Impact of trauma and torture on asylum-seekers

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Background: Because most asylum seekers come from regions in which war and human rights violations are common, a systematic investigation of exposure to traumatic events and their psychological impact was conducted. Methods: Over an eight month period, 573 asylum-seekers were interviewed shortly after arrival in Geneva, Switzerland, using a questionnaire to collect information on physical and psychological symptoms and previous exposure to traumatic events. Results: Sixty-two per cent reported exposure to one or more traumatic events, and 18% reported having been tortured. Overall, 37% reported at least one severe symptom during the previous week, most often of a psychological nature, such as sadness most of the time, insomnia, and anxiety. Persons who reported torture were more symptomatic than those who did not, and symptoms were consistent with diagnoses of depression and post-traumatic stress disorder. A follow-up visit was proposed to 28% of the entire sample, and to two thirds of those who reported torture. Conclusion: These findings suggest that a simple checklist such as the one used in this study may assist health professionals to identify asylum seekers in need of further assessment and care to reduce long-term post-traumatic psycho-social disability and strengthen coping capability.

Keywords: asylum-seekers, trauma, torture, post-traumatic disorders, medical screening

The number of asylum-seekers in Europe has increased ten-fold over the past decade, from about 70,000 applications in 1983 to 685,000 in 1992.[1] Switzerland is no exception to this trend. The genuine claim to asylum of many applicants has recently been questioned, and they are considered as economic migrants using the asylum channel to be admitted.[2] On average, only 9% are granted refugee status, and there is a tendency to limit their stay and to offer only a minimum level of social protection to dissuade future applicants.[3] In view of their short stay and restricted access to health services, very little is known on the health of asylum-seekers in Europe, and in particular on mental health.[4]

The Medical Policlinic (Department of Community Medicine) of the Geneva University Hospital has been in charge of the entry medical examination of all asylum-seekers assigned to the Canton of Geneva since 1984. Doctors and nurses progressively realised that sequelae of violence were not uncommon among asylum-seekers, impairing their ability to adjust to the new environment and leading in the most severe cases to repeated, ineffective hospitalisations for somatic complaints. It was then decided to conduct a systematic investigation of exposure to trauma, with two objectives:

- document the prevalence of severe trauma among asylum-seekers, and their symptomatic profile; and
- evaluate whether asylum-seekers exposed to torture had more severe psychological sequelae than those who did not.

The paper reports the results of this systematic survey and discusses its implications for reception and treatment of asylum-seekers.

METHODS

The Medical Policlinic of the Geneva University Hospital is an ambulatory facility staffed by doctors and nurses who perform the entry medical assessment of asylum seekers assigned to the Canton of Geneva within the first 15 days of arrival.

Before beginning the study, a number of instruments measuring the psychological impact of trauma were considered for possible utilisation. However, such questionnaires were too long and complex to be easily administered in a general practice setting, considering also that no additional resources (in terms of personnel, interpreters, etc.) were available to conduct this survey. Accordingly, a short questionnaire containing questions on traumatic events and current symptoms was developed, and tested at the Policlinic for a few months. The questionnaire in its final form contained three main sections: 1) basic demographic and social information; 2) a list of 16 physical and psychological symptoms that the person may have experienced in the last week; and 3) a list of eight traumatic events that the person may have experienced before his or her arrival in Switzerland. Many of the items in Sections 2 and 3 were selected from two instruments measuring anxiety, depression, post trau-

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matic stress disorder and traumatic events, the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist–25,[5,6] while others derived from the clinical experience of the staff working with asylum-seekers.

The 16 symptoms composing the questionnaire were the following: stomach pain, headache, back pain, joint pain, pain in the thorax, palpitations, shortness of breath, dysuria, lack of appetite, being anxious or irritable, difficulty concentrating, loss of memory, sadness most of the time, insomnia, nightmares, and recurrent and involuntary memories of past events. The symptoms were rated in three categories: 'absent' (score=0), 'a little or sometimes' (score=1), and 'extremely or very often' (score=2).

Eight traumatic events commonly experienced by asylum-seekers and refugees covered a range of events from detention, severe beating, torture and loss of family members. The events were rated as experienced or not experienced. We focused our analysis on torture because it is recognised as one of the most traumatising types of human rights violations, a deliberate dehumanising process in which one of the principal aims is to destroy trust, personality and self-esteem.[7,8]

Although we do not know what respondents may have comprehended when being asked whether they had been tortured, certainly the question was readily understood.

The questionnaire was administered by a trained nurse as part of the entry medical examination. The interview was conducted in the language most familiar to the asylum seeker out of the five spoken by the nurses (French, English, Italian, Spanish and German), because interpreter services were not routinely available. The checklist was easy to administer and it usually required 15 minutes per person. Before the interview, the purpose of the checklist was explained, and the voluntary nature and confidentiality of the information were stressed.

For the purpose of the analysis, only symptoms rated as having been present to an extreme degree or very often (score=2) were considered. Differences between subgroups of asylum-seekers exposed and not exposed to torture were measured by chi-squared test. All p-values reported are two-sided.

Table 1 Main socio-demographic characteristics of the study sample

Characteristic	N	%
Sex		
Females	208	36
Males	365	64
Age		
Median	27 years	
25th percentile	22 years	
75th percentile	33 years	
Education		
Illitterate	70	12
Primary education	150	26
Secondary education	279	49
University	74	13
Marital status		
Single	313	55
Married	230	40
Divorced	9	1
Widow	21	4
Religion		
Muslim	375	66
Christian	134	23
Other	64	11
Continent of origin		
Africa	250	44
Europe	210	37
Asia	98	17
Americas	10	2
Other	5	<1

RESULTS

From 1 May 1993 to 31 January 1994, the checklist was administered to 573 consecutive adult asylum-seekers presenting at the Medical Policlinic for the entry medical exam. Only two refused the interview. The main socio-demographic characteristics of the sample are summarised in *table 1*. Two thirds of asylum-seekers were males, and the median age was 27 years, similar for men and women. More men than women were single, 64% versus 39% respectively. Thirty-eight per cent were illiterate or had primary education, the remaining had high school or university degrees. Two thirds were Muslim, the others were Christian or of other religions. While the majority of asylum-seekers came from Africa (44%), the most represented national groups were former Yugoslavia (194 persons), followed by Somalia (107), Angola (52) and Sri-Lanka (22).

Table 2 summarises the type of traumatic events reported by the sample interviewed. Overall, 353 persons (62% of the entire sample) reported to have experienced traumatic events, 20% only one, and 42% two or more. Imprisonment, murder of family members, severe beating and lack of shelter, food or water were the events most frequently reported. Torture was reported by 18% of the sample (27% of men and 3% of women), often in association with other traumatic events, in particular severe beating (in 90% of asylum-seekers who reported torture), imprisonment (87%), and lack of shelter, food or water (69%). Self-reported health status was considered poor by

Table 2 Traumatic events reported by asylum-seekers

	N	%
To take part in or to be exposed to war actions	66	12
Imprisonment	186	33
Lack of shelter, food or water	147	26
Severe beating	173	30
Torture	104	18
Rape/sexual violence	13	2
Murder of family members	178	31
Disappearance of family members	95	17

Note: More than one event could be reported by each subject

17% of persons who did not report any traumatic event, by 35% of persons who reported at least one, and by 38% of those who reported torture.

Over one third of the sample (37%) reported to have experienced at least one symptom of severe intensity over the previous week; in almost three quarters of the cases, the symptom(s) were exclusively of a psychological nature. Out of the somatic symptoms, headache was the most commonly reported (9%), followed by stomach ache (4%) and loss of appetite (4%). Out of the psychological symptoms, sadness most of the time (11%), insomnia (11%) and anxiety (10%) were most frequently mentioned.

We further explored the symptoms profile of persons who reported to have been tortured, because of the extreme nature of the trauma, and of the simultaneous exposure to other traumatic events. Overall, persons who reported torture had a higher frequency of psychological symptoms than those who did not (51% versus 21% respectively, $p<0.001$). The percentage of asylum seekers reporting psychological symptoms increased when exposure to any traumatic event was reported, as compared to non-exposure. In particular, tortured asylum-seekers were significantly more likely to report anxiety, difficulty concentrating, sadness, nightmares, and recurrent memories of past events than those who were not exposed to torture (*table 3*). Nightmares and recurrent and involuntary memories of past events – symptoms which are specific to diagnosis of post-traumatic stress disorder – were almost three times higher in persons who reported torture than in the rest of the sample.

Finally, the nurse who conducted the interview proposed a follow-up visit to asylum seekers who presented somatic or psychological symptoms which, according to the judgement of the nurse, required a diagnostic assessment and appropriate treatment. The follow-up visit was proposed to 28% of the overall group, to 60% of those who reported torture, and to 70% of the (few) cases who reported rape or sexual violence.

DISCUSSION

The present survey documented a high prevalence of reported previous exposure to traumatic events in a sample of asylum-seekers just arrived in Switzerland. About two out of three asylum-seekers reported traumatic events, especially imprisonment, severe beating, murder of family members, and lack of shelter, food, or water. In our sample, persons who reported traumatic events were more likely to consider themselves to be in poor health than those who did not, and to list at least one severe symptom over the past week. Overall, one out of three persons reported at least one severe symptom during the past week, most often of a psychological nature. It is worth noting that the interview took place within 15 days from arrival in Switzerland, a period usually considered as 'arrival euphoria'. It is then possible that more people will become symptomatic at a later stage, when the uncertainty about the asylum claim will add to the past traumatic experience.[9] The study identified asylum-seekers reporting torture as a highly traumatised group, with a significantly higher prevalence of anxiety/irritability, difficulty concentrating, sadness, nightmares, and recurrent memories of past events, a profile consistent with the diagnoses of depression and post-traumatic stress disorder often seen in torture survivors.[10,11] Previous reports on the impact of trauma on human populations estimated that between 5% and 35% of refugees in Western countries have been tortured.[12] The prevalence of post-traumatic stress disorder varied from 10% to 86% according to the refugee population surveyed.[13,14]

Two aspects of the present study need to be discussed because of the potential to systematically bias the results, namely the lack of culture-specific questionnaires and over-reporting of traumatic events and symptoms. First, with a few exceptions, the interview could not be conducted by a trained interpreter in the mother tongue of the asylum seeker, because of shortage of resources and great diversity of nationalities. In order to minimise misunderstandings, the checklist was kept very simple, and only symptoms present to an extreme degree were considered in the analysis. Previous studies have convincingly demonstrated the presence of culture-specific trauma symptoms, and it may be argued that the impact of traumatic events could not be fully appreciated with a short interview adopting Western-oriented criteria.[6,15] If that was the case, the present assessment would represent a conservative estimate. Second, asylum-seekers might under-report or over-report traumatic events and symp-

Table 3 Psychological symptoms according to exposure to traumatic events and torture

	Exposure to traumatic events				Exposure to torture				
	Exposed		Not exposed		Exposed		Not exposed		χ^2 test[a]
	n	%	n	%	n	%	n	%	p value
Being anxious, irritable	42	12	13	6	19	18	36	8	0.001
Difficulty concentrating	7	2	4	2	5	5	7	2	0.034
Loss of memory	7	2	2	1	4	4	6	1	0.073
Sadness most of the time	49	14	15	7	23	22	40	9	<0.001
Insomnia	46	13	20	9	17	16	46	10	0.058
Nightmares	21	6	2	1	11	11	12	3	<0.001
Recurrent and involuntary memories of past events	46	13	18	8	24	23	39	8	<0.001

a: More than one symptom may be reported by each person

toms while the asylum claim was still pending. The first case – under-reporting – may happen when the asylum seeker fears to have reduced chances to be accepted due to potential invalidity. The second case – over-reporting – when he or she hopes to have better chances if the criteria for asylum are mainly humanitarian. The latter issue has been the object of study and controversy since World War II, when the claim to compensation of concentration camp survivors was assessed, and more recently when the entitlement to political asylum of torture victims was addressed by the forensic professions.[16,17] In our case, the interview was part of the entry medical examination, it was strictly confidential, and it was independent of any asylum claim procedure. If the potential for unreliable account certainly exists, we think that it was minimised under the circumstances described above.

Overall, the interview had minimal negative effects from the clinical point of view. Other studies have reported that, even in populations exposed to massive trauma, the use of a checklist or of other 'neutral' ways to elicit information on traumatic events is considered an adequate approach.[6] In general, survivors of torture and organised violence do not spontaneously mention exposure to severe trauma and its sequelae, particularly at time of arrival in a new country. Thus, it is essential that health professionals be sensitive to this dimension, and explore possible exposure to traumatic events in a non-intrusive and respectful manner. In our case, asylum-seekers were offered an understanding and caring environment, and were informed that the staff were available for further assistance. The nurses who carried out the interview proposed a follow-up visit to 28% of the overall sample, and to almost two thirds of those who reported torture. Unfortunately, the results of the follow-up visits were not recorded.

In conclusion, the present study revealed that asylum-seekers in a Western country present a high prevalence of previous exposure to traumatic events and current psychological symptoms. Offering appropriate services to those in greatest need poses a formidable challenge to health professionals, both because of the linguistic and cultural diversity and of the limited entitlements to health and social services of asylum seekers. A simple checklist as the one employed in our study may assist in the identification of persons in need of further assessment and follow-up. It is recognised that early intervention may reduce long-term psycho-social disability and strengthen coping capability whether the person remains in the receiving country or has to return home.[18] Early intervention is even more important in the case of asylum-seekers, whose family and social network – factors of key importance in the recovery of torture survivors – are severely disrupted.

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