 3.5% in civilians exposed to physical attack and in Vietnam veterans who were not wounded, and 20% in veterans who were wounded during war. Epidemiologic Studies on Vietnam veterans indicate the variability of their problems. Keane et al (1985) suggest that the frequency of PTSD in this group is approximately 15%. Card (1987) reported that 19% of Vietnam veterans could be diagnosed as PTSD. The corresponding figure for matched groups of non-veterans was significantly lower (12%). At present, it appears that there is insufficient epidemiologic information to answer the question of whether PTSD constitutes a clinical entity by itself and whether it appears as a consequence of torture. There are very few studies in Turkey on post torture disorders. In his study on ex-political prisoners, Kaptanoğlu (1991) reported a 36% rate of PTSD in 28 cases. Paker et al (1990), in their study with 196 nonpolitical prisoners who had torture experience and were still in prison, diagnosed PTSD in 38 participants.

The aim of the present study is to discuss the clinical symptoms and syndromes in a sample of Turkish torture survivors. Our assessment focuses on anxiety, because it is one of the most frequently encountered and most serious symptoms caused by torture.

Subjects and methods

The subjects in our study are 33 cases who applied to the Psychiatry Department of the Medical Faculty in Istanbul University with post torture problems between in 1988 through 1991. They may be classified into two groups according to the types of referral:

1) There were 10 cases (30%) of indirect referral. The torture experience was uncovered during interview in the outpatient department where they had applied for various other reasons.

2) The 23 direct referrals (69%) reported their experience at the initial interview.

The subjects were assessed by two methods: the self-rated assessments were made using the Spielberger State and Anxiety Inventories, and the anxiety factor of the Derogatis’ Symptom Checklist-90; for therapist-rated assessments, a semi-structured interview form, the Hamilton Anxiety Scale, and the 17 PTSD items in the DSM-III-R were used. The PTSD items in categories B, C, and D were rated on a 0-2 scale according to severity of the symptom. Category A was rated 1 for all of the subjects, indicating the presence of the traumatic experience without attempting to rate the severity. (Range=0-35, similar to Keane et al 1989). The semi-structured interview form used by the therapist to determine the social and personal characteristics as well as the trauma history, of the sample, consisted of 3 parts:

1) the psychiatric, social and political history of the individual prior to the torture experience;

2) the features of the torture-trauma period; and
3) the post-torture period, including the effects of trauma on intimate relationships, and other social networks.

Results

Six (18%) of the 33 participants were female, and 27 (2%) were male. The age range was 17-38 years, with a mean age of 27.4. Nineteen participants were single, 12 were married, and 2 were divorced. There were 3 primary school graduates, and 21 high school graduates in the study group. Nine subjects attended the university; 3 of these, however, had to quit university due to imprisonment.

All of the subjects had been political prisoners. The duration of imprisonment ranged between 2 months and 18 years. The specific forms of torture they experienced are listed in Table 1. All of them had been subjected to psychological torture and simple beating, and most also had electrical torture. The mean number of the different form of torture applied to each case was 6 and the range 3-11.

Table 1.

<table>
<thead>
<tr>
<th>Percentages of cases subjected to various form of torture.</th>
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<tbody>
<tr>
<td>Types of torture</td>
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<tr>
<td>Psychological torture*</td>
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<tr>
<td>Simple beating</td>
</tr>
<tr>
<td>Electrical torture</td>
</tr>
<tr>
<td>Beating by a group of wardens</td>
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<tr>
<td>Falanga</td>
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<tr>
<td>Suspension</td>
</tr>
<tr>
<td>Sexual torture</td>
</tr>
<tr>
<td>Other physical torture</td>
</tr>
</tbody>
</table>

1) Listing overbear others being tortured, threatening to torture close relations/spouse/children, forcing to cooperate or commit suicide, and threatening to pour corrosive on the genital organs.
2) Examples of sexual torture included leaving naked, threatening to mutilate the victim's sexuality by applying electricity to the genital organs, threatening to rape or abolish virginity, and applying a boner to the anus.

In addition to physical and psychological torture, most of the participants had experienced a long, continuous process of trauma, which interfered with different aspects of their lives. Some of the components of this process were the negative consequences of imprisonment, such as living as a fugitive, persecution by the police, doing military service with at stigma of "potentially dangerous", unemployment, lack of permanent residence, prohibition of professional practice, disrupted ties in intimate relationships, and chronic illnesses precipitated by prison conditions.

There were no significant medical or mental problems, and no addictions other than smoking during the pre-trauma period. The medical examination during the study period, however, revealed various forms of medical conditions in 9 (27%) of the 33 subjects. These included chronic kidney infections, tuberculosis, head injury, and various muscular and skeletal disorders.

Psychiatric disorders were diagnosed according to the DSM-III-R criteria (Table 2). Twenty-seven (82%) of the subjects exhibited anxiety disorders. The diagnoses were PTSD in 23 cases (70%), unspecified anxiety disorder in 2 cases, and social phobia in one case. One of the two unspecified anxiety disorders was concomitant with a brief reactive psychosis. Among the PTSD cases, only one third had a single diagnosis; 7 cases had major depressive episode, 4 somatoform disorder, one vaginismus, and one alcohol dependence as a concomitant diagnosis. The duration of the disorder was longer than 6 months in 21 of the 23 PTSD cases, and two thirds had delayed onset.

Table 2.

<table>
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<tr>
<th>Diagnosis (N: 33).</th>
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<tr>
<td>Anxiety disorders</td>
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</tr>
<tr>
<td>PTSD</td>
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<tr>
<td>Concomitant diagnoses:</td>
</tr>
<tr>
<td>Concomitant diagnoses:</td>
</tr>
<tr>
<td>Unspecified anxiety disorders:</td>
</tr>
<tr>
<td>Social phobia:</td>
</tr>
<tr>
<td>Psychotic disorders</td>
</tr>
<tr>
<td>Brief Reactive Psychosis</td>
</tr>
<tr>
<td>23 (67%)</td>
</tr>
<tr>
<td>Somatoform disorders</td>
</tr>
<tr>
<td>Hypochondriacal Neurosis</td>
</tr>
<tr>
<td>2 (67%)</td>
</tr>
<tr>
<td>Adjustment disorders</td>
</tr>
<tr>
<td>2 (6%)</td>
</tr>
</tbody>
</table>

The mean anxiety scores on SCL-90 anxiety factors, the Hamilton Anxiety Scale, and the State and Trait Anxiety Inventory for the whole group can be seen in Table 3. Both PTSD and non-PTSD subgroups had moderately high anxiety scores, without significant differences between them. Therefore, only the mean scores for the whole group are included in the Table. The range of the total PTSD scores was 6-28 in the whole group, and 12-28 in the PTSD subgroup of 23 cases. The frequency of the PTSD symptoms can be seen in the Figures. For the PTSD subgroup, the most frequently encountered intens were C-5 (feeling of detachment/estrangement) (21/23), D-1 (difficulty falling/staying asleep) (21/23), and D-5 (exaggerated startle response) (21/23), while C-6 (restricted range of affect) is the most frequent item in the non-PTSD cases (9/10). The lowest scores in PTSD cases were for B-3 (sudden acting/feeling as if the traumatic event was recurring) (12/23), and C-5 (psychogenic amnesia) (12/23). In non-PTSD cases, the lowest scores were recorded for item B-4 (intense psychological distress at exposure) (1/10) (Figures).

Table 3.

<table>
<thead>
<tr>
<th>Scores on anxiety.</th>
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</tr>
<tr>
<td>SCL-90 (anxiety factor)</td>
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<tr>
<td>Hamilton Anxiety Scale</td>
</tr>
<tr>
<td>Spielberger State and Trait Anxiety</td>
</tr>
<tr>
<td>State</td>
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<tr>
<td>Trait</td>
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</table>

Six subjects (18%) exhibited psychotic disorders; 4 cases had brief reactive psychoses, which were diagnosed con-
comitantly with anxiety disorders, and 2 cases were diagnosed as atypical psychoses.

Sixty-four percent of the whole group, and 74% of the PTSD subgroup had obsessive symptoms. These obsessions did not have the "recurrent and intrusive distressing event" theme, as recorded in PTSD category B. The most frequently encountered themes were illness, the prior partner, problems about identity, or a combination of these. Hypochondriac obsessions concerning health were the most frequent, with 12 (36%) cases, and were severe enough to effect daily life in 5 of the cases. These were mostly in the form of anxiety concerning physical illness such as cardiac or gastrointestinal disease; fear or mental illness was encountered less frequently. When we evaluate the symptoms longitudinally, we can observe that recurrent and intrusive obsessions predominate during the initial period after trauma/imprisonment, and that later, anxiety concerning health becomes the major symptom.

Table 4.

<table>
<thead>
<tr>
<th>Other difficulties.</th>
<th>Total n=33</th>
<th>PTSD n=23</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overt and recurrent obsessive thoughts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Overt Suspiciousness</td>
<td>21 (64%)</td>
<td>17 (74%)</td>
</tr>
<tr>
<td>2. Hypochondriac obsessions</td>
<td>15 (45%)</td>
<td>11 (48%)</td>
</tr>
<tr>
<td>3. Other</td>
<td>12 (36%)</td>
<td>9 (33%)</td>
</tr>
<tr>
<td>Delusions about being followed</td>
<td>5 (15%)</td>
<td>5 (22%)</td>
</tr>
<tr>
<td>Severe problems with partners</td>
<td>9 (27%)</td>
<td>6 (26%)</td>
</tr>
<tr>
<td>(Overt avoidance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post traumatic stress disorders (n=23)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute onset</td>
<td>8 (33%)</td>
<td></td>
</tr>
<tr>
<td>Delayed onset</td>
<td>15 (37%)</td>
<td></td>
</tr>
<tr>
<td>Chronic (longer than 6 months)</td>
<td>21 (77%)</td>
<td></td>
</tr>
<tr>
<td>Socio-economic status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. High income group</td>
<td>3 (9%)</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>2. Moderate income group</td>
<td>12 (36%)</td>
<td>7 (30%)</td>
</tr>
<tr>
<td>3. Low income group</td>
<td>14 (42%)</td>
<td>10 (43%)</td>
</tr>
<tr>
<td>4. Very low income group</td>
<td>4 (12%)</td>
<td>4 (17%)</td>
</tr>
</tbody>
</table>

A suspiciousness that did not meet the criteria of overt delusion, but carried obsessive features occasionally, was observed in 45% of the whole group, and 48% of the PTSD subgroup (Table 3). Symptoms of suspiciousness had been misdiagnosed as paranoid state in the previous medical consultations in some of these subjects. It appears that the premorbid personality of the individual prior to the trauma is an important guide in the assessment of such cases, and that it is necessary to consider that, frequently, there are significant alterations in personality after trauma.

Fourteen (61%) cases with PTSD, and 18 (54%) cases in the whole group had severe problems with their partners. Two of them divorced immediately after release, and two separated from their long-term partners. Three women and six men among the subjects persistently avoided having a partner after release.

In addition to their traumatic experience, approximately 50% of the individuals in the whole group had severe financial difficulties. The percentage of cases with economical problems was slightly higher in the PTSD subgroup (60%).

Discussion

The political torture survivors in our study comprised at heterogenous group with various social and psychological characteristics and different political backgrounds. It is reported that the majority of torture survivors are males, aged 20-40 years. Our group also consisted predominantly of males, who were approximately within the same age range, and had a relatively higher rate of high education, compared to the general population. These findings, however, should be interpreted with caution of potential selection factors that could effect the special features observed in a particular sample of cases, as pointed out by Petersen (1989).

Most of the subjects who experienced various symptoms had a history of multiple trauma. As previously reported by authors who have worked with political torture survivors, in addition to the torture experience, there is an accumulation of stressful events that have been exerted through social, economical, and political oppression, that have existed for long periods in the histories of some survivors, and that are still present in some others. Thus, traumatization through political violence becomes a process which extends over many years (Van der Veer 1990, Mollica 1988, Somnier et al 1991). It is obvious that these individuals who have experienced different number of times and durations of torture/imprisonment, have varying conceptions of their experiences, which in turn, effect the subsequent clinical picture. All of these factors, as well as the fact that being a political torture survivor involves a special identity (Van der Veer 1990), should be considered in the evaluation of psychological syndromes that develop after torture.

The clinical syndrome in our sample mostly complied with anxiety disorders, and especially with PTSD, which was diagnosed in 70% of our cases. Also, beside these full-PTSD cases, partial-PTSD was observed in the non-PTSD subgroup. Nearly all cases of PTSD were chronic and had delayed onset. In their studies with torture survivors, Mollica et al (1990) and Turner (1991) found major depressive disorder as the first, and PTSD as the second most frequent diagnosis. This is not in agreement with the present study, however, most of the PTSD cases in our sample also had major depressive disorders as a concomitant diagnosis.

The comparison of our results with those of the other two Turkish studies show that the rate of PTSD in our sample was significantly higher in our study group. We may suggest several reasons for this difference: First, the sample sources were different, the present study being hospital-based. Second, the study of Pecker et al (1990) involved nonpolitical prisoners, and we may speculate that political prisoners attribute different meanings to torture and react differently. Finally, the nonpolitical torture survivors in the latter study, were still in prison at the time they were interviewed. We should point out that the anxiety scores in our sample were also higher, as compared to those of the other two studies.

Our subjects exhibited complex clinical pictures, with more than one diagnosis and the involvement of obsessive thoughts, and difficulties with the partner. The finding of
multiple diagnoses in this group of patients is in agreement with other authors who have suggested that post-torture syndromes constitute a heterogeneous group, generally with more than one diagnosis for each case (Van der Veer 1990, Helzer et al 1987).

One important finding of the present study is the presence of intrusive thoughts, which were not limited to the traumatic experience. The most prominent ones concerned bodily damage, and loss of the partner. The interview revealed that recurrent and distressing recollections of the traumatic event were prominent during the first few years after trauma, and hypochondriac obsessions replaced them in the later period. This may be the result of using certain coping mechanisms for a long time, and a persistent avoidance of stimuli associated with trauma. In addition, the feeling of physical vulnerability, which a person exposed to multiple and severe attacks on his/her body might experience, should not be ignored. Other authors have drawn attention to this aspect of obsessive symptoms in post-torture cases, which is neglected in the present definition of PTSD categories (Kuhne et al 1988, Rasmussen 1990).

Glover (1988) had pointed out that conflict related mistrust is prominent among PTSD cases. Our results, which show a severe suspiciousness in approximately 50% of the whole group, support his findings. We should also mention that the content of thought disorders during the psychotic episodes were in the form of being punished or controlled. The development of such symptoms is understandable in people who have lived as fugitives and were pursued for long periods.

Our findings regarding the frequency of problems in relation to the partner are in accordance with those of other authors, who found relatively high divorce rates among similar groups of patients (Agger and Jensen 1989).

**Conclusion**

In our sample of 33 political torture survivors, the most frequently encountered diagnosis was anxiety disorders, with a 70% rate of full-PTSD, and partial-PTSD observed in the non-PTSD cases. Multiple diagnoses were prevalent, with major depressive episode as the most frequent concomitant diagnosis. In interpreting these results we must, however, take in to consideration the well-recognized diagnostic difficulties in torture survivors, such as the presence of concomitant diagnoses, the variability of social, political, and psychological backgrounds, and the difference concerning the traumatic experience itself. Also, clinical experiences with torture survivors have revealed the presence of many factors, which interfere with obtaining knowledge from these patients concerning the traumatic experiences, as well as their symptoms. These may include cultural sanctions against revealing the torture experience, and inaccuracy of reporting and instability of memory over time. We should also consider that the present sample was hospital-based, and that this fact could be expected to lead to an over representation of sick torture survivors. We believe that our subjects, who applied for various reasons, may not be representative of the whole population of political torture survivors.

One of the important findings in our study was that the traumatic period in the lives of the political torture survivors was not limited to the period of torture/imprisonment; on the contrary, a variety of social, economical, and emotional problems seem to lead to a continuous exposure to stress in most cases.

Another finding was that intrusive thoughts show a tendency to change over time; they are more frequently concerned with the traumatic experience during the first few years, and are replaced with hypochondriac obsessions later. Therefore, we suggest that the observable symptoms should be evaluated with respect to the period that has elapsed since the trauma.

Our results reveal that suspiciousness is frequent in this group of patients, and occasionally severe enough to cause diagnostic problems. We believe that this symptom deserves further investigation.

We conclude that PTSD, which is a relatively new diagnostic category, has to be reorganized and is not sufficient for the assessment of post-torture cases in its present form. Also, "core" PTSD symptoms associated with torture across cultures have not been established yet.

**References**


A discussion of concepts of anxiety focusing exclusively on DSM-III R as “American” and ICD-10 as “European” would miss some essential aspects of the subject by displacing it from its cultural and historical context. That context is of special significance in relation to anxiety, because it may help explain at least part of the difficulties and controversies surrounding this particular area of psychiatric nosology.

Definitions and terms

Anxiety, according to the Lexicon of Psychiatric and Mental Health Terms (WHO, 1989), is “a subjectively unpleasant emotional state of fear or apprehension directed towards the future, either in the absence of any recognizable threat or danger, or when such factors are clearly out of keeping with the reaction. Subjective bodily discomfort and manifest voluntary and autonomic bodily dysfunction may accompany the anxiety. Anxiety may be situational or specific, i.e. tied to some particular situation or object, or ‘free-floating’, when no such link to external triggering factors is apparent. Trait anxiety may be distinguished from state anxiety, the former referring to an enduring aspect of personality structure and the latter to a temporary disorder.” The Lexicon entry goes on with the comment: “the translation of the English term ‘anxiety’ into other languages may present particular difficulties because of subtle differences in connotation exhibited by words that refer to the same basic concept”.

Language, indeed, presents a major source of variation. Most languages are extremely rich in nouns, verbs and adjectives referring to different facets of the experience of anxiety. The original Latin root verb angere means to choke, or throttle, thus emphasizing the somatic sensation of constriction. Further differentiation of the bodily from the psychic elements of the experience is evidenced in angina, on one hand, and angor animi, on the other hand. This differentiation is retained in modern French, where angoisse stresses the bodily sensation, while anxieté refers primarily to a mental state (Porot, 1981).

The many subtle differences in the semantic space of words describing the experience of anxiety refer not only to its localization in the subjective psychosomatic space, but also to its intensity (e.g. the German Angst is more severe than the English anxiety) or temporal aspects (e.g. fright versus apprehension). This linguistic variation reflects the deep cognitive significance of the complex phenomenon of anxiety in most human cultures. At the level of psychiatric taxonomy, it creates obvious problems which led Sir Aubrey Lewis to deplore the usage of the term anxiety in psychiatry and to propose replacing it with the less ambiguous word fear, qualified by an appropriate adjective (Lewis, 1976).

Table 1.

Semantic Space.

<table>
<thead>
<tr>
<th>Anxiety, fear, dread, foreboding, worry, apprehension (English)</th>
<th>Anxiété / angoisse (French)</th>
<th>Angst, Ängstlichkeit, ängstliche Spannung (German)</th>
<th>Strakh, trevoga, anksiosnost (Russian)</th>
<th>Taijin kyofu, hitomishiri (Japanese)</th>
</tr>
</thead>
</table>

An overview of the history of the concept

The concept of morbid anxiety dates back to antiquity. Fear illnesses were among the earliest disorders of the mind to be recognized as such. The term phobia (phobos = terror) was used by Celsus and known to medical writers from the 5th century onwards, referring to irrational or disproportionate fears (Lewis, 1976). The idea of dread has, of course, been prominent in many religions, and represents a strong conditioning force in the Judeo-Christian tradition which has shaped the socialization of the personality over centuries. Richard Burton’s treatise Anatomy of Melancholy (1621) contains a description of what today we might call agoraphobia, and the writings of the German mystic Jacob Boehme (1575-1634) provide us with an astonishing insight into the phenomenology of acute dread (including, among other things, a possible description of a panic attack which he designated as “the little death”).

The history of the concept of anxiety would be incomplete without a reference to the fundamental phenomenological analyses of the Danish theologian Søren Kierkegaard (1813-1855). Anxiety, according to Kierkegaard, is a basic attribute of the human condition. It arises from the recognition, by the reflective intellect, that a negation of being or a state of nothingness is thinkable: “... with every increase in the degree of consciousness, and in proportion to the increase, the intensity of despair increases ... the more conscious, the more intense the despair” (Kierkegaard, 1849). The theme of anxiety is prominent in that stream of modern European philosophy which became popularly known as existentialism, and in this offshoot in psychiatry and psychotherapy known as existential analysis (Daseinsanalyse). Thus, to the philosopher Martin Heidegger (1889-1976), the expe-
rience of \textit{Angst} signals an awareness of the \textit{terminality} of existence; the acceptance of this is a pre-condition to human freedom. According to the \textit{Dasein} analysts, morbid anxiety is "cued off by a threat to some value the individual holds essential to his existence as a personality" (May, 1950).

Concepts of anxiety, therefore, have played an important role in European theology and philosophy. Much of what today is subject matter of the cognitive psychology of anxiety, has its precursors in the religious and philosophical thought since the late Middle Ages to the present day.

The brief excursion into the history of ideas and the cultural context in which concepts of anxiety develop should clearly emphasize two points: first, that anxiety is a term referring to a much broader range of phenomena and concepts than is usually implied by its usage in the clinical context, and secondly, that attempts at developing an 'universal' theory and classification of anxiety, without due regard to the contributions of cultural anthropology and ethno psychiatry, is open to bias and might be epistemologically flawed.

### Anxiety as a medical concept

Proceeding from such observations, the discussion of European and American concepts of anxiety disorders needs to be prefaced by the remark that the medicalization of anxiety, i.e. the carving out of certain segments of the phenomenology of anxiety from their cultural context and their transfer into the domain of clinical science is a trend which also has cultural motivation as one of its determinants.

This trend of medicalization of anxiety began in Europe with Pinel (1803) and Morel (1860) who developed the first classification system in which "phobia and other neuroses" were identified as a separate class of illnesses. In contrast to melancholia, dementia, and delusional states, the interest in delineating anxiety disorders appeared relatively late in European psychiatry. In the 1870's Benedikt (1870) and Westphal (1872) described under the names of \textit{Platzschwindel} (dizziness occurring in open spaces) and \textit{Platzangst} (fear of open spaces) the syndrome of agoraphobia. "Traumatic neurosis" as an abnormal reaction to severe stress was described by Oppenheim (1892), and Kraepelin incorporated a description of \textit{Schreckneurose} (fright neurosis) in the 1896 edition of his textbook (Kraepelin, 1896). In 1894 Wernicke described a \textit{fear psychosis} (\textit{Angstpsychose}) which was a prototype of one of the cycloid psychoses identified later by Kleist and Leonhard (Leonhard, 1957).

The merit for the description of anxiety neurosis as a clinical entity goes to Freud (1895). Initially, Freud regarded anxiety as one of the \textit{actual neuroses}, i.e. mainly as a somatic process resulting from dammed-up libidinal energy; later he replaced this view with the \textit{metapsychological} theory of anxiety (Freud, 1926) in which he attributed to anxiety an affective signal function with regard to danger coming from within the self, as a counterpart to "reality fear normally manifested by the ego in situations of danger". We also owe to Freud some basic descriptive distinctions, including those between generalized diffuse anxiety, anxiety attacks, and phobias.

The work of I.P. Pavlov (1849-1936) should also be mentioned in this context, especially as regards his experimental techniques of inducing and extinguishing \textit{neurotic} behaviour in laboratory animals. Pavlov regarded fear as the result of an environmental activation of the inborn passive-defensive conditioned reflex, manifesting itself in either behavioural inhibition or hyperkinetic excitement. Pavlov's theory and experimental work prepared the ground for the behavioural approaches to the treatment of phobias and obsessive-compulsive disorders.

### Cultural variation

The sublimation of the primary existential experience of anxiety in philosophical and theological ideas should not obscure the fact that the perception and interpretation of anxiety are not only part and parcel of the biological make-up of the species, but also part of everyday living and culture as a 'social construction of reality' (Berger and Luckmann, 1966). Traditional cultures are pervaded by the imagery, rituals and complex behavioural 'codes' reflecting the individual and collective experience of fear and anxiety and designed for coping with these. These cognitive and behavioural structures are so closely interwoven with the organization of everyday living, communication and interaction, that the problem of delimitation of morbid from 'normal' anxiety, and of 'state' from 'trait' anxiety is an extremely difficult one. The variation among cultures in this respect is greater than with other psychological constructs, such as depression or perceptual disorders, and almost every culture has developed its own 'folk nosology' of anxiety states. These traditional nosologies have not been sufficiently well studied, and their mapping onto current 'Western' concepts and diagnostic schemes is highly problematic (Good and Kleinman, 1985).

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**Table 2. History of Concepts and Terms.**

<table>
<thead>
<tr>
<th>Years</th>
<th>Authors</th>
<th>Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>5th century</td>
<td>Celsus</td>
<td>Phobia</td>
</tr>
<tr>
<td>5th century</td>
<td>Burton (1621)</td>
<td>Agoraphobia (&quot;Anatomy of Melancholy&quot;)</td>
</tr>
<tr>
<td>1809-1873</td>
<td>Morel</td>
<td>Phobia and other neuroses</td>
</tr>
<tr>
<td>1813-1855</td>
<td>Kierkegaard</td>
<td>Ontological anxiety</td>
</tr>
<tr>
<td>1880-1976</td>
<td>Heidegger</td>
<td>&quot;Being-in-the-world&quot; – &quot;In anxiety&quot;</td>
</tr>
<tr>
<td>1870</td>
<td>Benedikt</td>
<td>&quot;Platzschwindel&quot;</td>
</tr>
<tr>
<td>1872</td>
<td>Westphal</td>
<td>Neurasthenia</td>
</tr>
<tr>
<td>1889</td>
<td>Oppeheim</td>
<td>Anxiety as a response to stress</td>
</tr>
<tr>
<td>1896</td>
<td>Kraepelin</td>
<td>&quot;Schreckneurose&quot;</td>
</tr>
<tr>
<td>1894</td>
<td>Wernicke</td>
<td>&quot;Angstpsychose&quot;</td>
</tr>
<tr>
<td>1923</td>
<td>Jaspers</td>
<td>&quot;Free-floating&quot; versus object-related anxiety</td>
</tr>
<tr>
<td>1871</td>
<td>Da Costa</td>
<td>&quot;Irritable heart&quot;</td>
</tr>
<tr>
<td>1817</td>
<td>Lewis</td>
<td>&quot;Effort syndrome&quot;</td>
</tr>
<tr>
<td>1918</td>
<td>Oppenheim</td>
<td>&quot;Neuro-circulatory asthenia&quot;</td>
</tr>
<tr>
<td>1895</td>
<td>Freud</td>
<td>Anxiety neurosis (Angstneurose)</td>
</tr>
<tr>
<td></td>
<td>First theory:</td>
<td>Anxiety as a somatic process</td>
</tr>
<tr>
<td></td>
<td>Second theory:</td>
<td>Anxiety as a signal of danger coming from within</td>
</tr>
<tr>
<td></td>
<td>Pavlov</td>
<td>&quot;Weak inhibitory type&quot; of higher nervous activity</td>
</tr>
</tbody>
</table>

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**TORTURE, Suplementum No. 1, 1993**
The history of concepts related to anxiety, both in Europe and in North America, includes another important chapter, originally almost disconnected from psychiatry but closely linked to the war experience and the work of cardiologists and general physicians who described the cardiac manifestations of anxiety in considerable detail and under a bewildering variety of diagnostic terms. As pointed out by Skeritt (1983), new diagnostic categories for the cardiac and other somatic *neuroses* have tended to emerge after every major war.

The American contribution includes the first descriptions of battle anxiety made by Sillie (1863) and Hartshorne (1864) during the American Civil War, to be followed by the classic work of Da Costa (1833-1890), a Philadelphia physician who left his name to the eponym for the syndrome of *irritable heart* he described in 1871. Neurasthenia (Beard, 1880) was, of course, another major American contribution to the nosography of anxiety states which soon acquired worldwide currency, only to be banished from DSM-III a century later.

World War I enriched further the literature on psychosomatic manifestations of anxiety, with the concepts of the *effort syndrome* (Lewis, 1917) in Britain and *neuro-circulatory asthenia* (Oppenheimer, 1918) in the US. However, the link between these states and psychiatry was only made explicit during World War II (Jones and Lewis, 1941) with the introduction of the diagnostic terms *effort phobia* and *anxiety state* for the same conditions which had earlier been classified as functional cardiovascular disorders.

The most recent war-based input to the nosology of anxiety states was the research literature that followed the Vietnam war and the refinement of the concept of post-traumatic stress disorder, currently incorporated in both DSM-III-R and ICD-10 (Horowitz et al., 1980).

Finally, the historical background to the present state of concepts in the area of anxiety disorders on both sides of the Atlantic would be incomplete without mentioning some recent developments which have influenced researchers and clinicians and may explain certain differences in current trends and emphasis in classification.

One such development is Roth’s phobic depersonalization and Newcastle studies to ascertain the role and spread of behavior therapy in the treatment of phobias and obsessive-compulsive disorders (Marks, 1986), primarily in Britain and then elsewhere. By focusing on phobic avoidance as the main target of intervention, this approach has attributed a lesser significance to the management of panic attacks per se. In contrast, the discovery of the phenomenon of lactate-induced panic in susceptible subjects (Pitts and McClure, 1967) and of the effects of imipramine on panic attacks (Klein and Fink, 1962), has turned the attention of US researchers to this particular disorder earlier and to a much greater extent than in Europe.

**Anxiety disorders in ICD-10 and DSM-III-R**

In contrast to the situation prevailing in psychiatry in the 1960’s, when one of the dominant concerns was the lack of a ‘common language’ to enable valid scientific communication and comparison of research data within the discipline, today we have two major diagnostic systems and classification schemes, DSM-III-R and ICD-10, which are used by the majority of psychiatrists all over the world and share many features in common, in spite of differences that still exist.

While DSM-III-R is predominantly, if not exclusively, an American (or rather US) product, ICD-10 cannot be said to be entirely European, although many of its underlying concepts reflect, explicitly or implicitly, the traditions of several influential European ‘schools’ of psychiatry. In fact, ICD-10 is as ‘ecumenical’ as a psychiatric classification can be, considering the extremely varied background of the individuals who contributed proposals and comments at various stages of its development.

Nevertheless, ICD-10 is not a hybrid classification but has a logic of its own and represents, in the judgement of the group of people directly involved in its construction, a fair synthesis of the ‘state of art’ in clinical psychiatry in the 1980’s.

It should be emphasized that the two classifications, DSM-III-R and ICD-10, are in fact sisters under the skin, considering the history of miscegenation in their development. As pointed out by Spitzer and Williams (1988), “the DSM-III multiaxial system was a derivative of earlier, largely European, research on multiaxial systems”, and the Glossary of Mental Disorders, drafted for ICD-8 under guidance of Sir Aubrey Lewis, was a prototype of the glossary definitions in both DSM-III and ICD-10.

In a similar manner, the diagnostic decision rules of the CATEGO system were among the precursors of the operational diagnostic criteria (Feighner, RDC) incorporated in DSM-III. On the other hand, the existence of DSM-III and the experience with its use were a major influence and a stimulus in the development of ICD-10.

The tendency of bridging the gaps and making the two classifications converge in as many areas as possible was supported by deliberate efforts by the World Health Organization (WHO) and the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) of the United States. The joint programme launched by the two organizations, which included a landmark international conference in 1982 (WHO/ADAMHA, 1985) and a series of committee meetings, was an impressive manifestation of scientific collaboration involving experts from over 40 different countries.

The diagnosis and classification of non-psychotic disorders, and especially anxiety, has always been regarded to be one of the least satisfactory areas of psychiatric nosology. One of the participants in the 1982 international conference remarked that these disorders “have still to attract their Kraepelin and remain in a most unsatisfactory state” (Shepherd, 1985). Even a cursory look at ICD-9, DSM-II, and many other classification schemes in use prior to the 1980’s would notice the absence of a common denominator in the descriptive psychopathology, definition of clinical entities, and classification of syndromes in this area.

The state of the art today looks very different. The tables that follow illustrate the conceptual framework of the two classifications in those areas which comprise the anxiety disorders. I shall not attempt a detailed analysis
because of the time constraint; other speakers will surely address this issue in greater detail. However, I shall summarize the similarities and differences.

1. Common features. Both DSM-III-R and ICD-10 have adopted a very similar (but not identical) terminology and nomenclature of anxiety states and their constituent symptoms. Underlying this similarity is basic agreement on certain key concepts:

a) Panic disorder, a non-existent diagnosis in European psychiatry prior to DSM-III, is now also incorporated in ICD-10 in recognition of the evidence supporting its independent nosological status.

b) Two forms of agoraphobia, one without panic attacks and one characterized by panic attacks, are identified as separate diagnoses in the two classifications.

c) The definitions and diagnostic criteria for social phobia and specific (isolated), or simple, phobias are nearly identical in the two classifications.

d) Generalized anxiety disorder, no longer a residual category in DSM-III-R, is defined in a similar way in ICD-10.

e) Both classifications, depression is given precedence, if anyone of the anxiety disorders is only manifest in the context of an illness episode meeting the criteria for a depressive disorder of a given level of severity.

Table 3.

<table>
<thead>
<tr>
<th>ICD-10R Criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panic Disorder (Episodic Paroxysmal Anxiety).</td>
</tr>
<tr>
<td>Recurrent panic attacks (spontaneous, unpredictable, not associated with:</td>
</tr>
<tr>
<td>– Exertion</td>
</tr>
<tr>
<td>– Exposure to dangerous situations</td>
</tr>
<tr>
<td>Moderate degree: 3+/3 weeks</td>
</tr>
<tr>
<td>Severe degree: 4+ per week/4 weeks</td>
</tr>
<tr>
<td>Symptom checklist</td>
</tr>
<tr>
<td>Not due to:</td>
</tr>
<tr>
<td>– Physical disorder</td>
</tr>
<tr>
<td>– Affective disorder</td>
</tr>
<tr>
<td>– No consistent association with specific situation or object</td>
</tr>
</tbody>
</table>

Table 4.

<table>
<thead>
<tr>
<th>ICD-10R Criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agoraphobia with or without Panic Disorder.</td>
</tr>
<tr>
<td>A. Fear in or avoidance of at least two:</td>
</tr>
<tr>
<td>– Crowds</td>
</tr>
<tr>
<td>– Public places</td>
</tr>
<tr>
<td>– Traveling alone</td>
</tr>
<tr>
<td>– Traveling away from home</td>
</tr>
<tr>
<td>B. Autonomic anxiety in the feared situation</td>
</tr>
<tr>
<td>C. Significant distress</td>
</tr>
<tr>
<td>D. Symptoms restricted to feared situation</td>
</tr>
<tr>
<td>E. Criterion A not due to schizophrenia, affective disorder, OCD; not secondary to cultural beliefs</td>
</tr>
</tbody>
</table>

Table 5.

<table>
<thead>
<tr>
<th>ICD-10R Criteria: Specific (Isolated) Phobias.</th>
</tr>
</thead>
<tbody>
<tr>
<td>– Fear or avoidance of, eg, animals, birds, insects, heights, thunder, flying, small enclosed spaces, sight of blood or injury, infections, dentists, hospitals</td>
</tr>
<tr>
<td>– Autonomic anxiety in the feared situation</td>
</tr>
<tr>
<td>– Significant distress</td>
</tr>
<tr>
<td>– Symptoms restricted to feared situation, or when thinking about it</td>
</tr>
</tbody>
</table>

2. Differences. The two classifications proceed from different theoretical assumptions about the nature and pathogenetic mechanisms of the disorders in this group. Although not explicitly stated, these assumptions have apparently influenced the presentation and scope of the rubric anxiety disorders. In a less apparent way, these differences may also influence the manner in which diagnostic criteria are used, and the classification of the individual case.

a) Panic disorder is conceptualized in DSM-III-R as the primary condition in relation to agoraphobia, the latter being a complication or a subtype of panic disorder (Spitzer and Williams, 1988). In contrast, ICD-10 attributes a secondary position to panic disorder, by classifying it under other anxiety disorders and identifying two subtypes of agoraphobia, one without panic disorder and another with panic disorder.

b) ICD-10 includes a provision for the identification by a separate code of the common conditions exhibiting both anxiety and mild depressive features (mixed anxiety and depressive disorder). In DSM-III-R one is required to make a double diagnosis in such cases.

c) The rubric anxiety disorders in DSM-III-R is wider in scope than ICD-10: it includes obsessive-compulsive disorder and post-traumatic stress disorder, i.e. conditions which are classified under separate 2-digit alphanumerical codes in ICD-10. This difference reflects a deeper disagreement between American and European psychiatry than any other. European psychiatrists tend to regard anxiety as a common but relatively unspecified feature present in a great variety of disorders. Many of them would argue that in the absence of genetic and pathophysiological evidence, and in the presence of qualitatively different psychopathological structural features obsessive-compulsive dis-
Table 8. 
ICD-10R Panic Disorder.

Symptom Checklist
- Discrete episode, lasts only minutes, abrupt onset, crescendo course, dread
- A least one of:
  - Palpitations
  - Trembling
  - Hot/cold sweats or flushes
  - Dry mouth (not from medication or dehydration)
- Plus feeling that attack will end in loss of control, going mad, serious illness, or death
- Plus at least one more of:
  - Difficulty in breathing, or choking
  - Dizziness, unsteadiness, light-headedness
  - Feeling faint, unreal

Table 9. 
Anxiety Disorders in ICD-10.

Phobic Disorders:
- Agoraphobia ± panic disorder
- Social phobia
- Specific (isolated) phobias
- Other

Other Anxiety Disorders:
- Panic disorder
- Generalized anxiety disorder
- Mixed anxiety and depressive disorder
- Other mixed anxiety disorders

Table 10. 
DSM-III-R Anxiety Disorders.

- Panic disorder
  - With agoraphobia
  - Without agoraphobia
- Agoraphobia without history of panic disorder
- Social phobia
- Simple phobia
- Obsessive-compulsive disorder
- Post traumatic stress disorder
- Generalized anxiety disorder
- Anxiety disorder NOS

Table 11. 
ICD-10R GAD Symptom Checklist.

Moderate degree: 1+ out of Symptoms 1-4, Plus 3+ Out of 1-17
Severe degree: 1+ out of Symptoms 1-4, Plus 5+ Out of 1-17
1. Palpitations
2. Hot/cold sweats or flushes
3. Trembling
4. Dry mouth
5. Chest/epigastrium discomfort
6. Difficulty in breathing
7. Dizziness
8. Feeling faint or unreal
9. Loss of control
10. Muscle tension, aches and pains
11. Inability to relax
12. Feeling keyed up
13. Lump in throat
14. Exaggerated startle response
15. Difficulty in concentrating
16. Irritability
17. Difficulty in getting to sleep

order and post-traumatic stress disorder should be classified separately from the anxiety disorders.
d) ICD-10 includes the rubric anxious (avoidant) personality disorder. Its definition and diagnostic criteria make it sufficiently different from the avoidant personality disorder in DSM-IIIR. The ICD-10 category is more clearly focused on trait anxiety than its DSM-IIIR counterpart.

Conclusions
Neither ICD-10 nor DSM-IIIR, or any other existing diagnostic and classificatory system for that matter, can claim to be the ultimate answer to the many research and practical questions posed in this particularly complex and difficult area of psychiatric nosology. As in other fields of psychiatric classification, validating criteria include epidemiology and natural history, genetics, studies of cerebral function, and response to specific treatments.

Some progress along these lines has already been achieved. The Yale family-genetic study (Weissman, 1988) and, more recently, the Epidemiological Catchment Area (ECA) study in the US (Eaton et al., 1989) have helped to clear part of the epidemiologic nightmare (Weissman, 1988) which was created by the methodological obstacles to incidence and prevalence studies in this area. Similarly, long-term follow-up studies have highlighted aspects of the longitudinal course of the anxiety disorders. Family studies have adduced sufficient evidence to support the notion of genetic susceptibility in the anxiety disorders as a group, but have not yet demonstrated a specific genetic base for anyone of the clinical entities. Neurophysiological studies suggest the presence of a focal brain abnormality, and psychopharmacology has become one of the principal tools of investigation in this area.

It should be realized, however, that the application of 'state of the art' research tools and techniques is only in its beginnings. The combined results of clinical research, molecular biology, psychopharmacology and neurophysiology will both influence nosology and be influenced by its further development. In addition, such multidisciplinary research will need the support of a sound epidemiological database, as well as an adequate consideration of the cultural complexities underlying the research issues.

From this point of view, the co-existence of diagnostic classifications which agree on basic principles but offer a range of different options at the level of specific categories should be seen as an advantage, rather than a hindrance, to further research. One example illustrating the heuristic value of this approach is the delineation of panic disorder in both classifications but in different relationships to other disorders in the same group. Comparative studies, in which the same clinical material is assessed, diagnosed and classified in accordance with alternative classificatory rules may bring us closer to the answer of the question contained in the title of a Lancet editorial (1983): Panic - symptom or disorder? The same editorial concluded with the reminder that "when god Pan jumped out from the forests of Arcadia to startle unwary travellers, he was motivated as much by mischief as by the wish to terrify".

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TORTURE, Supplementum No. 1, 1993
Environmental stress factors in the work with torture survivors

By Marianne C. Kastrup, MD, PhD

Introduction
The problem of classification in psychiatry is particularly difficult, which is partly due to that psychiatry readily accepts the role of multiple factors in the etiology, pathogenesis, manifestation and prognosis of mental disorders.

In the current work with the development of universally acceptable and applicable classificatory systems, an increasing emphasis is placed upon the construction of a classification that allows a comprehensive assessment and reflects the multi-dimensionality of human life.

In order to obtain this aim, a unidimensional diagnostic system often omits important pieces of information which need to be recorded about the health condition, and a multidimensional diagnostic approach in the rating of the presenting problems may be a more suitable solution. In the DSM-III we find the possibility to code simultaneously several dimensions of relevance for the present mental status, and the development of a multiaxial system is part of the preparatory work related to the forthcoming ICD-10 and DSM-IV.

In the classificatory work hitherto, the possible existence and delineation of a “torture syndrome” has given rise to considerable debate (e.g. Allodi & Cowgill, 1982). In their work, a clustering of symptoms was described, including psychosomatic symptoms such as headache, nightmares, dizziness, affective dysfunction such as anxiety, depression; and behaviour concomitants such as irritability and withdrawal. Lately, an increasing attention is paid to the recognition of the PTSD as a useful instrument to describe the symptomatology of torture survivors. An accurate assessment of torture symptoms and a classification into a diagnostic system is a central issue (Mollica & Caspi-Yavin, 1992), and we still have to identify torture and culture specific symptoms.

Torture is well recognized as being a stress factor of maximum strength, but persons who have been exposed to torture may be in a position where they are faced with a number of other stressors following the torture experience and thus, it is natural to use the multidimensional approach in the recognition and codification of relevant stress factors.

Multiaxial classification
As pointed out by Mezzich and coworkers (1985), a multiaxial system (Mezzich et al, 1985) may purport to give a comprehensive description of the clinically significant factors. In this way the recording of important information is made possible in a number of areas and gives the evaluator several alternatives (Mezzich, 1988). Thus, a multiaxial diagnostic system may be seen as a further development of a descriptive non-etiological diagnostic approach, corresponding with greater ease to a multi-conditional etiopathogenesis and resulting in that therapeutic decisions are taken less arbitrarily.

The multiaxial systems developed till now reveal common patterns despite national diversity (Mezzich, 1988). The basic aim has been to evaluate several different domains of clinically relevant information and to assess each domain or axis quasi-independently from each other.

In most of the systems, four or five different domains have been evaluated as it is generally agreed upon that there is a trade-off between the aim of comprehensiveness and parsimony (Rey et al, 1988) and that any additional axis adds an order of complexity (Williams, 1987) that may result in a reduced frequency of use.

Stress-factors
Adverse life events and environmental stressors are known to have an influence on the development and manifestation of psychiatric disorders. A crucial issue is the effect of stressors on vulnerable individuals, and individual predispositions may result in a particular vulnerability and sensitivity towards adverse life events (Harris, 1989). Minor daily events may independently predict psychiatric disturbance (Monroe, 1983) and that even better as regards subsequent symptoms than major life events.

The role of coping strategies is a key issue in the research on the survival of severe traumata and of particular interest is the question on the individual ability to develop appropriate coping strategies in order to become less susceptible to the aftermaths of stressful events, in casu torture. In this context it is important to distinguish vulnerability which is a part of a predisposition to psychiatric morbidity (Cooper, 1989) and vulnerability which is a temporary consequence of a life crisis or life-threatening experience.

Of relevance is also the question of social support (Veiel, 1985), and the relationship between environmental stress factors and social support is complex and still debated (Bailey & Garralda, 1987).

Lack of social network and development of psychiatric disorder have been found related by some, (e.g. Henderson et al, 1981), while others (e.g. Brown & Harris,
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The codification of psychosocial stressors

The increasing recognition of coping strategies and mediating factors for the actual manifestation of a psychiatric disorder can be seen as an attempt to associate the stressors and adverse life events to the personality of the individual concerned.

In the case of torture survivors, it is of particular interest to elucidate how the choice of coping strategies may influence the short and long-term aftermaths, and whether it may be beneficial to change coping strategies over time.

Traditionally, the classification of psychiatric conditions takes place unidimensionally as the psychiatric core syndrome. A codification of abnormal psychosocial situations and environmental circumstances may take place on separate and independent axes. Till now, the advantages and benefits of the multidimensional approach are sparsely elucidated scientifically regarding the relationship among psychosocial stressors, social support and functioning, and psychiatric disorder. Even less research has been carried out about the particular problems of torture survivors vis-à-vis the codification of their specific stressors and the uses hereof in the management of their treatment.

Stress factors may be coded in two different ways. The codification may be typological and consist of categories that are qualitatively different from each other, resulting in a list of discrete events each of relevance for the prevailing condition. An inventory of stressors consists of a ranking of the stressors according to importance but with no attempt to assess their severity for the present condition. Another approach is the dimensional one, representing an ordered quantitative rank or interval scale, thereby providing an overall assessment of the severity of all stressors involved.

I. ICD-10 Classification

In the previous ICD-classifications, the focus of attention has been on the psychiatric core syndrome and the underlying personality, but with no separate coding of the psychosocial domain. Contrary to this, the ICD-10 will comprise a multiaxial approach and to that end it is suggested to modify the already existing Z-codes. These were originally developed in order to provide a possibility to rate other circumstances of a psychosocial nature relevant for the disease, which may take place either when a person encounters the health services for some specific purpose without being currently sick or when some circumstance or problem is present that influences the person’s health status without being in itself a current illness or injury (ICD-10, 1989).

In the ICD-10, the environmental factors may be coded on the Axis III according to headings that cover all aspects of human life, such as childhood factors, educational factors, factors related to economy, problems related to the primary support group, to the social environment, to legal and other circumstances and to family history of disease. Furthermore, it is possible to code life style/life management problems related to the personality and life style of the individual concerned.

We shall in other words be furnished with a possibility to code the existence of traumatic events of relevance for the present condition, including violations of human rights such as torture. With the aim to facilitate the rating of the environmental factors a careful selection of the Z-codes will take place. These may naturally be divided into:
a) environmental factors including all relevant events of a psychosocial nature with a further subdivision into recent or chronic difficulties, and
b) life style/life management problems including problems related to the personality and life style of the individual.

II. DSM-III and DSM-IV Classification

The DSM-III multiaxial classification has been used and evaluated more widely than any other multiaxial classification, and the experiences with the DSM-III multiaxial classification have all in all been favourable. In the DSM-III (1980) and the DSM-III-R, axes IV and V are concerned with psychosocial stressors and social functioning, respectively. The psychosocial stressors to be coded in axis IV should be specified as either acute or enduring with a scoring ranging from 0 = not accessible, and 1 = normal to 6 = severe, and 7 = the most severe stressors of a catastrophic nature. In the evaluation of the psychosocial axis, a number of methodological issues have been raised regarding its applicability and usefulness, and these considerations may also be pertinent when we deal with torture survivors.

In the evaluation of the psychosocial stressors it is required to assess the etiological significance of the adverse event and its importance for the current mental health status (Skodol and Shrout, 1989). In many instances – though not in the case of torture survivors – this is considered to be a major difficulty, and (Schrader et al, 1986) the usefulness of a psychosocial axis has been suggested to increase (Schrader et al, 1986) without this etiological requirement. An alternative could be to include all potentially relevant stressors, and with the severity rating being that of the most severe stressor. In the context of torture survivors, relevant stressors include the problems of exile, family disruption or changed balance of the family dynamics, the integration in the new environment, to mention only a few.

When considering the impact of environmental factors on an individual, a consideration of the relevant socio-cultural context is an integrated part, both at the individual level and in the general awareness whether factors considered stressful among individuals from one cultural group may be so among others.

The judgement how an average person in similar circumstances and with similar socio-cultural values would react to a specific stressor is strenuous unless the evalu-
uator is quite familiar with the cultural background of the patient and may run the risk of becoming stereotyped (Guarnaccia, 1991). This concern is of particular relevance to the clientele of torture survivors as they, when referred to treatment outside their country of origin, may be faced with considerable difficulties in expressing their problems in a way understood by the therapists available. An increasing understanding of the cultural and anthropological context is called for but also a recognition by the assessing clinician of his/her own more or less overt prejudices.

The individual vulnerability concerns as well the specific factors as the general strain and frustration perceived. By avoiding any interpretation of the significance of a symbolic trauma the rating may seem less subjective (Gyllenhammer & Wistedt, 1987). Working with torture survivors, it is a frequent experience that they on the contrary seem to be devoid of individual vulnerability premorbidly and many of them have in their former life been persons of high personal integrity, showing considerable courage and stamina.

In life event research it is frequently questioned whether it is the change that environmental factors lead to or whether it is their degree of undesirability that should be rated (Zimmerman et al., 1985). According to the literature, it is the undesirable factors which show an association with the emergence of psychiatric illness and not the desirable ones (Zimmerman et al., 1985). For the clinician there is a need to assess whether a specific factor can be considered undesirable or alien to a given individual, no matter how the clinician himself evaluates the situation. With regard to torture this assessment leaves little doubt as the pertinent stressors violate all respect for human dignity, irrespective of culture.

In any assessment of stress, the severity hereof is naturally taken into consideration. We may here either choose to judge the severity of each stressor, or we may choose to present a global rating of the severity. There are drawbacks in both cases. Evaluators may despite agreeing in identifying adverse events not agree in the rating of their severity (Rey et al., 1987). On the other hand, a global rating may give the impression that all types of stressors work through a single mechanism which is not in accordance with research findings indicating that different mechanisms may be operating (Williams, 1987).

In clinical practice we are also more likely to identify stressors which we consider of clinical relevance, and minor events seem less reliably identified, and therefore a short schedule of severe events may turn out to be more useful (Rey et al., 1987). For the DSM-IV, options are considered for shifting the axis IV from overall severity of stressors to either such a list of specific stressors or a focus on the appraisal of support factors (Mezzich, 1991).

It has been brought forward that the prognosis of a given episode is more favourable if it develops after a severe stressor than after a minor stressor, and that the first episode of a psychiatric disorder is particularly associated with severe stressors (Skodol & Shrut, 1989).

In the life event research, particular emphasis is placed on the impact of acute and major stressors. Here, there seems to be no stressor that fulfils these criteria more than torture. On the other hand, it should not be underestimated that for persons living under chronically strenuous conditions even a minor stressor may lead to a need for help (Gyllenhammer & Wistedt, 1987). The state of exile is typically a condition in which a continuous stress may be present, and a more explicit rating of chronic stressors may be a worthwhile innovation (Zimmerman et al., 1985). In the DSM-III-R, the solution has been chosen with the possibility to rate whether stressors represent predominantly enduring or acute strain, respectively.

**Specific problems for torture survivors**

The specific problems of torture survivors in this area is related to the fact that this population in contrast to a general psychiatric one shows limited psychopathology apart from the problems arisen as a consequence of a single major stressor, namely torture.

The global situation for the population of torture survivors is however more complex as it is frequently faced with a series of minor to major stress factors in the post-torture period. These problems are as mentioned related to the change in their social position maybe even with a change in country of residence having to adapt in an alien country where they may not be welcome and where there is no use for their experiences and knowledge.

Other problems may be on a more personal level as the exposure to torture and the subsequent symptom manifestations may have resulted in a shift in the family balance that may even further have led to a decline in self esteem. Adverse life events as a consequence of political repression lead to repeated traumatization of the individuals concerned (Başoğlu, 1992), who suggests that ongoing-traumatic stress in this way is a more appropriate term than post-traumatic stress. The interrelationship between all these factors is complex and far from elucidated. Further research is still needed where the individual vulnerability, the exposure to stress, the coping strategies and the social support systems simultaneously are taken into consideration.

**References**


Implications from the seminar
How to evaluate anxiety in torture survivors

By Søren Bøjholm, MD, Chief Psychiatrist

The purpose of our study would be to test the application of relatively straightforward concepts across the range of the individual’s cultural and social background.

Co-morbidity is a problem, whether talking about symptoms or diagnoses. With respect to symptoms, anxiety is highly correlated with depression. Most important, these symptoms represent a continuum, so there is the problem of a cut-off point. The hypothesis has to do with the cut-off point, because if one plans a treatment-related study, there is a higher cut-off point than if one does a general study to see whether guiding notions of existential dread are related to living in the Danish community and being a torture survivor citizen. The symptoms therefore are cut off at different levels according to the study and the hypothesis.

Responses related to anxiety, depression, and trauma are highly related to each other. The word PTSD is not used, because that is the Western term, but basically there is the problem of co-morbidity with responses that are related to anxiety, depression, and torture trauma.

It is decided not to include all the diagnostic criteria. It is also not possible to do culturally sensitive research on psychosis and/or organic brain disease, and with the current diagnostic categories in either DSM-III-R or ICD-10. We have to focus on what is most relevant and important. This again depends on what the hypothesis is and what the goals are.

There is the question of external cross-validation because the Western diagnoses cannot be used as a gold standard, i.e. be generally accepted; the diagnoses are currently developed and used by psychiatrists in the Western World and therefore influenced by the Western culture.

On the other hand, the comparison between the adapted standardized instruments for culture- and torture-specific adaptations to Western diagnoses has to be examined. WHO has a model and ongoing multinational studies for comparing the Western diagnoses. At least we can test the relationship between our findings and the cross-national findings and the so-called Western gold standards. Finally, the importance of external cross-validation, comparing symptoms, including culture- and torture-specific symptoms, with the degree and type of torture, the phenomenological symptoms that describe social parameters of coping, has to be cross-validated looking at different dimensions of the problem. To develop phenomenological descriptions and determine cultural specificity, we would consider:

- analysis
- publications
- literature
- the WHO matrix for the international depression study
- different descriptions of different clinical and cultural settings
- the important questions of key-cultural informants.

Concerning the measurement of anxiety in torture survivors, we will distinguish between anxiety as an outcome and anxiety as antecedent. The first tells us how well a person is doing, and the second why a person is not doing very well.

In understanding and measuring anxiety, we have to consider the differences in anxiety that are being experienced by the following three groups:

- torture survivors
- other refugees who have not been tortured
- Danish citizens of the same socio-economic status being treated for anxiety.

Before confronting the issue of how to evaluate anxiety, we want to look at some of the underlying dimensions of anxiety, rather than, as is more usual, at the anxiety symptoms themselves.

Two major dimension need consideration:

The first is control, which was reframed to the issue of choice – the choices people have. The choices range, for example, from small choices (when to get up, what to eat, whom to see, how to arrange one’s private space, what kind of therapy to have) to larger issues; for example, can I choose which country I will emigrate to, am I in control, do I have a choice as to whether or not I am perceived as competent, do I have control over my feelings? It is important to assess a range of choices that cover all aspects of a person’s daily life, and we have to measure or to assess this dimension.

The second dimension for consideration is meaning – what is important, what matters. To assess meaning is difficult, because meaning has so many different purposes, depending on culture and one’s experience, and even within any of these groups people differ a great deal. Here we find it necessary to cooperate with a very skilled anthropologist who knows a lot about qualitative techniques and who may use open interviews to elicit meanings that could be used in research. The issue of cultural sensitivity pervaded our discussion. For example, we are aware that in some cultures the individual is more
important than the group, whereas in others the group is more important than the individual. Political, religious, or other ideologies may have increased importance in yet other cultures. These differences have to be taken into account both for developing an assessment and for the interpretation of results concerned with differences between groups.

These two large dimensions, control and meaning, would help to explain anxiety, and they may be basic to the understanding of differences among the three groups just mentioned – torture survivors, non-tortured refugees, and a comparison group of Danish citizens being treated for anxiety.

Research:

Purpose
1. to be able to distinguish people who have been tortured from people who have not.
2. to be able to evaluate treatment so that therapists who are providing treatment for people who have been tortured may learn whether the treatment is having a beneficial effect, or any effect.

Aspects for inclusion in the evaluation:
First: beliefs. Beliefs about cause and relationships, about the world, the people around one, and oneself. What we would like to know here is the state of these beliefs before torture, after torture, before treatment, and after treatment.

Second: subjects the victim finds important in life – before and after torture, before and after treatment. By important we mean, for example: a person before torture may have valued the achievement of a certain status in an organization – a political organization or a business organization or something like that. After torture this may no longer be important – something else may be important. We want to know.

Third: harm – changes in the person's willingness to inflict harm on others. Again before and after torture, before and after treatment.

Fourth: functioning – at work and in the family, as well as the physical, personal, and occupational dimensions.

Fifth: the more traditional symptoms of anxiety. These can be evaluated in two phases. First, a development phase, in which the participants would be the torture survivors who had completed treatment at RCT; they would essentially become colleagues in research. We would ask them to help us to develop measurements. We would have some ideas about what would go into those measurements, and then there would be give and take. The development phase would concentrate on three of the aspects – beliefs, what is important, and harm. After developing these aspects with torture survivors, the second phase would assess the aspects in this group and compare them with those in the non-tortured refugees. Traditional analysis should then determine which items, if any, discriminate between the tortured and the non-tortured.

Clinical study:
Clients can act as their own controls. In our study, they will all be assessed when they are referred to RCT, at the time of treatment, during treatment, immediately after treatment and at a later follow-up.

In this way the treatment effect, if any, can be compared in torture survivors and non-tortured refugees in Denmark. The latter have been going through the normal processes of adapting to a new country.

We acknowledge that there may be cultural differences, especially in the dimensions that have to do with beliefs and values, and perhaps even in symptoms. It will not be possible to obtain large enough samples to make comparisons between different cultural groups. Thus, judicious, sensitive interpretation will be needed in the assessment of what effects, treatment or otherwise, may be due to culture differences.

Practical issues for future research
We propose in our study to test the above mentioned five aspects by a qualitative method on patients from RCT who have completed treatment.

At the same time we shall search the literature for relevant quantitative scales for assessment of the traumatic experiences of the patients and their levels of anxiety and depression. The relevance of these scales with respect to torture survivors will be examined. The scales will be applied to patients examined qualitatively and to patients receiving current treatment at RCT.

The qualitative and quantitative pilot study will serve to guide the preparation of a final design for a study aimed at
1) allowing us to point out people who have survived torture, and
2) evaluating the effect of present treatment of torture survivors.

RCT wants to implement a monitoring system to serve as a database for future research activities.
Psychiatry with Torture Survivors

A report of practice from the Rehabilitation and Research Centre for Torture Victims (RCT), Copenhagen, Denmark. By Peter Vest, MD, Finn Somnier, MD, and Marianne Kastrup, MD, PhD.

Psychiatry with Torture Survivors is written by three medical doctors, two psychiatrists and a neurologist, who have examined and treated hundreds of torture survivors. The book describes torture methods which RCT clients have survived, the psychological after-effects of these methods in the survivors, and the psychotherapy offered by RCT. Also included are two case studies, and the personal reflections of two former clients.

It is the hope of the authors that their book will be a practical contribution to the international literature on the rehabilitation and psychotherapy with the torture survivors.

Price: $10 or DKK50.

International monitoring

Monitoring the health and rehabilitation of torture survivors: A management information system for a rehabilitation and research unit for torture victims. København: IRCT 1992. By: Søren Bøjholm, MD; Anders Foldspang, MD, PhD, DMSc; Marianne Juhlcr, MD, DmSc; Marianne Kastrup, MD, PhD; Grethe SkyIv MD, MA; Finn Somnier, MD.

A system for stringent registration of torture, its effects, and their treatment is needed. RCT in Copenhagen, Denmark, has developed a monitoring system based on ICD trauma classification and DSM-III-R post-traumatic stress classification. The system is designed to record and compare effect of treatment/treatments, to allow international/interinstitutional exchange, and to aid management priority in decisions on resource allocation. It is the hope that it could also be an important part of preventive work against torture.

Price: $8 or DKK40.

Now to come in Spanish and French

The book Torture survivors – a new group of patients which was first published in Danish in 1987, came into existence on the basis of the experiences made during the last 10 years at the Rehabilitation and Research Centre for Torture Victims in Copenhagen. It describes the conditions resulting from torture, the rehabilitation, and nursing care, which it is today possible to offer the afflicted group of torture victims.

It is now available in English and Arab and is soon to come in Spanish and French.

Price: $10 or DKK50.

All the books can be obtained from:
IRCT
Postbox 2672
DK-2100 Copenhagen Ø
Denmark
Telefax: +45 31 39 50 20
RCT

The Rehabilitation and Research Centre for Torture Victims is an independent, humanitarian, non-political organization established in 1982 to help victims of torture and to contribute to the prevention of torture. Its main objectives are to rehabilitate persons who have been subjected to torture, to rehabilitate their families, to instruct Danish health professionals in the examination and treatment of persons who have been subjected to torture, and to carry on research into the nature, the extent and the consequences of torture.

IRCT

The International Rehabilitation Council for Torture Victims is a private non-profit foundation, created in 1986 by the RCT. The objectives of the foundation are, on an international basis, to support research into all aspects of torture, to support education and training of health professionals and of other relevant personnel in the medical, social, legal and ethical aspects of torture, and to serve as an international clearing house for information about torture activities.