

The Psychological Impact of Torture and Other Types of Systemic Abuse

Examining permanent residents and asylum seekers in the community and in detention in
Australia

Maritza Thompson

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Department of Psychology

The University of Melbourne

This thesis is dedicated to my parents. They left Chile following a brutal dictatorship looking for a safe place for their children to study and grow. It was their belief for justice, their strong belief for us to have an education and my own experience of witnessing the abuse of one human being against another that led me to study psychology. The people I have met through my research have taught me about survival and the complexity of the consequences of such experiences. This thesis is dedicated also to all my friends in Chile, those who survived torture and were released days before our forced migration to Australia in 1974. To my two children and husband, they have been so patient and tolerant; they have endured with me the struggles of this thesis. Their own beliefs for the rights of people are wonderful and hopefully our many dinner conversations resulting from this research have taught them about suffering and survival, and have contributed to who they are today, beautiful people who will always stand for the rights of others and theirs. To all the survivors of torture and other systemic abuse, who participated in this research, I feel an enormous gratitude for having trusted the staff and myself working in this project. Sharing with us your life history, dignity and survival was indeed a privilege. You have enriched my life beyond expectation and I dedicate this work to all of you and thank you for the honesty and trust you have given me.

Abstract

Concerns continue to be raised worldwide about the psychological impact of torture and other types of systemic abuse. Few controlled studies have investigated psychological distress resulting from torture and other systemic abuse or from the asylum seeking processes itself. No study has taken into account the impact of systemic abuse on the subjective 'self view'. By contrast, this thesis compares the degree of psychological distress, and 'self views' between three groups: survivors of torture, survivors of other types of systemic abuse, and a control group who experienced neither. It was expected that torture survivors would present with higher levels of psychiatric symptoms and greater negative self views compared to the other two groups. Similarly, it was predicted that survivors of other types of systemic abuse would present with higher levels of psychiatric symptoms and greater negative 'self views' compared to the control group.

A further question concerns residential status, that is, whether asylum seekers in detention have higher levels of distress and changes in 'self-view' compared to asylum seekers living in the community and those with permanent residency who never experienced the asylum seeking process. It was expected that asylum seekers in detention would present more negatively compared to asylum seekers in the community. It was also expected that asylum seekers in the community would present with greater psychiatric symptoms and negative 'self views' than permanent residents.

These hypotheses were tested in a sample of 259 people using a comprehensive methodology that included a semi-structured interview incorporating the structured interview for PTSD, the Global Assessment of Functioning and the ICD-10 for personality change. The interviews included three self report psychiatric scales: the SCL- 90-R, The Impact of Event

Scale, and The Repertory Grid (measuring 'self views'). Although torture survivors presented with increased psychiatric symptoms, there was no significant difference between torture survivors and survivors of other types of systemic abuse as measured by the IES and PTSD. Survivors of other systemic abuse presented with greater psychiatric symptoms than the control group on PTSD and IES measures, but not for the SCL-90-R. Torture survivors' 'self views' were more negative than the other two groups but not for present and future views of self. There was no difference between torture survivors and survivors of other systemic abuse on the GAF. There were significant differences between these groups on personality change.

The hypothesis that asylum seekers in detention will present with greater psychological distress and more negative 'self views' was not clearly confirmed. In fact, asylum seekers living in the community presented with greater psychological distress than both other categories as measured by the SCL-90. Both asylum seeker categories presented with greater PTSD symptoms than permanent residents; however, there was no significant difference between the two asylum seeker categories. There was no difference between the three residential categories on the GAF. There were significant differences between these categories on personality change and 'self view'.

The results are discussed in relation to: other studies, complexity of symptom presentation, 'self views' and resilience of survivors. The consequences of systemic abuse and asylum seeking are complex and worthy of further research.

Declaration

All work in this thesis comprises only from my original work except where due acknowledgment is made in the text to material used. The thesis is less than 100,000 words in length, exclusive of tables, references, and appendices. I, Maritza Thompson, declare that the research reported in this thesis was conducted in accordance with the principles for the ethical treatment of human subjects as approved for this research by the Research and Ethics Committees of Royal Park Hospital, Office of Psychiatric Services, Health Department Victoria on January 1993.

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Chapter 1

Introduction

Background to This Research

A pilot study was undertaken in 1989 to investigate the psychological sequelae of torture amongst Chilean and Salvadorian migrants (Thompson & McGorry, 1995). This study suggested that individuals who survived torture presented with higher levels of PTSD, depression and anxiety than those who survived other forms of state abuse. This pilot work established a research protocol for assessing the impact of torture and trauma. That study demonstrated that it was possible to access and interview survivors from a clinical research perspective without causing additional psychological distress. The present research project, which took place from 1993 to 1998, continued the earlier work with the support of the Departments of Psychiatry and Psychology at the University of Melbourne.

Due to the lack of support for this area of research in Victoria, as well as the researcher's work and family commitments, including a transfer to NSW, the study lapsed for 9 years. On its resumption in 2007, at a time when the topic of refugees had increased prominence in academia, the media and the general community, the data accumulated over the research period remained relevant and has become increasingly so. Meanwhile, new supervisors had to be found and the project was transferred completely to the Department of Psychology. It was then necessary to undertake a series of appropriate short courses related to

PhD general skills and to present the data to other post graduate research students and departments, including a research committee within the department. The work was fully resumed in 2008.

The Psychological Impact of Torture, Other Types of Systemic Abuse and Seeking Asylum

System abuse results from government structures where power is exercised subtly, to put into practice policies and structures with the aim of controlling society as a whole (Robertson, 2000). At times governments exercise power which is violent in nature to achieve this end (Donnelly & Diehl, 2011; Klein, 2008; Robertson, 2000). The level and intensity of organised violence or systematic abuse varies according to who is in power. It is organised in its nature because it is a systematic exercise organised by the state (Klein, 2008; Robertson, 2000). This type of system abuse, or organised violence, has a long history (Donnelly & Diehl, 2011). Torture is an extreme form of exercising this power in order to implement a particular philosophy and maintain control over a society (Donnelly & Diehl, 2011; Klein, 2008; Robertson, 2000; Scott, 1995).

Torture is inflicted by a group of people representing a government, political or religious organization. Torture for political purposes is predominantly used in secret with the aim of obtaining information (Donnelly & Diehl, 2011; Ortiz, 2001). It has been incorporated over the centuries into the service of the state (Donnelly & Diehl, 2011; Klein, 2008; Scott, 1995; Robertson, 2000). Torture continues to be a worldwide problem and the consequences of torture are complex as they include: anxiety, somatization, depression, enduring personality change, and physical injury (Başoğlu, Jaranson, Mollica, & Kastrup, 2001; Campbell, 2007; Hauksson, 2003; Ortiz, 2001; Sachs, Rosenfeld, Lhewa, Rasmussen, &

Keller, 2008; Silove, 2004; Wilson, 2004). Previous research has also indicated that these consequences are also found among those who have survived other types of systemic abuse (e.g., Başoğlu et al., 1994; Campbell, 2007; Ortiz, 2001; Thompson & McGorry, 1995).

The focus of previous research into torture has been on the psychiatric symptoms, based on case studies; first person accounts of the experience of torture (e.g., Cathcart, Berger, & Knazan, 1979; Knight, 2006) or case study series (e.g., Carlsson, Mortensen, & Kastrup, 2006; Rasmussen & Lunde, 1980; Sachs, Rosenfeld, Lhewa, Rasmussen, & Keller, 2008). Very few studies have been conducted where the distress of torture survivors was compared with that of survivors of other forms of state abuse and a control group (people who have not experienced trauma) (e.g., Başoğlu et al., 1994; Holtz, 1998; Thompson & McGorry, 1995). The first phase of this current study also examined the degree of psychological distress experienced by those same three groups: survivors of torture, survivors of other types of systemic abuse and a control group (migrants who had not experienced either). However, it extends this previous work by going beyond an examination of psychiatric symptoms by examining the ‘self’ before, during and after torture and other forms of abuse.

There has been little attempt to understand the subjective experience of torture (Wilson, 2004). Kelly’s (1955) personal construct theory is reviewed as a way of understanding the structure of ‘self’ and, within the context of this theory, the impact of torture and other types of systemic abuse have on ‘self view’ was explored. A unique contribution to this research was the use of the Repertory Grid measurements (originally developed by Kelly in connection with his Personal Construct Theory) to explore changes in ‘self view’ following a traumatic experience. This aims at understanding how self is defined in the face of major stressors by the survivors.

In the late 1970s, research into the consequences of torture and the provision of services for its victims began in Europe and Latin America. Only in the late 1980s was similar concern shown in Australia. Research investigating the psychological consequences of systemic abuse has demonstrated that refugees seeking asylum in Australia (see Chapter 4 for a definition of an asylum seeker), are facing a number of serious mental health difficulties (Austin, Silove, & Steel 2007). This research questions the degree to which the distress varies according to the survivor's residency status in Australia (1: permanent resident, 2: asylum seeker living in the community, and 3: asylum seeker living in detention). Again, the study goes beyond the measurement of symptoms but assesses functioning and self-views.

In the same period, partly as result of the recognition of the suffering of Vietnam veterans, 'posttraumatic stress syndrome' became the most common diagnosis for sufferers who had survived war and/or torture (American Psychiatric Association, 1980). Since that time, Post Traumatic Stress Disorder (PTSD) has become a concept synonymous with the consequences of any catastrophic events outside everyday life experience, e.g., torture (McNally, 2004). The ubiquitous nature of this diagnosis is such that it is assumed that anyone who has experienced a traumatic experience suffers PTSD (McNally, 2004; Watters, 2010). The focus on a diagnosis of PTSD can detract from any explorations of an individual's determination to survive torture. Furthermore, once a diagnosis of PTSD has been made, clinicians, allied health workers, legal advisers and others may be less likely to recognize the complexity of the torture experience and the capacity of individuals to survive such atrocities and integrate into a new society (Kordon et al., 1992; Watters, 2010). This thesis questions the applicability of blanket PTSD diagnoses as sufficient for describing: the clinical phenomena reported by survivors of torture and survivors of other types of systemic abuse as well as the subjective experience of those survivors.

Structure of this Thesis

A historical account of torture and its practice is outlined in Chapter 2 of this thesis. Chapter 3 reviews the literature on research into the psychological impact of torture and other systemic abuse amongst refugees around the world. Studies specifically related to Australia, which focus on the 1990s and 2000s, have also included the added consequences of experiencing seeking asylum in Australia; these are reviewed in Chapter 4. The concept of ‘self’ and the impact the experience of torture might have on survivors’ view of ‘self’, including the basic principles of Kelly’s theory, is described in Chapter 5.

Following the literature review in Chapter 5, Chapter 6 outlines the rationale and hypotheses for this research study. A unique feature of this study is that it questions whether stress-related symptoms and psychological impairment are present in all survivors of systemic abuse. Firstly, it questions the degree to which psychological distress and ‘self view’ vary between survivors of torture, survivors of other types of systemic abuse and the control group. Secondly, it explores the degree to which the distress and ‘self view’ vary according to the survivor’s residency status in Australia (1: permanent resident, 2: asylum seeker living in the community and 3: asylum seeker living in detention). To address these main research questions a sound and comprehensive methodology was adopted, which is outlined in Chapter 7. Section 1 addresses the first research question focusing only on the comparisons between the three groups with permanent residency living in Melbourne. Section 2 addresses the second research question of this study by focusing on the comparisons between the three residential categories. The methodology includes the operational definitions of the intake criteria for participants in Section 1 and 2 of the study. It outlines the interview structure and provides a description of the standardized psychiatric scales used in this study.

The results (Chapter 8) are presented in three sections. Firstly, Chapter 8 presents results related to Section 1 of this study. This section presents comparisons between the three groups (torture survivors, survivors of other types of systemic abuse and the control) on demographic variables, psychopathology measures and 'self views'. Section 2 is divided into Sections 2 A and 2 B. Section 2 A examines whether there was any interaction between the three residential categories and group membership (within all three residential categories participants were either 1: survivors of torture or 2: survivors of other types of systemic abuse). This is followed by a presentation of the main effect results for residency and group on demographics variables, psychopathology measures and 'self views'. Section 2 B presents the results obtained from further tests which investigated the interactions between residency and group in Section 2 A. Following Section 2B further analyses were conducted to explore the structure underlying the various psychopathology measurements, and predictors of psychopathology, Section 3 of the results chapter, presents these findings. The study findings, implications and limitations are discussed in Chapter 9. This includes whether the hypotheses of this study were confirmed, the limitations of diagnosis of PTSD and the complexity of the effect that torture, other types of systemic abuse and seeking asylum has on the self and psychopathology of survivors.

Chapter 2

The Practice of Torture

Introduction

The English word 'torture' derives from the Latin 'tortura' which is still used in Spanish to mean to twist, rack, and intimidate and is associated with the infliction of physical and psychological pain whilst being interrogated (Donnelly & Diehl, 2011; Kosteljanetz & Aalund, 1983; Scott, 1995). Torture represents the crudest form of information gathering, of exacting vengeance by punishing the individual, and attempting to challenge the person's beliefs and worldview (Donnelly & Diehl, 2011; Klein, 2008). It frequently precedes death, thus brutally increasing the individual's suffering (Kellaway, 2003; Klein, 2008; Kosteljanetz & Aalund, 1983; Scott, 1995). Torture was employed in primitive rituals in the ancient world as far back as Ramses II in the 13th century BCE, in medieval times as punishment, and in the witch-hunts of the early modern period (Donnelly & Diehl, 2011; Ruthven, 1976; Scott, 1995).

The desire to inflict pain through the use of torture and the acceptance of such cruelty upon other human beings, are negative aspects of human behaviour (Charny, 1986; Donnelly & Diehl, 2011; Klein, 2008). The torturer's sadistic behaviour is enjoyed by the torturer and linked to the exercise of power and the desire to inflict pain upon the victim (Charny, 1986; Donnelly & Diehl, 2011; Herman, 1992; Klein, 2008; Scarry, 1985; Scott, 1995). The torturer is not alone in this ecstasy of enjoyment as large numbers of people within his world are aware of these atrocities and share the excitement of the torturer (Amnesty International,

1975; Herman, 1992; Klein, 2008; Scarry, 1985). In the past torture was conducted publicly, as reflected in the writing of Bernard Shaw:

A public flogging will always draw a crowd; and there will be in that crowd plenty of manifestations of a horrible passionate ecstasy in the spectacle of laceration and suffering from which even the most self-restrained and secretive person who can prevail on himself to be present will not be wholly free. (Shaw, 1897, cited in Scott, 1995, p. 207).

This exercise of power is supported by a belief that torturers and their masters must maintain a pure system and that opposition to the authority's doctrines is 'a disease' (Klein, 2008). Those who opposed the dictatorships in Latin America between the 1970s-1990's were seen as carriers of diseases that were to be cured or eliminated (Klein, 2008). This is explained in Pinochet's impatient words, following criticism of his human rights record: "If you have gangrene in an arm, you have to cut it off, right?" (Klein, 2008, p.112). Torture was seen as a treatment to cure society of these diseases, a kind of medicine administered to the prisoners, referred to as the 'apestosos', the contagious or dirty ones (Klein, 2008). The possibly lethal treatment was claimed to be for the 'patient's' own good. It was similar to the early use of electricity in the 1700s, which was applied to those who were mentally ill in the belief that evil spirits had entered into the body and this electrical treatment would get rid of them (Donnelly & Diehl, 2011; Klein, 2008).

History of Torture

Torture as an instrument of repression and oppression may be traced back to ancient Greece and Rome where it was used for interrogation only on slaves and the lower classes, one of the oldest methods being crucifixion, after a savage whipping to weaken the victim (Donnelly & Diehl, 2011). Medieval and early modern courts in Europe deemed that torture

was a legitimate means of gaining confessions using such methods as the thumb screw, the rack and drawing and quartering before victims were burnt at the stake (Donnelly & Diehl, 2011) Torture was also employed to extract the names of accomplices, as in the witch hunts in England, Scotland and America (Donnelly & Diehl, 2011; Kellaway, 2003; Kosteljanetz & Aalund, 1983; Scott, 1995). In Colonial America women were punished by being subjected to the stocks and tongue clips were applied for the crime of talking too much (Brizendine, 2006; Donnelly & Diehl, 2011).

Throughout history the main purpose of torture has been to elicit the ‘truth’ via the application of tormenting types of interrogations (Amnesty International, 2011; Donnelly & Diehl, 2011; Kosteljanetz & Aalund, 1983; Peters, 1985; Scarry, 1983; Scott, 1995). However, it has extended beyond merely obtaining the ‘truth’; its purpose has included punishment, coercion and intimidation, not just of the victim, but of anyone related to the victim (Donnelly & Diehl, 2011; Kosteljanetz & Aalund, 1983; Peters, 1985; Scarry, 1983; Scott, 1995). These acts of violence were perpetrated in early Europe by zealous public officials (Donnelly & Diehl, 2011; Kosteljanetz & Aalund, 1983; Peters, 1985; Scarry, 1983; Scott, 1995). This often ferocious secular treatment was never as vicious as that administered by pious friars on pious heretics when the Church took control and systematized these acts during the Spanish Inquisition (Donnelly & Diehl, 2011; Franklin, 2001, Scott, 1995). However, torture was not permitted to be used on members of the priesthood (Donnelly & Diehl, 2011; Franklin 2001; Scott, 1995). Witch hunts in both Catholic and Protestant states of Europe and America increased in the 17th century when, paradoxically, the scientific revolution was gathering momentum (Kellaway, 2003; Robertson, 2000; Scott, 1995).

Revulsion against these practices in the 18th century led to reforms. Frederick the Great distinguished torture from war, and abolished torture altogether in his state by 1754 (Donnelly & Diehl, 2011). In 1798, Napoleon Bonaparte wrote of the ‘barbarous custom’ of

whipping men to obtain information as: "...useless. The wretches say whatever comes into their heads" (Napoleon Bonaparte translated by Howard, 1961, p. 274). He then forbade the use of such methods (Howard, 1961). Torture was eventually abolished in a number of European countries (Kellaway, 2003; Kosteljanetz & Aalund, 1983; Peters, 1985; Robertson, 2000; Suedfeld, 1990). However, systemic abuse continued to occur in the European colonies in the 19th century (Robertson, 2000). In the 20th century systemic abuse increased in magnitude with the widespread re-introduction of torture (Robertson, 2000).

Torture has been prohibited under international law since 1966 which did not come into full effect until 1976 (Kosteljanetz & Aalund, 1983; Robertson, 2000); however, since then there have been well documented atrocities, for example, in the Soviet Union, Latin America, Africa, Cambodia, Sri Lanka, Turkey, and in the disintegrating Yugoslavia. More recently, the US war against terrorism has generated a debate about the practice of torture with the purpose of obtaining information (Amnesty International, 2010; Kosteljanetz & Aalund, 1983; Robertson, 2000). Torture is prohibited under international law, yet it is still practiced throughout the world, with new technology being developed to further its application, combining physical and psychological methods (Amnesty International, 2010; Donnelly & Diehl, 2011; Kosteljanetz & Aalund, 1983; Office for Justice and Peace of Jayapura, Imparsial-Jakarta, Progressio Timor Leste, The Synod of the Christian Evangelical Church in Papua, Franciscans International, 2007; Scott, 1995; Williams, Pena, & Rice, 2010).

Torture, 200 years after Napoleon's prohibition, is still seen as necessary to obtain information by government officials represented by groups such as the police, secret police and military forces worldwide (Amnesty International, 2011; Donnelly & Diehl, 2011; Kosteljanetz & Aalund, 1983; Robertson, 2000) but those who experience it attest to its uselessness: "I was tortured three times. They used electric shocks on me twice. I was beaten

several times. After that I confessed. I confessed to things I never knew what they were” (Torture survivor testimony, 2010 in Amnesty International, 2011). Torture continues to constitute an aggravated and deliberate form of cruelty, an inhuman and degrading treatment or punishment currently reported to be practiced in at least 111 countries (Amnesty International, 2010).

Definition of Torture Today

The definition of torture continues to be debated. In 1975 Amnesty International stated torture: “is the systematic and deliberate infliction of acute pain in any form by one person on another or a third person, in order to accomplish the purpose of the former against the will of the latter” (Amnesty International, 1975, p.34). The World Medical Association (WMA) in the Declaration of Tokyo (1975) refers to torture as: “The deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason” (WMA Declaration of Tokyo, 1975, p.1). Following these definitions, in 1984 the United Nations General Assembly reviewed and refined the 1966 definition and concluded that torture is:

any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain

or suffering arising from, inherent in or incidental to lawful sanctions (United Nations, 1984, Article 1.1).

The United Nation's definition of torture is the one most commonly used today by the legal sector to investigate the allegations of torture and in scientific and social research to study the psycho/social and physical consequences of torture (Amnesty International, 1975, 1985, 2011; Hollifield, Warner, & Westermeyer, 2011; Robertson, 2000). Nevertheless, the current definition of torture continues to be debated (Amnesty International, 1975, 1985, 2011; Hollifield et al., 2011; Klein, 2008) as is the justification for its application for the purpose of obtaining information (Amnesty International, 2011; Gallagher, 2011; Savage, 2007). Some argue that this definition is limited, in that the emphasis on the infliction of pain does not allow for the inclusion of numerous other torture techniques (Kosteljanetz & Aalund, 1983). There are torture techniques which do not include the infliction of physical pain but that, nevertheless, still severely challenge the person's view of self, others and the world around them, by means of humiliation, acts of coercion and intimidation (International Rehabilitation Council for Torture Victims (IRCT) 2007; Kosteljanetz & Aalund, 1983; Somnier, Vesti, Kastrup & Genefke, 1992). Such torture methods also encompass the use of chemicals being injected into the victim or by forced ingestion which involves the participation of medical scientists in its development and application (Amnesty International, 1975, 1985, 1996; Kosteljanetz & Aalund, 1983). Torture methods such as sleep deprivation and isolation also damage the individual without the infliction of physical pain (IRCT, 2007; Kosteljanetz & Aalund, 1983; Somnier et al., 1992).

The debate about its justification was reignited after the attack on the World Trade Centre Twin Towers in New York in September 11, 2001 and the ensuing 'war on terror' (Amnesty International, 2011; Gallagher, 2011; McCourt & Lambert, 2004; Savage, 2007). This is the same debate which began in Chile, September 11, 1973 and continues to this day

(The Age, 2011). The debate has been inflamed by the use of torture in Guantanamo Bay, Pakistan and Iraq where the United States of America, under George W. Bush's administration, ordered officials to subject alleged terrorists to torture techniques such as waterboarding (Amnesty International, 2011; Donnelly & Dehl, 2011; Gallagher, 2011). The debate has broadened recently, not only as to what constitutes torture, but whether torture should be allowed or whether those who authorise it should be legally charged because of the physical and psychological damage caused by such assaults (Donnelly & Dehl, 2011; Klein, 2008).

Torture Techniques

The methods of torture used during periods such as the Spanish Inquisition have been described as constituting unique, diabolical, and inventive means of suffering (Donnelly & Dehl, 2011). Much thought and energy went into the use of disturbing and evil instruments designed to cause agony (Scott, 1995). It still does. Five hundred years later, there are still numerous documented forms of torture used throughout the world, for example, Amnesty International (1985, 1996, 2011), Allodi et al, (1985); Donnelly and Dehl (2011), Klein (2008), and United Nations Office of the High Commissioner for Human Rights (UNHCHR, 2004). These writers describe the methods of torture used historically and up to the present day. These techniques are described in the following Table 2.1.

Table 2.1

Torture Techniques Practiced Today and Their Definition

Types of Torture	Definition of Torture Techniques
Head Trauma	These techniques include blows to the head. Head blows can also happen by felling the victim and kicking the head and violently shaking the victim whilst down.
‘ Telefono’	Telefono” (telephone) – simultaneous blows to both ears either causing loss of hearing or damage to the head.
Falanga, Falaka, Basinado	These are systematic beatings to the soles of the feet, thickening the nerve endings, and causing severe pain when walking.
Insertion of instruments/Objects into the anus	Instruments used vary from bottles to police batons, tearing the rectum and fracturing the coccyx. Abscesses often occur after the insertion of such instruments.
Deprivation	The reduction of stimuli from the environment to an absolute minimum. This is done by blindfolding the person and keeping them in the dark by placing them in cells, niches, or rooms with no space for human movement. Communication is disturbed, memory impaired and identity weakened.
Asphyxiation	Often this starts by placing the head in a sack, which deprives sight as well as giving a sense of asphyxiation by placing a rope around the throat holding the sack tight to the face and neck. Other methods include a plastic bag over the head to the point of near suffocation followed by a sudden release. Sacks used as hood to cover the head and face can also be filled with dust and/or hot peppers
‘Submarino’	A common practice in South America in the 1970s and 1980s was known as ‘submarino’ where the head was forced into a bath or bucket of water and held down. It has been reported by Chilean survivors that drinking water was often dirty with excrement, urine, vomit.
Water boarding	
Beatings	Extreme beatings with fists, boots and rifle butts to the entire body.
Planton	Forced to stand for hours or days at a time, often with arms outstretched and/holding weights
Caballete’ (the easel or rack)	Forced to sit or stand in an iron bar, easel or rack
Dental Torture	This method of torture often results in horrific damage caused by forcing guns into the mouth and hitting the teeth; using electrical shocks that damage the gums; forcing out or breaking molars or other teeth in half; subjecting the tongue to beatings; and inducing mandibular breaks by prizing the mouth open.
Electrical Torture	Involves electric shocks transmitted through electrodes applied to different parts of the body. Some of these parts include the gums and the teeth causing teeth to be fractured or lost entirely. The “picana” is a type of electrical torture in which an electrically charged needle is applied to areas of heightened sensitivity such as the nipples, genitals, eyes, tongue and teeth. As stated by the United Nations, 2004, in this type of torture water or gel is often used to increase the impact of the torture and to prevent burn marks resulting from the electrical shock.
“picana”	

Table 2.1 continued

Torture Techniques Practiced Today and Their Definition

Types of Torture	Definition of Torture Techniques
Parrilla	Being tied to the metal frame of a bed to which electric current is applied
Suspension	This is where the body is hung in a position where the anchored body part supports the weight of the rest of the body. There are number of suspensions: cross - where the arms are spread and tied up by the hands, wrist or thumbs to a horizontal bar or beam. The entire body is suspended by the arms. "butchery suspension" (fixation of hands upwards, together or one by one), "reverse butchery suspension" (fixation of feet upward, head downward), "palestinian suspension" (forearms bound together behind the back with the elbows flexed 90 degrees and the forearms tied to a horizontal bar or beam, or suspending from a ligature tied around the elbows or wrists with the arms behind the back)
Parrot Perch	Suspension by the flexed knees on a bar, usually while the wrists are tied to the ankles. This type of suspension is familiar to those who were also sexually abused. Another type of suspension is forcing the individual to stand on a chair or the edge of a step, standing on one leg with an arm tied to a pole in a straight position.
Psychological Torture	Every physical torture is accompanied by psychological torture. Other techniques accompanying the physical torture are a counter-effect technique. Any response from the victim becomes the pretext for renewed or continuous torture, leaving the victim feeling helpless and confused by the meaninglessness of the process. There are also double-blind techniques where contradictory messages are given inducing confusion – the friendly and unfriendly interrogator. Other forms of psychological torture include humiliation; verbal abuse and threats to family; forcing victims to observe the torture on other family members; and mock executions. Methods of psychological control include: isolation, blind folds, verbal abuse, social deprivation, false accusation, forced intake of psychotropic drugs, humiliation, restricted movement and vision, sensory and sleep deprivation, watching loved ones being killed, raped or brutalization, rise and fall, loud noises and sexual torture.

All of the techniques described in Table 2.1 are systematically inflicted, organised and routine. They are often used in combinations. Doctors and psychologists have been reported to have played a major role in the implementation of torture (Australian Psychological Society (APS), 2007; Kosteljanetz & Aalund, 1983; Miles, 2009). Such health workers have been used as consultants to advise torturers on techniques and how to implement them in ways which do not kill the victim or else delay death. It has been reported that psychologists and doctors have also participated in the development of torture techniques and their implementation in order to inflict mental torture on the victims, and they have prescribed

medication for victims as part of the torture (APS, 2007; Holst, 1997; Kosteljanetz & Aalund, 1983; Miles, 2009; Suedfeld, 1990). However, it has been reported that medical practitioners have also been forced to participate in torture, to lie about the condition of the victim and be compulsorily restrained from maintaining records; all of these actions are unequivocally illegal and unethical.

Codes of professional ethics have strict guidelines that ban a practitioner or health worker from participating in torture (APS, 2007; WMA, 2006; Eitinger & Weisaeth, 1998; UNHCHR, 2004). Accordingly, in 1984, the American Psychological Association adopted an official policy on investigating psychologists, either as victims or as perpetrators, and made it clear that torture was a special case of human rights violations (Suedfeld, 1990). It appears that health professionals can be induced to inflict physical and psychological pain and other forms of suffering on others as a result of either enforcement by authorities or they can participate voluntarily because they share the ideological views of the perpetrating authorities (Charney, 1986; Suedfeld, 1990). Studies indicate that people under social pressure are able to participate in, or permit, the suffering of others despite torture being considered the most extreme act of violence that diminishes another human being (Asch, 1956; Kellaway, 2003; Kosteljanetz & Aalund 1983; Miles, 2009; Milgram, 1963; Nordgren, Morris Mc Donnell, & Loewenstein, 2011; Suedfeld, 1990). Charny (1986) recognizes this fundamental betrayal of professional ethics when he writes; “The awesome facts of the Holocaust render exiting models and values of virtually all disciplines nearly meaningless’ (Charny, 1986, p.144).

The Psychology of Torture and Pain

The definition of torture does include severe physical pain which consequently damages internal parts of the body and results in long-term physical pain (Williams, Pena, & Rice, 2010). The definition also includes the infliction of mental pain (Donnelly & Diehl,

2011; Herman, 1992). Scarry (1985) describes three simultaneous phenomena when describing the infliction of pain through torture. The first is the infliction of pain where the individual experiences overwhelming suffering, more empathetically real than any other human experience. However, it is almost invisible, unfelt and unknown to anyone but those closest to the victim. Frequently, those who are close to the victim are forced to witness the torture so as to inflict even greater pain on the victim (Klein, 2008).

Scarry's second phenomenon is the objectification of pain. That is, the internal feeling of the pain experienced by the victim which may be similar to the suffering of a victim from burns, cancer or a stroke. However, Scarry (1985) tries to differentiate the pain of burns or cancer from that pain experienced in torture by using eight elements to describe the specific nature of the pain suffered in torture. These elements are:

- (1) Aversion towards the torturer;
- (2) The loss of control over oneself from the pain of unknown objects entering the body; for example the 'picana' (see Table 2.1 above);
- (3) Forcing of the victim to attend to the most intimate and interior parts of the body, for example, through the application of sexual torture;
- (4) The destruction of the self, where the victim is totally humiliated in front of other torturers or in the presence of relatives or friends. Such examples are forcing the victim to apply electrical shocks to his friend or relative or forcing sexual abuse between victims (Klein, 2008);
- (5) Torture aspires to destroy language by manipulating the victim's language, and by placing words in his mouth in order to fabricate a confession. Sounds of agony become silent, the torturer controls when the victims can cry, when they can speak and what they speak;
- (6) The loss of perception and sensory deprivation when blinding pain takes away the ability to simply see the surroundings;
- (7) The totality of pain built on the first six elements where nothing is visible or audible, nothing can be touched or tasted or smelled; and
- (8) The worst part of the experience, when, without visible injury, the torture is unrecognized by others. Often, following the torture experience, the victim is kept in isolation until his/her physical marks are no longer present on his/her body (Hauksson, 2003). At this point the experience of torture is denied by authorities (Donnelly & Diehl, 2011). This refusal to acknowledge the pain, the torture, can be seen when the victim tries to tell his/her story and he/she is not believed as there are no physical marks to prove this physical and

psychological pain. The lack of acknowledgment and recognition of the experience becomes a negation and rejection. This continues for the survivor as he faces the real world outside the torturer's environment and tries to re-enter society (Klein, 2008; Robertson, 2000; Scarry, 1985)

Scarry's third phenomenon, and the ultimate goal of the torturer, is the translation of these eight elements of pain into the insignia of power; a conversion of the human suffering into a symbol of a regime's power and into a sense of enjoyment for the torturer (Scarry, 1985). This sense of enjoyment was described earlier by Herman (1992) and Scott (1995) when recounting the perpetrator's sadistic enjoyment at seeing the victim suffer and feeling their power and control over the individual. Foucault (1977) also discusses the concept of torture as a technique used to inflict pain in the development of control and power. He uses the term 'supplice' to describe torture, as a barbarous and cruel form of corporal punishment. This term has no direct translation into English that fully captures the extent of the physical and psychological pain. It describes infliction of systematic pain, the totality of torture in all its barbaric forms. The experience of torture is that of being alive, yet in a living hell.

“. . . torture is the act of maintaining life in pain, by subdividing it into a 'thousand deaths', by achieving, before life ceases "the most exquisite agonies" (Foucault, 1977, p.34)

Torture can make the individual lose touch with their surroundings, identity, personal values and reality. Torture is the degradation of the individual to their minimum level of identity (Perdomo, 1987; Scarry, 1985; Wilson, 2004). The Argentinean military regime, during the 1970s and 1980s, was well known for removing the children during the torture of their parents, not just to torment the victim but also their relatives and friends, by either killing the children and leaving the parents to live or by killing the mothers after giving birth and giving their children for adoption around the world. This was well documented by the

‘Mujeres de Plaza de Mayo’ who were the grandmothers who fought for decades to find their grandchildren (Arditti, 1999; Klein, 2008).

By these means torture aims to instill fear throughout the community, resulting in the disconnection of individuals from their culture, and creating a sense of apathy against retaliation (Foucault, 1977; Kira, 2002; Klein, 2008; Scarry, 1985). A further example of the use of torture to spread and instill fear was during the military dictatorship in Chile (Klein, 2008; Robertson, 2000). Many members of the Chilean society were subjected to torture, some of whom were not necessarily opposed to the military regime. The people subjected to torture included priests, teachers, farmers, doctors and children (Klein, 2008; Robertson 2000). A personal observation of this occurred during a visit by this researcher to a group of political prisoners in Valparaiso, Chile, where she was approached by one of the prisoners (Thompson, 1986). In desperation he begged for help, stating that he had no understanding of what was happening and that he had just been through 15 days of torture. He implored her to intervene on his behalf and convince the authorities that he was simply a Catholic working man with no political allegiance. His authenticity was evident in his fear of the other prisoners who were incarcerated for political reasons. A consequence of this type of fear resulted, for many Chileans, in a loss of connection to the community, mistrust, and an inability to be involved in political/community life, which included decision-making in activities that might affect their local community (Klein, 2008). Trust in normal social relationships was thereby damaged (Klein, 2008; Lira & Castillo, 1991).

Psychological Consequences of the Infliction of Pain and Suffering

The infliction of pain and suffering resulting from torture, sexual abuse, unexpected incidents and war experiences, have long been known to cause psychological consequences (trauma) (Donnelly & Diehl, 2011; Healy, 1993; Scarry, 1985; Valent, 1999; Yealland &

Buzzard, 1918). There have been historical and cultural changes in the way these psychological consequences manifest and present themselves as interpreted by clinicians and researchers over time (Healy, 1993; Herman, 1992; McNally, 2004; Valent, 1999; Watters, 2010). Symptom presentations may have been influenced by the major psychological and psychiatric teachers and theorists of the time, e.g., Charcot and Freud. Earlier, hysteria and dissociation were diagnoses given to describe a group of symptoms that have no physiological explanation, e.g., blindness, following war or rape. More recently symptoms are described within the context of panic disorder and PTSD, particularly in the light of war experiences (APA, 1994). Symptoms presented by individuals who have experienced catastrophic events have also been shown to be significantly influenced by their religious beliefs and cultural traditions which influence and shape their meaning to these catastrophic events (Kelly, 1955; Janoff-Bulman, 1992; Tol et al., 2007; Watters, 2010). Likewise mental health diagnoses are influenced by culture. PTSD is an example of the domination of Western culture, particularly that of the USA (Watters, 2010).

‘Trauma’ is a Greek word meaning ‘wound’, ‘a penetration of the body’, as in the case of a bullet or knife entering the person (Deutscher, 2007). It was a word used to describe the physical blow to the body resulting in physical pain and damage (Donnelly & Diehl, 2011; Healy, 1993; Scarry, 1985; Valent, 1999). The ancient Greeks and Romans developed the first hospitals to treat physically wounded soldiers. However, it was not until the end of the nineteenth century that psychological damage was thought to result from terrifying life events (Herman, 1992).

Attention was first given to psychological damage resulting from traumatic events such as war, during the seventeenth and eighteenth centuries and was referred to as ‘hysteria’ and this included what we now recognize as conversion disorder and dissociation (APA,

1994). William Cullen in 1785 described 'neurosis' (e.g., hysteria) as the disturbance to nervous functioning reflected in muscle fiber that are sensitive to internal or external stimuli (Healy, 1993). David Hume in 1780, following the introduction of reflex theory, argued that what is in our mind and what we see and remember result from association (Healy, 1993). In the next century, Bain (1855) proposed that association theory alone could not explain the complexity of human functioning. He stated that both the reflex and the association theory needed to be considered together, giving birth to scientific psychology. Charcot in 1857 argued that witnessing accidents or experiencing anything that shocks the individual, such as physical and sexual abuse, can lead to paralysis, loss of voice or vision, which are all common symptoms of hysteria (Herman, 1992), known now as conversion disorder (APA, 1994).

The concept of 'disassociation' resulting from experiences such as sexual abuse was introduced to explain memories or ideas that are either integrated or not through a process of association within the victim's mind (Dale et al., 2010). This integration either results in positive feelings if the memories or ideas were integrated or high anxiety if they were not integrated. Krishaber, in 1873 insisted that following a traumatic experience, disassociation leads to depersonalization (Healy, 1993). These symptoms, the "splitting of thought processes into compartments", were identified as dissociation in Pierre Janet's work in 1923 (Dale et al., 2010, p. 159). The concept of 'hysteria' resulting from external catastrophic events such as war, accidents and natural disasters was taken more seriously and was widely recorded (Healy, 1993). The first railway line opened in 1830 between Liverpool and Manchester and the first train accident occurred shortly after. People who survived presented with paralysis, blindness and deafness but they had no organic lesions (i.e., they had conversion disorder). Insurers began to focus on these conditions and it was referred to as 'traumatic neurosis', the first recorded cases of post-traumatic neurosis but they took the form of conversion disorders.

From a theoretical perspective during the 1890s and early 1900s, dissociation and hysteria were perceived as common sequelae from events such as war. Sigmund Freud in the 1890s, defined repression as the ‘warding off from conscious awareness of that which is painful’ following a traumatic experience (Dale et al., 2010; Healy, 1993). Freud disagreed with the concept of disassociation and argued that traumatic memories became isolated through a process of repression resulting in hysteria (Dale et al., 2010). Herman (1992) also stated that the repression or denial of experiences of sexual abuse, torture, and violence result in the victim feeling guilty, shameful, worthless, betrayed, and unlovable. The isolation and distrust that results can send him/her into a state of hysteria (Herman, 1992).

Varying war experiences had long produced a wider range of symptoms in different historical periods. In 1678 Johannes Hofer introduced symptoms which he called melancholia (akin to depression today) that were used to describe the psychological problems of Swiss soldiers serving in France (Valent, 1998). Da Costa in 1871 referred to ‘irritable heart’, known also as the Da Costa’s syndrome, relating to the psychological sequelae of soldiers serving in the American Civil War (Healy, 1993). More recently, coronary and gastrointestinal symptoms have been the main somatic symptoms found to result from a traumatic experience, such as those experienced during war. Perhaps these are more akin to symptoms identified in the anxiety disorders of today (Janoff-Bulman, 1992; Valent, 1998).

The term ‘battle neurosis’ was used initially in World War 1; however this concept was not new, in fact it was first described in the battle of Marathon in 490BC. A well known Athenian soldier presented with loss of sight and yet nothing had touched him, again perhaps indicating a conversion disorder (Healy, 1993). Later in the First World War this hysteria was called ‘shellshock’ in the belief that exploding shells caused the condition which included loss of sight or hearing, aphonia and paralysis (Healy, 1993). Yealland and Buzzard

(1918) referred to these symptoms as hysterical disorders of warfare or as described in the DSM III (APA, 1980) conversion disorder. Soldiers described their experience as if everything were on a stage and there was an awareness that something was happening but they were not quite there. This seems to be derealization - a dissociative process which includes the out-of-body experience of near death (Dale et al., 2010; Healy, 1993; Valent, 1998; van der Kolk, 1987). Such an experience is recorded by Keenan (1993) from his imprisonment in Beirut where he felt as though the experiences were not real but he read of them in his diary: "Yet it was so and I could not deny what my diary revealed to me" (Keenan, 1993, p. 81). It was estimated that in World War 1 a quarter of a million British soldiers were affected (Healy, 1993) and that war stress was clearly the cause of the neurosis (mostly dissociation and somatoform disorders) and the neurosis demanded psychological treatment, rather than punishment.

During the Second World War it was necessary to relearn the lessons of the First to deal with the larger number of combat-related illnesses being presented. The understanding of the nature of combat stress evolved, and there was recognition of the importance of morale. It was seen that combat stress related to overlapping factors, such as the intensity of the threat of death, the duration of the combat exposure, the number of comrades killed and the morale of the unit. A large psychological literature resulted (Healy, 1993). For the first time, close attention was given to the psychological sequelae in returned soldiers (Healy, 1993). It was soon clear that combat neurosis did not stop with combat or even with the ending of the war (Healy, 1993; Valent, 1998). Returning soldiers could become aggressive, psychotic and suffer from psychosomatic or depressive symptoms. These symptoms were of a greater range than reported in earlier periods and were no longer confined to hysterical or dissociative presentations. These symptoms could be extremely vivid and often merged with various personality and psychiatric disorders (Valent, 1998; van der Kolk, 1987). In the

Vietnam conflict old lessons had to be re-learned yet again, but for the first time documentation was widespread (Healy, 1993; Valent, 1998). The vulnerability of all combat soldiers to severe psychological stressors and consequent illness was now recognized. After the Vietnam War, pressure from the returned service community led to the diagnosis and acknowledgement of Post-Traumatic Stress Disorder (PTSD) rather than war neurosis or shellshock. This had now become associated with trauma and was recognised as a psychiatric disorder (Valent, 1998).

The DSM-I (APA, 1952) recognised traumatic neurosis and was followed by the DSM-II (APA, 1968) which associated trauma-related disorders of adult life (Davidson & Foa, 1992). PTSD was introduced in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III, APA, 1980) as a series of symptoms caused by external events that resulted in trauma. Previous to the introduction of traumatic neurosis, the traumatic event had been associated with war experiences as described above. PTSD was then seen to result from a catastrophic stressor other than war, but outside the ordinary range of human experience. PTSD was then formally recognised in the DSM-III (APA, 1980), and further revised in the DSM-III-R (APA, 1987). By the time PTSD was defined in the DSM-III-R there were clearly five main criteria that an individual had to meet to be given that diagnosis. These diagnostic criteria were:

- A. Having experienced an event that is outside the range of usual human experience.
- B. The traumatic event is persistently re-experienced which is identified in at least one of four different ways, for example, recollections, dreams, feelings of reliving the experience.
- C. Avoidance of stimuli associated with the trauma, as indicated by at least three of the seven criteria, for example, avoidance of thoughts and activities associated with the trauma, inability to remember certain aspects of the trauma.
- D. Persistent symptoms of increased arousal, as indicated by at least two of six criteria, for example staying awake at night, difficulty concentrating and outbursts of anger;
- E. The individual experiences the symptoms for at least one month.

Numerous events which result in the symptoms described by the criteria, such as war, sexual abuse, natural accident, were then recognized, as also being experienced by children, with long and short term effects, hence further revision led to the DSM-IV (APA, 1994) revised criteria. The main changes in the criteria were in criteria A and F. These changes were: Criteria A: 'The person has been exposed to a traumatic event in which both of the following have been present: 1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others. 2. The person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behaviour. Criteria F: The traumatic event caused clinically significant distress or dysfunction in the individual's social, occupational, and family functioning or in other important areas of functioning' (APA, 1994, p. 427-428).

The individual's response, following a traumatic life event, has been broadly described in two defined areas: 'avoidance'; denial, numbing and 'intrusion', unbidden thoughts and images (Sundin & Horowitz, 2002). The avoidance phase can last from weeks to months; however, a maladaptive avoidance may occur, which may last for years. Symptoms related to avoidance include: daze, amnesia, inability to visualize memories, inflexibility of thought, sleep disturbances, withdrawal from activities, and tension responses resulting in fatigue and headaches (Sundin & Horowitz, 2002). More common is the intrusive phase of vivid images, despair, anxiety, flashbacks and nightmares. Sundin and Horowitz (2002) include the following as intrusive symptomatology: hypersensitivity to associated events, startle reactions, intrusive repetitive thoughts, and emotions, distracted concentration, recurrent dreams and chronic arousal.

Watters (2010) argues that by being too focused on the diagnosis of PTSD when trying to understand reactions to events that are out of the individual's control, their coping abilities are minimised and their cultural characteristics, that assist in the individual processing of the experience, are ignored. Janoff-Bulman, (1992) and Watters (2010) emphasise that the meaning given by survivors to different traumatic events can have a major impact on the individual's positive or negative psychological processing and hence integration of the experience. Watters (2010) points out that the diagnosis of PTSD does not take into account the ongoing violence that can continue to impact on the population other than the unexpected experience he/she has just lived through. Nor does it take into account the "multiplicity of ways people and societies live through massive trauma, express their distress and suffering, and assign meaning to the human experience" (Watters, 2010, p. 104).

There are distinct limitations to the single approach of this one diagnosis (Janoff-Bulman, 1992; Herman, 1992; McNally, 2004; Turner; 2000; Thompson & McGorry 1995; Watters, 2010; Wenzel, Griengl, Stompe, Mirzael, & Kieffer, 2000). Traumatic experiences might result in conditions such as depression, anxiety, complicated bereavement; they can destroy the construction of self; and they can result in physical conditions (Janoff-Bulman, 1992; Hauksson, 2003; Herman, 1992; Watters, 2010; Wenzel et al., 2000). Traumatic experience can lead to intense fear when the world of the individual or community is shattered with terror (Janoff-Bulman, 1992, Kordon et al., 1992), that is the experience leaves the individual, and the broader community, with the realization that his/her world is no longer safe (Janoff-Bulman, 1992; Herman, 1992; Kordon et al., 1992). Janoff-Bulman (1992) described anxiety following a traumatic event: "as an expectation of danger, a danger that is neither immediate nor necessarily well defined. Anxiety is fear" (Janoff-Bulman, 1992, p.65).

Depression as a diagnosis also has a historical development and was associated with melancholia as stated earlier. Freud associated melancholia with mourning resulting from the loss of relationship from death of a loved one or break-up of relationships. The symptoms were described as a decline in self worth, a feeling of self blame for what went wrong, a feeling of inferiority and loneliness. The DSM-I (APA, 1952) defined these symptoms as a depressive reaction and DSM-II (APA, 1968) as a depressive neurosis resulting from a reaction to internal conflict or an identifiable event. Depression was either seen as a biological condition or reaction to an external traumatic event (Parker, 2000; van der Kolk, 1987). It has been found more recently that depression is very common among torture survivors and frequently found concurrently with PTSD (Jaranson et al., 2001). Further, Herman (1992) has argued that PTSD alone fails to capture the magnitude of the symptoms manifested in 'survivors of extreme situations'. Their symptoms are not like those with ordinary psychosomatic disorders and their depression and the degradation of their identity are of a different order as well. That is, PTSD fails to incorporate depression, depersonalization, different types of anxiety, changes in personality, alterations of self perception, withdrawal from significant others, and alterations in meaning and trust in families, friends and government institutions. Consequently she proposes naming the syndrome 'Complex Post Traumatic Stress Disorder' (Herman, 1992, pp.118-121).

Conclusion

This Chapter has covered a historical account of torture, and a description of its techniques. It also has reviewed the history of trauma and the relationship between catastrophic events such as war, natural disasters and sexual abuse and symptoms that has led to diagnoses such as neurosis, hysteria, melancholia, disassociation and depersonalization. More specific to war these diagnoses have been referred to DaCosta's syndrome, battle neurosis, shellshock and more recently PTSD (Hauksson, 2003; Herman, 1992). A debate generated since the late 1990s has been concerned with the adequacy of Post-Traumatic Stress Disorder (PTSD) as a diagnosis to explain the physical and psychosocial consequences following an event such as war. Forcing various symptoms into a single diagnosis such as PTSD has instigated a debate where it is argued that this diagnosis is limited in encompassing the vast consequences of traumatic experiences and equally fails to recognise resilience (Herman, 1992). More recently there has been an increase in the literature about the consequences of torture resulting in PTSD. This literature is reviewed in Chapters 3 and 4 and the argument by some clinicians as to the limitations of this diagnosis to describe the consequences of torture is also considered in this review.

Torture does not come in isolation; often it is accompanied by a number of different abuse experiences such as forced displacement, the disappearance of loved ones and the added experience of forced migration and seeking asylum resulting in complex posttraumatic stress (Herman, 1992). Whilst society has changed and the objectives of torture are broader, the desire to torture in the contemporary 'civilized' world has continued (Amnesty International, 2011; Kellaway, 2003; Kosteljanetz & Aalund, 1983; Robertson, 2000; Scarry, 1985; Scott, 2003). Torture remains today an act of violence adopted within a system, it is applied systematically and secretively as an instrument of repression and oppression that may be traced back to ancient Greece.

In modern times there are well documented atrocities in Nazi Germany, under the Soviet Union, during the Algerian war, under the South American dictatorships and during the period of the disintegration of Yugoslavia. Most recently, we have learnt about the use of torture of Iraqis in Abu Ghraib, and by the United States in Guantánamo Bay and by way of rendition to Egypt, to Iraq and to Afghanistan (Klein, 2008; Robertson, 2008). The definition of torture, its purpose and its techniques, have changed over time, but there is continuing debate as to what constitutes torture and even in the research field, what is causing the psychological damage. There are questions also about whether the torture itself is having the psychological impact or other pre-existing or subsequent traumatic experiences (Hollifield et al., 2011). Regardless of the academic debates, torture remains the most brutal means of attempting to obtain information and to maintain absolute control.

Torture survivors have experienced multiple traumas which can result in more complex consequences such as anxiety, depression, PTSD and the possible added physical consequences that result in an even more complex group of symptoms (see Chapters 3 and 4 for further review of this issue). Secondly, not all survivors of war and other catastrophic experiences such as sexual abuse and natural disasters experienced symptoms described by PTSD or depression and anxiety, as they are able to find meaning and process the experience in a way that leaves them symptom free. This too can be the case with survivors of torture and other systemic abuse (see Chapter 5 for more on this issue). The danger with too readily offering a diagnosis of PTSD when examining the consequences of torture, is that firstly, it might not fully cover the symptoms experienced by the person, nor secondly, fully acknowledge the horror of torture and the suffering that results. For those who do not meet the criteria for PTSD, the risk is that the experience of torture and other systemic abuse may not be validated. That non-validation can lead subsequently to more complex consequences such as depression and anxiety (Hauksson, 2003; Watters, 2010).

Chapter 3

Review of Studies Reporting on the Psychological Consequences of Torture and Other Types of Systemic Abuse

Introduction

As discussed in Chapter 2, the use of torture for the purpose of obtaining information and instilling fear into both an individual and a society has long been a feature of human history (Donnelly & Diehl, 2011; Klein, 2008). However, research into the psychological impact of torture only began in the late 1970's (Allodi & Cowgill, 1982; Başoğlu et al., 2001; Campbell, 2007; Lira & Castillo, 1991, Quiroga & Jaranson, 2005). The forced migration (see Chapter 4 for more detail on forced migration) that has resulted from continued world conflict and the practice of torture, has led to an increasing amount of research and the development of health services for refugees (Reid, Silove & Tarn, 1990). Discussion and debate about the inevitability of symptomatology, and the limitations of the PTSD diagnosis following the experience of torture continues (e.g., Ehrenreich, 2003; Hollifield et al., 2011; Steel et al., 2009; Tol et al., 2007; Watters, 2010). Chapters 3 and 4 review the research investigating the complex psychological impact of torture since the late 1970's outlining the discussion related to the limitations of the PTSD diagnosis for torture survivors and the refugee population.

To retrieve the selected literature presented in this chapter and Chapter 4, a series of searches using Super-Search (Medicine Dentistry + Health science-psychology and psychiatry) was conducted using the terminology: ‘psychological impact of torture +/-or consequences of torture’ and ‘sequelae of torture’. As the references were reviewed from the different data bases, many of these articles were repeated across the various data bases in SuperSearch. The combined number of papers obtained from these searches was 1251 for PsychINFO, 42 for PubMed, and 1101 for SCOPUS. The years covered in the search were between 1970 and 2011. Further refined searches adding ‘posttraumatic stress disorder and torture,’ resulted in 1217 more papers: 427 for PsychoINFO; 0 for PubMed; 790 for SCOPUS. Those selected for discussion were research articles specifically focusing on the psychological and physical consequences of torture. Excluded from the review were: general discussion papers which did not include this specific focus, papers that repeated findings from previous research already documented in text books or journal articles, papers specific to treatment modalities, papers that focused on children, war veterans or combat soldiers. A total of 44 papers were selected which reported first person accounts or empirical data derived from quasi-experimental trials. Whilst the breadth of studies included in this review is comprehensive it does not purport to be exhaustive. Various literature reviews have been undertaken which look at physical and mental health consequences of torture and other systemic abuse which have extensively documented research in this field (e.g., Başoğlu, 1992, 2009; Gerrity, Keane, & Tuma, 2001; Murray, Davidson, & Schweitzer, 2008; Quiroga & Jaranson, 2005; Steel et al., 2009; Tol et al., 2007).

This chapter excluded studies that focused on the psychological consequences of seeking asylum and being placed in a detention centre in Australia. The literature involving the psychological impact of being an asylum seeker in Australia is specifically reviewed in Chapter 4. The present chapter reviews papers that are indicative of the level of physical

and psychological sequelae resulting from the experience of torture.

Previous research into torture has focused on psychiatric symptoms, drawn from case reports and predominantly from case series. Case reports are first-person accounts of the experience of torture (see Table 3.1.). Examples of this type of research include: Cathcart et al., (1979); Doerr-Zegers, Hartmann, Lira, and Weinstein (1992); Gorst-Unsworth, (1992); Hinshelwood (1999); Knight (2006) and Ritterman (1985). Literature reviews have indicated that a number of case reports have been published on the study of torture survivors (Mollica, 1992, 2011). Mollica (1992) stated that case reports that obtain a clinical history of survivors of torture can “reveal considerable knowledge of the changing influence of torture on the life experience of individuals, family and communities” (Mollica, 1992, p. 29). Case series (which is the design format most adopted in the clinical literature investigating the consequences of torture) include a larger sample of cases describing the presentation of survivors (see Table 3.2). Research using this design varies as to the sample number and the constitution of the sample, for example, whether the sample comprised torture survivors or refugees in general. These assessments used psychometric scales and clinical diagnostic criteria, but the researchers ran the risk of not obtaining adequate information about the torture experience itself unless they conducted thorough structured interviews as well (Mollica, 1992; Watters, 2010).

In this chapter, 18 case series studies were included for review (see Table 3.2). Twelve out of 18 included torture survivors only as their target population. (These studies were: Allodi et al., 1985; Allodi, Berger, Beyersbergen, & Fantini, 1986; Allodi & Cowgill, 1982; Carlsson et al., 2006; De Zoysa, & Fernando, 2007; Domovitch, Berger, Wawer, Etlin, & Marshall, 1984; Hooberman, Rosenfeld, Lhewa, Rasmussen, & Keller, 2007; Kagee, 2005; Rasmussen & Lunde, 1980; Somnier & Genefke, 1986; Schweitzer, Melville, Steel & Lacherez, 2006; Tol et al., 2007). Six out of 18 studies included ‘refugees’ without

classifying them into groups such as torture survivors or survivors of other types of systemic abuse (included were: Başoğlu, Livanou, & Crnobaric, 2007, Kinzie, Fredrickson, Ben, Fleck, & Karls, 1984; Mollica, Wyshak, & Lavelle, 1987; Rasmussen, Smith, & Keller, 2007; Rasmussen, Reeves, Rosenfeld, & Keller, 2007; Sachs et al., 2008).

Very few controlled studies have been conducted where the level of psychological distress resulting from the experience of torture has been measured. Studies using a 'quasi-experimental design' where comparison is made between two groups such as torture survivors and survivors of systemic abuse, have included those by Holtz (1998), Paker, Paker, and Yuksel (1992) and Shrestha et al. (1998). Survivors of other types of systemic abuse in these studies act as the control group when they are compared to the torture survivor group.

As discussed by Başoğlu et al. (2001), Campbell (2007), Hollifield et al. (2011), Quiroga and Jaranson (2005) and Steel et al. (2009), torture does not come in isolation, that is, torture survivors have also experienced other types of systemic abuse. To control for these other experiences a third group is introduced, a group that has not experienced any systemic abuse. Studies including a comparison between survivors of torture, survivors of other types of systemic abuse and a control group (people who have not experienced systemic types of abuse) have been undertaken by Başoğlu et al. (1994) and Thompson and McGorry (1995).

In line with design and methodological considerations, the papers selected for review were summarised in more detail under three headings: (1) case reports where interviews, structured or otherwise, were conducted but no psychometrically-validated measures of psychiatric symptomatology were employed; (2) case series where interviews, whether structured or unstructured, were conducted and standardised psychometrically validated scales measuring psychiatric symptomatology were employed; and (3) quasi-experimental

studies which included two- or three-group comparisons. Studies in each of the three categories are briefly summarised under specific headings including the number of participants, assessments adopted, results and main points drawn from their discussion.

Case Reports on the Psychological Impact of Torture

Table 3.1 summarises six case studies that explored the techniques of torture and the physical and psychosocial consequences of torture. None of these studies used standardised measures of psychiatric symptoms; however, they all used either structured or unstructured interviews. Table 3.1 begins with studies or reports from the late 1970's when many of the Latin American countries were experiencing changes of governments and torture was implemented as an instrument of state punishment (Klein, 2008; Lira & Castillo, 1991; Doerr-Zegers et al., 1992; Robertson, 2000). Many people were forced into exile and concern grew amongst clinicians in Canada, Denmark, England and the USA about the physical and psychological wellbeing of these people (Cathcart et al., 1979; Gorst-Unsworth, 1992; Hinshelwood, 1999; Ritterman, 1985).

Participants.

It can be seen from examination of Table 3.1 that the participants represent a range of countries. Historically, between the late 1970s and mid-1980s, the research participants were mainly from Central and South America (Cathcart et al., 1979; Doerr-Zegers et al., 1992; Ritterman, 1985). Later research, through to the present time, includes participants from other countries such as Iran and Zimbabwe (Gorst-Unsworth, 1992; Hinshelwood, 1999; Knight, 2006). The number of participants also differs, with three of the six studies based on one single case report (Gorst-Unsworth, 1992; Knight, 2006; Ritterman, 1985). Two included two

case reports (Doerr-Zegers et al., 1992; Hinshelwood, 1999) and one included 11 case reports (Cathcart et al., 1979).

Assessments.

The assessment adopted in the case reports shown in Table 3.1 was based on structured interviews (Cathcart et al., 1979; Doerr-Zegers et al., 1992; Hinshelwood, 1999; Knight, 2006; Ritterman, 1985). Various types of structured interviews were administered, all of which included an account of the participants' history of torture and other trauma. Three of these six studies used an in-depth interview technique known as 'testimonies' (Cathcart et al., 1979; Ritterman, 1985).

A testimony is an account of the torture process, the types of torture in a given situation. It is defined as:

The act of revealing to a sympathetic listener or group of listeners, making public exactly what the torturer did to privately shame the victim with the aim of elevating the victim to his or her previous position of responsible political activism and to put her or him in the position of humiliating the perpetrators (Ritterman, 1985, p. 53).

Testimonies have been used as a psychotherapeutic process for treating torture survivors since the 1970s, and they also allow documentation and possible gathering of evidence against those who perpetrated the abuse (Agger & Jensen, 1990; Cienfuegos & Monelli, 1983). Perera, Puvimanasinghe, and Agger (2009) referred to testimony as a tool that facilitated the reconstruction of their clients' autonomy and sense of self-esteem. Cienfuegos and Monelli (1983) stated that the purpose of this exercise was "to transform the person's story about shame and humiliation into a public story about dignity and courage" (p.79).

In the remaining three studies, a clinical structured interview that resulted in a clinical diagnosis was adopted. The structured interview either corresponded to the DSM-III (APA, 1980) or the DSM III-R (APA, 1987) Diagnostic Interview Schedule (Doerr-Zegers et al., 1992; Hinshelwood, 1999; Knight, 2006). These interviews additionally incorporated a clinical interview that examined major depression and PTSD symptoms using the PTSD criteria of the Diagnostic Interview Schedule DSM-III or DSM III- R (Robins, Helzer, Croughan, & Ratcliff, 1981). One of these three studies included assessment for changes in personality (Doerr-Zegers et al., 1992). Two of the six studies in Table 3.1 included a medical examination (Cathcart et al., 1979; Doerr-Zegers et al., 1992). One of the six studies specified that a psychiatrist and/or a psychologist conducted the interview (Cathcart et al., 1979).

Results.

Throughout this 30-year period when the studies in Table 3.1 were conducted, the techniques used in torture events remained similar worldwide. These were discussed in Chapter 2. The torture that the participants reported in these particular studies were: cigarette burns, submersion under dirty water, electrical shocks, fractures, the 'telephone', food deprivation, hanging from hands or fingers or legs (the parrot) for long hours, interrupted by blows to different parts of the body, e.g., beating to the lower back; sexual torture including rape, both hetero- and homosexual; rapes by trained animals; and electrical shocks applied to the genitals. Additionally, some victims experienced insults relating to their political or religious beliefs, or comments aimed at breaking the trust of the victim, for example, being told that a relative or close friend had denounced them (Cathcart et al., 1979; Doerr-Zegers et al., 1992; Hinshelwood, 1999).

Further psychological torture included: mock execution; forced vacation of his/her home; harassment - such as anonymous death threats by telephone; destruction of property; forced witnessing of others being tortured; forced witnessing of sexual assault on others or forced rape of another survivor; forced undressing in the presence of others; being deprived of sight by being blindfolded from the time of detention; forced to be in confined spaces with light deprivation; being prevented from sleeping by introducing random noise or disturbances; and being placed in situations which put the victim's life in actual danger, e.g., the use of 'Russian roulette' (Doerr-Zegers et al., 1992; Gorst-Unsworth, 1992; Hinshelwood, 1999; Knight, 2006).

Physical and psychological consequences of torture.

The symptoms resulting from these techniques are both physical and psychological, irrespective of the nature of torture. Specific physical consequences were reported in three studies. They included: motor dysfunction, lumbar spine abnormalities, skin lesions, hearing deficit, geno-graphic evidence of fractures, trauma to teeth, joint abnormalities, inverted nipples, displaced fingers, obstetric and gynaecological issues such as child birth resulting from rape, headaches, pain in the arm or/and legs, back pain, palpitations, chest pain and abdominal pain, and menstrual dysfunction. Men and women suffered genital and anal discomfort following sexual abuse (Cathcart et al., 1979; Hinshelwood, 1999).

The psychological impacts of torture resulting from these techniques are variable. Some of the psychological consequences described by researchers include: insomnia with recurrent nightmares, anxiety, depression, irritable outbursts, impulsive behaviour or social withdrawal, loss of concentration or attention, confusion and disorientation, avoidance and intrusive thoughts (Cathcart et al., 1979; Doerr-Zegers et al., 1992; Gorst-Unsworth, 1992; Hinshelwood, 1999; Knight, 2006; Ritterman, 1985). One study reported on PTSD based on a

clinical interview for PTSD. Knight (2006) using the DSM-IV diagnosis for PTSD, assessed a Zimbabwean refugee. The researcher concluded symptoms of PTSD were present, accompanied by intense fear, helplessness and emotional numbing and loss of hope. This person had not experienced torture but was witness to mass destruction, violence and forced displacement. The researcher interviewed the individual before and after leaving his home country and concluded the symptoms were no different before or after leaving his country.

Other psychosocial consequences reported in the case studies in Table 3.1 were: difficulties in establishing relationships, inability to trust, inability to enjoy life, language difficulties, isolation, family and social problems resulting from not being able to find employment, loss of occupational status, marginalisation, deculturation and refugee disorientation (Doerr-Zegers et al., 1992; Hinshelwood, 1999). Gorst-Unsworth (1992) added to the list of psychosocial consequences: unemployment, qualifications not being recognised, breakdown of marriage, and refugee status - all of which led to low self-esteem. Gorst-Unsworth (1992) stated that shame is also a major consequence, which was also observed by Hinshelwood (1999). The factors contributing to a sense of shame included receiving income support from charities, which they had never experienced in their country of origin.

Personality changes were described by Doerr-Zegers et al. (1992) and Ritterman (1985). Ritterman (1985) concluded that torture damaged the person's personality; that is, the person was made to carry guilt resulting from being forced to witness their children being sexually abused, or from being forced to reveal the names of friends or colleagues. They suffered repressed feelings and thoughts and also ambivalence - a sense of not being here or there, resulting from forced migration and being in a situation that feels temporary. Ritterman (1985) defines this personality change with the acronym GRAPH: (Guilt, Repression, Ambivalence, Pessimism, and Humiliation). Doerr-Zegers et al. (1992) and he also stated that

torture made the person distant, indifferent, and emotionally frozen, beyond anxiety and depression.

Hinshelwood (1999), reporting on a case study, highlighted shame resulting from sexual torture as a major obstacle to recovery; often sexual assault is not mentioned by the victim and in this case study the importance of dealing with it, and with the impact it has had on the individual's personality and ability to function, was strongly indicated. The researcher concluded that shame paralyses the individual's ability to function in their everyday life. Hinshelwood (1999) further stated that shame is reinforced in the host country by the use of interpreters, because the person must learn to trust, not only the clinician, but also the third person present at the interview, namely the interpreter.

Advantages and limitations of the case study methodology.

The disadvantages of these examples of case report lies in the nature of the design; that is, they completely lack internal validity (Kazdin, 1982). The very small numbers included do not provide a basis for detailed statistical analysis, and given the greatly varying nature of the torture events themselves, it is difficult to connect particular experiences with the consequences (Kazdin, 1982). Also, there has been no systematic standardised gathering of information within and across the studies such as that provided via structured instruments and psychometrically-validated measures.

However, as stated by Mollica (1992) and Perera et al., (2009), case reports and interview methods, such as testimony, provide a valuable clinical history of torture survivors. The experiences that follow torture and release from imprisonment such as the loss of work, loss of membership of a particular organisation and community and forced migration, can be gathered from a testimony or in-depth interview. Where trust is established, through this

process of interview, a better understanding of the complexity of the impact of torture is obtained (Doerr-Zegers et al., 1992; Perera et al., 2009).

The studies presented in Table 3.1 have mostly been conducted outside the participants' country of origin, forcing researchers to use interpreters. The use of interpreters impacts on the reliability of the information transmitted, that is, on the accuracy of the expression of emotions, or of the nuances of the meanings within a particular language (Gorst-Unsworth, 1992). Shame and mistrust were reported in some of the studies presented in Table 3.1 (Knight, 2006; Ritterman, 1985). These feelings of shame and mistrust can limit the reporting of information from participants to the clinician. The process of information transmission becomes more limited simply by having an interpreter present. Doerr-Zegers et al. (1992) emphasize the issue of trust as a limiting factor on the information gathered. Nevertheless, in-depth interviewing provides a deeper understanding of the complexity of systemic abuse.

The case report studies shown in Table 3.1 have assisted in the development of new research activities in the area of torture sequelae. Their usefulness, particularly at the time when they were conducted, was the gathering of essential information to be used as evidence for legal purposes (Verdugo, 2006; Perera et al., 2009; Quiroga & Jaranson, 2005). The case report studies were used further as a basis for the development of structured interviews, specifically for torture victims, and for developing standardized psychometrically-validated scales to measure the level of psychological distress resulting from the trauma (Mollica & Caspi-Yavin, 1991). The strength of case histories is that they provide greater detail than quasi-experimental studies about the depth and breadth of the impact of torture and systemic abuse on a person's life and daily functioning. This is illustrated in the following case report

example from Doerr–Zegers et al. (1992) who introduced their case summary by first summarising the torture techniques that were practiced in Chile during the Pinochet regime:

During hours and days he/she is locked up in a very small cell, with permanent artificial lighting, and actively prevented from sleeping during at least 48 hours by means of noise disturbances. Then interrogation begins, accompanied by physical torture that can go on without interruption for hours or days...blows in different parts of the body (often mixed with insults in an effort to break political and religious belief, and trust in relatives and friends; victims were told, for example, that relatives and friends had denounced them), application of electric shocks to the more sensitive parts of the body, during which cardiac arrests are not uncommon...hanging in different painful positions for long hours, interrupted by blows..head submersion under water to the limit of resistance...mock executions, sexual tortures such as hetero-and homosexual rapes, or rapes by trained animals and some times in the presence of family members (Doerr–Zegers et al. 1992, p.178)

J was a student of administration in the provincial seat of the University of Chile...he was taken prisoner on the 21st September 1973, ten days after the coup, and remained imprisoned until December 1974. During the first period, he was subjected to all the previously described tortures...he resisted with courage...in the following months symptoms of ‘acute posttraumatic stress disorder’ appeared, but he maintained hope of some day regaining liberty. Among his fellows in prison he was considered as one of the most stable...however when he was discharged from prison, relatives found him very different: distant, indifferent, not moved by anything. From a very

competent and persistent young man he was transformed into an apathetic being, completely unable to face the usual difficulties of life. He dared to seek psychiatric help some years after being set free, with a chief complaint of severe phobias to closed spaces...everything was grey and opaque, including the future; he experienced a great emptiness and a complete distrust of everything and of everybody. The psychotherapeutic treatment succeeded in lightening his phobia but not in restoring his original personality (Doerr-Zegers et al., 1992, p.179).

It has been suggested by clinicians such as Allodi and Cowgill (1982), Doerr-Zegers et al. (1992), Elsass (1998) and Herman (1992) that the various psychiatric symptoms, including personality change and psychosocial consequences of torture, such as those described by Doerr-Zegers et al. (1992), be given a diagnostic label of 'complex posttraumatic stress' or 'torture syndrome'. The complexity of the consequences of torture and other types of systemic abuse are further discussed in the next section of this chapter. This section describes research based on case series where the psychological impact of torture is explored in terms of psychopathology measured by diverse standardised psychiatric scales and clinical interviews.

Table 3.1
Summaries of Case Study Reports Related to the Consequences of Torture

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results/Conclusion	Living in their country of origin/or living in host country
Cathcart, Berger, & Knazan	1979	3 women and 8 male refugees from Chile	In depth history including detailed account of torture, physical and psychological assessment	Torture: physical and psychological	Medical: Neuro-psychiatric disturbances. Physical and psychological distress	Living in Canada
Ritterman	1985	A 28 year old male medical graduate from El Salvador	Testimony technique	Torture: physical and psychological	Destruction of the person's personality	Living in Denmark
Gorst-Unsworth	1992	A 41 year old Iranian asylum seeker refugee.	Clinical assessment using the DSM-III (APA, 1980) diagnosis for PTSD and Major Depression	Torture experience	Diagnosed with PTSD, major depression and psychosocial consequences	Living in the United Kingdom
Doerr-Zegers, Hartmann, Lira, & Weinstein	1992	Two Chilean cases. 1:A male University student taken into prison from Sept. 1973 to December 1974 2:A 50 year old man in prison from Sept. 1973 for 2 years in different prisons	Clinical assessment included change in personality and the clinical diagnosis that corresponded to the DSM-III-R	Torture experienced by both survivors	Personality change and psychological consequences	Living in their home country in Chile
Hinshelwood	1999	Two asylum seekers: 1 male asylum seeker and 1 female asylum seeker. Both presented at the Medical Foundation for the Care of Victims of Torture, England	Clinical notes- testimony	Both experienced torture including sexual torture.	Psychological and psychosocial consequences	England
Knight	2006	A 45 year old farmer from Zimbabwe	Face-to-face semi-structured interview	Forced to vacate his home, harassment, property destroyed, forced to witness house being burned, death threat.	PTSD	Living outside his country

Note: DSM-III= Diagnostic and Statistical Manual of Mental Disorder-Third Edition; DSM-III-R= Diagnostic and Statistical Manual of Mental Disorder-Third Edition-Revised; APA= American Psychiatric Association; PTSD=Post Traumatic Stress Disorder

Case Series Studies Examining the Consequences of Torture and Other Types of Systemic Abuse

Table 3.2 includes 18 case series studies highlighting the physical and psychological consequences of torture. Even though some studies appeared to have used data collected in the early 1970's (i.e., Rasmussen & Lunde 1980), all studies in Table 3.2 were published from 1980 onwards. This reflects the world-wide movement of refugees at the time due to political and religious persecution, as well as the continuing use of torture. In the International Rehabilitation Council for Torture Victims (IRCT, based in Denmark), June 2008 report, more than 140 rehabilitation services for torture survivors were reported to exist globally. These programs are conducted in 73 countries (IRCT, 2008; Mollica, 2011).

The services themselves are partly represented in Table 3.2 as many of the studies were conducted in conjunction with the specialised services for torture survivors, for example, the IRCT in Denmark, where a large refugee population resides. A common observation which begins to be depicted across these 18 studies is the explorations of other traumatic experiences resulting from systemic abuse, such as witnessing people being shot, forced displacement, witnessing relatives or friends being taken away by authorities, witnessing others being tortured, witnessing mass killings, forced labour in concentration camps, religious or political persecution, threat to life and loss of property and house searches by authorities (Allodi et al., 1986; Başoğlu et al., 2007; Carlsson et al., 2006; Domovitch et al., 1984; Hooberman et al., 2007; Kinzie et al., 1984; Mollica, Wyshak, & Lavelle, 1987; Schweitzer et al., 2006; Sachs et al., 2008; Tol et al., 2007). The consequences of exile are also taken into consideration, as are the significance of political activism and strength of attachment to religious tradition (Başoğlu et al., 2007; Kinzie et al., 1984; Sachs et al., 2008; Tol et al., 2007). As per the previous section these studies are described under the following

headings: participants, assessments, results, discussion and reflections on results and finally advantages and disadvantages of these studies.

Participants.

Studies presented in Table 3.2 used a larger number of participants than those shown in Table 3.1, with sample sizes ranging from 13 to 769. Fourteen out of the 18 studies took place in the country in which the participant had been living as a refugee, for example, they took place in Canada, USA, Denmark, Australia, or India. The regions which the participants had left due to persecution, included Central and South America, Greece, Africa (part of Africa not specified), Vietnam, Cambodia, Laos (Hmong), Iraq, Afghanistan, South Africa, Sudan, Sri-Lanka (Tamil), Iran, India (Punjabi), Nepal, Turkey, and Tibet. Three studies took place in the participants' country of origin, for example, the De Zoysa and Fernando (2007) study took place in Sri-Lanka.

Assessments.

Over the course of the last 30 years, the research assessment method has become more complex with the introduction of psychometrically standardised measures. Fifteen of the 18 studies included semi-structured interviews and 11 of them administered standardised measures that were consistent across the studies (see Table 3.2). In addition to these 15 studies, the three remaining studies varied in their method of assessment: one used a community consultation process, whereby torture survivors were interviewed in a group setting (Allodi et al., 1986) and two used a questionnaire (Allodi et al., 1985; Domovitch et al., 1984). The questionnaire evolved from interviews conducted at the Canadian Service for

Torture Survivors and the Danish Medical Centre for Torture Survivors. Domovitch et al. (1984) described this questionnaire as consisting of 182 questions about demographic data, details of torture and imprisonment, and medical and physical history.

Nine out of the 18 studies shown in Table 3.2 included standardized scales. One study (Sachs et al., 2008) included the Symptom Checklist-90 (SCL-90-R, Derogatis, 1983) and the Impact of Event Scale (IES, Horowitz, Wilner, & Alvarez, 1979) was administered in one of the studies (Kagee, 2005). Out of the 18 studies shown in Table 3.2, the Hamilton Depression Scale (HDS) was used once by Carlsson et al. (2006) as was The World Health Organisation Quality of Life-Bref (WHOQL-Bref; WHOQOL Group, 1998). Five studies (Carlsson et al., 2006; Hooberman et al., 2007, Kagee, 2005; Sachs et al., 2008; Tol et al., 2007) incorporated The Hopkins Symptom Checklist (HSCL-25, Derogatis, Lipman, Rickels, Uhlenhuth, Covi, 1974; Mollica, Wyshak, de-Marneffe, Khuon, & Lavelle, 1987). Başoğlu et al. (2007) developed and included in their study the Exposure to War Stressors Scale (54 war-related stressors) and an Exposure to Torture Scale “that elicited information on 46 different forms of torture and related stressors. Each stressor event was rated as absent or present and for associated distress it was rated between 0= not at all distressing and 4= extremely distressing” (Başoğlu et al., 2007, p.278). Tol et al. (2007) included The Posttraumatic Stress Disorder Checklist-Civilian (PCL-C) which “is a 17-item symptom checklist, which assesses PTSD both according to the DSM-IV and as a continuous construct” (Tol et al., 2007, p.4). The Daily Coping Assessment (Stone & Neale, 1984) is a scale which was administered only in the study by Sachs et al. (2008). Six studies included questionnaires, namely Carlsson et al. (2006), Kagee (2005), Mollica, Wyshak, & Lavelle, (1987), Rasmussen et al. (2007), Sachs et al. (2008), and Schweitzer et al. (2006). These questionnaires included: The Life Events and Social History Questionnaire (Mollica, Wyshak, Coelho & Lavelle, 1985) and The Harvard Trauma Questionnaire (HTQ, Mollica, Caspi-Yavin, Bollini, Truong, Tor, & Lavelle,

1992). The HTQ was administered in five of these studies, namely Carlsson et al. (2006), Kagee (2005), Rasmussen et al. (2007), Sachs et al. (2008), and Schweitzer et al., (2006).

Twelve out of 18 studies displayed in Table 3.2 included semi-structured interviews with similar formats that covered general demographics, health before and after torture, conditions of imprisonment and its duration, the specific methods of torture employed and the participants' legal status at the time of interview (Başoğlu et al., 2007; Carlsson et al., 2006; De Zoysa & Fernando, 2007; Hooberman et al., 2007; Mollica, Wyshak, & Lavelle, 1987; Rasmussen & Lunde 1980; Rasmussen et al., 2007; Rasmussen, Reeves et al. 2007; Sachs et al., 2008; Schweitzer et al., 2006; Somnier & Genefke, 1986; Tol et al., 2007). Two of these 12 studies included medical examinations: Rasmussen and Lunde (1980), and Rasmussen et al. (2007). Rasmussen and Lunde (1980) also included a neurological assessment. One study included assessment for PTSD using the diagnostic criteria from the DSM-III (Mollica, et al., 1987). Başoğlu et al., (2007) and Rasmussen, Reeves et al., (2007) used the Clinician-administered PTSD Scale (CAPS, Blake et al., 2004), to diagnose current PTSD and the Structured Clinical Interview Diagnosis for DSM-IV-TR (SCID, First, Gibbon, Spitzer & Williams, 2004) for major depressive episodes.

Results.

The physical torture techniques that were reported in these studies are similar to those reported in previous case studies; however, some are culturally specific, that is, they are reported to have only been used within a particular cultural group. For example, in a Sri-Lankan study, the culturally specific technique of putting chilli powder in the victims' eyes was employed, and this was not reported in any other study (De Zoysa & Fernando, 2007). The physical torture reported in these studies included techniques such as: beatings, electric

torture, 'submarino', suspension, sexual torture,' planton', asphyxiation, witness to others being tortured, 'falanga/ falaka', cold water showers, aggravating wounds, applying weight on the testicles, removing nails with pincers, burning with cigarettes, the 'telefono' food deprivation, forced sterilization/IDU implant, forced drinking of petrol, and the parrot perch (see Table 2.1 for definitions).Therefore, although the torture methods are similar to those reported in previous studies, for example, Allodi et al. (1986), Kagee (2005), Knight (2006) and Paker et al. (1992), the amount of exposure to each method varies, thus there are differences in the physical damage resulting from each torture technique (Hooberman et al., 2007).

Somnier and Genefke (1986) explored the psychological methods of torture by looking at information collected by the Amnesty International medical group. The psychological methods of torture were: weakening techniques - teaching the survivor to be helpless and creating exhaustion; and personality destroying techniques – the induction of guilt, fear and loss of self-esteem. Psychological torture was reported and categorised into seven types, namely: isolation, induced debility or exhaustion, threats, degradation, occasional indulgence, pharmacologic manipulation and hypnosis. In addition, seven of the studies in Table 3.2 identify psychological techniques that conform with the categories of Somnier and Genefke (1986); they are: Başoğlu et al. (2007), Carlsson et al. (2006), De Zoysa and Fernando (2007), Hooberman et al. (2007), Rasmussen and Lunde (1980), Sachs et al. (2008), and Schweitzer et al. (2006).

De Zoysa and Fernando (2007) identified psychological techniques including: blind folding, food deprivation, death threats, witnessing torture, consumption of faeces/flesh, forced nakedness, threats to family, verbal humiliation, sexual assault and medical deprivation. The list was extended further by Başoğlu et al. (2007) with sham executions,

threats of rape and further torture, throwing urine/faeces at detainees, and fluctuation of the interrogator's attitude from a sympathetic and supportive style to an aggressive and threatening approach. Sleep deprivation and hearing others being tortured were included in the study of Rasmussen and Lunde (1980). Sachs et al. (2008) included religious persecution, family/friend imprisonment, forced labour, political re-education, surveillance, forced false confession, and Schweitzer et al. (2006) included forced separation from family, murder of family/friend, lack of shelter, brain washing, and imprisonment.

Physical and psychological consequences of torture and other types of systemic abuse.

The physical consequences of torture were burn scars on the skin, obstetric and gynaecological problems, hearing loss, orthopaedic problems, lower back pain and headaches. Survivors suffered pain and swelling as a result of hematomas, injuries to ears, eardrums and teeth, cardiopulmonary, as well as walking and gastrointestinal problems (De Zoysa & Fernando, 2007; Rasmussen et al., 2007; Sachs et al., 2008; Somnier & Genefke, 1986). Sachs et al. (2008) and Somnier and Genefke (1986) reported physical symptoms which included impaired hearing, vertigo, and distorted body image. The association between physical and psychological consequences becomes evident in more recent studies (Sachs et al., 2008; Somnier & Genefke 1986). However, Başoğlu et al. (2007) stated that it is hard to determine what contributes to the psychopathology resulting from physical torture and psychological torture, as both are experienced simultaneously, and that this represents a continuing cumulative exposure to stressors that cannot be easily distinguished from one other.

The wide-ranging consequences of torture were summarised in an earlier study presented by Allodi and Cowgill (1982), with their use of the term '*torture syndrome*'. Their description of torture syndrome was summarized as follows:

Psychosomatic: Pain, headaches, nervousness, insomnia, nightmares, panic, tremors, weakness, fainting, sweating

Behavioural and Personality changes: Withdrawal, irritability, aggressiveness, impulsiveness, suicide attempts, and sexual dysfunction (severe)

Affective: Depression (crying), fear, anxiety

Mental function: Confusion, disorientation, memory disturbances, loss of concentration or attention, blocking

Physical damage: Scars, burns, fractures, deafness, weight loss, other (teeth broken, tendons torn, rash)

(Allodi & Cowgill, 1982, p.100)

Studies reported in Table 3.2 reflect a shift in research from physical consequences of torture to a focus on the level of psychological distress as indicated by depression, anxiety and PTSD as assessed by standardised measures. Kinzie et al. (1984) was one of the first to refer to PTSD symptoms. Kinzie et al. (1984) reported the symptoms of 13 Cambodian patients presenting at the Indochinese Clinic in Oregon, USA. This research used a clinical interview that incorporated the assessment of PTSD symptoms from the section of the Diagnostic Interview Schedule (DIS: Robins et al., 1981). The research stated patients reported avoidance of memories related to their home country of Cambodia. They reported flashbacks such as thoughts and images triggered by present-day experiences. They presented with a sense of detachment from others; they reported family violence, anger or severe irritability, depression and sleep disturbances and nightmares. Others reported attempted suicide during imprisonment and soon after release.

The most common diagnoses resulting from torture and other forms of political violence have been post-traumatic stress disorder (PTSD), anxiety and depression (Carlsson et al., 2006). To gain a better understanding of the psychological impact of torture and the relationship between torture and symptomatology, more sophisticated statistical analyses were conducted in some of the studies included in Table 3.2. For example, in Başoğlu et al. (2007), Hooberman et al. (2007) and Rasmussen, Reeves et al. (2007) factorial designs were adopted that explored the relationship between symptoms and the traumatic experiences. The researchers assessed the traumatic events reported by the participants and analysed their relationship to the level of symptoms of depression, anxiety or PTSD reported by those participants.

Logistic regression analysis was used by Rasmussen, Reeves et al. (2007) to explore interactions between torture, chronic injury and the prediction of major depressive disorder and PTSD. The results indicated no interaction between torture and major depression ($p = .301$). However, there was a clear relationship between physical injury (resulting from torture) and both major depression ($p = .005$) and PTSD ($p = .008$). Rasmussen, Reeves et al. (2007) interpreted the clinical importance of these findings as being that untreated physical injury resulting from torture has long-term psychopathology which can be prevented with early medical intervention.

As in the Rasmussen and Lunde (1980) study, long-term neuropsychological complaints were also present in the Somnier and Genefke (1986) study resulting from physical torture. These complaints were: sleep disturbances, headache, impaired concentration, fatigues, nightmares, and fear/anxiety, tremors and shaking, and inward-turning aggression. What was significant, and as distinct from the Rasmussen and Lunde (1980) study, is that they found a strong relationship between physical trauma to the head resulting from torture and the occurrence of symptoms such as headache (36%), sleep

disturbance (47%), impaired hearing (15%), visual disturbances (14%), sexual disturbances (49%) and memory impairment (45%). Rasmussen and Lunde (1980) stated that 75% of their survivors of torture suffered from one or more of these impairments. However, in the Somnier and Genefke (1986) study it was found that not all survivors of torture presented with any long-term physical complaints. The latter report concluded that the physical symptoms tended to decrease with time and treatment. However, the psychological symptoms of high levels of anxiety, depression, and difficulties in establishing relationships, phobias and nightmares, appeared to persist over time. Nevertheless, as Rasmussen, Reeves et al. (2007) concluded, if injuries are chronic then a clear relationship between the physical and psychological consequences is maintained.

Sommier and Genefke (1986) concluded that the major consequence of psychological torture was personality change, and that the destruction of personality was evident where survivors were left with a sense of helplessness and hopelessness. A similar finding was reported by Başoğlu et al. (2007) who found that losing a sense of control during torture and the level of distress this caused at the time, determines the level of traumatic stress presented by survivors later in life, rather than the amount of torture experienced at the time of interrogation.

Tol et al. (2007) assessed disability and psychiatric symptoms (PTSD, anxiety and depression) amongst a group of torture survivors seeking help in a non-government centre for torture victims. To assess disability the World Health Organisation Disability Assessment Schedule II (WHO-DASII, (WHO, 2001)) was used. It is a health-status instrument which assesses functioning for six domains: communication, mobility, self-care, interpersonal, life activities, and participation. Using regression analysis they found high levels of psychiatric symptomatology among non-refugee torture survivors inside Nepal. Surprisingly, the study did not show that disability was predicted by depression alone or by co-morbid PTSD-

depression (depression; [$\beta = 0.583$, $t = 0.326$, $p = .745$], comorbidity PTSD-depression [$\beta = -2.368$, $t = -1.188$, $p = .236$]). However, PTSD and anxiety were the most important predictors of disability (PTSD; [$\beta = 16.608$, $t = 6.549$, $p = .000$], anxiety; [$\beta = 4.216$, $t = 2.362$, $p = .019$]). The authors of this study also compared their findings to those of other studies of Nepalese people who were seeking asylum outside Nepal and they concluded that anxiety among this population group is caused by being forbidden to work, family separation, and the length of time taken up by the asylum-seeking process (Tol et al., 2007).

Other studies that explored factors that predict psychiatric co-morbidity resulting from torture and other types of systemic abuse, are those of Başoğlu et al. (2007), Carlsson et al. (2006), Hooberman et al. (2007), Rasmussen et al. (2007), Sachs et al. (2008) and Schweitzer et al. (2006). For example, Hooberman et al. (2007) using a factorial analysis to describe and categorise various types of torture experiences, generated five factors: ‘witnessing trauma’, ‘family torture’, ‘beating’, ‘rape/sexual assault’ and ‘deprivation’. Further statistical analysis indicated that PTSD, anxiety, and depression were significantly correlated with the ‘rape/sexual assault factor’ [PTSD, $r = .27$, $p < .000$; anxiety, $r = .20$, $p = .0004$; depression $r = .16$, $p = .005$]. The other four factors did not display any significant association with psychological distress. Using ANOVA and t-test analyses they explored clinical and demographic variables and the differences between these factors. They concluded that four of these factors showed significant difference by gender. For example, women experienced significantly more traumas than men in the ‘family torture’ [$t(332) = 2.74$, $p = .01$] and the ‘rape/sexual assault’ factors [$t(314) = 5.34$, $p < .0001$]. This is a similar trend to results described by Mollica, Wyshak, & Lavelle (1987) where female Cambodian refugees, in particular widows who had experienced rape/sexual assault and relatives/spouses being killed, presented with major psychological impairments. Twenty-six of the 52 patients were

diagnosed with having PTSD, even though on the basis of the Global Assessment of Functioning Scale (GAFS), they did not reveal a low level of functioning.

Sachs et al. (2008) found that the level of psychological distress amongst torture survivors was overall relatively low with 12% of this subgroup having clinically significant symptoms of anxiety and 9.6% for depression. Using ANOVA Sachs et al. (2008) found “a small but significant main effect of trauma exposure on depression [$F(2,766) = 3.15, p < .05, \eta^2 p = .01$] and PTSD, [$F(2,766) = 6.38, p < .001, \eta^2 p = .02$.]” (Sachs et al., 2008 p.204). Sachs et al. (2008) explored predictors of psychopathology amongst Tibetan refugees and coping strategies as a possible mediator of psychological distress. Sachs et al. (2008) found that distress increased significantly with greater trauma exposure. Sachs et al. (2008) reported that religious persecution and family traumas (e.g., family or friends killed in prison or beating) were significantly associated with psychological distress. Multiple regression analyses were applied to investigate whether coping behaviours impacted on the association between trauma exposure and psychological distress. Sachs et al. (2008) concluded that ‘coping’ (principally via religious belief) appeared to mediate levels of psychological distress; coping strategies were found to be a significant predictor of lower symptom levels [$F(2,763) = 8.85, p = .003, R^2 = .01$]. This study reported an unusual degree of resilience among the 769 participants, 83 of whom had been tortured. The overwhelming majority of the Tibetans reported using religious coping strategies as well as a range of non-religious ones; for example, emotional support from loved ones, friends and/or professionals was endorsed by 77% of the participants. The positive relationship between coping strategies and distress is consistent with prior literature (Frankl, 1984; Janoff-Bulman, 1992; Lira & Castillo, 1991).

Three of the 18 studies presented in Table 3.2 questioned the relevance of PTSD as a diagnosis in a non-Western community (Kagee, 2005; Rasmussen et al., 2007; Rasmussen, Reeves et al., 2007). For example Kagee (2005) explored the psychological wellbeing of 148

black South African political activists who were tortured and detained during the apartheid years. The results indicated a minority of the sample (14.19%) scored above the cut-off points for clinical significance of 44 on the Hopkins Symptom Checklist (HSCL-25, Derogatis et al, 1974; Mollica, Wyshak, de-Marneffe et al., 1987) and 17.57% scored above the cut-off point of 44 for the Impact of Events Scale (IES, Horowitz et al., 1979). More than one-third of the sample scored in the clinical range, as measured by The Harvard Trauma Questionnaire (HTQ, Mollica et al., 1992) with 37.83% scoring above the cut-off point of 75. This means that symptoms from past traumatising continued to be an important predictor of psychological distress (Kagee, 2005).

Advantages and limitations of the case series methodology.

The increased numbers of participants in studies into the effects of torture, over the last 3 decades, has made the statistical findings more reliable and valid. The large samples also allow for complex analyses of responses to psychometric measurements. The clinical interviews have become more structured and sophisticated over time and consequently the findings are more reliable. Measurement of psychopathology has become standardised, e.g., see Sachs et al. (2008), Hooberman et al. (2007) and Rasmussen, Reeves et al. (2007) and further confirms the consequences of torture as complex. Schweitzer et al. (2006) included pre-migration data in multi-variance analysis, and found that a significant factor in predicting PTSD and somatisation was the destruction of the family unit, and also that females presented with more mental health problems than males. On the other hand, Rasmussen, Reeves et al. (2007) found that there was a lack of association between PTSD and demographic variables (age, gender and education).

Despite the large numbers, the limitations of these studies are that the samples were obtained via clinical settings or other accessible groups such as a prison or refugee camp, for

example, Tol et al. (2007), rather than through a random sample. It is a difficult methodological task to establish a large random sample. A weakness of the case series design is that there is no consistency in classification between participant groups (e.g. torture survivor vs survivors of other types of systemic abuse), (Hollifield et al., 2011). A further weakness is that not all studies controlled for post-migration stressors (Rasmussen et al., 2007). Another factor that is not taken into account in any of these studies is the varying lengths of time between the experience of torture and when the research was conducted, neither is the period over which the torture took place recorded nor the multiplicity of other simultaneous stressors.

Risks were also found in the use of interpreters when questionnaires were being administered and when the scales were not validated for a particular language. There is also no consistency in the studies to account for those who evidently have survived torture without suffering psychological damage. Sachs et al. (2008) is an example of one study that did investigate coping mechanisms among Tibetan refugees. In this study they examined the extraordinary resilience of Tibetan refugees while questioning the reliability of their own Western-style assessment.

Table 3.2

Case Series and Cross Sectional Studies Examining the Consequences of Torture and Other Political Violence

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Living in their country of origin or living in host country
Rasmussen & Lunde	1980	Research took place in 1975. A total of 135 torture survivors were interviewed.	A structured interview with a standard questionnaire was over 2-5 hours. Two doctors were present to conduct a medical examination which included a neurological evaluation	Torture	90% of torture survivors complained of symptoms of a physical and psychological nature which first arose during imprisonment and just after torture. 75% complained of psychiatric problems	42 from Chile living in Denmark, 35 from Greece living in Greece, 32 from Spain living in Spain, 13 from Argentina living in Italy, 5 from Northern Ireland examined in their own country and 8 from a mixed group examined in Denmark
Domovitch, Berger, Wawer, Etlin, & Marshall.	1984	104 torture survivors (91 male and 13 female)	A questionnaire partially derived from the Danish Medical Group. This was filled out by a physician. A Spanish speaking interpreter was used in 70% of cases.	98% imprisoned and tortured. The rest, all female, were abused physically, raped at home or workplace	Physical and psychological/psychiatric distress	Living in Canada
Allodi & Cowgill	1982	41 torture survivors from Latin America living in Toronto. (32 Males and 9 Females).	Psychiatric assessment	Torture: physical and psychological	Nervousness or insomnia with recurrent nightmares. Personality changes	Living in Canada
Kinzie, Fredrickson, Ben, Fleck, & Karls	1984	13 survivors of Cambodian concentration camps. (6 Males and 7 Females)	Clinical interview examining PTSD using the PTSD section of the Diagnostic Interview Schedule (Robins et al.,1981)	Pol Pot concentration camps	Psychological consequences	Living in USA
Allodi, Randall, Lutz, Quiroga, Zunzunegui, Kolff, Deutsch, & Doan.	1985	44 torture survivors (37 male and 7 female) from South American living in USA	A questionnaire about their torture experience. The assessment included a medical examination and assessment by a psychiatrist or psychologist in their own language	Torture: physical and psychological	Physical, psychological and psychosocial/consequences	Living in the United States

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Living in their country of origin or living in host country
Allodi, Berger, Beyersbergen, & Fantini.	1986	65 refugees from central America who had survived torture	Community consultation	Torture and forced exile	Psychosocial consequences	Living in Canada
Somnier & Genefke	1986	3 groups: Group 1=200 cases examined by Amnesty International Medical Groups (190 Male and 10 Female) Group 2=24 male torture survivors examined by the authors. Group 3=30 individuals elicited from Group 2 plus six others. (29 Male and 1 Female)	Semi-structured interview and medical examination of torture victims. Various methods of psychological torture employed. All males who had presented in the past to the neurology department were given a semi-structured interview.	Psychological, physical and pharmacological methods of torture.	Personality changes and long-term neuropsychological complaints	Most of them exiled from Latin America, Europe, Africa and Asia.
Mollica, Wyshak, & Lavelle	1987	52 Indochinese survivors of different types of systemic abuse. (25 Male and 27 Female). 18 Vietnamese, 21 Cambodian and 13 Hmong/Laotian.	Standardised interview. The Life Events and Social History Questionnaires (Mollica et al., 1985)	1-deprivation 2-physical injury or torture 3-incarceration or re-education camps 4-witnessing killing or torture 5-multiple traumas	Major affective disorder and PTSD	Living in the USA
Kagee	2005	Two stages to the study: 1 st stage consisted of 20 Black South African political activists who were detained and tortured during apartheid. 2 nd stage= 148 torture survivors (Gender not specified)	Hopkins Symptom Checklist (HSCCL-25), Impact of Event Scale (IES), Trauma Symptom section of the Harvard Trauma Questionnaire (HTQ), South African Former Detainees' Distress scale	All experienced systematic physical and psychological torture	On the HSCL-25 14.19% of sample scored above the cut-point for clinical significance of 44; on the IES 17.5% scored above 44; and on the HTQ 37.83% of the cut- off point of 75.	Living in South Africa

(continued)

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Living in their country of origin or living in host country
Carlsson, Mortensen, & Kastrup	2006	63 male refugees who had been tortured: 37 from Iraq, 7 Afghans, 5 from Iran, 14 from other countries admitted to a pre-treatment assessment at the Research Centre for Torture Victims (RCT)	Hopkins Symptom Checklist (HSCL-25); Hamilton Depression Scale (HDS); Symptom section of the Harvard Trauma Questionnaire (HTQ), and WHOQOL-Brief Semi-structured interviews	Torture, living in refugee camps, home searches by armed forces, soldiers in war and conflict.	Depression, and PTSD symptoms strongly associated with torture.	Living in Denmark
Schweitzer, Melville, Steel, & Lacherez	2006	63 Sudanese male refugees	Semi-structured interview which included questionnaires assessing socio-demographic, pre-migration trauma, anxiety, depression, PTSD, post-migration issues and perceived social support.	Various torture experiences, organised violence such as witnessing others being killed, threat to self and others by officials	Less than 5% met criteria for PTSD. 25% reported psychological distress	Living in Australia
Başoğlu, Livanou, & Crnobaric	2007	279 torture survivors from Sarajevo in Bosnia and Herzegovina, Banja Luka in Republica Srpska, Rijka in Croatia and Belgrade in Serbia (241 Male and 38 Female)	Semi-structured interview for survivors of war, Exposure to Torture Scale, Structural Clinical Interview for DSM- IV and Clinician Administrative PTSD Scale (DSM-IV)	Psychological and physical torture	Overlap between physical torture and psychological stressors in terms of their association with the level of distress and controllability. Physical torture was not associated with PTSD	Not clearly specified
Rasmussen, Smith, & Keller	2007	399 refugees from Africa, nationality not specified (249 Male and 150 Female)	DSM-IV PTSD symptoms from the Symptom section of the Harvard Trauma Questionnaire (HTQ). HTQ 16-item scale measuring the severity of PTSD (Mollica et al., 1992)	Extreme physical, psychological and pharmacological torture	symptom or depression. The finding supports a posttraumatic factor structure among Africans exposed to political violence	Living in the USA

(continued)

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Living in their country of origin or living in host country
Hooberman, Rosenfeld, Lhewa, Rasmussen, & Keller	2007	325 individuals were obtained from records from Bellevue/New York University program for Survivors of Torture (199 Male and 126 Female).	A semi-structured interview and two psychometric scales: Harvard Trauma Questionnaire (HTQ) Hopkins Symptom Checklist (HSCL-25)	A factor analysis generated a model with five factors corresponding to witnessing torture of others, torture of family members, physical beating, rape/sexual assault and deprivation/passive torture	These factors highly correlated with demographic variables and PTSD, anxiety, and depression were symptoms correlated with rape factors but no other factors were associated with psychological distress	Living in the USA
De Zoysa & Fernando	2007	90 victims of torture from Sri Lanka (83 Male and 7 Female)	Standard assessment format which included history of torture	Physical and psychological torture	Confirmation of torture practices in Sri Lanka	Living in Sri-Lanka
Rasmussen, Revees, Rosenfeld, & Keller	2007	116 Punjabi Sikh survivors of human right violations (72 Male and 44 Female)	Narrative, also CAPS (Blake et al., 2004) to diagnose PTSD, SCID (First et al., 2004) to assess major depression.	Torture, political violence	Injuries resulting from torture were long-term and as a consequence psychopathology was associated with major depression. A clear relationship found between chronic injuries and PTSD. Findings emphasize connections between physical and psychological trauma.	Living in India
Tol, Komproe, Thapa, Jordans, Sharma, & De Jong	2007	Population comprised of 201 torture survivors from mid-Western Nepal, (161 Male and 40 Female)	Assessment consisted of two parts: Part 1: demographics and torture experience, history. Part 2: Rating scales for PTSD used for Asian refugees in the United States (Carlson, & Rosser-Hogan, 1994), WHO-DASII (World Health Organisation Interview), HSCL-2, Checklist-Civilian version (PCL-C) to assess PTSD.	Torture: physical, and psychological	Importance of a PTSD-anxiety relationship. PTSD and anxiety symptoms were significant	Living in Rural Nepal

(continued)

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Living in their country of origin or living in host country
Silove, Steel, Bauman, Chey, & McFarlane.	2007	Vietnamese refugees (n= 1,161) resettled in Australia for 11 years Australian general population sample (n= 7,961) was drawn from a national survey.	The Composite International Diagnostic Interview (CIDI)	Vietnamese community has a history of war	PTSD prevalence for the overall sample groups was 3.5% Diagnosis of PTSD was present in 50% of Vietnamese and 19% of Australians with any mental disorder PTSD was equally disabling in both populations Trauma and PTSD continue to affect the mental health of Vietnamese refugees even after 10 years of resettlement in Australia Vietnamese community presents with physical symptoms rather than mental health symptoms compared to the Australian population	Living in Australia

(continued)

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Living in their country of origin or living in host country
Sachs, Rosenfeld, Lhewa, Rasmussen, & Keller	2008	769 Tibetan refugees arriving in India (651 Male and 118 Female)	A structured interview, Tibetan version of Hopkins Symptom Checklist, The Tibetan Harvard Trauma Questionnaire, the Somatization subscale of the Symptom Checklist-90 revision, Daily Coping Assessment. Three-category trauma exposure variable was used to investigate the relationship between persecutory experiences and psychological distress. Individuals who reported no potentially traumatic experiences n= 226 were compared to those who were tortured; 2: n=83 torture survivors; and 3: n=460 trauma exposure that did not constitute torture.	Torture, religious persecution, cultural deprivation, and ethnic discrimination	Low level of psychological distress. Anxiety and depression were more common but still occurred in only 12% for anxiety and 9.6% for depression. Only one participant met criteria for PTSD.	Living in India

Note: PTSD= Post Traumatic Stress Disorder; PCL-C = The Posttraumatic Stress Disorder Checklist-Civilian; WHO-DASII= World Health Organisation Disability Assessment Schedule II; CAPS= Clinician-administered PTSD Scale; DSM- IV= Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition; HDS= Hamilton Depression Scale; HTQ = Harvard Trauma Questionnaire; HSCL-25= Hopkins Symptom Checklist- 25; IES= Impact of Event Scale; SCID= Structured Clinical Interview for DSM-III-R; WHOQOL-Brief= World Health Organisation Quality of Life-Brief; Note: HDS= Hamilton Depression Scale

Quasi-Experimental Studies

A quasi-experimental design is used where it is not always possible to randomly assign persons to experimental and control groups; it is simply not ethical to randomly expose people to torture which would be a necessary condition for a randomised controlled trial (Trochim, 2006). Nor is it necessarily possible to obtain equivalent numbers in groups (Trochim, 2006). In a quasi-experimental study there is a control group that is defined by being not exposed to the variable of interest (e.g., torture), whilst everything else remains equal or very similar (Babbie, 1998).

Very few studies have compared people who have survived torture or other types of systemic abuse with a group that has not experienced traumatic events. Not having a control group makes it difficult for researchers who have been studying the effects of torture to offset any bias in their findings which indicate psychological consequences resulting from torture such as PTSD, anxiety and depression. The five studies reviewed in this section (see Table 3.3) adopted a quasi-experimental design. Three studies included a torture group and a control group, whilst the other two studies involved a third comparison group, namely those who had been exposed to other forms of systemic abuse. This allows us to ascertain whether people who had experienced other types of systemic abuse show similar increases in psychiatric symptomatology to torture survivors. Overall, the five studies investigated the level of psychopathology in each group and concluded that torture results in psychological damage; however, other traumatic experiences resulting from systemic abuse, can also have a psychological impact.

The following section covers the description of participants, including the split of participants into groups for the purpose of comparison. It describes the assessments given to

participants, which includes interviews and psychometric scales. The key results for each of the studies are presented followed by the main points that each study made subsequent to statistical analysis. Advantages and disadvantages of the studies are included followed by a conclusion for this chapter.

Participants.

Participants were obtained through availability and recommendation, through attendance at specialised services, or they were approached in refugee camps. Five studies involved comparisons of torture survivors with other groups (see Table 3.3). Başoğlu et al. (1994) investigated factors that related to long-term psychological consequences of torture amongst political ex-prisoners living in Turkey. The study involved three groups: Group 1 was comprised of 55 political activist prisoners who had experienced torture; Group 2 was comprised of 55 non-tortured political activists; and Group 3 included 55 participants with no history of torture and political activism. Thompson and McGorry (1995) investigated the psychological sequelae of torture amongst 30 Chilean and Salvadorian migrants living in Australia. Three groups were compared with one another: Group 1 comprised of 12 torture survivors; Group 2 included 10 survivors of other types of organised violence but not systematic torture; and, Group 3 included eight participants who migrated to Australia for economic reasons and had never experienced torture or any traumas related to system abuse/organised violence. A similar design was incorporated in Başoğlu et al. (1994) (see Table 3.3).

Three studies compared two groups, one of people who had been tortured and the other of those who had not (Holtz, 1998; Paker et al., 1992; Shrestha et al., 1998). Holtz's study comprised 35 Tibetan nuns and students who had been arrested and tortured. They matched that group with 35 controls who had not experienced arrest or torture. The Paker et

al. (1992) study was conducted in a Turkish prison for the purpose of controlling for imprisonment. They interviewed 246 prisoners of whom 38 were not torture survivors. Paker et al. (1992) proposed that torture would predict higher levels of psychopathology. Shrestha et al.'s study was of a larger group of 526 tortured Bhutanese refugees who were matched with a control group of 526 non-tortured refugees. In both cases (Holtz, 1998; Shrestha et al., 1998), the studies took place outside of the participants' own countries. In both studies the participants consisted of people who were political activists before their extended captivity.

Assessments.

Baçoğlu et al. (1994) used a two-part structured clinical interview in their assessment of survivors of torture. One part included questions related to demographic details and personal history including the experience of torture. The second part consisted of a scale of torture which incorporated self-ratings of severity of torture. Other assessments included the Structured Clinical Interview for DSM-III-R (SCID, Spitzer & Williams, 1983) which included the DSM-III-R Severity of Psychosocial Stressors Scale for adults to measure stressful life events before, during and after detention, but not including torture (APA, 1987), the PTSD checklist (from the Jackson Interview Form, Keane, Scott, Chavoya, Lamparski & Fairbank, 1985), Beck Depression Inventory (BDI, Beck, Ward, Mendelson, Mock, Erbaugh, 1961), Hamilton Depression Rating Scale (HAM-D, Hamilton, 1969), Hamilton Anxiety Rating Scale (HAM-A, Hamilton, 1959), State-Trait Anxiety Inventory (STAI, Spielberger et al., 1970) and the Turkish-language version of the General Health Questionnaire (Goldberg & Hillier, 1979).

The assessment in the Thompson and McGorry (1995) study included both a semi-structured interview which collected basic demographic details such as age, country of birth, length of time in Australia, marital status, reason for migration and migration status. A trauma history was included followed by the use of psychometrically-validated scales. These scales were the PTSD-Scale-Revised (Friedman, Schneiderman, West, & Corson., 1986), the SCL-90-R, Spanish version (Derogatis, 1983) and the IES (Horowitz et al., 1979). Details of these scales have been described in the study by Thompson and McGorry (1995). Simple statistical techniques, e.g., ANOVAs, were used to analyse the information gathered from the structured interviews and from the psychiatric scales, across the three groups.

Holtz (1998) conducted a brief interview that included the Hopkins Symptom Checklist-25 (HSCL-25, Derogatis et al, 1974; Mollica, Wyshak, de-Marneffe et al., 1987) which consisted of 10 anxiety questions and 15 depression questions - eight somatic symptoms were added to this checklist. However, it did not include a measurement of PTSD because of the difficulties Holtz identified in using Western concepts within the Buddhist culture. The Hopkins Symptom Checklist-25 (HSCL-25, Derogatis et al, 1974; Mollica, Wyshak, de-Marneffe et al., 1987) has been used in other South Asian refugee populations and the mean cumulative symptom scores above 1.75 have been found valid in predicting clinical diagnosis for anxiety and depression (Holtz, 1998). The McNemar chi-square test and t-tests were conducted to analyse the data in the Holtz (1998) study. Paker et al. (1992) included a semi-structured interview which incorporated the PTSD criteria from the DSM-III-R (APA, 1987); a medical examination; and, the Symptom Checklist-90-R (SCL-90-R, Derogatis, 1983). Shrestha et al. (1998), similarly to Holtz (1998), also used the Hopkins Symptom Checklist-25 (HSCL-25, Derogatis et al, 1974; Mollica, Wyshak, de-Marneffe et al., 1987) and similarly to Paker et al. (1992) the DSM-III-R criteria for PTSD (APA, 1987).

Results.

Başoğlu et al. (1994) and Thompson and McGorry (1995) described similar types of torture experienced by survivors. These were: the ‘telefono’, ‘falanga’, beatings to multiple parts of the body, rape of both men and women (including sexual violence with animals (dogs or rats)), forced eating of excrement, psychological or communication techniques, double-blind techniques, medical participation, hanging by wrists, and, sensory deprivation - reduction of stimuli from the environment to a minimum, e.g., by blind-folding (see Table 2.1 for the definitions of torture techniques). Başoğlu et al. (1994) found that participants reported a mean of 23 different forms of torture.

In the Thompson and McGorry (1995) study, the second group who had not directly experienced torture reported: forced displacement, house searches, witnessing violence in mass demonstrations, threats to one’s own life, threats to a relative or friend, experiencing the disappearance of friends or relatives, witnessing organised violence in their own home or nearby, or had relatives in jail as political prisoners. Only one participant mentioned migration being a traumatic experience and that was a participant from the third group - the control group. By contrast, Başoğlu et al. (1994) controlled for refugee and migration issues because all participants were residing in Turkey. In the Başoğlu et al. (1994) study, Group 2 was similar in demographic variables to the tortured group (Group 1).

Physical and psychological consequences of torture and other types of systemic abuse.

The results in both studies indicated that torture survivors were different to the two other groups as indicated by the number of participants presenting with PTSD symptoms, anxiety and

depression (Başoğlu et al., 1994; Thompson & McGorry, 1995). In the Thompson and McGorry (1995) study, however, the number of participants was relatively small; therefore, statistical analyses were limited. Overall, the results indicated that: seven out of the 12 torture survivors met the criteria for PTSD caseness, whilst five out of 10 survivors of other forms of organised violence met the criteria for PTSD caseness, and one out of eight met PTSD caseness for the control group (which was based on migration being experienced as traumatic).

The level of intrusion and avoidance as measured by the mean IES score was 40.8 for torture survivors, 31.8 for survivors of other forms of organised violence and 10.1 for the control group. The range for the IES can be between 0 to 75 (Horowitz et al., 1979; van der Ploeg, Mooren, Kleber, van der Velden, & Brom, 2004). The scores can be interpreted in the following way: 0–8 no meaningful impact; 9–25 the event might have an effect or could be indicative of PTSD, 26–43 the event has had a major effect and 44–75 is indicative of a severe impact affecting the person's ability to function (Horowitz et al., 1979; Thompson & McGorry, 1992; van der Ploeg et al., 2004). Therefore, in the Thompson and McGorry study a total score of 25 or more was regarded as indicative of PTSD.

A similar trend was indicated by the results of the SCL-90-R. The T-score values for male and female were obtained from the SCL-90-R manual II (Derogatis, 1983). The T-score indicates the participant's centile position relative to the norm, thus a score of 70 places the participants at approximately the 98th percentile regardless of the specific SCL-90-R dimension. The normative references used for calculations were for male and female non-psychiatric patients. Derogatis (1983) proposes that a score of 63 or greater for an individual on the Global Severity Index of the SCL-90-R or on two dimensions, indicates a psychiatric disorder such as depression, anxiety, psychosis or somatisation. The T-scores for the Global Severity Index for

all groups were all equal to or above 63 with the exception of females in Group 3 where the T score was 58. Overall, the mean score for all nine dimensions was higher for torture survivors and survivors of other systemic abuse. However, the SCL-90-R indicated, overall, that all groups including Group 3 (control) claimed high levels of distress.

Thompson and McGorry (1995) concluded that the high score for the control group may be explained by the distressing impact of migration and the adaptation process. It was suggested that migration may not be accepted by many as sufficiently stressful to satisfy criterion A of the DSM-III-R PTSD definition and it may be that the clinical picture could be regarded as a form of cultural bereavement (Thompson & McGorry, 1995). Torture survivors and survivors of other organised violence did refer to being in exile as a continuing part of their struggle as survivors, despite being both removed and far from direct persecution. Participants referred to a sense of feeling helpless, as well as feeling loss and guilt in being far away from their relatives and their culture.

In the Başoğlu et al. (1994) study the results indicated that 18% of Political Activist Survivors of Torture (Group 1) met the criteria for current PTSD; 4% for the Political Activist Non-Torture survivors (Group 2); and 0% for Non-Political Activist, non-survivors of trauma (Group 3). There was a statistically significant difference between the groups [X^2 (df = 2, 14, $p < .01$)]. A similar result was found for depression as measured by the HAM-D: the torture survivors' mean score was 5 (SD = 5.0) whilst for Group 2 it was 2.9 (SD = 3.4) and for Group 3 it was 2.9 (SD = 3.6) [X^2 (df = 2, 14.5, $p < .01$)]. The BDI demonstrated a similar trend where there was a significant difference across the three groups. The torture survivors' mean score was 9.5 (SD = 7.4) whilst for Group 2 it was 6.4 (SD = 5.6) and for Group 3 it was 5.7 (SD = 6.1) [X^2 (df = 2, 6.4, $p = .04$)]. For anxiety as measured by the HAM-

A, the overall result was also significant; the mean score for Group 1 was 7.5 (SD = 6.5), for Group 2 it was 3.9 (SD = 5.1) and for Group 3 it was 4.7 (SD = 5.3) [X^2 (df = 2, 12.0, $p < .01$)]. For anxiety as measured by the STAI there was no significant differences across the groups; for Group 1 it was 40 (SD = 11), for Group 2 it was 38 (SD = 9.4) and for Group 3 it was 35 (SD = 9.4) [X^2 (df = 2, 5.4, $p > .05$)].

Pearson correlation analysis and multiple regression analysis were applied to investigate the relationship between independent variables and psychopathology for the torture survivor group only. Seven independent variables were explored: pre-captivity variables (demographic details such as age, education, trauma, past psychiatric illness and family history of psychiatric illness); psychosocial stressors during and after captivity; perceived severity of torture; appraisal of behaviour under torture; duration of captivity; impact of captivity/torture on physical health, family, social life, economic status, work and political career; and, perceived support from spouse or partner, close relatives and friends. Pearson correlation analyses indicated that: “negative effect of trauma event on life areas and post-captivity stress correlated with PTSD symptoms, depression and anxiety measures [except for STAI-State]” (Başoğlu et al., 1994, p.360).

Post-captivity stress correlated with current PTSD symptoms ($r = .35$, $p < .01$), depression ($r = .30$, $p < .05$), and anxiety ($r = .28$, $p < .01$). Perceived severity of torture correlated positively with current PTSD ($r = .43$, $p < .001$). Multiple regression analysis was conducted to explore predictors of current psychological condition for the 55 torture survivors. For this analysis Başoğlu et al. (1994) included only those variables that correlated positively with the psychiatric scales plus a personal history of psychiatric illness in the family or self. Family history of psychiatric illness was a consistent predictor associated with

current PTSD [$R^2 = .04$, $\beta = .24$, $t = 2.1$, $p < .05$], depression [$R^2 = .07$, $\beta = .26$, $t = 2.6$, $p < .05$] and anxiety measured by the Hamilton Anxiety scale [$R^2 = .11$, $\beta = .34$, $t = 3.6$, $p < .01$]. Perceived severity of torture predicted current PTSD [$R^2 = .10$, $\beta = .30$, $t = 2.6$, $p < .05$] but not anxiety or depression.

Başoğlu et al. (1994) concluded that 'perceived severity of torture' did not predict anxiety and depression. This finding supports the evidence of PTSD being present in many survivors but not anxiety or depression, and that PTSD symptoms were the strongest discriminators between torture survivors and non-torture survivors. Başoğlu et al. (1994) added that although there was a significant difference between the three groups they examined in some of the measures, the percentage (18%) of torture survivors meeting the criteria for PTSD was relatively small.

Başoğlu et al. (1994) concluded that the overall level of moderate PTSD in their study could be due to a number of factors including: that participants were in their home country and therefore had better support from family or friends; that participants' commitment to their political struggle continued and the experience of torture became meaningful and significant; that torture was not an unexpected event as they had prior knowledge that this was a risk if captured; and finally, the perception of the traumatic event (how the individual understands the traumatic experience) can vary across cultures which can protect the individual from psychological damage (Başoğlu et al., 1994).

Başoğlu and Mineka (1992) discuss the possible advantage of political activity as a predictability factor that might give survivors a greater sense of control and protection against the experience. Similarly the study by Holtz (1998) reported that torture survivors stated that,

knowing that torture was a distinct possibility, gave them a degree of preparedness to confront the experience in a way that did not break them psychologically as the torturers would have expected.

Holtz (1998) in the Tibetan study examined the impact of torture and the experience of refugees in a comparison study where he compared 35 torture survivors with 35 non-torture survivors, living in a refugee camp in India. Eighty percent in both groups were nuns. Both groups were subjected to a range of psychological harassments using culturally-specific methods such as being forced to eat meat, in particular beef or pork, or being forced to work on a collective farm or being forbidden to enter a nunnery. Torture survivors reported a mean of 21 months in captivity and the mean length of torture application was 38 days. Eighty-three percent of the torture survivors reported being aware of the possibility of being captured and tortured and 80% reported being prepared for torture before being arrested. Also 52% of the torture survivors reported a doctor being present at the time of torture. The study found that the incidence of depression and anxiety was low; 14% of the torture survivors were diagnosed as having clinical depression compared to 6% in the control group at the time of the interview (Holtz, 1998). General anxiety disorder was present in 17% of the torture survivor group and 6% in the non-torture survivor group.

Holtz (1998) concluded that torture results in depression and anxiety impacting on the individuals' psychological wellbeing. A question considered by Holtz (1998) was "why 86% of the participants as a whole did not have elevated depressive symptoms" (p. 7). Holtz suggested that possibly social support among the community played a factor in reducing the risk of depression as well as the political commitment, and most importantly, the fact that 80% of the population studied had received Buddhist training as nuns. The Tibetan

community belief, influenced by their Buddhist teaching, is that “one’s suffering is little compared with the suffering of others” (Holtz, 1998, p. 8). Holtz (1998) concluded that it is the thought of one’s suffering as unimportant that encourages the resilience found in the Tibetan community.

Paker et al. (1992) found that long-term chronic injuries sustained under torture, or other forms of political violence, were strong predictors of long-term psychopathology. For example, in the Paker et al. (1992) study, the physical sequelae from torture explained 8% ($B = .30$, $p = .000$) of the variance in the General Symptom Index as measured by the Symptom Check List (GSI, SCL-90, Derogatis, Limptom, & Covi, 1973). Paker et al. (1992) also reported in their study that, of the torture survivors who met the criteria for PTSD (82 out of the 208 in the sample), 58 had physical injuries resulting from torture. Paker et al. (1992), using a multiple regression analysis, concluded further that a positive history of torture predicted a high level of anxiety ($\beta = .22$, $p = .0004$), obsessive compulsive behaviour ($\beta = .18$, $p = .005$), depression ($\beta = .16$, $p = .02$), interpersonal sensitivity ($\beta = .14$, $p = .03$), paranoid ideation ($\beta = .20$, $p = .002$), anger-hostility ($\beta = .20$, $p = .002$), phobias ($\beta = .14$, $p = .03$) and on the PSTD ($\beta = .15$, $p = .02$, GSI ($\beta = .19$, $p = .004$) and PTSD ($\beta = .19$, $p = .003$), which are all dimensions of the SCL-90 (Derogatis et al., 1973).

Shrestha et al. (1998) set the statistical significance for comparisons at .01 given the large number of statistical comparisons. They also used sequential logistic regression analyses to investigate the predictors of psychological status within the torture group. Similarly to Başoğlu et al. (1994), Shrestha et al. (1998) also reported that the PTSD diagnosis was made more frequently for the torture survivor group than for the non-torture survivor group (14% vs 3%, McNemar $\chi^2_{1} = 40.6$, $p < .001$). Similar results were obtained for

the HSCL-25 anxiety scores where torture survivors had significantly higher cumulative HSCL-25 anxiety scores than the non-torture survivor group (17.9 [SD= 6.1] vs 16.4 [SD=4.3] and for the cumulative HSCL-25 depression scores (22.6 [SD= 7.0] vs 21.3 [SD= 4.9]). Based on the HSCL-25 mean score of 1.75 as the cut-off value, they concluded that torture survivors scored significantly higher than the non-torture survivor group on both anxiety measures (43% vs 34%) and depression (25% vs 14%).

Shrestha et al. (1998) further looked at predictors of PTSD, depression and anxiety symptoms. A hierarchical logistic regression analysis was conducted where five predictors were entered into the analysis: (1) history of torture; (2) Buddhist religious belief; (3) illiteracy; (4) membership of political or human rights organisations in Bhutan; and (5) history of physical illness. They concluded that torture predicts symptoms of PTSD (OR = 4.6; 95% CI = 2.7-8.0), depression (OR = 1.9; 95% CI = 1.4 – 2.6) and anxiety (OR = 1.5; 95% CI = 1.1-1.9); and that Buddhist religious belief predicted the absence of high HSCL-25 depression scores (OR= 0.5; 95% CI = 0.3-0.9), or anxious scores (OR = 0.7; 95% CI = 0.4-1.0) whilst illiteracy predicted higher anxiety scores (OR = 1.4; 95% CI = 1.1-1.8). Shrestha et al. (1998) also looked at predictors within the torture survivor group for depression, anxiety and PTSD symptoms, and found that the total number of torture experiences was the only significant predictor of PTSD (OR =1.06; 95% CI =1.02-1.10).

Shrestha et al. (1998) concluded that both survivors of torture and other refugees who had not experienced torture presented with a high level of stress related to the refugee experience itself, although they further concluded that the differences between the two groups were related to the torture experience itself. However, the authors agreed with the comments by Başoğlu et al. (1994) that both studies did not clearly differentiate or control for an

interaction between traumatic symptoms resulting from torture and other traumas related to the refugee experience.

All five studies indicated that the severity of symptoms was low and only a small number of survivors met the criteria for diagnoses of PTSD, depression or anxiety. The five studies included comments that strong belief systems - either religious or political - provided the survivors with the resilience and strength to maintain a level of control during their experience of torture and other traumatic experiences resulting from political violence.

Limitations of quasi-experimental methodology.

A limitation of the studies conducted by Holtz (1998) and Thompson and McGorry (1995) is the small sample size. All five studies reported on convenience samples and this is another major limitation. Another limitation in all the five studies is the structure of the control group, for example, in the case of Shrestha et al. (1998) and Holtz (1998) studies it is not clear whether their control group (non-torture survivors) experienced any traumas, given that all subjects were living in refugee camps and had been forced to leave their homeland.

A sound control group is difficult to establish because groups drawn from other refugees or migrants, we could argue, have also suffered trauma and are not therefore a genuine control group. There is no consistency across studies of factors, such as other life stressors, that participants refer to in their histories. These may include a level of grief and loss at leaving their home, relatives and friends whose whereabouts in the case of refugees may be unknown.

Table 3.3

Quasi-Experimental Design Studies into the Impact of Torture and Other Systemic Abuse Amongst Refugees

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Living in their country of origin or living in host country
Paker, Paker, & Yüksel	1992	246 Turkish prisoners, 38 were not torture survivors. They were all non-political prisoners.	Semi-structured interview, Symptom Check List (SCL-90-R), Post traumatic stress disorder (PTSD) symptoms using the DSM-III-R (APA, 1987) criteria	Bad prison conditions. 208 people had experienced torture, physical and psychological	39% had physical sequelae, 81 out of the 208 met the criteria for PTSD (8% severe PTSD, 49% moderate and 43% mild).	Living in Turkey
Başoğlu et al.	1994	55 torture survivors 55 survivors of other forms of organised violence 55 participants who had not experienced any traumas	Structured clinical interview for survivors of torture. This interview included: "1) demographic detail, personal history forensic history (political), history of political activity, non torture stress factors before, during, and after detention, and posttraumatic adjustment. 2) a checklist of types of torture, the number and duration and a self severity of torture" (Başoğlu et al., 1994, p. 77). Structure Clinical Interview for DSM-III-R (SCID, Spitzer & Williams, 1983). PTSD checklist (Keane et al., 1985). "17 DSM-III-R symptoms of posttraumatic stress disorder are rated for severity on a scale of 1-5" (Başoğlu et al., 1994, p. 77). Beck Depression Scale. Turkish version (BDS, Beck et al., 1961). Hamilton Depression Rating Scale (HAM-D, Hamilton, 1969). Hamilton Anxiety Rating Scale (HAM-A, Hamilton, 1959). State-Trait Anxiety Inventory (STAI-state Turkish-language, Oner, & LeCompte, 1982). General Health Questionnaire Turkish version (Kilic, 1997). DSM-III-R Severity of psychosocial stressors scale: Adults (DSM-III-R, APA, 1987, p. 11).	55 ex-prisoners who had all survived torture, e.g., electrical shock, beatings, burning, rape, and twisting of testicles The second group had experienced harassment by authorities, exposure to social and political turmoil, loss of jobs	The demographics and clinical features were presented for the three groups. All three groups were matched for age, sex, education and marital status. The torture survivors had significantly higher scores on most measures of psychological status than the two groups. Their levels of anxiety and depression were within the normal range. PTSD was present at higher levels in torture survivors compared to the other two groups. However, not all met formal PTSD diagnostic criteria.	Living in Turkey
						(continued)

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Living in their country of origin or living in host country
Thompson, & McGorry,	1995	30 Participants were divided into three groups: Group 1: 12 torture survivors; Group 2: 10 survivors of other types of organized violence Group 3: 8 migrants who had not experienced any traumas	A semi-structured interview, the PTSD scale, SCL-90-R, the IES	Group 1: all experienced systematic torture as defined by the United Nations Convention for Human Rights Group 2: people who reported not being systematically tortured or incarcerated; however, they witnessed people being taking away, forced displacement Group 3: People who had migrated to Australia but who reported no experience of political violence and no connection to it in their home country	The proportion of people meeting the criteria for PTSD was higher for Group 1 where 7 cases met the diagnostic criteria for PTSD followed by Group 2 with 5 cases and Group 3 with 1 case. The same applied for the Impact of Event Scale and for the SCL-90-R, where all results tended to indicate that Group 1 and 2 presented with greater psychological distress than Group 3.	Living in Melbourne, Australia
Holtz	1998	35 Tibetan nuns and students who were refugees who had experienced some form of trauma 35 Tibetan nuns and students who were refugees, matched for demographics who had not experienced any traumas, formed the control group	A semi-structured interview that collected demographics and history of trauma. Hopkins Symptom Checklist-25 (Mollica et al., 1987)	35 Tibetan refugees who had experienced torture and other traumas, e.g., beating, electrical shocks to body, stripped naked, tied up by a rope, and blows to the ears	Seven survivors of torture suffered from depression as did 2 from the control group. General anxiety was present in 6 torture survivors versus 2 non-torture survivors. Depression was more common among newly arrived refugees. Political activism was associated with lower rates of depression. Overall, the number of people reporting depressive symptoms was very low. Buddhist training assisted in their assessed level of coping with the traumatic experiences.	Living in India
						(continued)

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Living in their country of origin or living in host country
Shrestha et al.	1998	526 Bhutanese tortured who were refugees 526 non- tortured refugees (control)	Structured interview which incorporated measurement for PTSD (APA, 1987) Checklist of torture type Checklist of medical complaints Hopkins Symptom Checklist-25 (Mollica et al., 1987)	Commonly reported torture techniques included: 97% severe beatings; 89% threats; 80% humiliations; 77% verbal sexual humiliations; 66% forced incongruent acts; 54% social isolation; 53% hygienic deprivation and 52% being tied down	Tortured refugees presented with higher level of PTSD symptoms They presented with higher anxiety and depression scores on the HSC-25 Buddhist religion predicted the absence of high depression scores	Bhutanese refugees living in Nepal

Note: APA= American Psychological Association; DSM-III-R= Diagnostic and Statistical Manual of Mental Disorders (Third Edition-Revised); PTSD=Post Traumatic Stress Disorder; SCID= Structure Clinical Interview; SCL-90-R= Symptom Check List 90 Revised; IES= Impact of Event Scale

Conclusion

The breadth of research that has been undertaken into torture and its consequences confirms the widespread usage of torture in the modern world and of the methods that are employed. The research continues to demonstrate a consistent pattern of consequences, namely PTSD, depression and anxiety. Individual coping mechanisms and resilience have started to become identified in more recent studies, and this opens up a further field of potentially fruitful research.

The research design adopted by researchers has evolved from the 1970s to the twenty first century. What began as case reports based on the use of interviews of victims of torture has developed into more detailed, complex style of structured interviews as well as the use of standardized testing to gather information about the symptomatology resulting from torture. In the 1970s, the participants were exiled individuals who presented at clinics in countries like Denmark and Canada. The arrival of refugees alerted the physicians, mental health and social/welfare workers to the needs of torture survivors. For example, Cathcart et al. (1979) interviewed three women and eight males who were Chilean refugees in a Canadian clinic. An in-depth history was taken and a physical and psychological assessment followed. Since the 1970s the sample groups for case studies have come primarily from clinics. The use of in-depth interviews/testimonies (Cathcart et al., 1979; Hinshelwood, 1999; Ritterman, 1985) have been replaced with, Clinical Structured Interviews and incorporate standardized criteria, such as the DSM-III (APA, 1980), DSM-III-R (APA, 1987) and more recently DSM-IV (APA, 1994, 2000). These have come to be used regularly to assess psychiatric symptomatology resulting from torture. As noted previously, the most common conditions identified are PTSD, anxiety and depression (Gorst-Unsworth, 1992; Knight; 2006; Mollica, Wyshak, & Lavelle, 1987; Shrestha et al., 1998). The earlier structured interviews also led to

the development of psychiatric scales, questionnaires and structured interviews specifically focusing on torture, like the Harvard Trauma Questionnaire used by Mollica, et al. (1992).

During these 3 decades the size of the samples increased from less than 10 in the early 1970s to 709 in Sachs et al. (2008). None of the samples studied have been randomly chosen. Given that torture is widespread, but not universally reported, it is impossible to gather large enough numbers of participants together to make a genuinely random selection possible. When large groups of refugees do arrive in one place together, they are not all survivors of torture, for example, those studied in Sachs et al. (2008). These large groups do allow for torture survivors to be separated from non-tortured refugees and so a control group can emerge, for instance in Shrestha et al. (1998), where everyone arriving at a particular time was interviewed in the one cohort, out of which 526 torture survivors and 526 non-torture survivors were selected. However, the matter of selecting a genuine control group remains in dispute.

Although the majority of the studies involved small sample sizes, consistency of assessment has been maintained with the use of psychometrically-validated measures. Examples of more sophisticated testing include the SCL-90-R, IES , the Tibetan Harvard Trauma Questionnaire, the HSQ, and the PTSD Checklist. Some of these psychometrically-validated scales have been translated into other languages and made culturally specific; however, not all diagnoses are considered culturally appropriate because, for instance, PTSD is considered incompatible with Buddhism (Holtz, 1998).

In early studies symptoms such as insomnia, recurrent nightmares, irritable outbursts, avoidance and intrusive thoughts were identified. Allodi and Cowgill (1982) described a wide range of psychological consequences arising from torture, which they named the 'Torture

Syndrome'. At the same time, however, the diagnosis of PTSD was becoming more widely used by researchers and it has superseded the notion of a specific 'Torture Syndrome' (Başoğlu et al., 2001).

As the numbers of those diagnosed with PTSD grew, predictors of the syndrome were sought through more complex statistical analysis. Rasmussen et al. (2007) used factorial analysis to explore the relationship between the physical and psychological methods of torture and depression, anxiety and PTSD. They concluded that there was a clear relationship between long-term physical injury and PTSD; however, even when the rate of physical symptoms declined, depression and anxiety can still persist (Rasmussen, Reeves et al. 2007). Furthermore, the use of the factorial design (Hooberman et al. 2007) demonstrated that rape and sexual assault were predictors of psychological distress as manifested in conditions or symptoms of PTSD, anxiety and depression. Mollica, et al. (1987) found that high levels of psychological distress were evident in women who had themselves experienced torture or sexual assault, or who were closely related to victims of torture or sexual assault, or whose partners had been murdered. It was also shown that common aspects of PTSD (intrusive thoughts, arousal and hyper-vigilance) correlated directly with high levels of anxiety (Mollica, et al., 1987).

Rasmussen and Lunde (1980) and Somnier and Genefke (1986) found that personality change was the major consequence of psychological torture. The destruction of personality was most prevalent where survivors were left with a sense of hopelessness and helplessness. This applied particularly to those who felt they had lost control or were without control during the torture process and this concept of hopelessness and helplessness was a major factor leading to depression. It was found repeatedly that, where survivors clung to a strong

belief of one kind or another, hopelessness and helplessness were less likely to occur. Başoğlu et al. (1994) demonstrates this in relation to political beliefs, and Sachs et al. (2008) also take it further with regard to Buddhist beliefs. In the mid-1990s many studies raised the concept of resilience, for instance, in Shrestha et al. (1998). In some studies specific coping mechanisms were identified and these included the level of insight, religious belief, strong political commitment, a level of awareness of the probability of torture as well as an understanding of what to expect from torture (Başoğlu et al., 1994; Paker et al., 1992). For those who were incarcerated together, the camaraderie among prisoners was also a source of strength, (Başoğlu et al., 2007; Thompson & McGorry, 1995).

While the methodology has become more reliable and refined and the psychometrically- based scales have been validated, the selection process for the sampling remains an issue of concern and there are still some scales that are not culturally appropriate. A diagnosis of PTSD remains problematic in the case of torture victims because the methods of torture are so varied, as are other pre- and post- torture experiences. Apart from the initial sampling, as in the controlled studies (i.e., Başoğlu et al., 1994; Holtz, 1998) further refined measurements have been introduced to control for these factors, i.e., the Turkish-language version of the General Health Questionnaire (Goldberg & Hillier, 1979); the SCL-90-R, Spanish version (Derogatis, 1983); the Impact of Event Scale (IES, Horowitz et al., 1979); and finally, the Hopkins Symptom Checklist-25 (HSCL-25, Derogatis et al, 1974; Mollica, Wyshak, de-Marneffe et al., 1987) has been applied to a diverse refugee population. The Harvard Trauma Questionnaire (HTQ, Mollica et al., 1992) was originally construed to measure PTSD based on the DSM-III-R (APA, 1987) diagnosis specifically for the purpose of assessing the impact of trauma in the Indo-Chinese population. More recently, the HTQ has incorporated

measurements for anxiety and depression and has been applied to a diverse refugee population (Silove & Kinzie, 2001).

Over the last 30 years some researchers have questioned the significance of pre- and post- migration factors affecting mental health. This was mentioned in a number of studies, e.g., Gorst-Unsworth (1992) and Hinshelwood (1999). In addition to the pre-migration factors such as torture, are post-migration factors which include: loss of work and residential status, loss of family members, language and cultural difficulties (Başoğlu et al., 2007; Quiroga & Jaranson, 2005; Sachs et al., 2008; Tol et al., 2007). While recent research consistently stresses the diagnoses of PTSD, anxiety and depression as consequences of torture, an inconsistency appears in the number of studies that report consequences that include personality changes, feelings of shame and distrust, physical and neurological changes, social and economic factors. This inconsistency or complexity of the psychopathology has led some researchers to a concept of ‘torture syndrome’ or ‘complex PTSD’ for torture survivors so as to encompass all of these various consequences.

Having reviewed the available literature on the subject of torture and trauma from around the world in the past 30 years, and considered the implications that arise from the findings of that research, the next Chapter moves to a consideration of the research that has taken place in Australia on this subject. The chapter takes into account the refugee phenomenon as it relates to Australia. It reviews the psychological consequences of torture in the context of asylum seekers, in particular ‘boat people’, in recent years. It considers also the psychological impact of life in Australian detention centres.

Chapter 4

The Post-Migration Experience: A Factor Impacting on the Mental Wellbeing of Torture Survivors Arriving in Australia.

The review into the psychological impact of torture and other systemic abuse presented in Chapter 3 indicated that depression, anxiety and PTSD are common psychological consequences following such experiences. Post-migration factors such as seeking asylum and or being placed in a detention centre result in serious mental health conditions (Silove, 2004). Refugees and asylum seekers present with chronic mental health problems such as depression, anxiety, PTSD, grief, and changes in personality (Carswell, Blackburn, & Barker, 2011; Coffey, Kaplan, Sampson, & Tucci, 2010; Murray et al 2008; Silove, Austin, & Steel, 2007; Silove, Sinnerbrink, Field, Manicavasagar & Steel., 1997, Silove, Steel, McGorry & Mohan 1998; Sinnerbrink, Silove, Manicavasagar, Steel, & Field, 1996, Sinnerbrink, Silove, Field, Steel, & Manicavasagar, 1997; Steel & Silove, 2001; Steel et al., 2009; Thompson & McGorry, 1995; Victorian Foundation for Survivors of Torture, 1998). Current research attempts to distinguish between the mental health problems which are the consequences of torture and other types of systemic abuse, and those that are exacerbated by, or associated with, their migration and post-migration experiences. These experiences are, in particular, forced migration, detention in Australia and the continued uncertainty which is often extended over many years and related to their residency status (Coffey et al., 2010; Johnston, Allotey, Mulholland, & Markovic, 2009; Silove, 2004).

The following chapter is divided into three sections. The first section offers a summary of the global displacement of refugees, the second section focuses on the Australian history of migration which includes: seeking asylum and the issues of mandatory detention. This section also defines terminology such as what constitutes a refugee, asylum seeker, and a detainee in a detention centre. The last section reviews Australian studies that examine the psychological impact of seeking asylum in Australia and the consequences of detention on refugees' mental health.

Global Displacement - A Brief Historical Summary

Forced displacement of people resulting from World War II, and subsequent wars and conflicts has been a notable phenomenon over the last 70 years (Rogers & Copeland, 1993; United Nations High Commissioner for Refugees (UNHCR), 1995). The end of the Second World War saw more than 15 million displaced people, 7 million seeking refuge in new continents (Widgren, 1988). The commencement of the Cold War resulted in people leaving the eastern bloc countries and being granted refuge in Western Europe, the USA, Canada, England, and Australia (Rogers & Copeland, 1993; Steel & Silove, 2000). By the mid-1970s, major changes occurred in the pattern of refugee movement (Rogers & Copeland, 1993; UNHCR, 1995). Many refugees were escaping dictatorial regimes which had over-thrown socialist/democratic regimes such as in Chile, Uruguay, Argentina (Klein, 2008). People were forced into exile following the conflict in Vietnam, and the rise of communist governments in Indo-China (Silove, 2004). Conflict and civil war in Central American countries saw people moving to North America and seeking asylum worldwide (Rogers & Copeland, 1993). In the former Yugoslavia the creation of new independent states and the subsequent war resulted in mass violation of human rights with hundreds of thousands of casualties and more than 2

million displaced people (Ambroso, 2011). Conflicts in the 1990's, in countries such as Somalia, Rwanda, Sierra Leone, Liberia, Sri Lanka, Iran, Iraq, and Afghanistan, has forced people into exile (Ambroso, 2011; Rogers & Copeland, 1993).

Conflicts and subsequent mass movement of people have seen the rise of refugee camps holding many thousands of people for extended periods of time, in countries of first asylum. This is an attempt to control the numbers seeking resettlement in Western countries (Silove, 2004; Steel & Silove, 2000). The situation continued to accelerate so that by the 1990s there were over 100 regions around the world experiencing social change as a result of war and political upheaval, and consequently 20 million people were seeking refuge in foreign countries (Steel & Silove, 2000). Estimates of 15.2 million refugees worldwide were reported at the end of 2009 (Phillips & Spinks, 2011). Australia is one of approximately 20 nations who participate in the UNHCR resettlement programs and in 2008 Australia accepted 8742 refugees (Phillips & Spinks, 2011).

By the end of 1992, 543,000 people were seeking refuge in Western Europe alone (Rogers & Copeland, 1993). Australia was experiencing a corresponding increase of people seeking refuge; 31,000 applications for refugee status were lodged between 1989 and 1996 (Steel & Silove, 2000). During this period popular destinations like Western Europe, North America and Australia were facing periods of economic uncertainty, which led to a rise in tensions within the local communities and within governments about the arrival of different ethnic groups (Steel & Silove, 2000). Consequently, most countries responded with ever more stringent procedures to test for refugee status, made more complex by an influx of what are popularly called 'economic refugees', as governments struggled to maintain a balance between assistance to the displaced and control of their own borders (Steel & Silove, 2000).

As a result, countries including the Australia, USA, and the UK have ‘processing centers’ or ‘asylum centers’ for asylum seekers (Carswell, et al., 2011; Schwarz-Nielsen & Elklit, 2009).

The consequences of seeking asylum on the mental health of refugees have given rise to increased clinician concerns. For example, recent investigations conducted in countries such as the UK, Denmark and Australia found the associations between post-migration factors such as detention and asylum-seeking processes and PTSD symptoms and emotional distress, to be significant (Carswell et al., 2011; Johnston et al., 2009; Schwarz-Nielsen & Elklit, 2009; Steel et al., 2009). For example, Carswell et al. (2011) investigated the relationship between post-migration issues such as residency determination issues, social support and the consequences of these experiences on 47 refugees and asylum seekers living in the UK. The results indicated that post-migration issues were significantly associated with PTSD symptoms and emotional distress. Schwarz-Nielsen and Elklit (2009) investigated the presence of symptoms of anxiety, PTSD and depression on 53 asylum seekers from Iraq living in Denmark whose application for refugee status had been rejected. Overall, the results indicated that 94% of participants had symptoms of anxiety, 100% had depressive symptoms and 77% had symptoms of PTSD as measured by Harvard Trauma Questionnaire-IV (HTQ, Mollica et al., 1992) and the Hopkins Symptom Checklist 25 (HSCL-25, Mollica, Wyshak, de Marneffe et al., 1987).

A Brief History of Migration to Australia

The history of Australia as a European nation is a history of migration. In the late 1780’s the first convicts were transported by the British Government to Botany Bay, New South Wales; the first forced migrants to come to Australia (Jupp, 2001). These people were convicted criminals and political prisoners from many parts of the United Kingdom. In 1791

the first Irish convicts arrived in Australia, most of whom were political prisoners and increasing numbers followed the uprisings of 1798 and the early 1800s (Jupp, 2001). Approximately 63,000 convicts in all were brought to the eastern colonies of Australia by the 1830s. Eventually, 160,000 convicts were transported to Australia as a whole. Between 1845 and 1852 a famine killed 1 million (one-third) of the Irish population forcing thousands to emigrate to America and Australia (Jupp, 2001). In the 1800s Irish people accounted for one-third of Australian immigration (Jupp, 2001). Free migration had begun to come to Australia in the 1790s and by the 1820s the demands of the wool industry in Australia and the social upheavals of industrialization in Britain resulted in increased immigration to the Australian colonies (Younger, 1975). The promotion of supported passages to Australia began in the 1830s. Government-assisted immigration used funds from the sale of land, and by 1830 around 14,000 settlers had arrived in Australia (Younger, 1975).

Historically, the migration process to Australia has been selective. From the 1850's, policies tended to restrict migration to Europeans (Younger, 1975). Newspapers and magazines around the country united to foster a fear of the Chinese who had arrived in large numbers during the gold rush period in the decades after 1851, and were the victims of a number of race riots in the gold fields in a number of the colonies. Partly as a result, it was from this time that the White Australia Policy began to gain popularity. In addition, forced internal displacement of Aboriginal people continued as the new settlers expanded into their territory (Younger, 1975). The rapid increase of migration during the Gold Rush led to a seven-fold increase in the population of the colony of Victoria, and successive waves of migrants arrived, largely from Britain, throughout the nineteenth century (Younger, 1975).

The White Australia Policy was enshrined at Federation (Immigration Restriction Act, 1901), and further immigration, of Europeans only, increased after World War 1, including migrants who were escaping from Nazism in the 1930s (Jupp, 2001). Post-Second World War 2 immigration was strenuously encouraged by the government under the slogan “Populate or Perish” (Jupp, 2001; Langfield, 2003). However, the Minister for Immigration, vigorously upholding the White Australia Policy, was recorded as saying ‘Two Wongs don’t make a White!’ (Calwell, 1947).

Definition of Terminology Used Today in Relation to Refugees and Asylum Seekers Arriving in Australia

At this point it becomes necessary to define the official and commonly-used terms that describe people arriving on Australian shores because, as Romano (2007) states: “Some journalists misunderstood or failed to check even very fundamental facts about the issues ... Newspaper headlines and stories mixed up terms such as ‘asylum seekers’, ‘refugees’, ‘boat people’, ‘illegals’, and ‘illegal immigrants’ and used them interchangeably” (Romano, 2007 p.185).

The United Nations Convention on the Status of Refugees defines a **refugee** as:

Any person who owing to well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country or who not having a nationality or being outside the country of his former habitual residence, is unable, or owing to such fear, is unwilling to return to it (United Nations, 1951).

Asylum seekers are: “persons who seek protection under the Convention on Refugees after entering another country on a temporary visa or without any documents” (Silove, Steel, & Watters, 2000, p. 604).

The Department of Immigration and Citizenship has two Humanitarian programs:

- The **onshore** (asylum or protection) component offers protection to people in Australia who meet the refugee definition in the United Nations Refugees Convention.
- The **offshore** (resettlement) component offers resettlement for people outside Australia who are in need of humanitarian assistance.

(Phillips & Spinks, 2011, p. 14-15)

Terms in the vernacular for Asylum Seekers include ‘**illegals**’ as used constantly by the previous Howard government (1996 to 2007), or at other times ‘**queue jumpers**’ who, it was claimed, should have waited in queues in overseas refugee camps, but are in fact those who arrive seeking refugee status and permanent residency (Burnside, 2007; Lusher, Balvin, Nethery, & Tropea, 2007; Phillips & Spinks, 2011). Phillips and Spinks (2011) further describe in their report that the term ‘**boat people**’ entered everyday use in the 1970s referring to the Vietnamese arrivals following the Vietnam War, and continues to be used to refer to those arriving, unauthorised, by sea; many of these arrivals have paid ‘people smugglers’ for their passage (Burnside, 2007; Gordon, 2007; Phillips, & Spinks, 2011). ‘Refugees’ are those who arrive with documents giving them immediate refugee status and ‘Migrants’, a term that replaced the post-war ‘New Australians’, are those who have been selected under schemes such as Skilled Migration or Family Reunion (Phillips & Spinks, 2011).

The Policy of Deterrent and Detention of Asylum Seekers Arriving by Boat –A Continuing Controversy

Harsh policies were implemented in Australia, particularly in response to fears about ‘boat people’. Initially, these displaced people came from Vietnam following the end of the war there in 1975 (Silove, 2004). While most Vietnamese had fled to other Asian countries, a few began arriving in Darwin in April 1976, increasing to 2059 by 1981 (Phillips & Spinks, 2011). A second wave came from Cambodia, Vietnam and Southern China, at a rate of around 300 a year between 1989 and 1998 and from 1999 a different group began arriving from the Middle East in larger numbers (Phillips & Spinks, 2011). Compared to the numbers in Europe and other countries, Australia has had very few unauthorised arrivals, with most asylum seekers arriving with valid visas by air and seeking refugee status ‘onshore’. At its first peak in 2000, only 3000 boat people arrived in Australia, compared to 1 million unauthorized Afghanis arriving in both Pakistan and Iran (Phillips & Spinks, 2011).

Prior to 1992, boat people were held in detention only on a discretionary basis, but the Keating Labor government (1991 to 1996) altered migration policy (Migration Amendment Act, 1992) supposedly to facilitate the processing of refugee claims, prevent de facto migration and to save costs (Mares, 2001; Phillips & Spinks, 2011). This mandatory detention policy was extended in that year to all unlawful non-citizens in order to facilitate the removal of people not entitled to be in Australia (Phillips & Spinks, 2011). This policy has continued and been maintained by successive governments to date (Phillips & Spinks, 2011).

The controversy surrounding the new ‘boat people’ shifted dramatically in 2001, prior to the Federal election. Both major parties had already agreed about the dangers in the

number of boat arrivals although they had different policies with regard to the ‘threat’ posed by these unauthorised arrivals. Compulsory incarceration had been in force since 1992 for all persons including children arriving in Australia without valid documentation (Steel et al., 2004). The popular media was emphasizing the cost to the Australian tax-payer and tensions were high inside the centres (Mares, 2001). Detainees were suffering from high levels of depression, anxiety, and self-harm and detained children were suffering psychological damage (Mares, Newman, Dudley, & Gale, 2002; Steel et al., 2004). The notion of ‘queue-jumpers’ emerged and the Minister for Immigration declared that Australia was being ‘deliberately targeted’ because of its ‘humanity’ (Mares, 2001). By 1999 the Liberal government had introduced the temporary protection visa (TPV) (Johnston et al., 2009; Mares, 2001). Under this visa asylum seekers were allowed to stay in Australia for a limited time, that is, for 3 to 5 years (Allison, 2007; Johnston et al., 2009). This visa also meant limited access to health, social and educational services. In addition, holders of this visa were not allowed to apply for other immigration programs such as family reunion (bringing in their spouse and children who were back in their homeland or in a refugee camp) (Johnston et al., 2009).

On August 26th 2001 the Norwegian freighter MV Tampa, in a straightforward rescue in accordance with the law of the sea, went to the aid of 438 asylum seekers (mostly Afghans fleeing the Taliban) who were stranded on a broken-down fishing boat mid-Indian Ocean (Burnside, 2007). Liberal Prime Minister Howard refused them entry to Australia in an intense stand-off where the asylum seekers were represented as a threat to Australia and their arrival as trespass (Burnside, 2007). His decision won popular support, and Special Air Service (SAS) personnel proceeded to take control of the vessel from the Captain, despite objections from Mary Robinson, United Nations High Commissioner for Human Rights. This

policy was a reversal of the stand taken by former Liberal Prime Minister, Malcolm Fraser, when a similar situation arose in 1977 with Vietnamese ‘boat people’ (Burnside, 2007). The asylum seekers were then refused entry by the Australian government of that time (Mares, 2007; Piper-Rodd, 2007).

The Tampa is a container ship completed in 1984 by Hyundai Heavy Industries Co., Ltd in South Korea for a Norway firm (Burnside, 2007; Piper-Rodd, 2007). The ship rescued 438 people whose boat had sunk (Piper-Rodd, 2007). The Tampa issue was then conflated in the media with the fear of terrorism following the terrorist attacks in the United State of America on the 11th of September 2001 (Burnside, 2007). Ultimately, the men, women and children on the Tampa were sent to the small Pacific Island of Nauru, which was not a signatory to the Refugee Convention, and its bankrupt government was paid ‘tens of millions’ to detain this group of refugees (Burnside, 2007) This led to what is generally known as the **“Pacific Solution”** and involved intercepting people before they could put foot on the mainland and taking them, against their will, to Nauru or Manus Island (Burnside, 2007). They were forbidden by law to apply for an Australian protection visa and were processed in these offshore locations to examine their claims for refugee status within the Refugee Convention, without any right of appeal. If they were found not to be refugees, they were sent back to Afghanistan. If they were found to be refugees, the government offered them to other countries, many of which were reluctant to take them. New Zealand accepted 131 refugees, 106 Afghans detained on the Pacific nation were granted refugee status in Australia after a long process, 14 were granted resettlement as non-refugees, one died and 186 applicants were sent back to Afghanistan after the Taliban had been temporarily removed (Burnside, 2007).

Numerous committees have been established over the years to deal with applications for refugee status. For example, in 1993, The Refugee Review Tribunal (RRT) was established to provide an independent review of decisions made by the Department of Immigration to refuse refugee status to an applicant. This was in response to the denial of refugee status to Cambodian onshore asylum seekers at the time (Lusher et al., 2007; Mares, 2001). The RRT continues as a resource for any asylum seeker who seeks to appeal an unfavourable Department of Immigration decision (Migration Review Tribunal and Refugee Review Tribunal, 2011)

Following much controversy over the Pacific Solution, detention centres and government policies for refugees and asylum seekers, many changes have taken place since the new Labour Australian government was elected in 2007. Changes have been made to the Migration Act, for example, the Migration Legislation Amendment Bill (No.4) of 1994, which denied on-shore asylum seekers the right to apply for refugee status in Australia and removed them from Australia as unlawful non-citizens. The Labor government has also abolished Temporary Protection Visas (TPVs) and closed some of the more controversial detention facilities such as the Baxter immigration centre (Port Augusta, South Australia) (Department of Immigration and Citizenship, 2008).

The Department of Immigration and Citizenship grants refugee status on the basis of applicants meeting the criteria for the United Nations Refugee Convention (The Department of Immigration and Citizenship, 2011a). The refugees accepted in this category have been subjected to torture or other forms of direct systemic abuse (The Department of Immigration and Citizenship, 2011a). In addition to applicants granted refugee status, many more torture and trauma survivors present within the other

categories of the special humanitarian program, for example, the Women at Risk visa: this is for women and their dependents who are subject to persecution. They are a concern to the UNHCR, as they are living outside their home country without protection from any relatives and are at high risk of human rights violations. The Emergency Sub-class Visa offers an accelerated processing arrangement for people who satisfy refugee criteria and whose lives or freedom depend on urgent resettlement. It is for those subject to persecution in their home country and assessed to be in a situation such that delays due to normal processing could put their life or freedom in danger (Department of Immigration and Citizenship, 2011a).

Apart from a period between 1999 and 2002 and mid-2009 most of the people in detention were visa over-stayers, unauthorized air arrivals and those whose visas had been cancelled rather than people arriving illegally by boat. Despite these facts the public debate continues to focus on boat arrivals (Phillips & Spinks, 2011). Asylum seekers arriving illegally continue to be placed in detention centres, which were managed originally by government agencies and later transferred to the private sector (Phillips & Spinks 2011). Controversies in Western Australia over the treatment of asylum seekers in the Port Hedland detention centre arose; this centre opened in 1991 and closed in 2004 (Burnside, 2007). Woomera in South Australia opened in 1999 and closed in 2003 after much controversy (Burnside, 2007). The Woomera migrant detention centre became the centre of public controversy on August 28th 2000 when more than 80 protesters, mostly Iraqi and Iranian men, injured 13 security guards during a protest over conditions and the length of their detention ((Burnside, 2007; Mares, 2001). To date, the number of asylum seekers has continued to increase and so does the number of people arriving by boat (Phillips & Spinks, 2011). However, the UNHCR March 2011 report indicated that

worldwide the number of individuals seeking asylum has “nearly halved in the last decade” (UNHCR, 2011, p. 1). The UNHCR further indicated that the 2010 figure of asylum seekers in Australia was “below levels reported by other industrialized and non-industrialized countries” (UNHCR, 2011, p.1). Australia received 8,250 applications according to the UNHCR figures for 2010 (UNHCR, 2011).

Regardless of the overall decrease in the number of people seeking asylum there is continued controversy regarding how the Australian government manages unauthorised arrivals who are seeking asylum (Johnston et al., 2009; Phillips & Spinks, 2011). The issues are related to the large number of asylum seekers being held in detention, the length of time taken for the processing of their applications for refugee status, the condition of the detention facilities, and most recently the government decision to send asylum seekers arriving by boat, to Malaysia, a decision which was challenged in the High Court of Australia and was found to be unlawful (Gordon, 2011). The Department of Immigration and Citizenship continues to exercise their mandatory detention policy and operates immigration detention centres which provide accommodation for people detained under the Migration Act 1958. These include: Villawood (established in Sydney in 1976), Maribyrnong (established in Melbourne in 1966), Perth (established in 1981), Christmas Island (established in September 2001), Northern Territory (established at Darwin in 2006), Curtin (established in Derby in 2010), Scherger (established at Weipa in 2010) and the Pontville detention centre in Tasmanian which opened in September 2011 (Department of Immigration and Citizenship, 2011b).

The Psychological Impact of Torture and Seeking Asylum in Australia

The health needs of migrants and refugees have been given increased attention in Australia since the 1980's, partly in response to worldwide concerns. Boman and Edwards (1984) reviewed the socio-cultural features of Australia's 51,000 Indochinese refugees who arrived in Australia by boat during the period between 1975 and 1982. In reviewing their resettlement in Australia, they concluded that whilst epidemiological studies documenting psychiatric disorders were still to be undertaken, the research indicated high levels of psychiatric dysfunction, particularly amongst those refugees who had a pre-migration history of persecution. In 1986 the NSW Health Department commissioned a study of the health care needs of migrants in Australia who had experienced torture or other forms of organised violence (Reid & Strong, 1987). The study found that many migrants, who either came here under the special humanitarian program, or as refugees, were survivors of 'organised violence' (Reid & Strong, 1987).

As a result of the Reid and Strong (1987) study and growing community concern about the health needs of survivors of organised violence, a service was established in NSW in 1988; the NSW Service for the Treatment and Rehabilitation of Torture and Trauma (STARTTS) (Reid, Silove, & Tarn, 1990). During the same period the Victorian Foundation for Survivors of Torture (VFST) was established (VFST, 2007). Other major Australian cities have since established services for torture survivors. Vastly increased media attention, particularly after the Tampa incident, was devoted to the issue of asylum seekers between 1999 and 2001. In the popular media, this attention was largely negative in nature, referring to the global increase in 'boat people', and to the fact that they were Islamic in origin, reflecting the unease of many Australians and also to the fact that most of the 'boat people' had paid 'people smugglers' for their passage (Romano, 2007). However, this attention also had positive effects. Many

professionals and other concerned public figures, as well as ordinary citizens, took up the plight of refugees with vigour. Health professionals, particularly, took a central role by contributing to education and awareness, undertaking research, and providing advocacy and giving priority to the health needs of refugees (Silove et al., 2000).

Table 4.1 summarises 16 studies conducted in Australia into the psychological consequences of seeking refugee status. A significant but limited number of studies have been undertaken on the basis of case studies or small group samples that explore the compound effects of seeking asylum in Australia following persecution in the home country. While there have been many studies into the migration experience itself, few have attempted to understand the effect of that experience on those who have already been traumatised. One limiting factor on the extent of this research has been what is perceived as its political nature. The treatment of asylum seekers, in particular those arriving in boats, has been a highly politicised issue over the past 10 years, which has affected research funding as well as access to people in the detention centres (Silove, 2004). However, it is now increasingly recognized clinically that a comprehensive assessment of clients' psychological well-being is not possible unless the post-migration experience is also taken into account (Burnside, 2007; Murray et al., 2008; Silove, 2004).

The studies shown in Table 4.1 further indicate that among other major factors contributing to the deterioration of the psychological wellbeing of refugees arriving in Australia is their migration status on arrival. Post-migration stresses exacerbates earlier emotional disturbances such as “fear of repatriation, stringent refugee determination procedures...accessing basic services” (Silove & Steel, 1998, p. 4). Such results are consistent over a wide range of sampling methodologies (Silove et al., 1998).

The Australian studies are reviewed and summarised under four headings: (1) permanent residency studies; (2) studies comparing permanent residents and asylum seekers; (3) asylum seekers and (4) detention centre studies.

Permanent residency studies.

Five out of the 16 studies reported in Table 4.1 included people living in Australia as permanent residents. The Thompson and McGorry (1995) study was discussed in detail in Chapter 3 as one of the very few controlled studies exploring the psychological impact of torture amongst the Latin American community residing in Melbourne, Australia. The pilot study was conducted during the late 1980's and early 1990's at a time when asylum seekers were not a mental health priority. The study reported, on the basis of a comparatively small sample, that torture had been the single most traumatic experience (Thompson & McGorry, 1995). Overall, the results found that the level of psychopathology was greater in the torture survivor group. For example, 58% of torture survivors, 50% of survivors of other types of systemic abuse and 12.5% of the control group met the criteria for PTSD. Torture survivors and survivors of other types of systemic abuse did refer to being in exile as a continuing part of their struggle as survivors, despite being both removed and far from direct persecution. Participants referred to a sense of feeling helpless, as well as feeling loss and guilt at being far away from their relatives and their culture.

A similar comment regarding the continuing struggle for refugees in regards to post-migration issues is reported in the study by Schweitzer et al. (2006). They explored post-migration issues affecting 63 Sudanese refugees with permanent residency in Australia. Their findings were also reported in Chapter 3. Overall, for psychological distress as measured by the HSCL-37 (Mollica, Wyshak, de Marneffe et al., 1987) the mean score for anxiety was

1.48 (0.44) and for depression the mean was 1.64 (0.53). For PTSD it was reported that 16% met the criteria for clinical 'caseness' (although the reporting level of caseness varies in the paper). Schweitzer et al. (2006) discuss the result in relation to other studies and report that their rates of depression and PTSD are generally lower than comparative studies. These results are lower than observed by Thompson and McGorry (1995). Schweitzer et al. (2006) further explored the association between post-migration stresses as measured by the Post-Migration Living Difficulties (PMLD) scale (Schweitzer et al., 2006). The PMLD is a check list developed to assess stress due to post-migration problems. Post-migration difficulties included concern about the family not living in Australia, difficulties in employment and adjusting to the Australian culture. These experiences were associated with depression and anxiety. An interesting finding was that length of time in Australia was associated with poorer mental health.

More recently, a survey conducted by Silove, Steel, Bauman, Chey & McFarlane (2007) assessed the relationship between trauma and PTSD with other mental disorders within 1,161 Vietnamese refugees who had resided in Australia for 11 years. Silove, Steel et al. (2007) compared the data collected from this sample with 7961 Australian-born participants. One of the aims of this survey was to investigate the long-term impact of pre-migration traumatic experiences on refugees and how they relate to post-migration demographics, health service utilisation and health status. The Vietnamese sample was obtained utilising a probability cluster sample of census tracts across five Local Government areas; this was followed by the random selection of an adult respondent from each of the households. This process identified 1413 people, of whom 1161 agreed to participate. Assessments utilised were: the Composite International Diagnostic Interview (CIDI 2.0) - this included the 12-month ICD-10 rates for anxiety, mood disorders and substance use; and, the

Medical Outcomes Study Short Form 12 (SF-12) measuring physical and mental functioning, covering a range from no or mild disability to moderate to severe disability. Service utilization, such as primary care physicians, mental health practitioners and traditional healers for the Vietnamese Community, was incorporated to assess how many services people had used over the years. Life exposure to trauma according to 10 broad categories was also incorporated. This section included 14 additional experiences derived from the Harvard Trauma Questionnaire designed specifically for Southeast Asian refugees. Ages ranged between 18 and 65+ for both groups, Vietnamese and Australians. They were also similar in their level of education.

Similarly to the Sudanese population in the Schweitzer et al. (2006) study, the Vietnamese were more socially disadvantaged than Australians, with lower rates of work, home ownership and greater reliance on government benefits. Further, the Vietnamese people had greater exposure to traumatic events related to combat and events which were life-threatening. Australians on the other hand, had greater exposure to natural disasters, witnessing serious injuries or killings and rape or sexual molestation. The Vietnamese community reported that 84% of their traumas were experienced in Vietnam or during their transition period to Australia.

For the Australian sample, the prevalence for ICD-10 mental disorders measured at 12 months was 18.6% and for PTSD it was 3.5%. PTSD was diagnosed amongst 19% of those with mental disorder. The prevalence of mental disorder within the Vietnamese community was 6.9%, and for PTSD it was the same as the Australians at 3.5%. Vietnamese people with a PTSD diagnosis reported a greater level of physical disability; on the other hand, the Australian population reported more mental health disability.

Other studies focused specifically on the impact of post-migration difficulties related to those who had experienced detention in Australia and who now had permanent residency (see Table 4.1). Two of these studies include Coffey et al. (2010) and Sobhanian, Boyle, Bahr, & Fallo (2006). Sobhanian et al. (2006) examined 150 former asylum seekers who had arrived from Iran and Afghanistan and were detained at the Woomera detention centre. They were interviewed upon their release. The refugees were asked to complete four psychological inventories: the Truncated Firestone Assessment of Self-Destructive Thoughts (T-FAST, Firestone & Firestone, 1996); the Quality of Life Inventory (QOLI, Frisch, 1994) a brief measure of life satisfaction; the Profile of Mood States (POMS, McNair, Lorr, & Droppleman, 1981) which is a self-report measure which can be administered individually or in groups; and the Suicidal Ideation Scale (SIS; Rudd, 1989). The participants were asked to complete the questionnaires twice. The first time they were asked to fill them in thinking about their situation when they were in the detention centre. The second one was at the time of the interview, which is when they were outside the detention centre and living in the community. The results indicated a difference in their psychological presentation between the time that they were in detention and when they were living in the community. The psychological states of the refugees improved significantly after their release from the Woomera Detention Centre as indicated by the results, for example that: “the mean score for suicidal ideation was significantly higher while the refugees were in the detention centre than when living in the Australian community ($M = 67.81, SD = 7.24,$ & $M = 20.34, SD = 7.39,$ respectively). This result was marked by a very large effect size ($\eta^2 = .96$) indicating that there was a major reduction in suicidal ideation following release of the refugees into the community” (Sobhanian et al., 2006, p. 13).

Coffey et al. (2010) interviewed 17 people who had been held for 2 years or more in an immigration detention centre. The assessment included a semi-structured interview exploring mental and physical health, daily life, significant events, and relationship and coping strategies. The interviews were undertaken on average 3 years and 8 months post-detention. Psychological symptoms were measured by the HSCL-25 (Mollica, Wyshak, de Marneffe et al., 1987), the HTQ (Mollica et al., 1992) and the WHOQOL-Bref (WHOQOL Group, 1998). Overall, the results indicated clinical symptoms of depression (mean score of 2.74, SD= 0.56), anxiety (mean score of 2.27, SD=0.63) and PTSD (mean score of 2.71, SD=0.45). Thirteen participants met the diagnostic criteria for depression and 11 for PTSD. Whilst the Coffey et al. (2010) study reported ongoing poor mental health it did not record psychological impact over time.

This supports findings of Schweitzer et al. (2006) who reported the association of distress continuing with time. Coffey et al. (2010) reported that participants expressed their experiences in detention as being dehumanising and that they were struggling in their new life. The experiences have been persistent in affecting the quality of their relationships, their view of self and their values. Demoralisation, concentration and memory disturbances were ongoing problems 3 years after the participants were released from detention. Coffey et al. (2010) concluded that the participants' ongoing difficulties at the time of their assessments appear to be directly related to their experiences in detention.

In contrast, Sobhanian et al. (2006) stated that participants reported an improvement in their wellbeing outside detention compared to how they rated themselves when they were in detention. It would be interesting to have further follow-up assessments to see if their mental health continues to improve as this was not the case with the participants in the

Schweitzer et al. (2006) study. Sobhanian et al. (2006) and Coffey et al. (2010) clearly demonstrated that detention has a significant impact on refugees. However, the ongoing mental health difficulties may be equally associated with pre-migration trauma histories and ongoing difficulties living in Australia.

Studies comparing permanent residents and asylum seekers.

Four studies out of the 16 studies shown in Table 4.1 compared asylum seekers with permanent residents on various psychiatric measurements. This expands the research into understanding the association between asylum seeking and psychopathology. These studies include: Johnston et al. (2009), Silove et al. (1998); Silove, Steel, McGorry, Drobny (1999), and Steel, Silove, Bird, McGorry, & Mohan (1999). Studies by Silove et al. (1998, 1999) and Steel et al. (1999) used the same sample and the results are reported across three different papers. Silove et al.'s (1998) comparative study researched the residency factor. The sample was made up of Tamils categorised in three different groups: 62 asylum seekers, 30 refugees, and 104 migrants. Johnstone et al. (2009) had a sample comprising of 71 Iraqi temporary protection visa holders and 60 Iraqi permanent humanitarian visa holders living in Melbourne, Australia.

In their study Silove et al. (1998) utilised a semi-structured interview that included demographic details and two psychometric scales: the HTQ (Mollica et al., 1992), and the HSCL-25 (Mollica, Wyshak, de Marneffe et al., 1987). Included also was the Post Migratory Living Difficulty Questions (PMLDQ, Sinnerbrink et al., 1996). Findings from this study are further presented in subsequent papers by Silove et al. (1999) and Steel et al. (1999). Johnston et al. (2009) in their assessments included the MOS-SS (Sherbourne & Stewart 1991), SF-36 General Health Scale (Ware, Snow, Kosinski, & Gandek, 1993), the SF-36

Physical Functioning Scale (Ware et al., 1993), the HSCL-25 (Mollica, Wyshak, de Marneffe et al., 1987), and the Personal Wellbeing Index (PWBI, International Wellbeing Group, 2006).

Silove et al. (1998) reported the demographic details for 62 asylum seekers, who at the time of the study represented approximately 60% of the Tamil asylum seeker population in the state of NSW, Australia. Of the participants, 77% were male and 42% were employed. This group of asylum seekers was compared to 134 Tamils with permanent residency, of whom 30 were authorised refugees (people who were given permanent residency after having applied for refugee status on their arrival in Australia) and 104 were immigrants (people who came to Australia having already obtained a permanent resident visa). From the HTQ it was reported that more than 40% of both the 'asylum seekers' and the 'refugee group' had experienced a number of traumatic events prior to coming into Australia. Among these were exposure to the unnatural death or murder of others, and forced separation from family members. Twenty six percent of asylum seekers reported having experienced torture, whilst 13% was the figure reported for the refugee group and 1% for the immigrant group. Chi-square comparisons indicated a significant difference in trauma exposure across the three groups. Analysis of the HSCL indicated that asylum seekers scored over three times the risk of obtaining high depression, anxiety and PTSD scores compared to the migrant group. For example, the depression mean score for asylum seekers was 1.92 (SD=0.65), for refugees 1.65 (SD=0.59), and for immigrants the mean score was 1.45 (SD=0.49), with a significant difference between the three groups based on a one-way ANOVA [$F=13.15$, $df=2,193$, $p<0.0001$]. The post-immigration difficulties reported by the three groups included worries about obtaining treatment for health problems, bad working conditions, conflict with immigration officials and isolation. Based on a factor analysis, factors associated with high

levels of distress for asylum seekers were: refugee determination processes, fear of being sent home, social and cultural isolation and family concern for those who remained in the home country.

Silove et al. (1998) and Steel et al. (1999) reported on the level of PTSD as indicated by the HTQ. No significant difference was indicated between asylum seekers and the refugee group [(M=1.73, SD =.55) for asylum seekers and (M=1.62, SD =.59) for refugees]. However, both groups obtained significantly higher scores than the immigrant group (M=1.37, SD =.44), [F(2,193)=10.7, p<.01]. Steel et al. (1999) conducted a path analysis to examine the relationship between pre-migration trauma and posttraumatic stress (PTS) symptoms. They reported that three pre-migration trauma experiences accounted for 20% of the variance of PTS symptoms; these were detention, organised violence and exposure to conflict. In addition, post-migration stress factors accounted for 14% of the variance of PTS symptoms; these were health welfare, asylum difficulties, adaptation difficulties and loss of culture and support. The path model suggested that pre-migration detention and extreme abuse such as torture were most significant in determining PTS symptoms, a finding that is consistent with the Thompson and McGorry (1995) study.

Silove et al. (1999) explored health service accessibility for asylum seekers in comparison to permanent residents within the Tamil community. They concluded that over 60% of asylum seekers experienced difficulties accessing medical and dental services. Accessing such services exceeded difficulties reported by refugees and migrants across the seven health and welfare services explored.

As shown in Table 4.1, Johnston et al. (2009) compared 71 temporary protection visa (TPV) Iraqi refugees with 60 Iraqi permanent humanitarian visa refugees. Their study found

that 46% of Iraqi temporary visa (TPV) refugees reported symptoms consistent with a diagnosis of clinical depression. This compared to 25% of Iraqi humanitarian visa refugees. The researchers reported that a temporary visa status is a significant determinant of psychological distress. Johnston et al. (2009) reported that both groups reported similar pre-migration persecution. As such they stated that trauma did not play a role in explaining the differences in psychopathological outcome between the two groups. Qualitative data was obtained from a semi-structured interview with the TPV refugees only. The TPV refugees expressed anger at their lack of control over their situation, a perception of injustice and a sense of rights violation.

Asylum seekers studies.

Five out of 16 studies presented in Table 4.1 included participants who were asylum seekers living in the community (Hosking, Murphy, & McGuire, 1998; Silove, Curtis, Mason, & Becker, 1996; Silove et al., 1997; Sinnerbrink et al., 1996; VFST, 1998). The number of participants in these studies ranged from three (Silove et al., 1996) to 60 participants (Hosking et al., 1998).

Silove et al. (1996) adopted a case study methodology using a clinical assessment that incorporated a physical and psychiatric assessment conducted by two clinicians from the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS). They found that the mental state of three Cambodian asylum seekers, who had gone on a hunger strike following their long-term detention in Australia, had deteriorated severely during this time. A clinician from STARTTS conducted a physical and clinical assessment. On the basis of their assessment they concluded that the mental states of all three of the participants had altered markedly throughout the strike, that they were culturally

disoriented in relation to language and the legal system in Australia, and that they were highly anxious and depressed.

Clinicians from the Victorian Foundation for Survivors of Torture (VFST, 1998) study, conducted semi-structured interviews with 50 East Timorese asylum seekers. Of the 50 participants, 33 were interviewed at their presentation to the VFST and 17 of the 50 were interviewed by a VFST staff member whilst in a detention centre. They all had: a history of traumatic experiences such as torture, harassment, rape and other sexual assaults; family members who had been killed by authorities; and an experience of detention in Australia. The VFST concluded that all participants presented with symptoms of PTSD, for example, 98% reported sleep disturbance, 93% reported recurrent and intrusive memories, and 91% reported poor concentration and anxiety. Symptoms of depression were reported by 94% of asylum seekers, and 45% reported suicidal thoughts. Associated symptoms included self denigration, guilt, grief and hopelessness.

The other three asylum seeker studies incorporated various psychometric, general health and post-migration difficulties assessments (Hosking et al., 1998; Silove et al., 1997; Sinnerbrink et al., 1996). Sinnerbrink et al. (1996) used psychometric scales which included: HTQ (Mollica et al., 1992); the Dartmouth Coop Functional Health Assessment Chart (COOP-Chart, Nelson et al., 1987), the Duke-University of Northern Carolina Health Profile (DUHP, Parkerson et al., 1981). In addition, a 24-item checklist for post migratory living problems was incorporated. The checklist was devised by Sinnerbrink et al. (1996) following wide consultation and is reported in later studies as the Post Migratory Living Difficulties Check-list (e.g., Steel et al., 2004; Steel et al., 1999). A structured interview assessed difficulties associated with accessing health care. Silove et al. (1997) also reported on the

inclusion of the Composite International Diagnostic Interview Schedule for PTSD (CIDI; WHO 1990) and the HSCL-25 (Mollica, Wyshak, de Marneffe et al., 1987). This was an extension to the assessments undertaken by Sinnerbrink et al. (1996).

Hosking et al. (1998) incorporated in their assessment the HSCL-25, the DUHP and the COOP as in the Sinnerbrink et al. (1996) and Silove et al. (1997) studies. In addition, Hosking et al. (1998) included the General Health Questionnaire (GHQ, Goldberg & Hillier, 1979), the Zung Self-Rating Depression Scale (Zung, 1965), the Spielberger State Trait Anxiety Inventory (Spielberger, 1983) and the Medical Outcomes Study-36 (MOS-36, Sherbourne, & Stewart, 1991).

Sinnerbrink et al. (1996) and Silove et al. (1997) reported on findings associated with research on 40 asylum seekers of 21 different nationalities who attended a community resource centre in Sydney. Participants reported pre-migration histories of numerous traumatic experiences including torture. Sinnerbrink et al. (1996) and Silove et al. (1997) reported that a total of 79% of participants had traumatic experiences, and 26% had experienced torture. Silove et al. (1997) further reported that out of the 30 participants presenting with trauma history, 14 met the criteria for PTSD. For the remaining participants who did not meet the criteria for PTSD but who had a history of trauma exposure, 11 met at least one major symptom from the sections of the PTSD criteria B, C or D (Silove et al., 1997). They added that PTSD was associated with post-migration stressors; examples of the latter included delays in processing refugee applications ($\chi^2=6.17$, $df=1$, $p=0.013$); not having permission to work ($\chi^2=5.78$, $df=1$, $p=0.016$) and racial discrimination ($\chi^2=4.75$, $df=1$, $p=0.029$). Sinnerbrink et al. (1996) reporting on the result of the COOP function data, found that asylum seekers were more impaired in their emotional health and social functioning than

a normative patient group. The results from the DUHP indicated that 20-22 participants reported nervousness, headache and/or depression.

Hosking et al. (1998) reported on 60 asylum seekers of different nationalities and they were recruited from different agencies throughout Australia which specialise in providing services for this population group. Hosking et al. (1998) concluded that 60% of the asylum seekers in their study presented with high levels of anxiety and depression. They further stated that 22% rated their experience of seeking asylum as 'good', whilst 35% said it was 'fair' and 43% rated it as being 'difficult'. They further stated that the psychological distress was directly associated with the length of time between lodging an application for refugee status and knowing the outcome. In Silove et al. (1997), anxiety scores were associated with female gender ($p=0.029$), conflict with migration officials ($p=0.025$), and loneliness and boredom ($p=0.045$). Depression was statistically associated with boredom ($p=0.043$). They further concluded that past trauma exposure was only linked to PTSD ($p<0.0001$). Those who met the criteria for PTSD reported serious stress associated with post-migration issues related to the asylum-seeking process.

All five studies described post-migration trauma experiences as including: fear of being sent home, delays in processing the refugee application - which can be from 2 to 5 years - no permission to work, no access to medical treatment and long-term separation from family.

Detention centre studies.

Table 4.1 shows two studies comprised of participants in detention. Mares et al. (2002) recorded observations made of asylum seeker detainees in two Australian detention

centres. Mental health workers gained access to families in detention by accompanying the lawyers representing the families. They presented two case studies that they report as representative of experiences of Australian detainees. The first case documents a mother's experience of childbirth during detention and her feelings of confusion, lack of information and isolation from her family whilst in hospital. The parents reported despair and helplessness. The authors linked the parent's untreated depression to their 2-year old child's behavioural problems.

In the second case of another family with two teenagers and a 3-year old, Mares et al. (2002) describe a very barren environment with limited activity. The family were described as traumatised by their detention and the children as deprived of basic human rights. The children's behaviour, depressed mood and thoughts were related to their detainment, experience of their father's despair and of riots witnessed in the detention centre. The family reported a suicide attempt by the father, anxiety, depression and self-harm concerns and a sense of helplessness, guilt and fears for their future mental health.

Steel et al. (2004) also reported on the mental health of asylum seekers living in a remote detention centre. They carried out structured psychiatric phone interviews of 10 families from the same ethnic background, which included interviewing 14 adults and 20 children who had been in detention for more than 2 years. Phone interviews were conducted as access to the detention centre for research had not been forthcoming. Incorporated was a detention experience checklist-based, child-specific schedule for affective disorders and schizophrenia, and a clinical interview for disorders based on the DSM –IV and a parenting questionnaire (see Table 4.1 for instrument details). As with Mares et al. (2002), contact was arranged by legal workers. The families all reported traumatic experiences in their home

country and a range of traumatic experiences in travelling via South East Asia and by boat to seek asylum in Australia. At the time of interview all families were appealing rejection of their refugee protection applications.

All the families reported trauma experiences whilst in detention which included witnessing: riots, violence between detainees and detainees and guards, self harm and suicide attempts. Negative experiences included assaults, being called by a number not a name, family separation and fear of being sent home. These findings are consistent with other reports on detention centre experiences (e.g., Coffey et al., 2010; Johnstone et al., 2009; Silove et al., 1996).

Steel et al. (2004) found that the psychiatric assessment results reported that every adult was diagnosed with a major depressive disorder and 86% were diagnosed with PTSD. Psychiatric disorders, reported retrospectively, indicated that adults displayed a threefold increase and children tenfold. The findings raised significant concerns about the treatment of detainees, the high number of asylum seekers presenting with mental health problems and the harm associated with the policy of mandatory detention on families who arrive without entry documentation (Steel et al., 2004).

Limitations of these studies.

There is an inconsistency of methodology within Australian research on this topic. Some studies are based on in-depth interviews while the majority are case series that incorporate a varying number of standardised psychiatric scales. There are a few standardised scales such as the HTQ and the HSCL that are used in many studies; however, they are the exception which makes comparison of mental health findings more complicated than

necessary. As with all cross-cultural research, Western translated and back-translated measurements will inevitably risk trans-cultural error (Silove et al., 2007; Watters, 2007). Furthermore, translation of scales and the use of interpreters is an on-going difficulty experienced in research with this population group.

Extrapolation of results from studies with small sample sizes is an inherent problem within research generally but particularly within this area (e.g., Coffey et al., 2010; Sinnerbrink et al., 1996; Steel et al., 2004; Thompson & McGorry, 1995; VFST, 1998). The lack of clear classification of participants as defined by their traumatic experiences leaves uncertainty regarding whether torture is assessed reliably and how this abuse predicts level of psychopathology (Hollifield et al., 2011).

The various controversies surrounding asylum seekers, particularly those in detention, has made access very difficult. A limitation in all Australian studies is obtaining an epidemiologically representative sample. As Silove et al. (1997) discussed, volunteer population groups may only represent a small range of asylum seekers in the community. As in their sample, the participants were utilizing a community centre; this could exclude others who did not know of the centre, are too unwell to participate or too occupied with work to be included. A further difficulty with assessing asylum seekers in detention has been access to the participants. Asylum seekers interviewed have generally been seen in conjunction with lawyer visits and without full authority endorsement as experienced by Steel et al. (2004) whose assessments were based on telephone interviews as the only means of access.

A factor included in the discussion of many of the studies is the potential for bias in the participants' responses who are possibly wanting to exaggerate their stories in the hope that doing so will assist them to gain some advantage or sympathy within the system

(Johnston et al., 2009; Silove et al., 1997; Silove et al., 1998; Steel et al., 2004). Another response factor relates to the opposite circumstance where people restrain themselves from telling their experience of torture and its impact on self. For example, due to cultural constraints, both male and female participants may well under-report experiences of sexual assault (Silove et al., 2007). Without minimizing the amount of evidence supporting the negative effects of detention on mental health, it should be noted that some research interviews took place after a crisis, e.g., following hunger strikes or riots (Mares et al., 2002; Silove et al., 1996; Steel et al., 2004).

A factor that was not clearly explored by the Australian studies is the coping strategies adopted by refugees to cope with their pre- and post- migration traumatic experiences. As mentioned in Chapter 3 (Başoğlu et al., 1994; Sachs et al., 2008; Tol et al., 2007) factors such as religious belief, political commitments, level of family support, and the validation of the experience by authorities, assist survivors in their ability to confront adversity.

Another limitation of these studies is the investigation of personality change or impact the pre-and post- migration traumatic experiences have on self-views. Coffey et al. (2010) using a qualitative analysis reported on the impact that detention in Australia had on self such as demoralisation, a sense of helplessness, guilt and feeling of failure to significant others. Turner (2000) reported that it is important for clinicians and researchers to understand the alterations on personal beliefs, religious and political values, mistrust towards the world, social withdrawal and estrangement resulting from torture and other types of systemic abuse. Turner (2000) suggested that the use of the ICD-10 (WHO, 1992) diagnosis of enduring personality change is a helpful addition to classification systems and furthers the understanding of the impact of traumatic events.

A consideration that is not included in the Australian studies and can impact on the level of psychopathology of asylum seekers, is a clear relationship between the frequent changes of policies by all governments (e.g., the introduction of TPV versus their withdrawal, the Pacific Solution immigration policy (i.e., sending people to other countries for processing or to remote detention centres)) and the results in high levels of anxiety and constant changes that leave the asylum seeker psychologically vulnerable.

Conclusion

All studies presented in Table 4.1 found that refugees with permanent residency and those seeking asylum met the criteria for PTSD, anxiety and depression. However, the degree of psychopathology related to their experience before they came to Australia, including torture, and what degree is related to their present situation, is still not clear. Due to Australia's small population and, in international terms, the small number of asylum seekers arriving in the country, the limitations of research into this cohort of refugees is understandable. Further to that, the reluctance of governments to facilitate access to asylum seekers hinders the work of researchers. In particular, there is a paucity of research into the impact of torture and trauma on the victims of this violence prior to their seeking asylum in Australia. The focus of attention has been instead on the effects of the survivors' status and their place of residency in this country.

Conversely, in this study, concern is given to the full impact of torture and systemic abuse on the victims and, consequently, a penetrating understanding of the effects of the violence is sought. This begins with the initial violation, its immediate impact and any response the victim is able to make to the assault on their physical and mental wellbeing. Additionally, this research seeks to understand how the trauma affects the individual's sense of self and how a survivor may draw on that self-knowledge as a coping mechanism. The following chapter draws on Kelly's

(1955) theoretical understanding of self giving an understanding of the impact torture has on the 'self' and the ability of victims to survive such atrocities.

Table 4.1

Case Studies, Case Series and Cross Sectional Studies Examining the Consequences of Torture and Seeking Asylum in Australia

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Study Design
Thompson & McGorry As previously documented in Chapter 3 (Table 3.3).	1995	30 Participants were divided into three groups: Group 1: 12 torture survivors Group 2: 10 survivors of other types of organized violence Group 3: 8 migrants who had not experienced any traumas	A semi-structured interview, the PTSD scale, SCL-90-R, the IES	Group 1: All experienced systematic torture as defined by the United Nation Convention for Human Rights Group 2: People who reported not being systematically tortured or incarcerated; however, they witnessed people being taken away, and forced displacement Group 3: People who had migrated to Australia but who reported no experience of political violence and no connection to it in their home country	The proportion of people meeting the criteria for PTSD was higher for Group 1 where 7 cases met the diagnostic criteria for PTSD followed by Group 2 with 5 cases and Group 3 with 1 case. The same applied for the impact of event scale and for the SCL-90-R, where all results tended to indicate that Group 1 and 2 presented with greater psychological distress than Group 3.	Quasi-experimental
Silove, Curtis, Mason, & Becker.	1996	3 Cambodian asylum seekers who were on a hunger strike and subsequently were admitted to a Sydney NSW Hospital	Clinical assessment, physical and psychiatric assessment conducted by clinicians from STARTTS	All 3 had experienced complex trauma and persecution in Cambodia. Living in a detention centre in Australia between 2-3 years. Experienced hunger strike whilst living in detention in Australia.	Physical health deterioration requiring hospitalisation. Expressed extreme fear of returning to Cambodia. Withdrawn, depressed and uncommunicative. One woman became psychotic	Case studies

(continued)

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Study Design
Sinnerbrink, Silove, Manicavasagar, Steel & Field.	1996	40 asylum seekers from 21 different countries 21 Males 19 Females	Harvard Trauma Questionnaire (HTQ, (Mollica, et al., 1992)), traumatic events section. A 24-item post- migratory living difficulties checklist devised by the authors following wide consultation and includes items such as immigration process, accessing employment and healthcare. The Dartmouth COOP Functional Health Charts (COOP-Chart (Nelson et al., 1987). It measures physical fitness, emotional status, pain experience, daily activities, social activities, changes in health and overall health. The Duke-University of Northern Carolina Health Profile (DUHP, Parkerson et al., 1981). It measures health status, component for somatic and psychological symptoms was used. Structured Interview assessing the difficulties in accessing health care in Australia	30 out of 38 participants (79%) completing the HTQ reported exposure to past trauma. 10 participants reported being tortured.	Asylum seekers were more emotionally distressed than a normative group of patients, and more impaired in social functioning compared with patients with minor medical illnesses (COOP-Chart) 20 to 22 participants reported nervousness, headache and /or depression (DUHP) 27 reported problems accessing medical services	Case series

(continued)

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Study Design
Silove, Sinnerbrink, Field, Manicavasagar, Steel.	1997	As per Sinnerbrink et al., (1996) (as above)	As per Sinnerbrink et al. (1996 (as above) with the addition of the: Hopkins Symptom Checklist-25 (HSCL-25 validated by Mollica et al. (1987)). The Composite International Diagnostic Interview schedule (CIDI) for PTSD (developed by the Sydney Training and Reference Centre for WHO-CIDI) (no reference cited)	As per Sinnerbrink et al. (1996) (as above) 30 participants or 79% of participants reported trauma events on both the HTQ and the CIDI module for PTSD. Trauma events are detailed and included: witnessing murder or unnatural death, being close to death, forced separation and brainwashing.	HSCL-25 mean scores for anxiety and depression were below normative threshold for clinically significant distress. The CIDI for PTSD reported 14 (36.8%) participants met criteria for PTSD. Higher anxiety was associated with female gender, conflict with immigration officials, loneliness and boredom and poverty. Pre-migration trauma exposure was associated with PTSD PTSD was associated with post-migratory stressors. Post migration stressors included: fear of being sent home; delays in processing refugee application; no permission to work; no access to medical care and separation from family and friends	Case series

(continued)

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Study Design
Silove, Steel, McGorry, & Mohan	1998	196 Tamils living in Sydney, 62 Asylum seekers 30 Authorised refugees arriving with permanent residency 104 Migrant with permanent residency	Harvard Trauma Questionnaire (HTQ (Mollica et al., 1992)). Post Migratory Living Difficulties Questions as developed by (Sinnerbrink et al. (1996) (see above) with additional questions following Tamil community consultation . Questions covered 23 common post migration difficulties. Hopkins Symptom Checklist-25 (HSCL validated by Mollica et al. (1987))	26% of asylum seekers survived torture Asylum seekers did not differ from refugees on measures of past trauma (13% of the refugees survived torture) The migrant group reported a smaller range of traumatic experiences compared to asylum seekers (one of the migrant participant is recorded as having been tortured)	Asylum seekers leave their home country for similar risk reasons as those of people who leave with a permanent residency visa. Asylum seekers presented with higher level of distress on factors related to refugee determination, family concerns, health and welfare compared to the other two groups. Asylum seekers displayed over three times the risk of developing depression, anxiety and/or PTSD compared to the migrant group.	Case series
Hosking, Murphy, & McGuire.	1998	60 asylum seekers 37 Male 23 Female The majority of asylum seekers arrived in Australia by plane with a visitor's visa or student visa. Asylum seekers originated from 26 different countries.	Hopkins Symptom Checklist-25 (HSCL validated by Mollica et al. (1987)) General Health Questionnaire (GHQ) Zung Self-Rating Depression Scale Spielberger State-Trait Anxiety Inventory MOS 36 Short-Form Health Survey Dartmouth COOP Functional Health Assessment Charts Duke-University of Northern California Health Profile A Self Report Assessment of Exposure to Post-Migration Stressors	Torture Rape Beatings	Almost half of asylum seekers had no immediate family in Australia 31% had dependents (spouse, children) in Australia, 40% had dependents overseas, 60% of the asylum seekers displayed high levels of psychological distress as indicated by scores measuring depression and anxiety. The psychological distress was strongly associated with the length of time since lodging their applications for refugee status without a decision being made	Case series

(continued)

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Study Design
Victorian Foundation for Survivors of Torture (VFST)	1998	50 East Timorese asylum seekers. 35 Males and 15 Females. 33 were interviewed when they approached the Foundation for assistance. 17 were assessed by VFST staff at the Curtin Detention Centre.	A semi-structured interview	Harassment, Physical assaults, Arrest and detention, Rape and other sexual assaults, Torture, Family members being killed, Witnessing murders and killings	All presented with symptoms of PTSD. 94% presented with symptoms of depression. 45% presented with symptoms of depression associated with suicidal thoughts.	Case series
Silove, Steel, McGorry, & Drobny	1999	As per Silove et al. (1998) (see above)	Post Migratory Living Difficulties Questions per Silove et al. (1998) (see above)	Traumatic experiences not described. However, these details are described in Silove et al. (1998) as it is the same sample.	60% of asylum seekers rated having serious difficulties accessing health services. 23-27% of refugees had difficulties accessing health services. 1-6% of migrants had difficulties.	Case series

(continued)

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Study Design
Steel, Silove, Bird, McGorry, & Mohan.	1999	As per Silove et al. (1998) (see above)	As per Silove et al. (1998) (see above) without further analysis of the Hopkins Symptom Checklist-25. Path analysis, was used to examine a range of experiences to explore the pathways that lead to posttraumatic stress (PTS) symptoms. This method assesses the impact of each predictor (e.g., traumatic experience) on the outcome variable (e.g., PTS symptoms).	As per Silove et al. (1998) (see above) Three components resulted from pattern matrix loading for the 16 trauma events from the HTQ. These were: Detention and Abuse; Traumatic Loss, and Exposure to Conflict Three components resulted from pattern matrix loading for the 23 post-migration living difficulties following removal of any set that did not produce an independent statistical association with PTS symptoms: 1 Health Care Welfare and Asylum; 2 Adaptation Difficulties, and 3 Loss of Culture and Support.	All three trauma components collectively accounted for 20% of the variance of PTS symptoms. Detention and Abuse was the largest followed by Traumatic Loss and then Exposure to Conflict. Post-migration stress contributed 14% of the variance of PTS symptoms. Adaptation Difficulties was the largest followed by Loss of Culture and Support and then Health Care Welfare and Asylum.	Case series
Mares, Newman, Dudley, & Gale	2002	Two families: one family with two children and one family with three siblings (two teenage and one child).	In depth interview	Trauma reported referred to present situation in the detention centre	Depression and anxiety. One case study reports adult male suicide attempt. Guilt and Grief related to not being able to protect family members.	Case study

(continued)

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Study Design
Steel, Momartin, Bateman, Hafshejani, Silove, Everson, Roy, Dudley, Newman, Blick, & Mares	2004	14 adults and 20 children living in a remote detention centre. The interview was administered by three same-language speaking psychologists by phone.	Semi-structured psychiatric interview which included: Structured Clinical Interview for DSM-IV Axis I disorders (First et al., 2004), and the Detention Experience Checklist. This check list was based on previously designed post-migration living difficulties checklist and covered 60 key experiences. Detention Symptom Checklist: a list of nine stress symptoms adapted from standard measures of post-traumatic stress (Mollica et al., 1992). Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL, Kaufman et al., 1997) Parenting questionnaire: questions about parenting competency before and during detention.	All adults reported traumatic experiences in country of origin. One reported to have been imprisoned and tortured in country of origin. In detention in Australia all reported various traumatic experiences in detention: witnessing riots where detainees were beaten with batons by detention centre guards; detainees fighting each other; fire breakouts; self harm by detainees and witnessing suicide attempts.	Psychiatric assessment indicated that the prevalence of psychiatric disorder appeared to increase markedly from the period of detention. Every adult was diagnosed with a major depressive disorder and 12 with PTSD. Two adults had evidence of psychotic symptoms and severe major depressive disorder and both had made previous suicide attempts. None of the adults had reported prior detention depression. Most adults reported that their ability to parent was undermined by detention.	Case series
Sobhanian, Boyle, Bahr, & Fallo	2006	150 former refugee detainees from Woomera Detention Centre	Psychological Status Inventory, Truncated Firestone Assessment of Self-destructive Thoughts (T-FAST), Quality of Life, Inventory The Suicidal Ideation Scale, Profile of Mood States	Number of traumatic experiences not specified	The psychological states of refugees improved significantly after their release from the Woomera Detention Centre	Case series

(continued)

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Study Design
Schweitzer, Melville, Steel, & Lacherez	2006	63 Sudanese male refugees who had experienced torture	Semi-structured interview which included questionnaires assessing socio-demographic, pre-migration trauma, anxiety, depression, PTSD, Post-migration issues and perceived social support (PMLD).	Various torture experiences, organised violence such as witnessing others being killed, threat to self and others by officials	Evidence of trauma. Less than 5% met criteria for PTSD. 25% reported psychological distress	Case series
Steel, Momartin, Bateman, Hafshejani, Silove, Everson, Roy, Dudley, Newman, Blick, & Mares	2004	14 adults and 20 children living in a remote detention centre. The interview was administered by three same-language speaking psychologists by phone.	Semi-structured psychiatric interview which included: Structured Clinical Interview for DSM-IV Axis I disorders (First et al., 2004), and the Detention Experience Checklist. This check list was based on previously designed post-migration living difficulties checklist and covered 60 key experiences. Detention Symptom Checklist: a list of nine stress symptoms adapted from standard measures of post-traumatic stress (Mollica et al., 1992). Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL, Kaufman et al., 1997) Parenting questionnaire: questions about parenting competency before and during detention.	All adults reported traumatic experiences in country of origin. One reported to have been imprisoned and tortured in country of origin. In detention in Australia all reported various traumatic experiences in detention: witnessing riots where detainees were beaten with batons by detention centre guards; detainees fighting each other; fire breakouts; self harm by detainees and witnessing suicide attempts.	Psychiatric assessment indicated that the prevalence of psychiatric disorder appeared to increase markedly from the period of detention. Every adult was diagnosed with a major depressive disorder and 12 with PTSD. Two adults had evidence of psychotic symptoms and severe major depressive disorder and both had made previous suicide attempts. None of the adults had reported prior detention depression. Most adults reported that their ability to parent was undermined by detention.	Case series

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Sobhanian, Boyle, Bahr, & Fallo	2006	150 former refugee detainees from Woomera Detention Centre	Psychological Status Inventory, Truncated Firestone Assessment of Self-destructive Thoughts (T-FAST), Quality of Life, Inventory The Suicidal Ideation Scale, Profile of Mood States	Number of traumatic experiences not specified	The psychological states of refugees improved significantly after their release from the Woomera Detention Centre	Case series
Schweitzer, Melville, Steel, & Lacherez	2006	63 Sudanese male refugees who had experienced torture	Semi-structured interview which included questionnaires assessing socio-demographic, pre-migration trauma, anxiety, depression, PTSD, Post-migration issues and perceived social support (PMLD).	Various torture experiences, organised violence such as witnessing others being killed, threat to self and others by officials	Evidence of trauma. Less than 5% met criteria for PTSD. 25% reported psychological distress	Case series

(continued)

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Study Design
Silove, Steel, Bauman, Chey, & McFarlane	2007	<p>Vietnamese refugees (n= 1,161) resettled in Australia for 11 years 577 males and 7, 584 females</p> <p>Australian general population sample (n= 7,961) was drawn from an Australian Bureau of Statistics national mental health survey (Henderson, Andrews, & Hall, 2000). 4122 males and 3839 females</p>	<p>The Composite International Diagnostic Interview (CIDI, (Andrews & Peters,1998)). 14 experiences from the Harvard Trauma Questionnaire (HTQ) were included to expand the CIDI trauma events.</p> <p>ICD-10 (International Classification of Diseases and Related Health Problems (WHO,2007)).</p>	<p>Vietnamese community reported higher exposure to direct combat; life threatening accidents; torture or being terrorised; violence to someone close and other stressful events.</p> <p>The Australian population had higher exposure to natural disasters; witnessing serious injury or killing; rape and sexual molestation.</p>	<p>PTSD prevalence for both groups was 3.5%.</p> <p>Diagnosis of PTSD was present in 50% of Vietnamese and 19% of Australians with any mental disorder.</p> <p>Trauma was the major contributor to mental disorder in the Vietnamese population.</p> <p>Trauma and PTSD continue to effect the mental health of Vietnamese refugees even after 10 years of resettlement in Australia.</p> <p>Vietnamese community presents with physical symptoms rather than mental health symptoms compared to the Australian population.</p>	Case series

(continued)

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Study Design
Johnston, Allotey, Mulholland, & Markovic.	2009	71 Iraqi Temporary Protection Visa (TPV) holders 60 Iraqi Permanent Humanitarian Visa holders living in Melbourne (PHV) Data was collected between 2004 and 2005.	Medical Outcomes Study Social Support Scale (MOS-SS, Sherbourne, & Stewart, (1991)). Self-Reported Physical Health: SF-36 General Health Scale (Ware, Snow, Kosinski, & Gandek, (1993)). SF-36 Physical Functioning Scale (Ware, Snow, Kosinski, & Gandek, (1993)). Hopkins Symptom Checklist-25 (HSCL validated by Mollica et al. (1987)). Personal Wellbeing Index (PWBI, Australian Unity Wellbeing Index: Cumulative Psychometric record). Perceived Constrains subscale (Lachman & Weaver, 1998). Sense of Control Scale, and State-Trait Anger Expression Inventory (STAXI, Spielberger, 1991).	Reported persecution prior to coming into Australia Separation from spouse and/or child in Australia	TPV refugees suffered a higher level of clinical depression and lower sense of wellbeing compared with PHV refugees. TPV status was a significant determinant of psychological distress. Policies that violate human rights are associated with adverse health outcomes.	Case series

(continued)

Author	Year	Sample	Measurement	Trauma	Diagnosis/Results	Study Design
Coffey, Kaplan, Sampson, & Tucci.	2010	16 Male refugees 1 Female refugee All participants had been in an Australia detention centre. They were interview on an average of 3 years and 8 months after their released from detention. They have been given permanent visas	Semi-structured interview. Hopkins Symptom Checklist-25 (HSCL validated by Mollica et al. (1987)). Harvard Trauma Questionnaire (HTQ)-specifically the PTSD scale in part IV of the HTQ. The World Health Organisation Quality of Life Assessment short version (WHOQOL-Bref , WHO quality of life group, 1998))	Pre-detention trauma experiences not reported	Qualitative data identified four themes for the detention period and they were: 1. Confinement and deprivation, 2. Injustice and inhumanity, 3. Isolation and fractured relationship and, 4. Hopelessness and demoralisation. Themes for post-detention period included: 1. Insecurity and injustice, 2. Relationship difficulties, and 3. Changes to view of self The mean scores for depression, anxiety and PTSD were at clinically significant levels.	Case study

Note: CIDI= Composite International Diagnostic Interview schedule; PTSD= Post Traumatic Stress Disorder; HTQ= Harvard Trauma Questionnaire; WHO= World Health Organisation; IES= Impact of Event Scale; SCL-90-R= Symptom Check List 90 Revised; STARTTS= New South Wales Service, Australia for the Treatment and Rehabilitation of Torture and Trauma Survivors

Chapter 5

The Tortured Self: A Personal Construct Theory

Perspective

Most research within the area of torture has been preoccupied with psychiatric symptoms and diagnosis as shown in Chapters 3 and 4. Wilson (2004), in his book 'Broken Spirits', offers further understanding of the consequences of torture on the self. Wilson states that the experience of torture results in a complex trauma beyond the specific diagnoses of PTSD, depression, and anxiety. Torture and other systemic abuse aims at breaking the individual's sense of control thereby resulting in the fragmentation of self. Human-inflicted atrocities lead to the loss of internal self-continuity and connection (Wilson, 2004). This is similarly commented on by Kordon et al. (1992) in their review of torture in Argentina. Kordon et al. (1992) state that torture targets the individual's complex representation of self and value systems. They define self as the feeling of 'oneness' that allows the maintenance of an internal coherence. Torture takes away this sense of 'oneness' and renders the victim completely dependent on the torturer. This chapter investigates the consequences of torture on the self; how the self can be broken into fragments or, in some individuals, remain intact and whole.

As Wilson states:

Trauma impacts the psychic core of the very soul of the survivor and generates a search for meaning as to why the event had happened...The alternative of psycho formative processes may lead to a de-centering of the self, a loss of groundedness and a sense of sameness and continuity.

Fragmentation of ego-identity has consequences for psychological stability, well-being and psyche-integration, resulting in proneness to dissociation. In many cases of PTSD, the fragmentation of ego-identity is a fracturing of the soul and spirit of the person...such a broken connection in an individual's existential sense of meaning may be a precursor to major depression, psychological surrender, and in extreme cases, suicidality and death. (Wilson 2004, p.111).

As discussed in Chapters 3 and 4, people who have experienced torture and other forms of organized violence suffer from conditions such as depression, anxiety and PTSD (e.g., Allodi & Cowgill, 1992; Başoğlu, 1997; Başoğlu et al., 1994; Mollica, Wyshak, & Lavelle, 1987; Rasmussen et al., 2007). But we need to go beyond diagnostic and symptom description and examine the impacts of trauma on the self.

Both Lifton (1967) and Victor Frankl (1984) went beyond symptom and diagnostic description and described the psychological aftermath of torture and systemic violence as a 'vacuum state' where the person is left with no capacity to create a meaning of his or her experience of torture, or imagine him/herself in the future. The person exists within a state of emptiness, caught in the trauma, a kind of endless psychological "black hole" (Wilson, 2004, p. 120). It is here that the individual experiences the "archetypal abyss" encountered in myth and literature (Wilson, 2004, p.135). Extreme trauma penetrates beneath the mask of self-presentation in profoundly negative and life-altering ways that lead to despair, aloneness and confrontation with evil and death. It is a universal struggle to overcome fear, anxiety and uncertainty and to mend the damaged and fragmented self (Wilson, 2004).

While Wilson (2004) discusses the fragmentation of self, he also states that survivors can retain a sense of autonomy, energy, validity, and integral coherency. Studies of Holocaust survivors (Krystal, 1988; Niederland, 1968), more recent torture victims (Ortiz, 2001) and victims of ethnic genocide (Lindy & Lifton, 2001), also describe a similar phenomenon to that of Kordon et al. (1992) and Wilson (2004). That is, the self can be destroyed, resulting in utter 'psychological surrender', but equally the self can enter into a state where the will to live is maintained and the victims do not psychologically surrender. By means of this kind the victim can reach a point during torture where they are able to exercise control of their inner self (Keenan, 1993; Lira & Castillo, 1991; Thornton, 1989). In his book 'An Evil Cradling', Brian Keenan (1993) recalls that during his incarceration:

I had attempted to create imaginary pictures to decorate the walls. Each day I would collect these mental images and try to project them onto the wall, to hold them there framed and contained within my understanding. (Keenan, 1993, p. 85).

Further insight into how people survive systemic abuse is offered in a wide variety of literature. They are to be found, for example, in: 'Body in Pain: The Making and Unmaking of the World' by Steven Scarry (1985), 'No Future Without Forgiveness' by Desmond Mpilo Tutu (2000) and through poets such as W. H. Auden (see 'Refugee Blues', 1979), and Wilfred Owen (see his renowned First World War poem 'Dulce et Decorum Est', 1917). Such works demonstrate the way in which the survivor processes extreme experiences and attempts to integrate them in a way that goes beyond psychopathological diagnoses and the measurement of psychiatric symptoms. In this literature we are presented with the inner

struggle as the physical and emotional pain forces the individual to the point where choices are made that can allow them to integrate their suffering within their inner self.

In any given situation, even those as severe as torture, a choice is made, and these choices can become a turning point in the way the victim survives. This is explained in the book 'Man's Search for Meaning' by Viktor Frankl (1984, p.75):

They may have been few in number, but they offer sufficient proof that everything can be taken from a man but one thing: the last of human freedoms-to choose one's attitude in any given set of circumstances, to choose one's own way. And there were always choices to make. Every day, every hour, offered the opportunity to make a decision, a decision which determined whether you would or would not submit to those powers which threatened to rob you of your very self, your inner freedom; which determined whether or not you would become the plaything of circumstances, renouncing freedom and dignity to become molded into the form of the typical inmate.... any man can, even under such circumstances, decide what shall become of him-mentally and spiritually (Viktor Frankl, 1984, p.75).

Similarly, Keenan writes:

As my anger diminished I felt a new and tremendous kind of strength. The more I was beaten the stronger I seemed to become. It was not strength of arm, nor of body but a huge determination never to give in to these men, never to show fear, never to cower in front of them....there was a part of me they could never bind nor abuse nor take from me. There was a sense of self greater than me alone, which came and filled

me in the darkest hours. Because of it, their violence energized me and I felt nothing (Keenan, 1993, p.204).

At these moments of conscious choice these tortured individuals integrated their experience into the self in ways that we can associate with Kelly's (1955) personal construct theory which centres on the individual's ability to choose the way they view self in a particular situation.

The Tortured Self: George Kelly's Personal Construct Theory

Kelly explains: "the self is, when considered in the appropriate context, a proper concept or construct" (1955, p.131). Constructs are the individual's views of his world and how he makes sense of it, which together form the individual's construct system. Kelly's theory is based on the individual acting as a scientist. Individuals are constantly forming and testing hypotheses. That behaviour occurs as a result of making sense of the world through experiences and then anticipating events (Wright, 2004).

Kelly (1955) explains that man can represent his environment; he can place alternative constructions upon it and, indeed, do something about it. He also insists that if the person has a negative experience and fails to reconstrue the event and rebuild it within his personal construct system, he fails to validate that experience (e.g., through the use of denial). It could be concluded, with relation to torture, that whatever horror is being inflicted on the individual, he/she can determine the way to interpret it, and find meaning in it, even as it is occurring.

The core of Kelly's (1955) construct theory is that an individual's perception of the world is made up of meanings that are applied by the person:

Man looks at his world through transparent patterns or templates which he creates and then attempts to fit over the realities of which the world is composed. The fit is not always very good. Yet without such patterns, the world appears to be such an undifferentiated homogeneity that man is unable to make any sense out of it. Even a poor fit is more helpful to him than nothing at all. Let us give the name constructs to these patterns that are tentatively tried on for size. They are ways of construing the world (Kelly, 1955, p. 9).

Kelly (1955) discusses 11 corollaries that are foundational to the understanding of personal construct theory; Table 5.1 contains a brief description of each corollary to assist the reader. The Choice corollary is clearly associated with the views expressed by Frankl (1984) and Keenan (1993). An individual can choose to apply different meanings to events whether present, past or future. As Kelly states:

A person chooses for himself that alternative in a dichotomized construct through which he anticipates the greater possibility for extension and definition of his system. The person's construction system varies as he successively construes the replications of events (Kelly 1955, p. 103).

If we examine torture, forced migration and asylum seeking from the perspective of personal construct theory, we can interpret them as an attack on the survivor's self-construct system. Keeping in mind Kelly's notion that: "a man creates his own ways of seeing the world in which he lives; the world does not create them for him" (Kelly 1955, p. 12), these experiences force an individual either to formulate new emerging constructs or to have old ones shrink and become rigid resulting in a more negative way of describing self. It depends on how each individual chooses to integrate these experiences that will determine their

survival and the continuity of building their self construct system. This integration differs from person to person as explained by Kelly in the Individuality Corollary (Kelly, 1955, p.103) (see also Table 5.1).

Table 5.1

Kelly's Personal Construct Theory. Definitions of the Eleven Colloraries

Colloraries	Definition
Construction	We anticipate future events according to our interpretations of recurrent themes.
Individuality	People have different experiences and therefore construe events in different ways.
Organization	We organize our personal constructs in a hierarchical system, with some constructs in a superordinate position and others subordinate to them. This organization allows us to minimize incompatible constructs.
Dichotomy	All personal constructs are dichotomous, that is, we construe events in an either/or manner.
Choice	We choose the alternative in a dichotomized construct that we see as extending our range of future choices.
Range	Constructs are limited to a particular range of convenience, that is, they are not relevant to all situations.
Experience	We continually revise our personal constructs as the result of experience.
Modulation	Not all new experiences lead to a revision of personal constructs. To the extent that constructs are permeable they are subject to change through experience. Concrete or impermeable constructs resist modification regardless of our experience.
Fragmentation	Our behaviour is sometimes inconsistent because our construct system can readily admit incompatible elements.
Commonality	To the extent that we have had experiences similar to others, our personal constructs tend to be similar to the construction systems of those people.
Sociality	We are able to communicate with others because we can construe their constructions. We not only observe the behavior of others, but we also interpret what that behavior means to them.

Note: Kelly, 1955, p. 50.

Let us suppose the individual, even during the experience of torture, can enter into a stage of rebuilding his construct system by integrating that experience. In doing this he accesses different construct systems related to religion, significant others, political beliefs, and cultural values, and/or enters into a world where he redefines all existent construct systems which define him/her. In this way, he/she can leave existent ones unchanged or he/she can make existent constructs tighter or looser. For example, religious beliefs may remain unchanged or become stronger. Tol et al. (2007) and Sachs et al. (2008) describe the latter with regard to Tibetan refugees who had been tortured but became stronger in their religious beliefs as a consequence. Another example is when a person's desire to live and fight for life is most under threat, leading to high levels of anxiety or despair, and it is at this point that choices are made, as discussed by Frankl (1984) when he talks of choice as the last of human freedoms. If an individual makes this choice and the experience is integrated into his construct system, he is most likely to survive the torture experience without fragmentation. If the integration does not take place and the self remains fragmented, PTSD and other psychopathologies will result.

Cason, Resick, and Weaver (2002) in a review paper, emphasized the importance of the personal constructs theory, based on Kelly's (1955) theory, in that it gives the researchers and clinicians a better understanding of the process that takes place in the integration of an event and the reconstruction of self (constructs) as these events occur. They summarized the theory by stating that from a 'construct theorists' point of view, constructs describe current experiences and future events whereby the individual surveys the situation and considers relevant alternative constructions. However, a person must not become 'stuck' in that phase but rather move to a second phase of construal which involves narrowing the range of focus and choosing how to deal with the problem as it is presented. The third phase of this re-

construing is to make a choice between the relevant negative and positive poles of the chosen construct, for example, 'weak' and 'strong', or 'afraid' or 'confident'. Subsequent experience will either validate or invalidate that choice. This process may have to be repeated in order to finally make sense of a traumatic event.

The question of validation and invalidation applies to the asylum seeker who chooses to escape persecution. An individual arrives in Australia with the hope of being accepted, of being able to feel safe and protected and where her/his experience of persecution is validated by the choice he/she has made of coming to Australia. However, on arrival, the individual's testimony of their experiences of persecution in their homeland is not believed by the authorities and she/he thus enters into a long-term process where she/he is continually challenged with denial and disbelief of their experience. One wonders what happens to the asylum seekers' construct system when confronted with events that challenge the process of continuing reconstruction of his/her construct system (her/his view of themselves in this world). Kelly (1955) is clear that such a situation generates anxiety (e.g., p. 533); nevertheless, he sees the resolution of the problem as being within the individual's existing construct system. As Kelly's theory states: "It is not what happens around him that makes a man experienced; it is the successive construing and re-construing of what happens, as it happens, that enriches the experiences of his life" (Kelly, 1955, p.73).

During this re-construing a shift occurs from the positive construct pole to the negative construct pole, which Kelly (1955) describes as 'slot-movement'. This shift may be a temporary one with the construct later moving back to its original position. This suggests that a new event, e.g., being held in detention where previous traumatic experiences are not validated, does not change the self view overall, but changes the position of self between the

two poles; for example, a person who suffers torture and is now trapped in a detention centre might change the way they perceive self from 'strong' to 'weak', from 'confident' to 'vulnerable', from an 'independent' person to a 'dependent' one during their incarceration.

Cason et al. (2002) elaborates on 'slot movement' by noting that many constructs can be used to describe a single event, in this case torture or other traumas resulting from systemic abuse. The survivor can describe him/herself as 'intelligent-stupid,' 'a fighter-non fighter,' 'beautiful-ugly,' or 'vulnerable-non-vulnerable'. Cason et al. (2002) states that once a person is located somewhere within the construct (between the positive and negative pole), i.e., 'strong' as opposed to 'weak', predictions can be made about the person's subsequent actions within this construct's opposite poles. For example, it could be hypothesised that a torture survivor placed in a detention centre is going to present in the same place between the strong and weak poles when viewed at two different time points, say 'self during torture' and that of 'self in detention'. If this prediction is validated, the construal of the person remains invariable across the points in time. If predictions are invalidated, the self will be reconstrued in some other way, meaning that the experience of detention might not have the same negative effect as torture (Cason et al., 2002). The discriminations between constructs ('beautiful-ugly') are bipolar. Walker and Winter (2007) explain that the contrast between the two poles is central to an understanding of change. The contrast can give an indication of the person's current way of seeing the world, and change will be reflected through the analysis of this bipolarity as measured by the Repertory Grid.

Cason et al. (2002) emphasised that the 'construct focus' perspective on the understanding of traumatic experience is the newest of the models they reviewed, and the one with the least empirical support. This researcher has similarly found few empirical studies

examining self-change following man-made atrocities. However, there is considerable potential for the use of the Repertory Grid as a measure of construct elaboration.

The Repertory Grid

The Repertory Grid (or Repertory Test; Kelly, 1955) assists in assessing the way individuals construe and make sense of their world given a particular event, e.g., torture. It allows the investigator to explore the relationship between the individual's elements (the person's experiences of that event) and their constructs (what the individual uses to construe, to build the interpretation and integration of a given situation or event) (Kelly, 1955). Elements are key aspects of the Grid as they define the research area in question (Bell, Vince, & Costigan, 2002) and "the construct is the basis upon which elements are understood" (Kelly, 1955, p. 109). Overall, a Repertory Grid consists of: (1) elements that are representative of the content area under study, e.g., 'self now' versus 'self in 10 years time'; (2) a set of personal constructs that the participant uses to compare and contrast these elements, e.g., 'fighter versus non-fighter'. Constructs are elicited from the individual and can also be supplied by the researcher (see Chapter 7, Figure 7.1 containing the full list of elements and constructs); and (3) a rating system that evaluates the elements based on the bipolar arrangement of each construct. Ratings can be made on a Likert Scale ranging from one to seven, one representing the positive side of the pole and seven the negative side (e.g., 'beautiful-ugly'). In constructing the Repertory Grid, Fransella and Bannister (1977) recommended that a minimum use of five to seven elements would make the administration of the grid more manageable when distributing it to a large group. They stated that in a large group the examination of more elements is a disadvantage.

There are numerous Repertory Grid methods and they have been used as assessment tools in areas such as social science, science and economics (Fransella & Bannister, 1977; Walker & Winter, 2007; Wright, 2004). Fransella and Bannister (1977) stated that the Repertory Grid can be as creative as allowed by the imagination. In using the Grid a researcher should: (1) clearly establish the objectives of using the Grid; (2) have a clear understanding of how the Grid is to be administered; and (3) choose the appropriate applied analysis. Walker and Winter (2007) divided the methodology for eliciting constructs and elements in a Repertory Grid into two: the grid method and the non-grid method. One of the non-grid methods includes the self-characterization and textual analysis which Kelly (1955) based on an autobiographical sketch in the third person (Walker & Winter, 2007). Kelly stated that the character sketch allows the individual to use his/her own construction system for describing self during a particular event or in comparison to another person, for example, 'self before the most traumatic experience' or 'self as a torture survivor'. The Grid-based method includes the construct-element method.

The construct-element method is the one most commonly adopted by researchers. Kelly (1955) developed this method where the elements selected depend on which aspects of the participant's construing are to be evaluated (Fransella & Bannister, 1977; Walker & Winter, 2007). The elements ('self before torture', 'self now') are sorted in terms of a number of constructs, for example: 'fighter-non-fighter', 'vulnerable-non-vulnerable'. Constructs can be supplied or elicited from individuals who are representative of the participants being studied. This type of Repertory Grid can then be distributed to a larger sample and comparisons can be made across the groups on their views of self, e.g., 'self view before the experience of torture' compared to 'self view of survivors of other traumatic experiences'. This research

study adopted these two methods: namely, the self-characterisation method and the element-construct-based method to explore the changes in self view following the experience of torture, other types of systemic abuse and the experience of seeking asylum.

Measures have been developed to explore the extent of differentiation and integration in a construct system, of the tightness or looseness of construct relationships, and of logical inconsistencies in construing (Fransella, Bell, & Bannister, 2004). The literature indicates relatively high test-retest reliability of particular grid measures and their validity, for example, in differentiating between certain groups or predicting behaviour (Fransella et al., 2004). There are a number of analytical methods that incorporate various statistical analyses such as correlations and factor analysis, when analysing the Grid. One of the many analytical methods is cognitive complexity which provides a measure of the differentiation among constructs and how participants use constructs to define self at a particular time in their life. This measure was introduced by Bieri (1955) who measured the similarity of a pair of constructs with a matching score. Subsequently, Bannister (1960) used a correlation to describe this similarity and the average correlation across all pairs of constructs described the cognitive complexity (or, in Bannister's terms, intensity) of the grid. However, correlations cannot be calculated where all elements are similarly rated on a construct (which can happen for supplied constructs). This is particularly likely when the number of elements is relatively few. However, the intraclass correlation, introduced as a measure of cognitive complexity by Bell and Keen (1980) circumvents this problem.

The computer programmes that have been developed to analyse the Grid data include HICLAS (De Boeck, 1986) - a more general computer programme that allows examining of the relationship between life events (elements) and a hierarchical model of each participant's

construct system. Another computer programme is the GRIDSTAT by Bell (1996, 1998, 2009). This is a program designed for the analysis of a Repertory Grid and it is a DOS-based programme designed to carry out cognitive complexity indices.

Empirical Research Using the Repertory Grid: The Impact of War and Systemic Abuse in Self

The Web of Science was researched for articles between May 1993-2011 with a combination of words, that included: ‘repertory grid and PTSD’, ‘repertory grid’; ‘personal construct theory and torture’; ‘the psychological impact of torture on self/using repertory grid’; ‘repertory grid and war trauma’; ‘the elaboration of trauma’; and ‘personal construct theory and PTSD’. No studies empirically examined the impact of torture on self. Because war is arguably closest to torture in nature, this chapter reviews the related empirical literature. Only two studies were found. These had empirically investigated changes in the construct system of the damaged self (see Table 5.2). These two studies adopted the method of the Repertory Grid and used specific measurements derived from the Grid.

Table 5.2

Empirical Studies of the Impact of War and Other Systemic Abuse on Self Using the Repertory Grid

Author	Year	Sample	Measurement	Trauma	Results/Conclusion
Sewell, Cromwell, Farrell-Higgins, Palmer, Ohlde, & Patterson	1996	30 male Vietnam combat veterans hospitalized for PTSD and 30 with no PTSD or any other psychiatric disorder	Numeric matrices were elements based on the participant's best and worst events over a 10-year period through their life history. Constructs were elicited individually by each person using the triadic method. The elements and the constructs made up the Repertory Grids)	War Trauma	Patients with PTSD rated negative life events more extremely than did the non-PTSD group, especially life events after Vietnam
Sermpezis and Winter	2009	18 males and 18 females with PTSD	Repertory Grids and questionnaires. The Repertory Grid method was the same as Sewell et al. (1996)	Torture survivors 10% Female rape 10% Mugging 10% Female child sexual abuse 6.66% Domestic violence 10% Traffic accidents 33.33%. Other types of trauma were represented by suicide attempt, fighting at war, and the 7th of July terrorist attack	They found over-elaboration resulting in PTSD

The different impacts that experiences such as war can have on the individual were observed in participants selected for a study by Sewell et al. (1996) outlined in Table 5.2 above. Half of the 60 subjects suffered from PTSD, the other half did not, yet all had seen combat duty in Vietnam. Sewell et al. (1996), using an extension of Kelly's theory, maintained that PTSD results from the individual developing isolated constructs or unelaborated constructs; that is, the traumatic experience cannot be incorporated into the existing construct system of the individual, resulting in an "unelaborated construct

subsystem” (Sewell et al., 1996, p.92). Some examples of the elements used in the Grid employed by Sewell et al. (1996) were ‘self as child’, ‘self as student’, ‘self prior to Vietnam’, ‘self in Vietnam’ and ‘self after Vietnam’. Individually, they asked participants to compare how two of those elements were the same and different to a third element. This resulted in the constructs which describes the elements. Those with PTSD who had been exposed to combat described their experiences (i.e., the element) with less elaboration.

Elaboration is a measure of the network (hierarchical linkages) linking the traumatic event to other events and constructs in a HICLAS model. This differed from those not suffering from PTSD (Sewell et al., 1996, p. 81). The mean elaboration level of the traumatic event was 2.70 (SD=1.37) for the PTSD group and 3.30 (SD= 1.32) for the non-PTSD group (the control group). Sewell (1996) proposed possible ways in which the individual who experienced war might construe this experience positively into their self-system. Sewell (1996) stated that personality factors can influence the elaboration process of the experience (the processing of the experience, its integration and acceptance). Also, the individual can create meaning for the experience of war, that is, find the purpose and significance of it and somehow integrate this experience and connect it to earlier traumatic experiences already construed. Therefore, the constructs the soldier could construe may include, ‘the fighter’, ‘strong-willed’ and ‘emotional/rational thinker’, and these may be linked to constructs that exist from previous experiences, such as childhood abuse or accidents. The person’s construct system may then be described as elaborated and extended (i.e., more adjectives used to describe the experience and connected to pre-torture self); that is, the individual’s integrity of self is maintained and there is no evidence of PTSD.

By contrast, Sewell (1996) in a different study expressly links psychiatric symptoms/disorder to the damaged self. He hypothesised that some individuals who developed PTSD following the Vietnam War experience did so as a result of having experienced an earlier traumatic event in their life, e.g., child sexual abuse. This early experience of abuse results in an unelaborated sub-system (isolated from the rest of the individual's construct system, disconnected or fragmented, for example, a bitter, isolated, emotionless and angry person). The new traumatic experience, the war, then acts as a stimulus to the pre-existing isolated construct system (negative view of self) and can result in complex PTSD, severe anxiety and depression (Sewell, 1996). Consequently, individuals who have already developed negative views about their world, based on negative experiences in the past, will tend to be vulnerable to new traumas. Conversely, those who had integrated their previous negative experiences will be less vulnerable to developing psychiatric symptoms/disorder. Sewell acknowledges, however, that the magnitude and uniqueness of an event can render any individual open to profound negative consequences.

More recently, Sermpezis and Winter (2009) tested Sewell's (1996) hypothesis by studying a group of people who had experienced various traumas and all of whom had been diagnosed with PTSD. The results did not support the Sewell et al. (1996) hypothesis that PTSD resulted from under elaboration of the traumatic event where in fact they found the opposite - over-elaboration resulting in PTSD. Sermpezis and Winter (2009) concluded that the models used in assessing the Grid data collected by Sewell et al. (1996) depended on how the constructs pole were coded – 1 and 0 for the elicited and contrast poles gave different elaborations to 0 and 1 for elicited and contrast poles. Sermpezis and Winter (2009) in considering the limitations of the HICLAS models, explored their results further by considering an alternate model based on asymmetric relationships between constructs using a

model devised by Bell (2004), the GRIDSTAT. Sermpezis and Winter (2009) stated that their results supported the opposite position to that of the Sewell et al. (1996) hypothesis, that is, traumatic events are more elaborated.

As demonstrated in this chapter, people in extreme circumstances make choices and changes occur which can be identified by the application of Kelly's (1955) Personal Construct Theory, and the Repertory Grid. Since this research originated there has been an increase in the application of the Repertory Grid in diverse research areas. However, regardless of this increase the current thesis contains the only empirical study in the area of torture survivors and asylum seekers where the Repertory Grid was used to explore changes of self view following such extreme events.

Chapter 6

The Psychological Impact of Torture and Other Types of Systemic Abuse on Refugees

Concerns continue to be raised about the psychological impact of torture and other types of systemic abuse both in Australia and overseas. The recent increase in asylum seeking worldwide is cause for alarm and remains a highly contentious issue in Australia as evidenced by the reaction to the latest policy of transferring asylum seekers who arrive in Australia by boat to Malaysia (Gordon, 2011). The politicized nature of the debate in this country has contributed to the limited amount of research that has been conducted (as indicated in Chapter 4). Further, because of the restrictions that the Australian government has placed on information gathering and the remoteness of detention centres, research in Australia remains limited (see Chapter 4). However, the increased number of asylum seekers coming to Australia and the issues that arise as a consequence, as indicated by the Commonwealth Ombudsman's call for an inquiry (Commonwealth Ombudsman, 29th July 2011) only increase the relevancy of such studies. This chapter places the current study in the context of Australian research. It explains the need for further research in this area leading to two main research questions explained below. Finally, it introduces the hypotheses for this research.

The study in its first section (Section 1) focused on permanent residents living in Melbourne who had experienced torture or other types of systemic abuse and those who had

come to Australia without having experienced either form of abuse. In Section 2 the study focused on the comparison between the survivors of systemic abuse who had permanent residency from Section 1 with survivors of systemic abuse who were seeking asylum and were living in the community or living in a detention centre in Australia (see Chapter 7, for details and definitions).

The Need for Research on Survivors of Torture, Other Types of Systemic Abuse and Residency

The difficulties of torture survivors and survivors of other types of systemic abuse are wide-ranging and derive from a number of sources which are shared with other migrants, particularly refugees, and relate to the psychological, social and cultural impact of resettlement, usually forced and in adverse circumstances. However, some problems derive directly from the experience of torture and other types of systemic abuse, consequently compromising the degree to which more general requirements can be met in the host country. It is important to grasp the specific long-term impact that systematic torture has on the individual to better understand the varied symptomatology and needs of survivors. For example, Doerr-Zegers et al. (1992) showed delayed onset of depression and anxiety symptoms, extreme mistrust, and loss of interest in life years after the experience, and apparent personality changes in the individual.

It is urgently required that, to assist in the future development of health services for survivors of systemic abuse, sound epidemiological knowledge is to be available to health, educational and government officials so to better enhance the integration of refugees at all levels of society (Australian Psychological Society, 2011; Murray et al., 2008). In most centres where specialist services have been established, the first generations of research studies have concentrated on describing the sequelae of torture and trauma in their client populations. To advance on earlier studies, it is necessary to continue identifying and assessing the consequences

of torture and of other types of systemic abuse (Quiroga & Jaranson, 2005). A further need for research is to increase the documented evidence of how torture impacts on individuals so as to further denounce this horrendous practice (Wenzel, Hardi, Friedrich, & Allodi, 2009).

Finally it is necessary to increase awareness of survivors' difficulties, including survivors seeking asylum, those living in the community and those living in detention in Australia and enhance present health services (Murray et al., 2008; Silove & Steel, 2009). Asylum seekers, as defined in Chapter 4, are people who come into Australia and make application for protection/refugee status. During the entire period of this research there has been constant controversy in all forms of media about the asylum seeker phenomenon (Mares, 2001; Murray et al., 2008; Thompson & McGorry, 1998). At the time this research was being conducted community workers and other health professionals were beginning to take notice of this issue because of the lack of services to the asylum seekers living in the community (Thompson & McGorry, 1998). Also, services that were available for torture survivors at the time were seeing few asylum seekers (Thompson & McGorry, 1998). During this research, and since, there have been changes in the Victorian services to provide limited resources to the asylum seeker community, including those in detention. Services such as the Asylum Seeker Resource Centre was established in 2001 (Asylum Seeker Resource Centre, 2011) and the Victorian Refugee and Asylum Seekers Health Network which was only established in 2007 (the Victorian Refugee and Asylum Seekers Health Network, 2011). However, there is still today a strong demand for consistent assessments of the torture and systemic abuse experienced by asylum seekers particularly when there are so many life matters dependent on a thorough and accurate process (Australian Psychological Society, 2011; Murray et al., 2008).

Research Questions

The current study focused on two main questions. The first concerned whether torture survivors had higher levels of distress and changes in self-view compared to survivors of other systemic abuse and a control group of migrants. The second question concerned whether the distress and changes in self-view varied according to residential status, that is, whether asylum seekers in detention centres had higher levels of distress and changes in self-view compared to asylum seekers living in the community and those who had a permanent residential status.

Research into torture has almost exclusively focused on psychiatric symptoms. Mostly our knowledge has been derived from case studies, first person accounts of the experience of torture, or case study series (see Tables 3.1, 3.2, & 4.1). Very few studies have been conducted where psychiatric symptomatology is measured comparing torture survivors with survivors of other forms of systemic abuse and a control group (see Tables 3.3 & 4.1).

More recent research and reviews into the psychological consequences of torture has questioned PTSD as a major consequence (e.g., Sachs et al., 2008; UNHCHR, 2004). This is because, over the years, research has indicated that not all survivors meet the PTSD criteria although they do present with other distressing psychological symptoms such as a high level of anxiety, depression, paranoid ideation, grief and loss (Başoğlu et al., 2007; Kagee, 2005).

A further complication is that the torture experience is mostly superimposed upon multiple factors resulting from other forms of organised violence, such as witnessing relatives being killed or tortured, disappearance of loved ones and/or friends and forced internal or external migration. People who experienced other types of systemic abuse will not necessarily

have directly experienced torture. Nevertheless, research has indicated that people in this group also suffer psychological distress (Silove & Steel, 1998). A difficulty in attempting research into survivors of torture is the matter of discriminating between the psychological sequelae that result from the torture and that which results from the experience of other forms of organised violence. A further impediment to research is in establishing a control group that is free of psychological sequelae. A further factor that is important to measure is the 'level' of sub-components of 'the migration experience' itself. Included in that experience are separation from family, loss of social and occupational status, lack of social support networks, problems with settling, uncertainty about the future, economic and housing difficulties, cultural differences and even racism and other prejudices (Başoğlu et al., 2001).

Although a few studies have compared the psychiatric symptoms of torture survivors with those who have experienced other forms of systematic abuse, very few studies have compared both groups to those migrants who have not suffered torture or other types of systemic abuse. Nor have any studies been undertaken which include such a diverse refugee groups that explore changes to self that are based on Kelly's theoretical perspective as described in Chapter 5.

The literature reviewed in Chapter 4 indicates that other major factors contributing to the deterioration of the psychological wellbeing of refugees arriving in Australia is their migration status on arrival. Post-migration stresses exacerbate earlier emotional disturbances such as "fear of repatriation, stringent refugee determination procedures...accessing basic services" (Silove & Steel, 1998, p. 4). Research investigating the psychological consequences of experiencing torture has demonstrated that refugees seeking asylum in Australia are

inevitably dealing with serious mental health conditions (Coffey et al., 2010; Johnston et al., 2009; Silove et al., 1996; Steel et al., 2004).

While the arrival of ‘boat people’ in Australia began in the 1970’s following the Vietnam War, very little research took place before 1990 because statistical information, at point of entry, regarding the number of asylum seekers were not available until 1993 (Crock, 1993). Research into consequences of torture began overseas in the 1970’s and has continued and the methodology has become more sophisticated. It was not until the late 1980’s that research began in Australia (Hosking, 1990; Reid & Strong, 1987). However, the few studies which have been conducted to date, have not clearly identified the level of distress resulting from different residential situations and how this relates to the experience of torture, or to other experiences of systemic abuse.

Hypotheses

Following these research questions the hypotheses are presented in two sections in line with the research structure. Section 1 relates to the first research question addressing the degree to which psychological distress and view of self varies across three different groups: torture survivors, survivors of other types of systemic abuse and the control group (migrants who have not experienced either). All participants have permanent residency. Section 2 presents the hypotheses derived from the degree to which psychological distress and view of self varies according to the residential status mentioned above.

Section 1: the degree to which psychological distress and view of self varies between survivors of torture, survivors of other systemic abuse and participants who have not experienced these forms of abuse.

1. Survivors of torture (Group1) will present with greater levels of psychiatric symptoms and poorer psychosocial functioning level compared to survivors of other types of systemic abuse (Group 2), and the control (Group 3, participants who have migrated without previous trauma).
2. Survivors of other systemic abuse (Group 2) will present with higher levels of psychiatric symptoms and poor psychosocial functioning compared to the control group (Group 3).
3. Survivors of torture (Group 1) will report a higher negative self-rating and will have a more negative view of self in the future than the other two groups (1 and 2).
4. Survivors of other types of systemic abuse (Group 2) will report a higher negative self rating and will have a more negative view of self in the future compared to the control (Group 3).
5. Based on the cognitive complexity measurement it is expected that Torture survivors (Group 1) will rate their self description in a more constricted manner than both Groups 2 and Group 3
6. Based on the cognitive complexity measurement it is expected that survivors of other types of systemic abuse (Group 2) will rate their self description in a more constricted manner than the control group (Group 3).

Section 2: the degree to which the distress and view of self varies according to the survivor's residential status in Australia.

1. People in detention centres will present with higher levels of psychiatric symptoms and poorer functioning levels than asylum seekers living in the community and compared to permanent residents.
2. Asylum-seekers living in the community will have greater levels of psychiatric symptoms and poorer functioning than permanent residents.
3. The self ratings and the self discrepancy rating will demonstrate that people living in detention will report a higher negative self-rating than the other two residential categories.
4. The self ratings and the self discrepancy rating will demonstrate that asylum seekers living in the community will report a higher negative self rating than the permanent residents.
5. Based on the cognitive complexity measurement it is expected that the detention centre category will rate their self description in a more consistent constricted manner than both asylum seekers living in the community and permanent residents.
6. Based on the cognitive complexity measurement it is expected that asylum seekers living in the community will rate their self description in a more consistently constricted manner than permanent residents.

Chapter 7

Method

Participants

In this study there were a total of 259 participants recruited in two stages. Firstly, there were 183 participants, who had permanent residency (Section 1) and whose voluntary participation was sought by means of an approach to community agencies. Secondly, 201 participants (Section 2) included 125 permanent residency participants from Section 1, together with 76 asylum seekers who were either accessed through community agencies or, following permission, were accessed from a detention centre. Individuals were informed that the research intended to explore the effects of torture and trauma. Anyone who had arrived from countries that had experienced political repression was encouraged to participate, irrespective of their personal experiences. The participant's life experiences were unknown prior to the interview. All participants were recruited between 1993 and 1998, a period when many people exited countries where torture was taking place; 124 countries according to Amnesty International (Wenzel et al., 2000). The participants in Section 1 came from Latin America, Ethiopia and Somalia. The participants for Section 2 came from the Middle East, Africa, Central America, Europe, and Asia (see Appendix A) for participant's country of birth).

Section 1: Survivors of torture, other types of systemic abuse and the control group.

For Section 1 of the study the 183 participants were further classified into three different groups as originally accomplished by Thompson and McGorry (1995) and recently adopted by Hollifield et al. (2011). This classification resulted in: 56 survivors of torture (Group 1); 69 survivors of other types of systemic abuse (Group 2); and, 58 in the control group (Group 3) who were participants who had never experienced any type of systemic abuse. None of the participants in Section 1 had ever sought asylum or lived in a detention centre in Australia (see Table 7.1 for sample distribution).

Table 7.1

Group Distribution for Section 1 of the Study

Group	Permanent Residents
Survivors of Torture (Group 1)	56*
Survivors of Other Systemic Abuse (Group 2)	69*
Control Group (Group 3)	58
TOTAL	183

Note: *The Permanent Resident sample of survivors of torture and other systemic abuse are the same for Sections 1 and 2 of the Study.

Participant recruitment.

Section 1 of the recruitment process addressed research questions regarding the psychological impact of torture and other types of systemic abuse by comparing three groups of people: torture survivors (Group 1), survivors of other type of systemic abuse (Group 2) and the control group (Control Group; migrants who had not experienced any type of systemic abuse). All participants in Section 1 had permanent residency in Australia.

A list of possible referral agencies was produced to provide access to participants. Some of these agencies included: the Spanish Welfare Centre; the Somalia Relief Association; the Ethiopian Community Organisation; The Migrant Resource Centre; The Richmond Community Health Centre; The Refugee Advice and Casework Service; The Victorian Foundation for Survivors of Torture; The Dandenong Migrant Resource Centre; and, the Footscray Community Health Centre. The agencies received a letter stating the importance of this research and a research protocol summary (see Appendix B1 and B2). This was followed by a telephone call to the co-ordinator of the agency arranging, where possible, a personal meeting with the staff to explain the study in more detail. Only a few agencies gave their support.

The majority of the agencies responded negatively, believing that the study could re-traumatise individuals, some felt they could not ask the potential participants, while other agencies appeared not to value the research. Others seemed fearful and some were under-staffed with no time allocated to assist in research. A 'snowball' effect evolved; as participants gained trust they rang or encouraged others to participate. Individuals who participated in the interview, were asked to contact anyone who he/she knew who might wish to participate in the study. This was the most effective manner of recruitment.

Section 2: Permanent residents, asylum seekers living in the community and in detention.

Section 2 included three residential categories with a total number of 201 participants:

125 permanent residents (Groups 1 and 2 from Section 1), 34 asylum seekers living in the community, and 42 detention centre residents (See Table 7.2).

Table 7.2
Residential Categories and Group Distribution for Section 2 of the Study

Group	Permanent Residents	Asylum seekers in the community	Asylum seekers in Detention	Total
Survivors of Torture (Group 1)	56*	23	19	98
Survivors of Other Systemic Abuse (Group 2)	69*	11	23	103
TOTAL	125	34	42	201

Note: *The Permanent Resident sample of survivors of torture and other systematic abuse are the same for Sections 1 and 2 of the Study.

Participant recruitment process.

Section 2 of the recruitment was aimed at addressing the variation in the degree of psychological distress according to residential status once they arrived in Australia. Three residential categories were formed to address this question: asylum seekers living in the community, asylum seekers living in a detention centre in Australia, and those with permanent residency. Participants who were seeking asylum were either torture survivors or survivors of other systemic abuse. The nature of all asylum seekers, whether living in the community or in detention, was that they had experienced systemic abuse or torture that forced them to leave their country. The purpose of selecting the permanent resident

participants (only from Groups 1 and 2) was to facilitate the comparison between three residential categories: permanent residents (non-asylum seekers), asylum seekers living in the community and asylum seekers living in detention, which allowed the researcher to explore any differences in the level of distress resulting from the participant's residential status.

For Section 2, different ethnic organisations, the divisions of general medical practices, as well as legal agencies working with asylum seekers living in the community or in detention, were involved in asking their clients if they would participate in the research. This was followed by a telephone call to the potential participant who was told the names of the agency and the worker who had passed on their name. If they agreed to participate a meeting time and place was arranged. The place where the interview was conducted was the participants' choice; they could choose to be interviewed in their home or in the researcher's office (MT), or at a community organisation where they felt comfortable.

All participants from an immigration detention centre who were seeking asylum were invited to participate in the study. The participants from the immigration detention centre were also referred by the Refugee Advice and Casework Service or the immigration detention centre manager. Access to those in detention was extremely difficult. However, trust had developed between the researcher (MT), the legal agencies and the management of the detention centre at the time. Consequently, those who were claiming refugee status were asked to participate and out of 72 people in the detention centre during the period between 1997-1998, 42 agreed to participate. They were informed that, in no way, would this participation assist in their on-going applications for protection visas or would it jeopardise their application; all information was kept confidential.

The criteria for group membership.

The participants defined as survivors of torture (Group 1) had to meet the criteria defined below to clearly separate them from those who had suffered other violent and systemic traumatic experiences. These criteria are based on the current United Nations (UN) definition of torture, which is the most widely accepted definition and the one adopted officially by 210 countries (Hollifield et al., 2011). Nevertheless, there is an area of contention as to when physical abuse becomes torture (Başoğlu, 1992; Campbell, 2007; Hollifield et al., 2011).

The selection of the group titled ‘Survivors of Other Types of Systemic Abuse’ (Group 2) was based on common traumatic experiences as documented by people living with repressive regimes. For the purpose of this research “system abuse” refers to abuse implemented by government organizations. “Systematic” refers to the gradual and calculative implementation of power by an individual or group on behalf of a government, community or religious authority. These acts are committed against large numbers of people within the state, community or religious group. Such acts of violence can be displayed through racism, discrimination, physical, sexual and psychological abuse, through acts of coercion, intimidation, degradation, isolation and negation. This type of violence is referred to as ‘systemic’ or ‘systematical’ abuse because it is violence built into a system (Kellaway, 2003). Survivors of systemic abuse have experienced multiple traumas which can result in anxiety, depression, PTSD and possibly the physical consequences of torture, which result in a more complex group of symptoms. The criteria for group membership were as follows:

Survivors of Torture (Group 1) included: people who had experienced systematic torture as defined by the United Nations (1984), Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The criteria for membership of this group were as follows:

1. The person had been subjected to the systematic infliction of severe pain or suffering.
2. Physical and mental pain must have been inflicted by one or more persons on the tortured individual on behalf of a public official or other person acting in an official capacity.
3. The techniques used included a combination of physical abuse, such as electrical shocks, insertion of objects, severe beatings, forced intake of drugs, sexual assault, burns and the use of psychological torture such as sensory deprivation, humiliation, mock executions or witnessing the torture of others.

Survivors of Other Types of Systemic Abuse (Group 2) included: people who had been through a traumatic experience linked to political/religious/ethnic repression which was defined by people meeting at least two of the following criteria as developed in the study by Thompson and McGorry (1995):

1. The persecution has included direct threats upon an individual's life or the threatening of the life of a family member.
2. Witnessing at home or on the streets, the shooting of a relative, friend or others by officials.
3. Having family members disappear.
4. Being subjected to police/military house searches, experiencing threats, violence, physical and/or verbal assault.
5. Being involved in a mass demonstration in which violence occurred.
6. Being forcibly displaced.
7. Being forced to live in a refugee camp.

Control (Group 3): Participants were migrants who had voluntarily come to Australia and who did not meet the criteria for Groups 1 and 2 (that is, they had not been persecuted or tortured).

1. They were individuals who had come to Australia for reasons relating to family reunion and economic well-being; all had permanent residency and they had never sought asylum.
2. This group was included to assist in separating issues related to migration and adaptation from those related to torture and other types of systemic abuse.
3. Other traumas, such as motor vehicle accidents, natural disasters, and complicated bereavement were not considered as a major part of the study, but were documented for all three groups.

The criteria for the residential category.

Permanent Residents came to Australia under different immigration categories which allowed them to obtain a residential permanent visa prior to arrival. All participants from Section 1 of the study met the criterion of never having sought asylum in Australia.

Asylum Seekers living in the community were people who:

- Arrived in Australia with a tourist, student, working or sports visa and who, on their arrival either by boat or plane, sought refugee status.
- Sought refugee status on arrival but never experienced detention in Australia and had been living within the general Australian community.
- Met the criteria for either having survived torture or other systemic abuse in their country of origin.

Asylum Seekers living in detention were people who:

- Arrived by boat or plane and sought refugee status without having travel documentation on arrival. Subsequently, they were placed in detention in one of the Australian detention or processing centres. At the time this research was conducted, the Department of Immigration operated several detention centres.

Research Team

The team comprised of: the principal researcher (MT), three female research assistants who were employed to assist with interviewing Latin American participants in Section 1 of the study and two male qualified interpreters utilised as cross-cultural workers to assist the researcher (MT) with interviewing the Somalian and Ethiopian community. The interviewers were required to have extensive interview skills, speak Spanish and have counselling and research skills. The cross-cultural workers needed to be fluent in their own language and English; all had extensive experience in their community. The cross-cultural workers played two major roles: firstly, they were the direct link between their community and the researcher (MT), that is, they assisted the researcher in accessing the communities; and secondly, and most importantly, they assisted with interpreting for those who did not speak English and also for those who did but who felt better expressing their life history in their own language. In this way, emotions and cultural idiosyncrasies of language and expression were not missed. The number of cross-cultural workers in Section 2 of the study increased to five (of the five, four were male and one female), reflecting the diversity of the participants' language backgrounds.

All five cross-cultural workers and the three research assistants were provided with training and support from MT during this period. Training was provided to ensure consistent and effective interviews in the area of torture and trauma. MT provided training in the areas of assessment, communication and debriefing. The training looked at methodological issues specific to research in this area (see Appendix C). It covered cultural issues, language, politics, beliefs and values. Training was provided to ensure consistent research questions. It incorporated a theoretical understanding of PTSD and the history of torture and trauma. The

training took place over a 3-day period (see Appendix C). The research assistants were briefed about the characteristics of the communities and their meeting places. Prior to commencing the interviews the team spent time learning about particular social events related to the communities, introducing themselves to these communities, and learning about their culture.

With the support of the cross-cultural workers, the researcher (MT) contacted community agencies and scheduled appointments. The researcher (MT) spent time going to the community organisations and other providers such as Department of Education (English classes), health department and community health services, giving talks about general wellbeing of refugees and migrants and the experiences of torture and other traumas. By providing information, and entering the individuals' community, a path was opened to invite people to participate in this research. As stated earlier, individual meetings were flexible, allowing for interviews to be conducted in the homes of participants, sitting with them over a cup of tea, or during dinner, or at a temple.

Assessments

The methodology involved the construction of an assessment protocol and attention to the process of interview. The method incorporated a qualitative and descriptive approach in building the structured interview, as well as quantitative analyses where psychiatric scales were incorporated in order to assess symptomatology resulting from trauma. It was estimated that the whole interview would take 3-4 hours (Appendix D1).

Semi-structured interview (STI- see Appendix D1).

Thompson and McGorry (1995) explored the implication of torture and trauma amongst Chileans and Salvadorians, using a methodological approach which included a semi-

structured interview and self-rating scales. For the purpose of this study, modifications were made to the semi-structured interview developed by Thompson and McGorry (1995). New, open questions were incorporated to explore the individual's life history in a thorough, humane and systematic style.

The interview included variables related to the assignment of participants into groups (Section 1) and their residential categories (Section 2) by eliciting information relevant to the defining characteristics of the three groups in Section 1 (torture survivors, survivors of other systemic abuse and the control group) and the three categories in Section 2 (permanent residents, asylum seekers in the community and asylum seekers in detention).

The interview schedule was divided into four sections. The questions for each of the four sections are included in Appendix D1. It was designed in such a way that each section would progress gradually into the discussion of torture and other traumas, after first establishing rapport between the subject and the researcher. This study attempted to address those factors that Watters (2010) claims are missing from most Western-style traumatology research, such as, the lack of identification of all traumatic events and the level of destruction of important social networks that are meaningful to the survivor (Silove & Kinzie, 2001; Thompson & McGorry, 1995; Watters, 2010). The semi-structured interview aimed to incorporate broader aspects of the traumatic experience, not just the specifics of the trauma itself. It took into account the ongoing consequences of violence and the destruction of the social environment. It gave the participants the opportunity to “express their distress and suffering and assign meaning to the human experience” (Watters, 2010, p. 104). As the study progressed into Section 2 the implications of seeking asylum and living in a detention centre in Australia were explored. The interview schedule was designed in the following order:

STI: demographic details.

Demographic details were included to ascertain the individual's present status and to provide an opportunity for the interviewer to establish rapport with the participant. This included age; gender; ethnic background; religion; length of time in Australia; migration status; marital status; schooling; occupation in their country and occupation now; housing in their country and their housing now. Every demographic question had the purpose of assisting in the understanding of the participants' life experiences and their impact; for example, migration status was included to provide a direct insight into the possible circumstances as to why the individual left his/her country of origin and whether they came to Australia under the Australian humanitarian program or with refugee status.

STI: traumatic experience.

If participants advised that they had experienced torture or other traumas they were encouraged to discuss their experiences at any time during the interview. This was based on the testimony method, described in Chapter 3, where the torture process, and the types of torture techniques experienced, was described by the participant. As they talked about their experiences, factors such as what they learned from the experience; how they coped at the time of the event; what was the most difficult thing to cope with; how they felt; and how they were feeling at the present time, were discussed. Included also in this part were the experiences of individuals in refugee camps or in other countries of exile before coming to Australia.

How participants defined torture and who was responsible for it was also added so as to explore the individual's own perception and definition of torture and whom they believed

was responsible for such an act. Questions were included that enabled the researcher to discuss other experiences that the participant had found to be traumatic. All these questions were framed to allow the participant to discuss their worst life experience, with the interviewer assessing for PTSD at the time they lived their worst traumatic experience, and during the last 4 weeks prior to the interview, including at the time of the interview.

STI: The Structured Interview for Post-Traumatic Stress Disorder.

The Structured Interview for Post-Traumatic Stress Disorder (SI-PTSD; Davidson, Smith, & Kudler, 1989) was designed to diagnose PTSD based on the DSM-III-R (APA, 1987) criteria. It is used to assess the severity and frequency of PTSD symptoms (e.g., nightmares). It also allows the mental health professional to assess constricted affects through observation (rather than questions). The SI-PTSD has acceptable reliability with a Kappa coefficient of .79 and an alpha of .94, intraclass correlations from .97-.99 (inter-rater reliability), and a 100% diagnostic agreement between raters (Blake et al., 1995; Davidson et al., 1989). The SI-PTSD has been validated based on phenomenological studies describing the psychiatric consequences of war, natural disaster, and rape (McNally, 1992).

Due to the period in which data for this study were collected (1993-1998), the SI-PTSD based on the DSM-III-R (Davidson et al., 1989) was adopted for all the interviews conducted to maintain consistency. The DSM-III-R (APA, 1987) is based on five criteria for identifying the symptoms of PTSD. These diagnostic criteria were:

A. Having experienced an event that is outside the range of usual human experience.

- B. The traumatic event is persistently re-experienced which is identified in at least one of four different ways, for example, recollections, dreams, feelings of reliving the experience.
- C. Avoidance of stimuli associated with the trauma, as indicated by at least three of the seven criteria, for example; avoidance of thoughts and activities associated with the trauma, inability to remember certain aspects of the trauma.
- D. Persistent symptoms of increased arousal, as indicated by at least two of six criteria, for example: staying awake at night, difficulty concentrating and outbursts of anger.
- E. The individual experiences the symptoms for at least one month.

The original SI-PTSD (Davidson et al., 1989) included probes that concerned war-related experiences and symptoms. Modifications were made in each of the parts to include probes that related to the experience of torture or other traumatic experiences. To differentiate between worst ever symptoms and those of the last 4 weeks, two scorings were obtained. Firstly, the participant was asked about symptoms that immediately followed the event and were experienced at least 1 month after the event, the “worst ever”. Secondly, the participant was asked about symptoms just 4 weeks prior to the interview and including at the time of interview, the “last four weeks”. Having two scores allowed for the exploration of any changes in the symptoms since the experience occurred. These ratings ranged from 0= not at all; 1=mild; 2=moderate; 3=severe; 4=extremely severe.

STI: present situation.

Following the parts identified above, participants were asked questions about their lives in Australia. This process had two aims: one was to follow the participant's experience forward to the present time, the here and now, allowing them to reach the point where they had begun and therefore reaching the end of the interview. The second aim was to investigate the individual's adaptation to life in Australia. The questions focused on any traumatic experiences in Australia; how they felt about being in Australia; what they liked and disliked about Australia, as well as any hopes or plans they had for returning to their country of origin. For those who were seeking refugee status, this part was of the greatest importance in exploring the major needs of asylum seekers and assisting with possible referral processes.

Global Assessment of Functioning- Modified.

The Global Assessment of Functioning-Modified (GAF-M: APA, 1987; Goldman, Skodol, & Lave, 1992) was introduced in Axis V of the DSM-III-R (APA, 1987) and again in the DSM-IV (APA, 1994). This scale is used by researchers and clinicians to subjectively assess the social, occupational and psychosocial functioning of a person (APA, 1987; Hall, 1995; Moos, Nichol, & Moos, 2002). In the DSM-III-R (APA, 1987), the scale is divided into nine equal intervals with a value range from 1-90 (See Appendix D2). In the DSM-IV (APA, 1994) the scale had minor changes with ratings ranging from 0-100. The current research adopted the GAF-M (Goldman et al., 1992) based on the DSM-III-R Axis V (APA, 1987) as this research commenced prior to the introduction of the DSM-IV (APA, 1994).

Each interval of the GAF-M is accompanied by a behavioural descriptor ranging from 'impairment' to 'superior', using a nine-point range. For example, the lowest level of functioning ranges between 1-10 and corresponds to a persistent inability to maintain minimal personal hygiene, unable to function without harming self or others or without considerable external support. The highest level of functioning interval ranges between 81-90= good functioning in all areas, interested and involved in a wide range of activities and socially effective.

Goldman et al. (1992) reviewed the literature that examines the reliability and validity of the GAF-M which evolved from the Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss, & Cohen, 1976). Goldman et al. (1992) stated that there are no published studies regarding the reliability or validity of the DSM-III-R GAF-M (APA, 1987). Hall (1995) reported that, based on the DSM-III (APA, 1980) criteria for Axis V, the literature suggests that the GAF has reasonable validity although limited in its reliability. Hall (1995) assessed the validity and reliability of the modified GAF in a small group of staff members who used the GAF-M to assess patients. The GAF-M was administered on admission and discharge of patients. For both assessments the intraclass correlation coefficient was .81 and for the discharge group it was .95, indicating good reliability. To explore the concurrent validity, the GAF-M was correlated with the Zung Depression Scale (Zung, 1965). The Pearson Product correlation coefficient was $-.73$, $p < 0.001$ indicating acceptable validity (Hall, 1995). The final scoring within this interval was based on criteria provided by Hall (1995).

International Classification of Diseases -10 (ICD-10) Enduring Personality

Change.

The ICD-10 (WHO, 1992, 1993, 2010) includes a category on enduring personality change after catastrophic experience (EPC, see Appendix D3). This explores any change in the individual related to his or her personality including: a hostile or mistrustful attitude towards the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of being 'on edge' as if constantly threatened, and estrangement. These changes are attributed to extreme stress such as living in a concentration camp, torture, disaster, or prolonged exposure to a life-threatening situation, e.g., being taken as a hostage (Beltran & Silove, 1999; Doerr-Zegers et al., 1992; Hauksson, 2003; Turner, 2000). The personality change is not attributed to pre-existing personality disorder or to mental disorder other than PTSD. Another criterion is that the change should have been present for 2 years. The scoring was dichotomous: 1= criteria present, 2= criteria not present. All criteria had to be met for a participant to be given a score of 1= yes, personality change present or 2= no, personality change not present. The final score entered for analysis in SPSS was based on this dichotomous variable giving a percentage of the number of participants who met the criteria for personality change.

The Psychometric Scales.

Self-rating scales were also included in the interview to measure the level of psychological morbidity and self-perception in relation to change over time. Three self-rating scales were incorporated which included:

Self- Report Symptom Checklist Revised.

The Self-Report Symptom Checklist Revised (SCL-90-R; Derogatis, 1983, see Appendix D4) is a multi-dimensional self-report symptom inventory designed to measure psychological symptomatic distress (Derogatis, 1983). There are 90 items to the inventory, each rated on a 5-point scale of distress, ranging from 0 = 'not at all' to 4 'most of the time'. The 90 items reflect symptomatic distress in terms of nine primary symptom dimensions and three global indices.

These are labelled as follows:

1. Somatization: (SOM). This dimension indicates bodily dysfunction reflective of distress, measured by items such as headaches, hot or cold spells and pains in heart or chest. This includes 12 items.
2. Obsessive-Compulsive: (O-C). This dimension reflects psychiatric symptoms which can be classified as compulsive, phobic, or obsessive. Behaviours such as general cognitive performance are also included, for example, the mind going blank, worry about sloppiness or carelessness. This includes 10 items and an example is having to do things very slowly to insure correctness.
3. Interpersonal Sensitivity: (INT). This dimension focuses on feelings of personal inferiority in comparison with others. Individuals who score high on INT indicate an acute self-consciousness and negative experiences about communication and interpersonal behaviour with others. This includes nine items and an example is feeling shy or uneasy with the opposite sex.
4. Depression: (DEP). This dimension identifies signs of clinical depression represented by withdrawal from life interest, lack of motivation, thoughts of suicide, and other

items corresponding to depression. This includes 13 items and an example is feeling lonely.

5. Anxiety: (ANX). This dimension includes items which indicate high levels of manifest anxiety such as nervousness, panic attacks and feelings of terror and apprehension. This includes 10 items and an example is one's heart pounding or racing.
 6. Hostility: (HOS). This dimension affects the individual's state of anger. This is measured by items dealing with aggression, irritability, rage and resentment. This includes six items and an example is temper outbursts you cannot control.
 7. Phobic Anxiety: (PHOB). This dimension focuses on a specific fear response to a person, place, object or situation which leads to avoidance or escape behaviour. This includes seven items, and an example is feeling afraid to travel on buses, subways, or trains.
 8. Paranoid Ideation: (PAR). This dimension focuses on paranoid behaviour as a disordered mode of thinking. Items include suspiciousness and autonomy loss. This includes six items and an example is feeling that you are watched or talked about by others.
 9. Psychoticism: (PSY). This dimension is aimed at representing the construct as a dimension of human experience. It provides a graduated continuum from mild interpersonal alienation to dramatic evidence of psychosis. This includes 10 items and an example is hearing voices that other people do not hear.
- Additional items include those that 'load' on several of the dimensions but do not belong specifically to any of the nine dimensions. These items contribute to the global

scores of the “90” items. This includes seven items and an example is thoughts of death or dying.

There are three global indices of distress derived from the SCL-90-R:

- **Global Severity Index: (GSI).** This represents the best single indicator of the current level of distress and the intensity of perceived distress. This is the mean of all endorsed items and it is the most commonly used in research. It is used where a single summary measure is required. For clinical and research purposes the GSI mean score represents the best measurement of distress level (Derogatis, 1983., Creamer, Burgess, & Pattison, 1992., Elliot et al., 2006). For this reason the mean score for the GSI was used in the current study to explore differences across groups and residential categories.
- **Positive Symptom Distress Index: (PSDI).** This functions as a measure of the response style: that is, a measure of whether the subject is “augmenting” or “attenuating” symptomatic distress. The mean score of positive items is utilized; however, it was not used in the current research as the GSI is the most commonly reported index.
- **Positive Symptom Total: (PST).** This is a count of the number of symptoms the subject reports as positive. Again, this was not considered necessary to use in the current study as the most commonly used measure, the GSI, was considered sufficient for the current study.

The SCL-90-R symptoms are scored on nine separate dimensions, for example, somatisation and obsessive compulsive behaviour, providing scores for the same nine symptom dimensions plus a General Symptom Index (GSI-mean score of all items). The reliability of the scale is high. Test-retest reliability over a 1-week interval ranged from a low of .78 for hostility to a high of .90 for phobic anxiety. Most coefficients were in the .80s. Test-reliability was slightly lower over a 10-week period and ranged between .68 for somatisation to .83 for paranoid ideation (Derogatis, 1994). A concurrent validation study using the MMPI and the SCL-90 found that comparisons of the nine primary dimensions of the SCL-90 with a set of the MMPI scales reflected a high degree of convergent validity for the SCL-90 (Derogatis, Rickels, & Rock, 1976). It has been widely administered to individuals with many different experiences including people who have survived war trauma and torture (Elliott et al., 2006; Paker et al., 1992; Weathers, Ruscio, & Keane, 1999).

The Impact of Event Scale.

Horowitz et al. (1979) developed the Impact of Event Scale (IES; Horowitz et al., 1979, see Appendix D5) as a 15-item self-rating scale which assessed current subjective distress following a traumatic event. The IES incorporates items derived from frequently used statements that people use to describe episodes of distress following a traumatic event (Horowitz et al., 1979). The 15-item scale is divided into two sub-scales, namely, intrusion and avoidance. The intrusion response includes seven items based on: disturbing thoughts and images, troubled dreams, strong waves of feelings and repetitive behaviour. The subset scale for intrusion comprises of the following items: 1, 4, 5, 6, 10, 11, and 14. The avoidance responses include denial of meanings and consequences of the event, blunted sensation, behaviour inhibition and

awareness of emotional numbness. The subset scale for avoidance comprises eight items, namely, items 2, 3, 7, 8, 9, 12, 13 and 15 (see Appendix D5). The response ranges from 'Not at all'=1 'Rarely'=2, 'Sometimes'=3, 'Often'=4. The total score for intrusion is 28 and the minimum is 7. The total number for avoidance was 32 and minimum 8. Mean scores for each participant were obtained for intrusion and avoidance.

Test- retest reliabilities for the two sub-scales were 0.79 (intrusion) and 0.82 (avoidance) (Horowitz et al.,1979). In a review evaluating the IES's psychometric properties 18 estimates of the internal consistency of the IES intrusion and avoidance for different populations were analysed. The mean alphas were =0.86 (range 0.72-0.92) for intrusion and =0.82 (range 0.65-0.90) for avoidance. Based on the 0.80 criterion (Sundin & Horowitz, 2002) avoidance and intrusion in the IES are consistent, measuring a homogeneous construct (Sundin & Horowitz, 2002).

This scale has been used in diverse studies to assess the impact of traumatic experiences (Horowitz et al., 1979; Marsella, 2001; van der Ploeg et al., 2004; Solomon, Weisenberg, Schwarzwald, & Mikulincer, 1987). The results have been found to correlate with the results from PTSD scales and the SCL-90 questionnaire (Sundin & Horowitz, 2002; Wilson, Smith, & Johnson, 1985) adding to its validity. The IES has been consistently administered by researchers in the area of trauma including research into the psychological impact of torture (McFarlane, 2004; Priebe et al., 2010).

Note that this study did not use the IES-R (Weiss, 2004) which includes a third sub-scale, hyperarousal, as it was developed after the data collection for this research was completed. All reviews presented about the IES are based on studies where the original IES (Horowitz et al., 1979) had been adopted.

The Repertory Grid.

The Repertory Grid (Grid, Kelly 1955) was developed to assess changes in self as perceived by participants resulting from their life experiences, including their traumatic experiences. The aim of The Grid is to add to our capacity to explore the individual's world view on the basis of his/her concept of self. The elements must be representative of the population we choose to study. The elements represent the areas in which construing are to be investigated. For the purpose of this study and the specific population group, the six elements were based on the individual's self-concept in relation to: 1. Self prior to surviving a traumatic experience; 2. Self during this experience; 3. Self after the experience; 4. Self as a migrant/as an asylum seeker; 5. Self now (self at the time of the interview); and 6. Self in 10 years from now (see Diagram 7.1). Self-characterisation is a way by which we can elicit constructs describing the characteristics of the group, based on the elements. The self characterization method was adopted to elicit the constructs for the purpose of this research. It resulted in a grid with six elements and 21 constructs (see Diagram 7.1). The self-characterisation method involved gathering a group of people from diverse ethnic backgrounds, who were representative of the participants in this study sample. They were given the self-characterisation instructions as per Kelly (1955) to elicit the constructs resulting from the six elements described above. They were instructed to describe self in each of the six stages in their life. These stages were represented by the six elements, and using the self-characterisation instruction defined by Kelly (1955) allowed for the eliciting of the construct. The instruction was:

“I want you to write a character sketch of Harry Brown (Isabela Escobal), just if he/she were the principal character in a play. Write it as it might be written by a friend who knew her intimately and very sympathetically, perhaps better than anyone else ever

really could know her/him. Be sure to write it in the third person. For example start out by saying, ‘Harry or Isabela is.....and before her most traumatic event she was....’ “.

(Kelly, 1955, p. 323).

The different ethnic groups included Latin Americans, Africans, Tamils, Turks, Iranians, South East Asians and Algerians. The technique was acceptable across the cultures represented by the participants of this study. The constructs were elicited from adjectives used by people to describe the self at the different points in time in their sketch (see Diagram 7.1 for construct (adjectives elicited) to described self. Keeping in mind Kelly’s (1955) theory, those elicited constructs are more meaningful and are used in more complex ways than those constructs supplied by the researcher. Therefore, the purpose of using the self characterization method to elicit the constructs was expected to be more meaningful across the population being studied in this research. Following the self characterisation resulting in the elicitation of 21 constructs (also referred to as attributes), the element-construct method was also employed by using the same Grid (see Appendix D6 for complete Repertory Grid) which resulted from self characterisation to administer to all participants. This method was adopted so the same Grid could be distributed to a larger sample and comparisons could be made across groups on the changes to self view following a traumatic experience.

Norms do not exist for these attributes. There is an assumption that the attributes have the same meaning for the people across the different groups. This is an assumption which is true of any self-report rating. In this study the Grid was rated on a Likert scale 1 to 7. The minimum rating was 1, indicating closeness to the positive attribute and the maximum was 7, indicating maximum distance from the positive attribute (closeness to the negative attribute).

The Repertory Grid was distributed to the 259 participants of this study. It was the last scale to be filled by the participant. For the final statistical analyses any Repertory Grid that was missing data was eliminated. A total of 243 Grids were entered each with six elements and 21 constructs per element.

Procedure

The assessment and testing session commenced with participants being informed of the research purpose and to reinforce the fact that they could withdraw from the interview at any time. Also in Section 2 of the study all participants who were seeking asylum were informed that their participation would not impact on their application process in any way as it was independent of the immigration department. A Plain Language Statement (PLS) was provided and the cross-cultural worker explained the study as well (see Appendix E1). When the consent form (see Appendix E2) was signed the SCL-90-R was administered followed by the semi-structured interview, the GAF and PC, the IES and finally the Grid. This order was consistent across all participants.

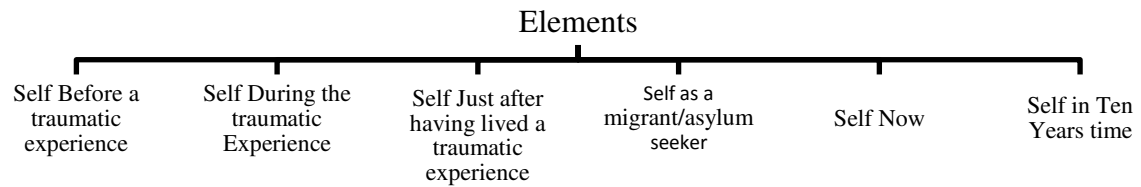
This methodology adopted ethical principles to investigate the psychological impact of torture and other types of systemic abuse on refugees that were in accordance with the study by Thompson and McGorry (1995). Overall, four main principles were adopted in this research: 1. a humanitarian approach to research; 2. a compassionate approach to interviewing and research overall; 3. a cross-cultural, sensitive approach; and 4. a psychotherapeutic approach to interviewing (see Appendix F for more detail on these principles). In consideration of these principles a psychotherapeutic interview was held to

ensure that interviewees were treated as individuals not as traumatized survivors of abuse. This prevented the interview becoming an interrogation which might resemble earlier traumatic experiences. The interviews were arranged at a place of the interviewees choosing: their home, their garden or another familiar environment. Because of the length of the interview breaks were taken at the time of their choosing. Both the environment chosen and the flexibility allowed for breaks ensured that the concentration and attention of the participants was maintained. Because of the diversity of ethnicity, cultural values and religious belief, it was necessary to distinguish between responses to culture and the trauma itself. The researchers needed to be cautious in interpreting behaviour as any neglect of cross cultural issues would risk serious misunderstandings. A level of trust was essential between researchers and participants in this study. Revealing the torture experience in an interview might increase the participant's anxiety and lead to resistance to continue or an urge to disclose a long history. Consequently no time limits were imposed.

At the time of this research the guidelines and principles for researching the consequences of torture and seeking asylum were not as clearly defined as they are today. Nevertheless, the four principles mentioned conform with those set out by the Istanbul Protocol (UNHCHR, 2004) and research standards and ethical considerations as described by writers in this field (e.g., Marsella, 2001; Physicians for Human Rights, 2001; Quiroga & Jaranson, 2005; Watters, 2010; Wenzel et al., 2009).

Figure 7.1

Repertory Grid



Constructs	
Healthy	Unhealthy
Happy	Sad
Knowledgeable	Ignorant
Patient	Impatient
Not lonely	Lonely
Dreamer	Realist
Romantic	Un-romantic
Enthusiastic	Un-enthusiastic
Open-person	Closed-person
Ambitious	Un-ambitious
Not-vulnerable	Vulnerable
Optimistic	Pessimistic
Relaxed	Tense
Secure	Insecure
Not-bitter	Bitter
Intelligent	Stupid
Independent	Dependent
Unfearful	Fearful
Fighter	Non-fighter
Trustful	Mistrustful
Free	Imprisoned

Chapter 8

Results

Chapter Overview and Analytic Approach

This Results chapter is divided into three sections addressing the research questions outlined in Chapter Six:

Section 1 addresses the first research question related to the degree to which psychological distress varied between survivors of torture, survivors of other types of systemic abuse, and migrants who had not experienced these forms of abuse (the control group). To address the first research question, Section 1 focused on comparisons of these three groups on the psychopathological and self measurements. All three groups had Australian permanent resident status.

Section 2 addresses the second research question which relates to the degree to which the distress varied according to the survivor's residency status in Australia (1: permanent resident, 2: asylum seeker in the community and 3: asylum seeker in detention). Within all three residential categories participants were either 1: survivors of torture or 2: survivors of other type of systemic abuse. The control group from Section 1 was redundant; that is, migrants who had not experienced either torture or other types of systemic abuse were not included in Section 2. By eliminating the control group a 3 by 2 cross-factorial design was conducted to investigate possible interactions between the two independent variables

(residential category and group). Due to the presence of two independent variables (residential category and group) it was necessary to study the interaction of these two variables. Therefore, Section 2 is divided into Sections 2 A and 2 B. Section 2 A examines whether there was any interaction between residential categories (1: permanent resident, 2: asylum seeker in the community and 3: asylum seeker in detention) and group membership (1: survivors of torture or 2: survivors of other type of systemic abuse). This is followed by presentation of the main effect results for the two independent variables (resident and group) where there was no interaction between residency and group (Keppel & Wickens, 2004).

The main effect result “expresses the differences among the means” (Keppel & Wickens, 2004, p. 197) on the psychopathological and self measurements between the three residential categories and between the two groups. The main effects are “most appropriately interpreted when interaction is absent” (Keppel & Wickens, 2004, p. 197). A series of two-way analyses of variance was conducted to identify interactions between residency and group. Where there was no interaction the main effect for residents is presented with post-hoc comparisons which determine whether there were significant differences in the means between the three residential categories (permanent residents, asylum seekers in the community and asylum seekers in detention). Post-hoc tests were not applied to the main effect for the independent variable (group) as there were only two groups: torture survivors and survivors of other types of systemic abuse.

Section 2 B presents the results obtained from further tests which investigated any of the interactions between the two independent variables (resident and group) in Section 2 A. The purpose of further investigation of any interaction was to examine the statistical significance of the interaction between the two independent variables. Using simple effect

analysis, the effect of one independent variable (residency) at each level of the other independent variable (Group 1 and 2) was adopted. For example, in this study the residency variable had three levels (permanent, asylum in the community and asylum in detention) and the other independent variable had two levels (Group 1: torture survivors and Group 2: survivors of other types of systemic abuse). The statistical programmer to examine the simple effect was MANOVA (Keppel & Wickens, 2004).

Following the results from Section 2A and B it was important to examine the linear relations between measurements and to determine the strength of the relationship between the measurements used in this research: correlations within the psychiatric pathology scales, and between the psychiatric scales and the three self-measurements from the repertory grid. A factor analysis was conducted to explore the structure underlying the various psychopathology measurements (Pallant, 2005). These results are presented in Section 3.

Section 3 also reports on three multiple regression analyses concerning 21 traumatic experiences as predictors of psychopathology measurements identified in the interactions in Section 2 B, namely the results for the two IES subscales and for PTSD for the past 4 weeks. Then two logistic regressions were conducted to ascertain which traumatic experiences were the best predictors of (i) personality change (as measured by the ICD-10) and (ii) fear of losing control during the traumatic experience. These two dependent variables were categorical in nature (yes/no response).

In order to test the hypotheses in Section 1, 26 participants were needed for each of the three groups, accepting a significance level of $p=.05$, with power set at .80 and in order to obtain a large effect size ($ES=.80$ (Cohen, 1992)). For each group in Section 1 the number of participants was above 26. In order to test the hypotheses concerning the main effect for

residency in Section 2, 26 participants were needed for each of the three residential categories, accepting a significance level of $p=.05$, with power set at .80 and in order to obtain a large effect size ($ES=.80$ (Cohen, 1992)). For each residential category in Section 2 the number of participants was above 26. However, 64 participants would be needed in each of the three groups in Section 1 and the three residential categories in Section 2, accepting a significance level of $p=.05$, with power set at .80 and in order to obtain a medium effect size of .50 (Cohen, 1992).

The Levene Test of equality of error variances was used to assess conformity with the assumptions of ANOVA for normally distributed errors and constant variance. Assumptions of normality and contrast model residuals were assessed for each statistical analysis model adopted for the purpose of testing the hypotheses separately and were found to be reasonably satisfactory.

The Repertory Grid data was analysed by SPSS for the self ratings and self-discrepancy scores, and by the repertory grid analysis program, “Gridstat” (Bell 2009) for measuring cognitive complexity. To avoid summarizing ratings within individuals and preserve between-construct variation, a mixed- model statistical analysis was conducted on self ratings of constructs across the six elements. This enabled the analysis to identify the differences between the three groups (survivors of torture, other types of systemic abuse and the control), and the degree of difference between residential categories. Post-hoc comparisons were conducted to statistically analyse the differences between groups and the residential categories.

Section 1: Comparison Between Survivors of Torture, Other Types of Systemic Abuse and the Control Group, all with Permanent Residency

Firstly, comparisons were made between these three groups in terms of demographic characteristics. Chi-square tests were conducted to compare these groups in terms of gender, marital status, living in a rural area or city prior to immigrating into Australia and the level of education and employment status. Also compared were the number of traumatic events experienced by participants and whether participants believed they were able to maintain control during those traumatic experiences. Finally, the percentages of participants meeting the criteria for ICD-10 Personality Change resulting from a traumatic experience were compared across the three groups. One-way analyses of variance (ANOVAS) with post-hoc tests were conducted to explore differences between the three groups in terms of age and length of time in Australia.

The second part of Section 1 of this chapter focuses on the hypotheses related to the degree to which scores vary on measures of psychopathology and the Repertory Grid between survivors of torture (Group 1), survivors of other types of systemic abuse (Group 2) and the control group (Group 3). Mean scores were obtained on the nine dimensions SCL-90-R and the GSI score, the two sub-scales for the IES, namely avoidance and intrusion, the GAF and the two PTSD severity scores, namely, the PTSD worst ever score following the traumatic experience and the PTSD score for the last 4 weeks just prior to the research interview. The percentages of participants meeting the criteria for PTSD are also presented. Also examined is the difference between these three groups for the Repertory Grid analysis on measurements for: self-view rating; self-view rating discrepancies; and cognitive complexity (see Chapter 5 for further explanation of Grid measurements).

Demographic characteristics.

Table 8.1 displays demographic characteristics for each of the three groups. A chi-square analysis found differences in gender ($\chi^2(2, n= 183) = 8.70, p=.013$) and adjusted residuals showed there was a smaller proportion of females within the survivors of torture group compared with the other two groups (see Table 8.1).

From Table 8.1 it can be seen that there were no differences between groups across demographic variables, e.g., whether people were in a relationship, held religious beliefs and prior location of rural or city environment, educational qualifications and work in their country or work in Australia.

Table 8.1

Demographic Characteristics of the Three Groups

Demographics	Survivors of torture Group 1 (n=56)	Survivors of other types of systemic abuse Group 2 (n=69)	Control Group3 (n=58)	χ^2 Value	p Value
Male	66% (n=37)	43% (n=30)	41% (n=24)		
Female	34% (n=19)	57% (n=39)	59% (n=34)	8.70	.013
In a relationship	61% (n=34)	59% (n=41)	55% (n=32)	.402	.818
Religious belief	86% (n=48)	91% (n=63)	91% (n=52)	1.321	.516
Living in Rural Area	23% (n=13)	19% (n=13)	19% (n=11)		
Living in a City Area	77% (n=43)	81% (n=56)	81% (n=47)	.449	.799
Education completed	95% (n=53)	96% (n=66)	97% (n=56)	.248	.883
Working in country of origin	70% (n=39)	67% (n=46)	67% (n=39)	.136	.934
Working in Australia	37% (n=21)	23% (n=16)	41% (n=24)	5.323	.085

Table 8.2 displays the various traumatic events experienced across all three groups. Comparison between groups indicates that survivors of torture were statistically different in the number of experiences they have endured other than torture. Table 8.2 indicates that the experience of torture does not come in isolation. For example rape, witnessing rape of a family member by official authorities, being kept in captivity, being kidnapped and forced displacement are all reported experiences of the survivors of torture group. Survivors of other types of systemic abuse and the control group have also experienced numerous traumatic experiences, although to a lesser extent for the control group.

Consequences of trauma.

Participants were asked if they were afraid of losing control as a result of their traumatic experiences. An overall significant difference was indicated across the three groups ($\chi^2(4, n=183) = 85.048, p=.000$); 91% survivors of torture said yes, as did 75% survivors of other types of systemic abuse, and 33% of the control group. The participants were also asked if they talked about their traumatic experience. There was a significant difference across the three groups ($\chi^2(4, n=183) = 91.876, p=.000$); 32% of survivors of torture said yes, as did 56% of the survivors of other types of systemic abuse, and 24% of the control group.

Another question put to the participants was whether they thought their traumatic experience had changed their personality. There was a significant difference across the groups ($\chi^2(2, n=183) = 41.78, p=.000$). The percentage of individuals meeting the criteria for personality change on the basis of the ICD-10 for survivors of torture was 58.9%, followed by survivors of other types of systemic abuse (29.0%) and the control group (3.4%).

Table 8.2

Traumatic Events: Comparisons Between Groups Along with Chi-square and Significance Values

Event	Survivors of torture Group 1 (n=56)	Survivors of other types of systemic abuse Group 2 (n=69)	Control Group 3 (n=58)	χ^2 (n=183)	P
Serious physical injury (accident)	21% (n=12)	14.0% (n=10)	5.2% (n=3)	6.448	.040
Combat	27% (n=15)	5.8% (n=4)	3.4% (n=2)	18.791	.000
Experienced rape	27% (n=15)	3% (n=2)	7% (n=4)	19.115	.000
Witnessed rape of family members forced by officials to be done amongst family members	0% (n=0)	3% (n=2)	0% (n=0)	3.341	.188
Witnessed rape of family done by officials	12% (n=7)	7% (n=5)	0% (n=0)	7.351	.025
Assault	34% (n=19)	32% (n=22)	17% (n=10)	4.835	.089
Captivity	71% (n=40)	30% (n=21)	5% (n=3)	56.000	.000
Being kidnapped	29% (n=16)	6% (n=4)	0% (n=0)	26.889	.000
Natural disaster	45% (n=25)	46% (n=32)	38% (n=22)	.988	.610
Seeing loss of life	70% (n=39)	62% (n=43)	19% (n=11)	35.136	.000
Threat to life	82% (n=46)	87% (n=60)	25% (n=15)	61.753	.000
Witnessed violence in mass demonstrations	68% (n=38)	56% (n=39)	34% (n=20)	13.290	.001
Witnessed killing of family member	54% (n=30)	51% (n=35)	7% (n=4)	34.419	.000
Experienced disappearance of relatives or friends	59% (n=33)	70% (n=48)	24% (n=14)	27.641	.000
Relative in jail as political prisoner	46% (n=26)	55% (n=38)	24% (n=14)	12.808	.002
Search as result of organised violence	84% (n=47)	74% (n=51)	26% (n=15)	47.610	.000
Forced displacement	66% (n=37)	62% (n=43)	14% (n=8)	40.179	.000
Lived in refugee camps	25% (n=14)	35% (n=24)	10% (n=6)	10.345	.006

One-way ANOVAS were conducted. Means, standard deviations and respective F values and significance levels for the three groups for age and length of time in Australia are shown in Table 8.3. The difference in age between groups was significant (F(6.209), $p = .002$). Post-hoc Scheffe tests revealed that the difference between groups only reached significance between the survivors of torture (Group 1) and the control group (Group 3) ($p = .003$) with Group 1 being the oldest. No significant difference was identified between the three groups for the length of time in Australia (F(1.776), $p = .172$).

Table 8.3

Means, Standard Deviations for Each of the Three Groups and Analysis of Variance Results for Age and Length of Time in Australia

Demographics	Survivors of torture		Survivors of other types of systemic abuse		Control		F Value	P Value
	Group 1 (n=56)		Group 2 (n=69)		Group 3 (n=58)			
	Mean	SD	Mean	SD	Mean	SD		
Age	35.32 ^a	7.49	32.19 ^{ab}	8.43	30.53 ^b	5.69	6.209	.002
Length of time in Australia	4.30	2.66	3.58	2.48	3.53	2.25	1.776	.172

Note=Groups that do not share the same alphabetical superscript are significantly different from one another

Comparison between the three groups on measures of psychopathology.

SCL-90-R.

Using nine one-way between-groups ANOVAs with planned comparisons for each of the nine dimensions plus a tenth for the GSI, a statistically significant difference was identified between all three groups on five of the nine SCL-90-R dimensions: anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism. Scores (Means and SDs) are displayed in Table 8.4. Planned contrasts found that Group 1 obtained significantly higher scores than both Groups 2 and 3 on all five SCL-90-R dimensions. On four of the same five dimensions there were no significant differences between Groups 2 and 3. On the fifth measure of Psychoticism, Group 2 obtained significantly lower scores than Group 3.

For the GSI a statistically significant difference was found between survivors of torture (Group 1) and both survivors of other types of systemic abuse (Groups 2) and the control group (Group 3). However, no statistically significant difference was identified between Group 2 and Group 3. Inspection of Table 8.4 shows that Group 1 obtained the highest mean scores of the three groups on the GSI.

Table 8.4

Means and Standard Deviations for the Three Groups for the SCL-90-R Scores

SCL-90-R Dimensions	Survivors of torture		Survivors of other types of systemic abuse		Control		F	p
	Group 1 (n=56)		Group 2 (n=69)		Group 3 (n=58)			
	Mean	SD	Mean	SD	Mean	SD		
Somatization	1.00	.84	.70	.71	.71	.88	2.66	.073
Obsessive- Compulsive	1.34	.82	1.13	.74	1.05	.99	1.73	.181
Interpersonal Sensitivity	.98	.73	.71	.55	.80	.87	2.30	.104
Depression	1.26	.94	1.08	.74	1.15	1.04	.64	.529
Anxiety	1.11 ^a	1.02	.71 ^b	.65	.71 ^b	.81	4.54	.012
Hostility	.97 ^a	.86	.58 ^b	.59	.60 ^b	.74	5.49	.005
Phobic Anxiety	.78 ^a	.83	.51 ^b	.63	.45 ^b	.71	3.78	.036
Paranoid Ideation	1.10 ^a	.87	.67 ^b	.70	.72 ^b	.85	5.02	.008
Psychoticism	.75 ^a	.76	.42 ^b	.41	.51 ^c	.73	4.45	.013
SCL 90 GSI	1.06 ^a	.75	.76 ^b	.50	.79 ^b	.80	3.37	.036

Notes= Groups that do not share the same alphabetical superscript are significantly different from one another.
GSI= General Symptom Index.

IES- Intrusion and Avoidance.

To explore differences between groups, two one-way between-group ANOVAs with planned contrasts were conducted for the IES variables of intrusion and avoidance. A statistically significant difference was obtained between groups for the two dependent variables. Groups 1 and 2 both obtained significantly higher scores than Group 3 on both measures. Groups 1 and 2 did not significantly differ on either measure. Group mean scores can be inspected in Table 8.5.

Table 8.5

Means, Standard Deviations and Significance Values for the Three Groups for the IES Sub-scales of Intrusion and Avoidance.

	Survivors of torture Group 1 (n= 56)		Survivors of other types of systemic abuse Group 2 (n= 69)		Control Group 3 (n= 58)		F value	p value
	Mean	SD	Mean	SD	Mean	SD		
Intrusion	15.91 ^a	6.55	13.57 ^a	6.37	8.66 ^b	4.50	22.65	.000
Avoidance	18.70 ^a	6.97	16.09 ^a	6.28	9.74 ^b	4.11	34.92	.000

Notes= 1 Groups that do not share the same alphabetical superscript are significantly different from one another.

2 IES= Impact of Event Scale

PTSD and the GAF measures.

Table 8.6 displays the means and standard deviations for the three groups for two PTSD variables and the GAF. Three one-way ANOVAs with planned contrast were conducted. Planned contrasts found that survivors of torture (Group 1) obtained significantly higher scores than the control group (Group 3) for the two PTSD variables. For one PTSD variable (PTSD just after the worst experience), Groups 1 and 2 were not significantly different from one another but both obtained significantly higher scores than Group 3. For the second PTSD variable (PTSD last four weeks), Group 1 obtained significantly higher scores than both Groups 2 and 3. In turn, Group 2 obtained significantly higher scores than Group 3. For the GAF score, Group 3 obtained significantly higher (i.e., better) scores than both Groups 1 and 2 which did not differ significantly from one another.

Table 8.7 displays the percentages of participants that met the DSM III-R criteria for PTSD. PTSD ‘worst ever’ is based on what the participants rated symptoms to have been following their traumatic experience. The percentage of participants meeting the criteria for PTSD is highest for torture survivors (Group 1) followed by survivors of other types of systemic abuse (Group 2) and the control group (Group 3). The percentage of participants meeting the criteria for PTSD ‘last 4 weeks’ (the four weeks prior to interview) was higher for torture survivors followed by survivors of systemic abuse and the control group. All percentages for last four weeks were lower than worst ever percentages.

Table 8.6

Means, Standard Deviations and Significance Values for the Three Groups for the PTSD and GAF Measurements.

	Survivors of torture (Group 1) n=56 Mean	SD	Survivors of other types of systemic abuse (Group 2) n=69 Mean	SD	Control (Group 3) n=58 Mean	SD	F value	p value
PTSD just after the worst experience	2.94 ^a	.71	2.32 ^a	.88	.47 ^b	.93	133.91	.000
PTSD last four weeks	2.00 ^a	.79	1.44 ^b	.87	.30 ^c	.70	60.65	.000
GAF	67.14 ^a	14.74	67.61 ^a	11.84	76.21 ^b	10.30	10.08	.000

Note= 1. Groups that do not share the same alphabetical superscript are significantly different from one another.

2. GAF= Global Assessment of Functioning

Table 8.7

Percentage of Participants Meeting the Criteria for PTSD within Each Group

Variables	Survivors of torture (Group 1) n=56	Survivors of other types of systemic abuse (Group 2) n=69	Control (Group 3) n=58	χ^2 value	p value
PTSD just after the worst experience	84%	68%	9%	73.834	.000
PTSD last 4 weeks	23%	19%	5%	7.699	.021

Repertory Grid-comparison on self rating across the three groups.

Table 8.8 displays statistical differences between Groups 1, 2 and 3 in the way they self-rated constructs in three of the six elements; ‘Self during the most traumatic experience’, ‘Self after the most traumatic experience’ and Self as a migrant. The difference was significant with Group 1 having a higher mean score for these three elements in their construct rating, meaning they rated the self as more negative. For these three elements there were no statistically significant difference between the Group 2 and 3 mean scores; both had a lower mean score than Group 1. There was no significant difference between groups for ‘Self before the most traumatic experience’, Self now and for ‘Self in 10 years time’.

Repertory Grid- comparison on self discrepancies ratings across the three groups.

Table 8.8 displays the mean scores obtained for self discrepancies across constructs measured against self before the traumatic event for each of the five elements. A higher mean score in this analysis represents a less complex construct system, therefore less flexible, more restricted and more negative. There were significant differences in the level of self discrepancy between the three groups on three of the five elements: Self before-self during, Self before-self after, and Self before-self as a migrant. Pair-wise comparisons indicated that Group 1 obtained higher mean scores than Groups 2 and 3. Survivors of other types of systemic abuse (Group 2) and the control (Group 3) did not significantly differ from one another on three of these five discrepancies.

Repertory Grid: difference in the cognitive complexity across the three groups.

Table 8.8 displays the differences between the three groups in the level of restriction in the self rating within the group across constructs for the six elements. Group 1 displayed a significant difference compared to Groups 2 and 3 in cognitive complexity. This means that there was more restriction in the use of constructs by torture survivors to describe self.

Table 8.8

The Differences in Self Ratings Across Constructs for Each Element Between Survivors of Torture, Survivors of Other Types of Systemic Abuse and the Control Group

Elements	Survivors of torture		Survivor of other types of system abuse		Control		F	p
	Mean	SD	Mean	SD	Mean	SD		
Self Rating Over Time								
Self before trauma	1.97	.12	2.08	.11	2.21	.13	.951	.388
Self During	5.48 ^a	.20	4.51 ^b	.18	4.28 ^b	.22	9.920	.000
Self After	4.70 ^a	.21	3.64 ^b	.19	3.39 ^b	.24	10.556	.000
Self as Migrant	3.87 ^a	.20	3.11 ^b	.18	2.68 ^b	.20	9.010	.000
Self Now	3.10	.20	2.78	.18	2.76	.19	1.020	.363
Self in 10 Years	2.17	.16	2.18	.14	1.85	.16	1.518	.222
Self Discrepancy								
Self before trauma- Self During	3.73 ^a	.19	2.72 ^b	.17	2.38 ^b	.21	13.084	.000
Self before trauma- Self After	2.98 ^a	.19	2.11 ^b	.17	1.72 ^b	.22	10.827	.000
Self before trauma- Self as Migrant	2.28 ^a	.18	1.64 ^b	.16	1.36 ^b	.19	6.630	.002
Self before trauma- Self Now	1.64	.16	1.49	.14	1.36	.17	.688	.504
Self before trauma- Self in 10 Years	1.06	.13	1.19	.12	1.03	.14	.459	.632
Cognitive complexity	.66 ^a	.25	.51 ^b	.25	.43 ^b	.29	10.484	.000

Note: 1 Groups that do not share the same alphabetical superscript are significantly different from one another

2 A higher score indicates more negative appraisal

Group and gender interactions on the various measures of psychopathology.

Due to the difference in gender (see Table 8.9) further analyses using two-way ANOVAs were conducted to assess whether gender interacted with the groups on any of the measures of psychopathology. There were significant main effects for both group and gender (see Table 8.9). There was no significant gender and group interaction effect as can be seen in Table 8.9. However, in line with the significant main effects for gender, inspection of Figures G1-G4 (Appendix G1-G4) indicates that females obtained higher scores than males for most measurements, irrespective of group membership.

Table 8.9

Gender Group Interaction Effects Based on Psychopathological Measures.

Measures	Group main effect		Gender main effect		Group and gender interaction	
	F	p	F	p	F	p
SCL-90-R						
Somatization	5.81	.004	22.33	.000	.397	.673
Obsessive-Compulsive	3.87	.023	19.30	.000	.704	.496
Interpersonal Sensitivity	3.79	.025	10.17	.002	.371	.690
Depression	2.45	.089	28.79	.000	.712	.492
Anxiety	9.05	.000	21.92	.000	.761	.469
Hostility	7.00	.001	6.77	.010	.237	.789
Phobic Anxiety	5.94	.003	15.44	.000	.130	.878
Paranoid Ideation	7.89	.001	9.77	.002	.917	.402
Psychoticism	7.31	.001	9.09	.003	2.424	.092
SCL-90-R GSI	6.89	.001	22.45	.000	.533	.588
IES Intrusion	26.42	.000	10.26	.002	.089	.915
IES Avoidance	37.26	.000	7.64	.006	7.644	.667
PTSD just after the worst experience	134.99	.000	4.16	.043	.344	.709
PTSD last four weeks	63.53	.000	6.86	.010	.013	.987
GAF	10.91	.000	1.44	.232	.629	.535

Note= 1 GSI=Global Severity Index 2 IES= Impact of Event Scale 3 PTSD= Post-Traumatic Stress Disorder 4 GAF=Global Assessment of Functioning

Summary.

Overall, the results supported the hypothesis (Hypothesis one) that torture survivors (Group 1) present with higher levels of psychopathology and a lower level of functioning compared to Group 3. However, in comparison to Group 2 the severity of the symptoms resulting from the traumatic experiences were not as clearly observed. There were no statistical differences between the level of intrusion and avoidance as measured by the IES, the PTSD worst ever and the level of functioning. However, there was with the PTSD score when scoring for the 'last 4 weeks'.

The hypothesis (two) that survivors of other systemic abuse (Group 2) will present with higher psychological distress than Group 3 (control) was also not as clearly observed. There was one significant difference between Group 2 and 3 for the SCL-90-R (psychoticism). For the other measurements, whilst Group 2 had higher mean scores, these were not significantly different to Group 3. Group 2 presented with higher levels of distress as measured by intrusion and avoidance (IES) and PTSD worst ever and last four weeks compared to Group 3. Also Group 2 presented with lower level of functioning than Group 3 (Hypothesis two).

The results from the self rating and the self discrepancies ratings across the three groups indicated that self before a traumatic experience was seen most positively by all three groups. However, self during a traumatic experience was seen most negatively by survivors of torture followed by survivors of other types of systemic abuse and the control group. These results confirm Hypotheses three and four that there is a significant difference between groups with Group 1 being more negative at the time of the experience. However, these hypotheses did not hold when comparing the groups before the experience, now, and in 10

years time. Based on the cognitive complexity measurement torture survivors (Group 1) rated their self description in a more constricted manner than both Groups 2 and Group 3 (as predicted in Hypothesis five). However, for Hypothesis six, survivors of other types of systemic abuse (Group 2) showed no significant difference in their self description to the control group (Group 3).

Section 2: Comparison Between the Three Residential Categories: Permanent Residency, Asylum Seekers Living in the Community and Asylum Seekers Living in Detention

In addition to exploring the impact torture and other types of system abuse have had on psychopathology, self, and functioning of participants, their residential status was examined as another factor contributing to their psychological well-being. As stated in the methodology in Chapter 7 and in the introduction to this chapter, three types of residential categories were explored: Permanent residency (Permanent), Asylum seekers living in the community (Asylum Seekers), and Asylum seekers living in a detention centre in Australia (Detention).

Presented first in this section are Chi-square analyses which were conducted for residency to explore: (1) the participant's demographic characteristics, (2) personality change, (3) whether participants feared losing control and felt frightened during their traumatic experience, and (4) the percentage of participants within each of the residential categories that met criteria for PTSD.

Demographics according to residential status.

Table 8.10 displays significant differences between the three residential categories for three of the demographic characteristics: gender, religious belief and working in Australia. There were clearly less females across the three residential categories compared to males. Table 8.10 shows a smaller number of females in detention compared to males (a ratio of 1:5). The difference between gender being largest in this residential category.

Table 8.10

Demographic Characteristics Across Residential Status Categories

Demographics	Permanent residents (n=125)	Asylum seekers (n=34)	Detention centre (n=42)	χ^2 Value	p
Male	54% (n=67)	53% (n=18)	83% (n=35)		
Female	46% (n=58)	47% (n=16)	17% (n=7)	12.33	.002
In a relationship	60% (n=75)	38% (n=13)	50% (n=21)	5.48	.064
Religious belief	89% (n=111)	100% (n=34)	100% (n=42)	9.15	.010
Living in Rural Area OR	21% (n=26)	29% (n=10)	21% (n=9)		
Living in a City Area	79% (n=99)	71% (n=24)	79% (n=33)	1.17	.557
Education completed	95% (n=119)	94% (n=32)	100% (n=42)	2.28	.319
Working in country of origin	68% (n=85)	73% (n=24)	74% (n=31)	0.65	.724
Working in Australia	30% (n=37)	26% (n=9)	0% (n=0)	15.91	.000

Table 8.11 displays the number of traumatic events experienced across the three residential categories. The table shows a statistically significant difference across the three residential categories for 13 out of the 19 experiences. There were no significant differences between the three residential categories in relation to having experienced torture. For nine of these experiences the detention centre category had higher percentages than permanent residents and asylum seekers residents.

Table 8.11

Percentages, Chi-square and Significance Values for the Traumatic Events Experienced across the Three Residential Categories

Event	Permanent residents n=125	Asylum Seeker n=34	Detention centre n=42	χ^2	P
*Serious physical injury (accident or natural disaster)	18% (n=22)	65% (n=22)	.0% (n=0)	49.57	.000
Torture	45% (n=56)	68% (n=23)	45% (n=19)	5.85	.054
Combat	15% (n=19)	21% (n=7)	21% (n=9)	1.14	.567
Experienced rape	14% (n=17)	3% (n=1)	5% (n=8)	4.49	.108
*Witnessed rape family (forced within family)	2% (n=2)	9% (n=3)	0.0% (n=0)	7.10	.029
Witnessed rape family (done)	10% (n=12)	21% (n=7)	21% (n=9)	5.18	.075
*Assault	33% (n=41)	47% (n=16)	62% (n=26)	11.55	.003
*Captivity	49% (n=61)	12% (n=4)	52% (n=22)	16.73	.000
Being kidnapped	16% (n=20)	3% (n=1)	19% (n=8)	4.61	.100
*Natural disaster	46% (n=57)	47% (n=16)	5% (n=2)	24.08	.000
*Seeing loss of life	66% (n=82)	68% (n=23)	88% (n=37)	7.85	.020
*Threat to life	85% (n=106)	53% (n=18)	93% (n=39)	22.49	.000
*Witnessed violence in mass demonstrations	62% (n=77)	23% (n=8)	62% (n=26)	16.63	.000
*Witnessed killing of family member	52% (n=65)	47% (n=16)	90% (n=38)	21.77	.000
*Experienced disappearance of relatives or friends	65% (n=81)	26% (n=9)	88% (n=37)	31.05	.000
Relative in jail as political prisoner	51% (n=64)	65% (n=22)	50% (n=21)	2.18	.336
*Search as result of organised violence	78% (n=98)	59% (n=20)	88% (n=37)	9.43	.009
*Forced displacement	64% (n=80)	6% (n=2)	95% (n=40)	64.40	.000
*Lived in refugee camps	30% (n=38)	59% (n=20)	5% (n=2)	26.27	.000

Note: * indicates statistical significant difference across the three residential groups.

The participants who reported torture reported in their testimony the torture techniques endured. The techniques experienced by torture survivors are consistent with those described in Chapter 2. Over 95% of torture survivors experienced: head trauma, deprivation, asphyxiation (submarino, water boarding), beatings, psychological torture and verbal abuse. Over 70% experienced electrical shock, forced eating of excrement or forced consumption or injection of chemicals. Sexual torture was reported by 57.1% and suspensions of various types were also reported by 69 % of torture survivors. (See Appendix H for a more detailed list of torture techniques reported).

Consequences of trauma.

Table 8.12 details responses to the question on personality change resulting from the participant's most traumatic experience. There was an overall significant difference across the three residential categories (χ^2 (2, n=201) =46.605, p=.000). The detention centre category had the highest percentage of individuals meeting the criteria for personality change, with 100% saying 'yes' to personality change. This was followed by asylum seekers with 73% and permanent residents with 42%.

The same trend applied to the question in regards to fear of losing control. There was an overall significant difference across the three residential categories (χ^2 (2, n=201) =6.972, p=.031). The detention centre category had the highest percentage (98%) of individuals responding in the affirmative followed by asylum seekers (91%) and permanent residents (82%).

This pattern did not apply to the question regarding talking about the most traumatic event. There was an overall significant difference across the three residential categories (χ^2

(2, n=201) =27.580, p=.000). Asylum seekers living in the community responded with the highest percentage (91%) followed by permanent residents (45%) and detention centre residents (36%).

Table 8.12

Percentages, Chi-square and Significance Values Across the Three Residential Categories for Consequences of Trauma

Consequences of Trauma	Permanent residents n=124	Asylum seekers n=34	Detention centre n=42	χ^2_{Value}	P
Change of personality resulting from the most traumatic experience -ICD-10	42% (n=53)	73% (n=25)	100%(n=42)	46.605	.000
Afraid of losing control resulting from most traumatic event	82% (n=103)	91% (n=30)	98% (n=41)	6.972	.031
Talk about the most traumatic event	45%(n=56)	91%(n=31)	36%(n=15)	27.580	.000

Table 8.13 displays the percentages for three residential categories who met the criteria for PTSD diagnosis. There was no significant difference between these categories in the percentage of those who met the criteria for PTSD following the traumatic experience. However, there was a statistical significant difference for PTSD for the ‘last four weeks’ measurement, with the permanent residents having a higher percentage meeting these criteria, followed by detention centre residents and then the asylum seekers in the community.

Table 8.13

Percentage of Participants Meeting the Criteria for PTSD within Each Residential Category

	Permanent Residents n=125	Asylum seekers n=34	Detention centre n=42	χ^2 value	p value
PTSD just after the worst experience	75%	77%	76%	.033	.984
PTSD last four weeks	40%	25%	35%	20.624	.000

Section 2 A: Interaction between residency and group.

A series of two-way analyses of variance was conducted to identify interactions between residency and group on two demographics (Age and length of time in Australia), the 15 measures of psychopathology and on the grid measurements. “An interaction is present when the effects of one independent variable on behaviour change at the different levels of the second independent variables” (Keppel & Wickens, 2004, p. 201). Therefore, the focus is only on the effects of independent variables (Group and Residency) on the dependent variables (e.g., psychometric scales). On the other hand, where the interaction is not statistically significant, the attention focuses on the detailed analysis of the main effects with post hoc comparisons. A large main effect, relative to an interaction, indicates that we should consider both the main effect and the interaction when describing or interpreting data (Keppel, 1991, p. 232). In the case of this research the main effect for psychopathology is presented and only where an interaction was identified further investigation was conducted. Simple effect was used to understand further the interaction; where it is happening and what this interaction is about. Simple effect helps us in the interpretation of any interaction (Keppel & Wickens, 2004).

Using two-way ANOVAs to examine interaction between residency and group for demographics related to age and length of time in Australia.

Table 8.14 shows the results for the analysis of variance which were conducted to examine interaction between residency and group on: (1) Age and (2) Length of time in Australia. No significant interaction effect between residency and group on Age and Length of time in Australia was identified. However, there was a significant main effect for residency in Age ($F(2,195)=4.29$; $p=.015$) but not for Group ($F(2,195)=.666$; $p=.415$). There was also a significant main effect for residency in the Length of time in Australia ($F(2, 195)=7.99$; $p=.000$) but not for Group ($F(2,195)=.046$; $p=.831$).

Table 8.14 indicates that the difference between residential status on Age lies in the detention centre category. People in this category are significantly younger than asylum seekers living in the community and permanent residents. No significant difference was indicated between permanent residents and asylum seekers.

Also displayed in Table 8.14 is a statistically significant difference between permanent residents and asylum seekers, in that permanent resident have been in Australia for a longer period. No significant difference was found between permanent residents and people living in detention and similarly there was no significant difference between asylum seekers and people in detention. Asylum seekers living in the community had the least time in Australia (2 years) followed by the detention centre group (3 years living in detention) and permanent residents (4 years).

Table 8.14

Interaction Effect for Group and Residency and Main Effects for Age and Length of Time in Australia

	Group 1	Group 2	Total	Interaction between group and residency	
	Mean (SD)	Mean (SD)		F	P
Age (Years)					
Permanent residents	35.3 (7.5)	32.2 (8.4)	33.59 (8.2) ^a		
Asylum seekers	33.1 (8.8)	36.5 (15.7)	34.18 (11.3) ^a	2.0	.14
Detention centre	31.6 (8.7)	27.8 (5.7)	29.50 (7.3) ^b		
Length of time in Aust. (years)					
Permanent residents	4.3 (2.7)	3.6 (2.5)	4.0 (2.6) ^a	1.5	.22
Asylum seekers	1.6 (2.0)	2.6 (2.3)	2.0 (2.1) ^b		
Detention centre	3.0 (2.7)	3.0 (2.7)	3.0 (2.6) ^{ab}		

Note: Groups that do not share the same alphabetical superscript are significantly different from one another.

Examining interactions between residency and group using two-way ANOVAs on various measurements.

A series of two-way analyses of variance was conducted to examine the interaction between residency and group on the 15 measures. Presented in Tables 8.15 are the interaction effect between residency and groups for these measurements. Table 8.15 displays no significant statistical interaction effect between residency and group for the SCL-90-R nine dimensions including the GSI, the GAF, and the PTSD measurements. However, significant statistical interaction effects are displayed between residency and groups for the IES subscales of intrusion and avoidance; these two interactions are further explored in Section 2 B of this chapter.

Table 8.15

Interaction Effect between Residency and Group and Main Effect for Residency and Group for all Measurements

Measurements	Interaction between residency and group		Main effect for residency		Main effect for group	
	F	p	F	p	F	p
SCL-90-R						
Somatization	1.715	.183	7.77	.001	9.03	.003
Obsessive-Compulsive	1.104	.334	7.15	.001	5.54	.020
Interpersonal Sensitivity	1.837	.162	9.29	.000	10.85	.001
Depression	.523	.593	24.74	.000	2.71	.101
Anxiety	2.115	.123	11.83	.000	11.96	.001
Hostility	2.142	.120	3.48	.033	8.18	.005
Phobic Anxiety	1.610	.202	16.54	.000	6.56	.011
Paranoid Ideation	1.716	1.82	6.21	.002	7.32	.007
Psychoticism	1.157	.317	11.01	.000	7.91	.005
SCL 90 GSI	1,614	.202	1.93	.000	9.46	.002
*IES-Intrusion	4.135	.017	15.10	.000	8.06	.005
*IES-Avoidance	5.415	.005	5.51	.005	10.36	.002
PTDS WE	1.988	.140	.27	.762	19.51	.000
PTSD 4 weeks	2.768	.065	11.54	.000	8.62	.004
GAF	.076	.927	2.66	.072	0.19	.662

Note: *indicates significant interaction between residential categories and Groups

A series of two-way analyses of variance was also conducted to examine the interaction between residency and group on the Grid measures. Presented in Table 8.16 are the interaction effect between residency and groups for these measurements. Table 8.16 displays no significant statistical interaction effect between residency and group for the 12 Grid measurements.

Table 8.16

Interactions Between Residential Status and Groups and Main effects for Residency and Group for self rating across construct for the six elements

Measurements	Interaction between Residency and Group		Main Effect for Residency		Main effect for Group	
	F	p	F	p	F	p
Self Ratings						
Self before trauma	1.516	.222	1.923	.149	3.090	.080
Self During	.872	.420	4.080	.018	7.100	.008
Self After	1.097	.336	9.976	.000	7.250	.008
Self as a migrant /refugee/asylum seeker/	.730	.483	32.059	.000	3.184	.076
Self Now	.458	.633	28.927	.000	1.648	.201
Self in 10Yyears Time	.124	.883	4.515	.012	.125	.724
Self Discrepancy						
Self before trauma- Self During	.726	.485	1.352	.261	9.475	.002
Self before trauma- Self After	1.134	.324	6.035	.003	7.266	.008
Self before trauma- Self as a Migrant/Asylum seeker	.189	.828	21.877	.000	4.018	.047
Self before trauma- Self Now	.248	.781	22.815	.000	2.008	.158
Self before trauma- Self in 10 Years	1.732	.180	2.139	.121	1.642	.202
Cognitive Complexity	1.841	.162	.108	.898	10.474	.001

Main effect for the three residential categories for psychometric measurements.

Table 8.17 displays the main effects for the three residential categories. The results indicate significant statistical differences between the three residential categories in 13 out of 15 measurements. Post-hoc comparisons indicated that for two of the nine dimensions for the SCL-90-R the permanent resident participants were statistically significantly different to asylum seekers living in the community and detention centre categories. However, no significant difference was indicated between asylum seekers and detention centre residents.

Six of the nine SCL-90-R dimensions indicated a significant statistical difference between permanent residents and asylum seekers and between asylum seekers living in the community and detention. However, there was no significant difference between permanent and detention centre residents. For one of the SCL-90-R dimensions, paranoid ideation, there was a statistically significant difference between permanent residents and asylum seekers, yet no statistical difference was displayed between permanent and detention centre residents. Further, there was no statistically significant difference indicated between asylum seekers and detention centre residents for the SCL-90-R dimension of paranoid ideation.

Also shown in Table 8.17 is that for PTSD ‘last four weeks’ there was a significant difference between permanent residents and asylum seekers and detention centre residents. There was no difference between asylum seekers and detention centre residents. No significant statistical difference was found for PTSD ‘worst ever’ score and for the GAF across the three residential categories.

Table 8.17

Main Effects for Residency: Means, Standard Deviations and Significance Difference between Residential Categories for all Measurements

	Permanent n=125		Asylum n=34		Detention n=42		F	p
	Mean	SD	Mean	SD	Mean	SD		
SCL-90-R								
Somatization	.83 ^a	.80	1.40 ^b	.96	1.31 ^b	.62	7.77	.001
Obsessive-Compulsive	1.22 ^a	.79	1.92 ^b	.96	1.31 ^a	.42	7.15	.001
Interpersonal Sensitivity	.83 ^a	.65	1.60 ^b	1.11	.93 ^a	.44	9.29	.000
Depression	1.16 ^a	.83	2.12 ^b	1.07	2.15 ^b	.91	24.74	.000
Anxiety	.89 ^a	.85	1.91 ^b	1.18	1.07 ^a	.55	11.83	.000
Hostility	.76 ^a	.74	1.16 ^b	1.00	.60 ^a	.36	3.48	.033
Phobic Anxiety	.63 ^a	.73	1.60 ^b	1.13	.51 ^a	.37	16.54	.000
Paranoid Ideation	.86 ^a	.80	1.55 ^b	1.11	1.15 ^{ba}	.55	6.21	.002
Psychoticism	.57 ^a	.61	1.19 ^b	.88	.45 ^a	.32	11.01	.000
SCL 90-R GSI	.90 ^a	.64	1.64 ^b	.95	1.2 ^c	.44	1.93	.000
IES-Intrusion	14.61 ^a	6.5	20.82 ^b	7.32	19.83 ^b	4.01	15.10	.000
IES-Avoidance	17.30 ^a	6.7	22.70 ^b	6.50	19.60 ^{ba}	4.70	5.51	.005
PTDS WE	2.60 ^a	.86	2.74 ^a	.83	2.70 ^a	.57	.27	.762
PTSD 4 weeks	1.63 ^a	.86	2.22 ^b	.88	2.29 ^b	.51	11.54	.000
GAF	67.4 ^a	13.1	63.47 ^a	16.4	62.76 ^a	6.39	2.66	.072

Note: Groups that do not share the same alphabetical superscript are significantly different from one another.

Main effect indicating the difference between the three residential categories on the self rating measurements.

Table 8.18 displays a significant difference across the three residential status categories for five of the six elements. A high mean score means a negative self rating. There was no difference between the three residential categories for self rating in the ‘Self before trauma’ element. Asylum seekers living in detention scored higher in their self rating on four out of the six elements (self during; self after; self as an asylum seeker in detention and self now) compared to permanent residents. Asylum seekers living in detention scored higher than asylum seekers living in the community on one of the elements (self as an asylum seeker in detention). Asylum seekers living in the community recorded significantly higher mean scores than permanent residents and asylum seekers in detention, on two out of six elements (self after the traumatic experience and self now). Asylum seekers living in detention scored significantly lower mean scores than permanent residents and asylum seekers living in the community for self in 10 years time.

Table 8.18 shows that there is a significant difference in self discrepancy ratings across residency status for three of the five elements. Permanent residents scored significantly lower mean scores (a more positive self rating) than asylum seekers for ‘self after’ and ‘self now’. There is a significant difference between asylum seekers in detention and both asylum seekers living in the community and permanent residents for the element of ‘self as an asylum seeker living in detention’. Table 8.18 displays no differences between the three residential categories in the level of restriction and similarity of self rating measured by cognitive complexity within the categories across constructs for the six elements. This means the three residential categories were similar in their use of constructs.

Table 8.18

Main Effects for Residency: Means, Standard Deviations and Significant Differences Between Residential Categories for Grid Measurements in Self Ratings Across Constructs for Each of the Six Elements

Elements	Permanent residents		Asylum seekers living in the community		Detention-asylum seekers		F	P
	Mean	SD	Mean	SD	Mean	SD		
Self Rating Over Time								
Self before Trauma	2.02	.07	2.11	.15	2.30	.12	1.923	.149
Self During	4.50 ^a	.12	5.27 ^{ab}	.25	5.66 ^b	.20	4.080	.018
Self After	4.17 ^a	.13	5.06 ^b	.28	5.19 ^b	.22	9.976	.000
Self as a migrant /asylum seeker	3.49 ^a	.14	4.07 ^a	.29	5.61 ^b	.23	32.059	.000
Self Now	2.94 ^a	.14	4.31 ^b	.31	4.96 ^b	.24	28.927	.000
Self in 10 Years	2.18 ^a	.10	2.58 ^a	.23	1.77 ^b	.17	4.515	.012
Self Discrepancy								
Self before trauma- Self During	3.23	.12	3.37	.26	3.62	.21	1.352	.261
Self before trauma- Self After	2.55 ^a	.13	3.20 ^b	.26	3.30 ^b	.21	6.035	.003
Self before trauma- Self as a migrant/ Asylum seeker/	1.96 ^a	.13	2.35 ^a	.26	3.56 ^b	.21	21.877	.000
Self before trauma- Self Now	1.56 ^a	.12	2.56 ^b	.25	3.04 ^b	.20	22.815	.000
Self before trauma- Self in 10 Years	1.12	.08	.97	.18	1.39	.13	2.139	.121
Cognitive Complexity	.58	.02	.60	.05	.60	.37	.108	.898

Note= 1 Groups that do not share the same alphabetical superscript are significantly different from one another

2: A higher score indicates more negative appraisal

Main effect for group: examining the differences between torture survivors and survivors of other systemic abuse which makes up the residential categories.

Section 1 of the results chapter, where the degree to which psychological distress varies between the three groups; survivors of torture, survivors of other systemic abuse and the control group, found that torture survivors presented with greater psychopathology than survivors of other systemic abuse and the control group. A similar pattern was encountered in Section 2 (where the control group from section 1 was excluded) when examining the main effect for group (torture survivors and survivors of other types of systemic abuse). The results in Table 8.19 also indicate that torture survivors presented with greater psychopathology than survivors of other systemic abuse.

Main effect for groups: comparison between torture survivors and survivors of other types of systemic abuse for all grid measurements on self ratings for the six elements and 21 constructs.

Table 8.20 displays the difference between survivors of torture and survivors of other systemic abuse on their self ratings across elements. There is a significant statistical difference displayed for 'self during the traumatic experience' and 'self after'. Group 1 displays higher mean scores compared to Group 2. Table 8.20 below shows that there was a significant difference between the two groups on three of the elements for self rating discrepancy across the constructs. These are 'self during', 'self after' and 'self as a refugee/migrant/asylum seeker', with torture survivors presenting with the highest mean scores.

There was a significant difference between Groups 1 and 2 in cognitive complexity. Survivors of torture (Group 1) scored a higher mean score than Group 2. This means that

there was more similarity or restriction in the use of constructs within torture survivors to describe self than Group 2.

Table 8.19

Main Effects for Group for all Measurements of Psychopathology

Variables	Torture survivors Group 1		Survivors of other types of system abuse Group 2		F	p
	Mean	SD	Mean	SD		
SCL-90-R						
Somatization	1.23	.89	.85	.70	9.03	.003
Obsessive- Compulsive	1.52	.86)	1.20	.70	5.54	.020
Interpersonal Sensitivity	1.20	.88)	.79	.59	10.85	.001
Depression	1.70	1.07	1.39	.92	2.71	.101
Anxiety	1.37	1.08	.84	.70	11.96	.001
Hostility	.99	.87	.60	.56	8.18	.005
Phobic Anxiety	.97	.95	.57	.67	6.56	.011
Paranoid Ideation	1.30	.92	.82	.73	7.32	.007
Psychoticism	.84	.78	.47	.48	7.91	.005
SCL 90-R GSI	1.28	.82	.89	.55	9.46	.002
IES-Intrusion	18.30	6.90	15.30	6.50	8.06	.005
IES-Avoidance	20.31	6.45	17.06	6.33	10.36	.002
PTDS worst ever score	3.00	.70	2.37	.84	19.51	.000
PTSD 4 weeks score	2.10	.79	1.70	.87	8.62	.004
GAF	65.18	14.09	67.00	11.55	0.19	.662

Table 8.20

Main Effect for Groups: The Differences in Self Ratings between Survivors of Torture and Other Systemic Types of Abuse

Elements	Torture survivors		Survivor of other types of system abuse		F	p
	Group 1		Group 2			
	Mean	SD	Mean	SD		
Self Rating Over Time						
Self before trauma	2.02	.09	2.27	.11	3.090	.080
Self During	5.62	.15	5.00	.18	7.100	.008
Self after	5.15	.16	4.47	.19	7.250	.008
Self as a migrant/asylum seeker	4.63	.17	4.16	.20	3.184	.076
Self now	4.25	.18	3.90	.21	1.648	.201
Self in ten years	2.21	.13	2.14	.15	.125	.724
Self Discrepancy						
Self before trauma- Self During	3.77	.15	3.04	.18	9.475	.002
Self before trauma- Self After	3.34	.16	2.69	.18	7.266	.008
Self before trauma- Self as a migrant/asylum seeker	2.86	.15	2.38	.18	4.018	.047
Self before trauma- Self Now	2.55	.19	2.22	.17	2.008	.158
Self before trauma- Self in 10 Years	1.26	.10	1.06	.12	1.642	.202
Cognitive Complexity	.66	.03	.53	.03	10.474	.001

Note 1: A higher score indicates more negative appraisal

Section 2B: Further exploration of the interaction between residential categories and groups: The Impact of Event Scale.

As indicated earlier in Section 2A Table 8.15, there was a significant statistical interaction effect displayed between residency and group for the two IES subscales; intrusion and avoidance. These are displayed again in Table 8.21 below and in Figures 8.1 and 8.2.

Table 8.21

Interaction Effects between Residency and Group for the IE Sub-Scales Intrusion and Avoidance

IES	Torture Survivors Group 1		Survivors of other systemic abuse Group 2		Total	Interaction between group and residency	
	Mean	SD	Mean	SD		F	p
IES-Intrusion							
Permanent. R	15.91	6.54	13.57	6.36	14.70 ^a		
Asylum. C	23.2	6.24	15.81	7.11	20.90 ^b	4.135	.017
Detention	19.31	4.66	20.26	3.44	19.83 ^b		
IES-Avoidance							
Permanent. R	18.70	6.96	16.09	6.27	17.25 ^a		
Asylum. C	25.34	3.68	16.90	7.54	22.61 ^b	5.415	.005
Detention	19.00	4.17	20.08	5.11	19.60 ^{ab}		

Note: R= residency, C= asylum seeker living in the community

Figure 8.1

Interaction Effect Between Residency and Group for IES Intrusion

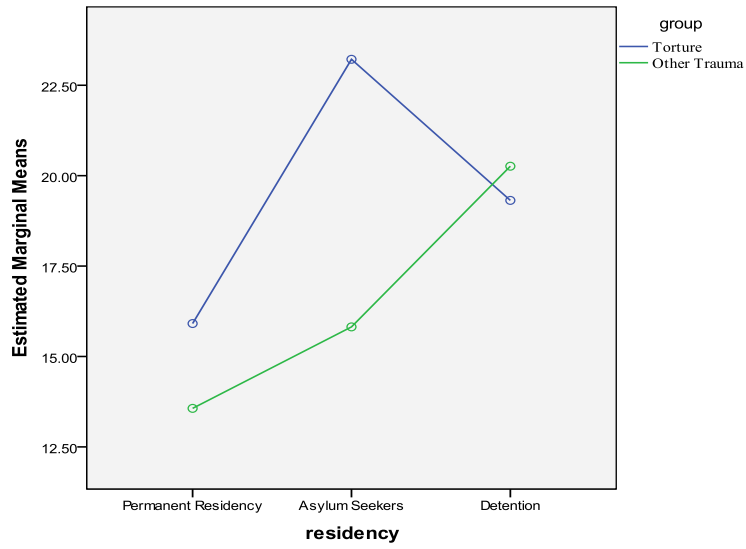
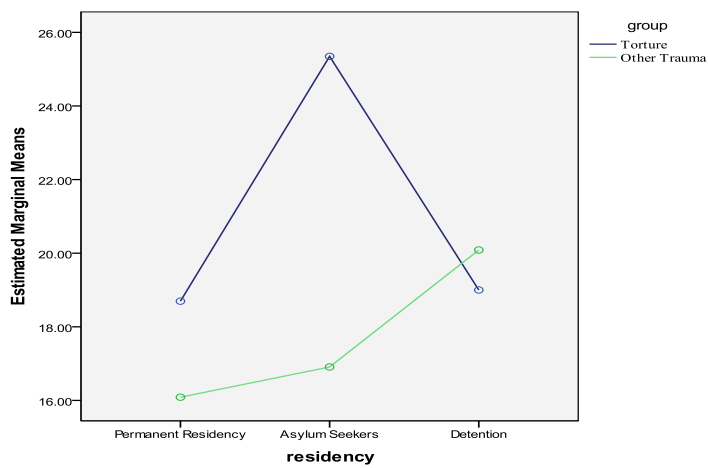


Figure 8.2

Interaction Effect Between Residency and Group for IES Avoidance



Simple effect analysis on the interaction for the IES.

A significant interaction between group and residency was identified for intrusion and avoidance as demonstrated in Table 8.21 (see Figures 8.1 and 8.2 for a graphical representation of differences among means and interaction for intrusion and avoidance).

Simple effects analysis using MANOVA was chosen to investigate further the interaction. This means that each factor (for example group) is examined separately at the individual levels of each of the other factor's (residential) level. 'Level' refers to the different components that are included or make up each factor. For example in this study Factor A (group) has two levels (level 1= torture survivors and level 2 = survivors of other types of systemic abuse). Factor B (residency) has three levels) level 1 = permanent residents, level 2 = asylum seekers living in the community and level 3= asylum seekers in detention. Therefore, the statistical design for the analysis of the interaction is a 2x3 design.

Intrusion and Avoidance-group within residency.

The mean difference between the two levels for group within the three residency levels is significantly different for permanent residents and for asylum seekers living in the community for both avoidance and intrusion as displayed in Table 8.22. However, there is no significant difference in the means between the two group levels for asylum seekers in detention for both intrusion and avoidance. Therefore, the experiences of torture and other types of systemic abuse are no different in the effect they have on intrusion and avoidance for participants in detention. It is therefore indicated that the interaction (displayed in Figures 8.1 and 8.2) is because of the lack of differentiation between torture survivors and other types of systemic abuse in the detention centre category in regards to intrusion and avoidance mean scores.

Table 8.22

Tests of Significance for IES Intrusion and Avoidance Using Unique Sums of Squares Group Within Residency

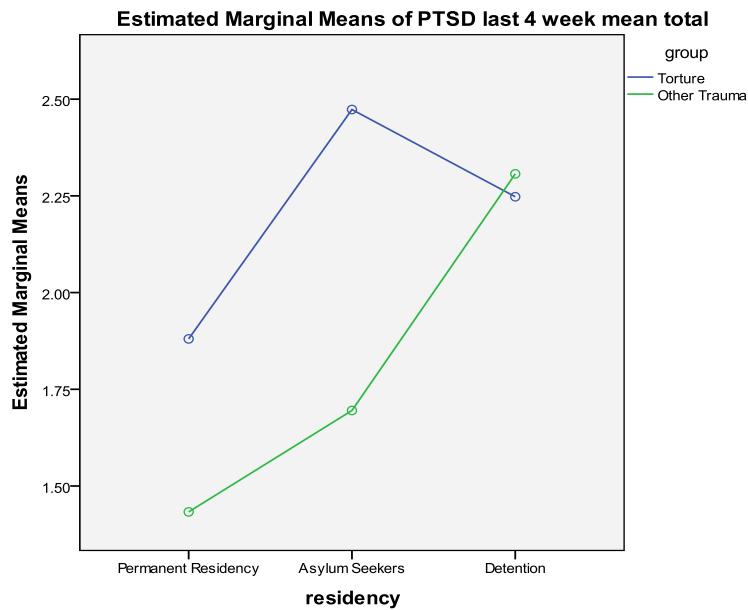
	Source of variation	Sum of squares (SS)	Degree of Freedom (DF)	Mean Square (MS)	F	P
Intrusion	Group WITHIN Permanent Residency	229.84	1	229.84	6.28	.013
	Group WITHIN Asylum Seekers living in the community	750.43	1	750.43	20.52	.000
	Group WITHIN living in Detention Residency	25.60	1	25.60	.70	.404
Avoidance	Group WITHIN Permanent Residency	247.43	1	247.43	6.79	.010
	Group WITHIN Asylum Seekers living in the community	891.15	1	891.15	24.46	.000
	Group WITHIN living in Detention Residency	17.73	1	17.73	.49	.486

Cross-over between groups for PTSD last 4 weeks within residency.

No statistical significant interaction between group and residency was identified for the PTSD last four weeks as demonstrated in Table 8.21. However, due to the fact that the mean score for PTSD ‘last four weeks’ (2.768, $p=.065$) shows this interaction to be marginally significant compared to the remaining non significant interaction, which is demonstrated by Figure 8.3. This graphically indicates a crossover between groups within residency (detention).

Figure 8.3

Crossover between Residency and Group for PTSD Last 4 Weeks Severity Mean Score



Summary.

People in detention centres did not present with higher levels of psychiatric symptoms compared to asylum seekers living in the community and permanent residents as was expected (Hypothesis 1, Section 2). In seven out of nine SCL-90-R dimensions there was no statistical difference between asylum seekers in detention and permanent residents. However, there was a statistically significant difference between these categories on depression and somatization. Even though detention centre mean scores for depression was slightly higher than asylum seekers living in the community this was not significant.

There were no statistical differences between asylum seekers in detention and asylum seekers in the community on three of the dimensions (somatization, depression and paranoia ideation). There was a statically significant difference between these two categories on the other six dimensions with asylum seekers living in the community obtaining higher mean scores. The overall GSI, a measurement of all nine dimensions, indicated that the total mean score for distress was statistically higher for asylum seekers living in the community followed by the detention centre asylum seekers and the permanent residents.

For the 'PTSD worst ever' measure, there was no statistical difference between the three categories. For PTSD 'last four weeks' the mean score for detainees was not statistically higher than for asylum seekers living in the community. However, the score for the detainees group was statistically higher than for the permanent residents. The hypothesis that asylum seekers in detention would have poorer functioning levels than asylum seekers living in the community and permanent residents was not statistically supported, although there was a trend in this direction.

Asylum-seekers living in the community did have greater levels of psychiatric symptoms than permanent residents (Hypothesis 2, Section 2) as measured by the SCL-90-R, the IES (intrusion and avoidance) and the PTSD over the last four weeks. As stated above, this hypothesis did not hold for level of functioning as there was no significant difference between asylum seekers living in the community and permanent residents.

The self ratings and the self discrepancy ratings (Hypotheses 3 and 4, Section 2) demonstrated no difference for the element 'self before the traumatic experience' for any of the three categories. Nevertheless, people living in detention reported a higher negative self-rating than permanent residents for 'self during', 'self after', 'self as an asylum seeker in detention' and 'self now'. They also reported a significantly higher negative self as 'asylum seeker' than the asylum seekers living in the community. The self ratings and the self discrepancy rating demonstrate that asylum seekers living in the community report a higher negative self rating than the permanent residents and the detention centre residents only in 'self after the traumatic experience' and 'self now'.

Based on the cognitive complexity measurement it was expected that the detention centre asylum seekers would rate their self-description in a more consistent constricted manner than both asylum seekers living in the community and permanent residents (Hypothesis 5, Section 2). Also it was expected that asylum seekers living in the community would rate their self description in a more consistently constricted manner than permanent residents (Hypothesis 6, Section 2). Neither of these two hypotheses held as all participants appeared to use the construct in a non-constricted manner.

Results of significance for discussion in this section were the cross over between group and residency for the two subscales of the IES, intrusion and avoidance. The results

indicated that a history of torture and other systemic abuse and living in detention related to the level of intrusion and avoidance. This implied that both group membership and residency influenced the level of traumatic symptoms as measured by the IES. Further exploration of the relationship between the various traumatic experiences as predictors of the level of avoidance and intrusion are presented in Section 3. Also presented in Section 3 are the traumatic experiences as predictors of personality change and fear of losing control.

Section 3: Exploring Relationships: Correlations, Factor Analysis and Predictors

Correlations.

Three sets of correlation analyses were conducted to explore the direction of relationships of all measurements. Explored were: (i) the correlations among psychometric measurements (Table 8.23), (ii) between the grid measurements and the psychometric measurements (Table 8.24), and (iii) between the grid measurements (Table 8.25). The purpose for this exercise was to investigate the strength in the relationships between all measurements. All three sets of correlations clearly indicated strong linear correlations between, and among, all measurements. A very strong correlation is noted in Table 8.23 between PTSD for the last four weeks and the two IES subscales of intrusion and avoidance. Similar results are indicated in the correlations among the nine SCL-90-R subscales and with the three trauma measurements. Table 8.23 indicates a very strong correlation between the GSI with all measurements, although this can be seen as a redundant correlation as the GSI represents a total score for all nine SCL-90-R dimensions.

Table 8.24 indicates a strong relationship between five out of six grid measurements and the psychiatric scales. The discrepancy measurement 'self-before the traumatic experience and in ten years time' did not indicate a strong relationship. This can be an indication that self changes to a more positive view.

Table 8.23

Correlation between psychometric scales for the 259 participants

	PTSD last 4 week mean total n=259	IES intrusion n=259	IES avoidance n=259	SCL 90 GSI n=259	SCL 90: Somatization n=259	SCL 90: Obsessive-Compulsive n=259	SCL 90: Interpersonal Sensitivity n=259	SCL 90: Depression n=259	SCL 90: Anxiety n=259	SCL 90: Hostility n=259	SCL 90: Phobic Anxiety n=259	SCL 90: Paranoid Ideation n=259	SCL 90: Psychoticism n=259
PTSD last 4 week mean total	1												
IES	.724**	1											
Intrusion													
IES	.659**	.802**	1										
Avoidance													
SCL 90 GSI	.511**	.579**	.440**	1									
SCL 90: Somatization	.495**	.558**	.400**	.884**	1								
SCL 90: Obsessive-Compulsive	.428**	.486**	.408**	.881**	.725**	1							
SCL 90: Interpersonal Sensitivity	.354**	.407**	.346**	.862**	.656**	.766**	1						
SCL 90: Depression	.480**	.576**	.386**	.892**	.792**	.765**	.701**	1					
SCL 90: Anxiety	.504**	.587**	.444**	.936**	.845**	.768**	.761**	.807**	1				
SCL 90: Hostility	.367**	.371**	.340**	.782**	.633**	.665**	.707**	.616**	.716**	1			
SCL 90: Phobic Anxiety	.444**	.472**	.425**	.806**	.691**	.688**	.702**	.611**	.809**	.572**	1		
SCL 90: Paranoid Ideation	.425**	.454**	.336**	.848**	.687**	.728**	.781**	.707**	.753**	.725**	.633**	1	
SCL 90: Psychoticism	.388**	.411**	.346**	.857**	.662**	.758**	.799**	.651**	.785**	.743**	.730**	.759**	1

Note: **=Correlation is significant at the 0.01 level (2-tailed)

Table 8.24

Correlation Between Repertory Grid Measurements and the Psychometric Scales

	Scl-90-R Somatisation	SCL 90-R Obsessive- Compulsive	Scl-90-R Sensitivity	Scl-90-R Depression	Scl-90-R Anxiety	Scl-90-R hostility	Scl-90-R Phobic anxiety	Scl-90-R Paranoid	Scl-90-R Psychoticism	IES Intrusion	IES Avoidance	PTSD-last 4week
Cognitive Complexity	.307**	.265**	.231**	.334**	.313**	.254**	.191**	.273**	.197**	.305**	.269**	.290**
Discrepancy B4-During	.297**	.280**	.246**	.344**	.284**	.257**	.219**	.296**	.236**	.357**	.333**	.357**
Discrepancy B4-After	.426**	.331**	.289**	.463**	.421**	.293**	.307**	.401**	.276**	.451**	.390**	.469**
Discrepancy B4-As a migrant/asyl um seeker	.457**	.283**	.223**	.512**	.396**	.262**	.220**	.342**	.182**	.458**	.330**	.466**
Discrepancy B4-NOW	.519**	.398**	.315**	.643**	.476**	.295**	.261**	.387**	.266**	.493**	.282**	.489**
Discrepancy B4-10YRS	.172**	.213**	.197**	.244**	.199**	.219**	.111	.164*	.178**	.117	-.006	.179**

Note: **= Correlation is significant at the 0.01 level (2-tailed) * = Correlation is significant at the 0.05 level (2-tailed).

Inter-correlations between grid measurements.

An inter-correlation analysis between grid measurements was conducted to explore the relationship among all these measurements. Table 8.25 indicates a strong relationship between the self discrepancy and cognitive complexity measures. The correlation between ‘Discrepancy B4-10YRS’(the discrepancy between ‘self view’ before the traumatic experience and ‘self view’ in ten years time)’ and cognitive complexity (restricted view of seeing one’s self) indicated that there is no relationship. Similarly there was no positive correlation between ‘Discrepancy B4-10YRS’ and ‘Discrepancy B4-During’ or ‘Discrepancy B4-After’ the experience.

Table 8.25

Inter-correlations of Grid Measurements

Measures	Cognitive Complexity	Discrepancy B4-During	Discrepancy B4-After	Discrepancy B4-As a migrant/asylum seeker	Discrepancy B4-NOW	Discrepancy B4-10YRS
Cognitive Complexity	1					
Discrepancy B4-During	.677**	1				
Discrepancy B4-After	.606**	.735**	1			
Discrepancy B4-As a migrant/asylum seeker	.402**	.518**	.716**	1		
Discrepancy B4-NOW	.337**	.385**	.608**	.747**	1	
Discrepancy B4-10YRS	.034	-.013	.079	.192**	.312**	1

Note:

**= Correlation is significant at the 0.01 level (2-tailed)

*= Correlation is significant at the 0.05 level (2-tailed).

B4=Before

Factor analysis between psychiatric measurements.

Due to the positive linear correlation in all three sets of correlations and the inter-correlations for grid measurements, it was appropriate to explore the interrelationships amongst the psychiatric scales using factor analysis. Factor analysis was conducted to explore the interrelationships among the psychiatric scales, namely, the nine SCL-90-R dimensions, the two IES scores and the PTSD severity mean score for last four weeks. Guadagnoli and Velicer (1988) suggested that a minimum of 150 cases is required before undertaking a factor analysis. This study was considered appropriate for factor analysis as the total sample size consisted of 259 participants. A correlation matrix 'should show at least some correlations of $r=.3$ or greater' to be considered suitable for factorial analysis (Pallant, 2005, p.178). Inspection of the correlation matrix (see Appendix I) indicated that the 12 psychiatric scale variables were appropriate to be entered into the factor analysis with correlation coefficients of $r > .3$. The Kaiser-Meyer-Olkin value = .925 was also above the recommended value of .60 with a Bartlett's test significance ($p=.000$) (Pallant, 2005).

A parallel analysis (Horn, 1965) indicated a two-factor solution. The adopted method of factoring was an un-weighted least square solution with oblimin rotation which explained a total of 73.1% of the variance. Factor 1 contributed 62.2% of the variance and Factor 2 contributed 10.9% of the variance. The Pattern Matrix-rotated solution shown in Table 8.26 indicated that in Factor 1 all nine dimensions from the SCL-90-R were high with the nine dimensions loading between .934 and .739. This suggests that 62.2% of the variation could be attributed to general psychopathological factors. In Factor 2 intrusion was the highest loading at .943 and the lowest was PTSD last 4 weeks with a loading of .725 (see Table 8.26). This suggests that 10.9% of the variation could be attributed to indicators of

trauma. The results of this factor analysis support the importance of both general psychopathological and trauma measurements in accounting for consequences of systemic abuse.

The Factor Matrix Correlation between Factors 1 and 2 of 0.554 indicates that the factors are quite highly correlated (>0.3) (see Table 8.26). This suggests that general psychopathological and trauma measurements are distinct but related.

Table 8.26

Pattern Matrix Resulting From Factor Analysis and the Factor Correlation Matrix

Pattern Matrix	Factor 1	Factor 2
Psychometric Scales		
SCL-90-R Interpersonal Sensitivity	.934	
SCL-90-R Psychoticism	.929	
SCL-90-R Paranoid Ideation	.874	
SCL-90-R Anxiety	.858	
SCL-90-R Obsessive-Compulsive	.845	
SCL-90-R Hostility	.826	
SCL-90-R Depression	.746	
SCL-90-R Somatization	.745	
SCL-90-R Phobic Anxiety	.739	
IES- Intrusion		.943
IES- Avoidance		.850
PTSD-last 4 weeks Severity Symptoms		.725
Factor Correlation Matrix		
Factor 1	1.000	.554
Factor 2	.554	1.000

Traumatic experiences as predictors of psychopathology.

The following section explores the relationships between the traumatic events reported by participants in the three residential categories in Section 2 and the variability of the two IE sub-scales; avoidance and intrusion. Even though there was no interaction effect between group and residency, the PTSD scores for the last 4 weeks were also explored in relation to traumatic experiences as predictors of PTSD. There were two purposes for this analysis: (1) to test further the hypothesis that torture experience was the major contributor to the distress individuals endured, as measured by the IES and PTSD severity scores, independent of other traumatic experiences. Further (2) that seeking asylum and living in a detention centre in Australia were additional experiences which added to the distress as measured by the IES and PTSD severity scores. Taking this major point into account, these experiences were added to the list of what participants had been through and were then explored as to whether or not they added to the level of distress.

To explore which traumatic experiences (independent variables) influenced the values, or best predicted the values displayed by the IES intrusion and avoidance subscale and PTSD ‘last 4 weeks’ (the dependent variables), three individual hierarchical multiple regression analyses were performed. This means that the independent variables (traumatic experiences) were entered in steps (in this section these steps are referred to ‘blocks’). Block 1 only included the 18 traumatic experiences, excluding three variables, namely torture, asylum seekers living in the community and asylum seekers in detention. Block 2 included 19 experiences which included torture. Block 3 comprised of the 21 experiences which included torture and asylum seeking living in the community and living in detention.

Before determining which traumatic experiences would be entered into the models, an analysis was conducted to check that the correlation between each of the independent variables (the 21 traumatic experiences) was not excessively high. If the correlation was of .70 or more between two independent variables, one of the variables (one of the traumatic experiences) should be omitted. The correlation of .70 was used in accordance with the suggestion of Tabachnick and Fidell (2001, p.84). In the example presented in this study the highest correlation between traumatic experiences for all three regressions (intrusion, avoidance and PTSD last 4 weeks) was -.51, which is less than .70; therefore all 21 traumatic experiences were included in the models. Multicollinearity is examined as part of the multiple regression (see Appendix J1-J3). The subsequent Tolerance values and Variance Inflation Factor (VIF) results were reviewed. Tolerance is an indicator of how much of the variability of trauma experiences (independent variables) is not explained by other traumatic experiences. There was no indication of high multiple correlations with other independent variables as scores were greater than .10, a commonly quoted cut-off point for the presence of multicollinearity (Pallant, 2005).

A violation of the regression assumptions could affect the stability and integrity of the regression analysis therefore, four assumptions were examined. These were: linearity of the phenomenon measured, homoscedasticity, independence of the error term and normality of the error term distribution. The assumptions of linearity and homoscedasticity were evaluated by plotting the dependent variables residuals on the vertical axis against the corresponding values of the independent variables on their horizontal axis. If linearity exists there will be no apparent pattern in this plot (Hair, Tatham, Anderson, & Black, 2006). This was undertaken for all three regressions.

A visual inspection of the residual plots of all three regressions suggested that the regression equation did not deviate substantially from linearity and were homoscedastic for intrusion and avoidance, and PTSD last 4 week score (see Appendix K1-K9). An inspection of the normal probability plot showed that the distributions were essentially normal for all regressions conducted (see Appendix K1-K9).

Results for intrusion, avoidance and PTSD.

As stated earlier, 18 of the traumatic experiences were entered into Block 1. Block 2 included 19 traumatic experiences (18 + torture) and Block 3 included another two traumatic experiences: seeking asylum while living in the community and seeking asylum living in a detention centre in Australia, making a total of 21 traumatic experiences (see Appendix L).

Intrusion.

The Block 1 model was statistically significant ($F(18, 182)=2.358, p < .05$); the R^2 was .435. This indicates that 43.5% of the experiences in this model explained the variance in intrusion. Two variables were significant in the first step (Block 1) of the multiple regressions, namely experience of rape and captivity ($p < 0.05$).

The Block 2 model, which included torture, was statistically significant ($F(19, 181)=2.685, p < .05$); the R^2 was .469. This indicates that 46.9% of the experiences in this model explained the variance in intrusion level. The R^2 change from Block 1 to Block 2 was .031 and was statistically significant ($F(1,181)=7.137, p < 0.05$). Three variables were significant in the Block 2 of the multiple regression; the experience of rape, captivity, and

torture ($p < 0.05$). To explain the extent to which the experience of torture contributed to the variability of intrusion, after removing the effect of the other traumatic experiences, the R^2 change value was considered and in this case it was .031. This means that the experience of torture explained an additional 3.1% of the variance in intrusion level. This is a statistically significant contribution ($F(1,181)=7.137, p=.008$).

The Block 3 model, which included asylum seeking in the community and asylum seekers in detention, plus all variables from Block 2 model, was also statistically significant ($F(21, 179)=4.109, p < .05$); the R^2 was .570. This indicates that 57.0% of the experiences in this model explained the variance in intrusion level. The R^2 change from the Block 2 model to the Block 3 model was .105 and was statistically significant ($F(2,179)=13.984, p < 0.001$). Five variables were significant in the final step (Block 3) of the multiple regressions. These were rape, captivity, torture, living in a detention centre and seeking asylum living in the community ($p < 0.05$). To explain the extent to which the experience of being an asylum seeker living in the community and an asylum seeker living in detention contributed to the variability of intrusion, after removing the effect of the other traumatic experiences, the R^2 change value was considered and in this case it was .105. This means that the experiences of being an asylum seeker in the community or in detention explained an additional 10.5% of the variance in intrusion level. This is a statistically significant contribution ($F(2,179)=13.984, p=.000$).

Avoidance.

The Block 1 model was not statistically significant ($F(18,182)=1.521, p > .05$); the R^2 was .362. This indicates that 36.2% of the experiences in this model explained the

variance in avoidance level. Two variables were significant in the Block 1 of the multiple regressions; the experience of rape and witnessing the rape of family members by officials ($p < 0.05$).

The Block model 2 which included torture, was statistically significant ($F(19,181)=1.991, p < .05$); the R^2 was .416. This means that 41.6% of the experiences in this model explained the variance in avoidance level. The R^2 change from Block 1 to Block 2 was .042 and was statistically significant ($F(1,181)=9.221, p < 0.05$). Two variables were significant for Block 2 of the multiple regression; the experience of torture and captivity ($p < 0.05$). To explain the extent to which the experience of torture contributed to the variability of avoidance, after removing the effect of the other traumatic experiences the R^2 change value was considered and it was .042. This means that the experience of torture explained an additional 4.2% of the variance in avoidance level. This is a statistically significant contribution ($F(1,181)=9.221, p = .003$).

The Block model 3 was statistically significant ($F(21, 179)=2.323, p < .05$); the R^2 change was .463. This indicates that 46.3% of the experiences in this model explained the variance in avoidance level. The R^2 change from Block 2 to Block 3 was .041 and was statistically significant ($F(2,179)=4.705, p < 0.05$). Two variables were significant in the final step for Block 3 of the multiple regressions; the experience of torture and the experience of living in a detention centre in Australia ($p < 0.05$). To explain the extent to which asylum seeker living in the community and asylum seekers living in detention contributed to the variability of avoidance, after removing the effect of the other traumatic experiences, the R^2 change value was considered and in this case it was .041. This means that these two

experiences explained an additional 4.1% of the variance in avoidance level. This is a statistically significant contribution ($F(2,179)=4.705, p=.010$).

PTSD last four weeks.

The Block model 1 was statistically significant ($F(18,182)=3.411, p<.05$). The R^2 was .252, meaning 25.2% of the experiences in this model explained the variance in PTSD level.

The Block model 2 was statistically significant ($F(19,181)=2.172, p<.05$); the R^2 for Block model 2 was .283. That is 28.3% of the experiences in this model explained the variance in PTSD level. Four variables were significant in Block 2 of the multiple regression; the experience of rape, assault, seeing loss of life and torture ($p<0.05$). To explain the extent to which the experience of torture contributed to the variability of PTSD severity score, after removing the effect of the other traumatic experiences, the R^2 change value was considered and in this case it was .031. This means that the experience of torture explained an additional 3.1% of the variance in PTSD level. This is a statistically significant contribution ($F(1,181)=7.706, p=.006$).

The Block 3 model was statistically significant ($F(21, 179)=4.356, p=.000$). The R^2 for Block 3 was .338, that is, 33.8% of the experiences in this model explained the variance in PTSD level. To explain the extent to which asylum seeking and living in detention contributed to the variability of PTSD, after removing the effect of the other traumatic experiences, the R^2 change value was considered and in this case it was .055, meaning that these two experiences explained an additional 5.5% of the variance in the PTSD level. This is a statistically significant contribution, as indicated by the significant change value of

($F(2,179)=7.496, p=.001$). Four variables, namely, rape, seeing loss of life, torture, and living in a detention centre in Australia were significant ($p < 0.05$) in predicting PTSD scores.

Logistic regression - exploring the relationship between traumatic experiences and personality change and the fear of losing control.

Two separate logistic regressions were used to explore the relationships with the traumatic experiences. One logistic regression concerned 'personality change' and the traumatic experiences and the other was with 'fear of losing control' and traumatic experiences. These two dependent variables (personality change and losing control) are categorical in nature (yes/no answer). These analyses assessed how well the set of predictor variables (the traumatic experiences) could predict the two respective categorical dependent variables (personality change and losing control).

The first logistic regression presented below concerned personality change. For this logistic regression the 'detention centre' as an experience was excluded from the analysis. The reason for this was that 100% (all participants in detention) said 'yes' to personality change as measured by the ICD-10 (see Table 8.12). SPSS uses maximum likelihood estimation for logistic regression and it "falls over" when there is a 100% (or 0%) for the outcome (in this case the outcome being 100% indicating "yes" to personality change (predictor). With detention excluded 20 experiences were left to investigate as possible predictors of personality change.

Logistic regression- personality change and traumatic experiences.

A two-step (2 Bock models) analysis using the entry method was adopted to allow evaluation of the unique contribution made by the predictors 'torture', 'seeking asylum living

in the community' beyond that of other predictors. For this set of results we adopted Pallant's (2005) suggestion of highly significant values being less than .05.

There are three components to this analysis. Firstly, Block 0 model is the baseline resulting from the analysis without any of the independent variables (the traumatic experiences) used in the model. The results obtained for Block 0 model is that 59.7% of the cases classified by SPSS will have personality change.

Secondly, Block1 model included the 19 traumatic experiences. Block1 model excluded asylum seekers living in the community as a possible predictor of personality change. The rationale for this was to explore the influence of experiences prior to migration. In the case of Block 1 model the value was .019 which is $p < .05$. Therefore, the model as presented by Block 1, is significant [$\chi^2(19) = 33.881$, $p = .019$]. That is, this model explains 1.9% of the variance of personality change. Further supporting the Block 1 model is the Hosmer-Lemeshow Goodness of Fit Test with [$\chi^2(8) = 11.364$, $p = .182$], where the significant value is greater than .05, indicating this model is supported. The Cox & Snell R^2 and the Nagelkerke R^2 values which provide an indication of the amount of variation in the dependent variables (personality change) by the model, ranged from .155 to .210 meaning, between 15.5% and 21.0% of the variability is explained by these sets of traumatic experiences for Block 1 model. The results obtained for Block 1 is that 69.7% of the cases classified by this model will have personality change.

Thirdly, the Block 2 model, included asylum seeking living in the community. In the case of the Block 2 model the value was .020 which is $p < .05$; therefore this model was significant [$\chi^2(20) = 34.941$, $p = .02$]. The Goodness of Fit test for Block 2 model was [$\chi^2(8) = 11.891$, $p = .156$]. The Cox & Snell R^2 and the Nagelkerke R^2 values for the Block 2 model

ranged from .160 to .216. This means that between 16% and 21.6% of the variability of personality change is explained by these sets of traumatic experiences. The results obtained for Block 2 is that 71.6 % of the cases classified by this model will have personality change. This is higher than predicted by Block 0 and 1.

In Block 1 model the Wald statistic and adjusted odds ratios for 'torture' were larger and significant ($p < .05$). Values less than .05 are the variables that contribute significantly to the predictive ability of the model. In the case of Model 1, torture [OR= 6.4, 95% CI = .157 - .789, $p=.011$] contributed significantly to 'yes to personality change'. The other 18 traumatic experiences did not contribute significantly to the model. In the case of Block 2 model 'torture' [OR= 5.2, 95% CI = .168-.876, $p=.023$] displayed significant results. The odds ratios presented are statistically significant at $p < .05$. Block 2 model shows that if a person has been tortured they are nearly 5.2 times more likely to say yes to personality change than those who have not been tortured.

Fear of losing control and its relationship to the traumatic experiences.

For this logistic regression (fear of losing control) all 21 experiences were entered in this analysis. The Block 1 model included torture (19 experiences in total) and the Block 2 model included seeking asylum living in the community and seeking asylum living in detention (a total of 21 experiences). Both Block 1 and 2 models indicated that torture as a traumatic experience can significantly predict the variability of value for 'fear of losing control'. Similar values were found for both Block 1 and 2 models. Wald statistic and adjusted odds ratios for 'torture' and 'experienced combat' are larger and significant ($p < .05$) in the Block model 1. Values less than .05 are the variables that contribute significantly to the predictive ability of the model. In the case of the Block model 1, torture [OR= 6.8, 95% CI =

.037 - .624, $p=.009$] contributed significantly as well as experienced combat [OR= 8.0, 95% CI = 1.99 - 43.6, $p=.005$]. The other 17 traumatic experiences did not contribute significantly to this model. In the case of the Block model 2 'torture' [OR= 6.2, 95% CI = .039 – .680, $p=.013$] and 'experienced combat' [OR= 8.4, 95% CI = 2.112 – 48.869, $p=.004$] displayed significant results. The odds ratios presented are statistically significant at $p <.05$. The Block Model 2 shows that if a person has been tortured they are nearly 6.8 times more likely to fear losing control than those who have not been tortured and for those participants who experienced combat are 8.0 times more likely to fear losing control than those who have not experienced combat. The remaining 19 experiences did not contribute significantly to either block model.

Chapter 9

Discussion

Summary

Torture continues to be a worldwide problem with serious psychological consequences (Campbell 2007; Donnelly & Diehl, 2011; Hollifield et al., 2011). These findings are consistent, regardless of the research design adopted, with international and national studies. For example, Allodi et al., (1986), Başoğlu et al. (1994), Rasmussen et al. (2007), Silove et al. (1997) and Tol et al. (2007) all concluded that torture had significant negative consequences on the psychological wellbeing of refugees. PTSD is commonly the first diagnosis made following an experience of torture (Campbell, 2007; McNally, 2004; Watters, 2010); however, consistent with other extant research (Coffey et al., 2010; Sachs et al., 2008; Steel et al., 2004; Steel et al., 2009; Turner, 2000), the present study indicated that there can be psychopathological consequences other than PTSD, such as depression, anxiety, personality change, and also changes in self-perception.

Further, these results indicated that post-migration factors related to residential status also impacted on refugee mental health. It would appear that the uncertainty of obtaining permanent residency in Australia is a significant stressor that exacerbates refugee mental health problems and this is consistent with other recent findings, for example, Coffey et al. (2010) and Steel et al. (2004). Overall, the results from this study indicated that torture, other types of systemic abuse and the asylum seeking process have complex psychological consequences (Tol et al., 2007).

Psychological Impact of Torture and Other Types of System Abuse

In the current study survivors of torture obtained higher symptom scores on anxiety, hostility, paranoid ideation and phobic anxiety as measured by the SCL-90-R compared to survivors of other systemic abuse and the control group. This supports Hypothesis 1 (Section 1) that torture survivors would display greater psychopathology than survivors of other types of systemic abuse and those who have migrated without previous traumas. This is consistent with findings of the study by Başoğlu et al. (1994) where they found the same trend for anxiety as measured by the HAM-A. They also found this relationship on their two measures of depression (HAM-D; BDI) a result not found with the SCL-90-R dimension for depression in this study. Holtz (1998) using the HSCL-25 also reported that torture survivors had higher levels of anxiety compared to non-torture survivors. The trend for depression and somatic symptoms was in the same direction; however, the differences were not statistically significant.

Hypothesis 2 (Section 1), that survivors of other types of systemic abuse would present with higher levels of psychopathology according to the SCL-90-R compared to the control group was not supported. For only one of the dimensions on the SCL-90-R was there a significant difference between Groups 2 and 3. The rest of the dimensions were very similar to one another. This is not surprising given that the control group included a cross-section of the migrant community where symptoms of depression, anxiety, and hostility could be present for reasons other than experiencing systemic traumatic abuse. The stressors associated with the migration experience or a history of psychiatric disorders could contribute to anxiety and/or depression (Başoğlu et al., 1994; Schweitzer et al., 2006; Thompson & McGorry, 1995).

This study indicated no differences between torture survivors and survivors of other types of systemic abuse in the level of intrusion, avoidance and PTSD severity symptoms as measured by 'PTSD worst ever'. However, there was a difference between Groups 1 and 3 and between Groups 2 and 3 for 'last 4 weeks'. While acknowledging that other types of systemic abuse can impact substantially on survivors, the results indicated PTSD symptoms can vary over time, and participants who experienced torture presented with higher levels of symptoms than both survivors of other types of systemic abuse and the control group when comparing them on the 'last 4 weeks' measurement for PTSD. Equally, survivors of other types of systemic abuse presented with higher mean scores than the control group, thereby following the pattern stipulated by Hypotheses 1 and 2 (Section 1). The 'last 4 weeks' score in this study might therefore be a more reliable indication of long-term, entrenched PTSD.

A similar pattern of change was observed for the number of people meeting the criteria for 'Life time PTSD' and for 'Current PTSD' in Başoğlu et al.'s (1994) study. As with the present study, Başoğlu et al. (1994) reported the percentages of people meeting the criteria at two different times, one, referring to the past following the experience, and the other to the present. Başoğlu et al. (1994) who also compared three groups, found that 33% of 'torture survivors' met the criteria for 'Life time PTSD' compared to 11% 'non-torture survivors' and 0% for 'Group 3'. For 'Current PTSD' 18% of 'torture survivors' met the criteria compared to 4% for 'non-torture survivors' and 0% for 'Group 3'. For the present study, 84% met the criteria for 'worst ever PTSD' compared to 68% of survivors of other types of systemic abuse and 9% of the control group. For the 'PTSD last 4 weeks' the percentage decreased with 23% of torture survivors meeting the criteria, 19% of survivors of other types of systemic abuse and 5% of the control group. Even though Başoğlu et al. (1994) reported an overall decrease in people meeting the criteria for 'Current PTSD' compared to 'Life time PTSD', the

significant difference was maintained between groups for current PTSD ($p < .01$) as also found in the present study.

The variations in PTSD prevalence are consistent with the literature reported by Steel et al. (2009). Steel et al. (2009) investigated the prevalence of PTSD and depression using a meta-analysis for the period of 1980-2009. They reported that the prevalence rates for PTSD varied hugely between 0% - 99%. Factors that may account for the variation of the PTSD prevalence included the methodological characteristics of the studies examined, and the cumulative exposure to trauma (Steel et al., 2009). Other studies have suggested such variations in results might be associated with survivors' resilience based on such factors as political and religious beliefs and personal strengths (Başoğlu et al., 1994; Holtz, 1998; Sachs et al., 2008; Tol et al., 2007).

However, in the current study the results of intrusion and avoidance, which also measures the level of distress resulting from 'the most traumatic experience in the last seven days', indicated no significant difference between survivors of torture and survivors of other systemic abuse. This contradicts the results of 'the last 4 weeks PTSD' where a significant difference was indicated across the three groups and was consistent with Hypotheses 1 and 2 (Section 1). Those individuals who do not experience torture, but who are survivors of a system that is abusive, can also have equivalent negative consequences, which highlights the support needs of all refugees, not just those who have survived torture.

As stated by Hauksson (2003), Turner (2000), Steel et al. (2009) and Wenzel et al. (2009), PTSD has been an important diagnosis in describing the consequences of torture and for the development of treatment programs. However, in the years since the appearance of PTSD as a diagnosis, questions have been raised about its adequacy in fully encapsulating the

consequences of torture. The controversies vary from issues related to discrepancies reported by researchers regarding the prevalence of PTSD, the cultural relevance of the diagnosis, and the limitations of the diagnosis in incorporating or accommodating other conditions such as personality change, disassociation and depression (Beltran & Silove, 1999; Campbell, 2007; Holtz, 1998; Murray et al., 2008; Steel et al., 2009; Turner, 2000; Watters, 2010). As Turner (2000) states: “PTSD is an important but insufficient diagnosis to explain the whole of the reaction to torture” (p. 296). As stated by Beltran and Silove (1999) and Turner (2000), further measurements, e.g., the Global Assessment of Functioning (GAF, DSM-III-R; APA, 1987), and the Enduring Personality Change (ICD-10: WHO, 1992, 1993, 2010) need to be administered when trying to understand the impact of torture and other types of systemic abuse on clients’ level of functioning and personality, respectively.

In the present study various measures were incorporated in addition to the assessment of PTSD. The ICD-10 personality change results supported Hypotheses 1 and 2 (Section 1) where overall there was a significant difference across the groups ($p=.000$). The percentage of survivors of torture (58.9%) meeting the criteria for personality change was higher than survivors of other types of systemic abuse (29%) and the control group (3.4%). The results from the Global Assessment of Functioning (GAF, DSM-III-R; APA, 1987) supported the fact that survivors of torture and survivors of systemic abuse had a lower level of functioning compared to the control group. This may be indicative of issues related to adaptation: being in a new country, having to face learning a new language, or taking on new jobs which are not necessarily within survivors’ areas of expertise (Carlsson et al., 2006; Murray et al., 2008). However, Gorst-Unsworth (1992), Hinshelwood (1999), Mollica, Wyshak, & Lavelle et al. (1987), and Thompson and McGorry (1995) thought such factors may also impact on

migrants. This was evident in some of the results from the control group, whose informal comments concerned feelings of helplessness and feeling loss and guilt in being far away from their relatives and culture.

A major and unique contribution from this study is the exploration of differences between the three groups on how systemic abuse changes the perception of the self. Using the Repertory Grid, this study was able to demonstrate that all three groups presented an understanding of self prior to the traumatic experience, a positive view of self at the time of interview and for the future. While the differences were highly significant between the three groups at the time of the actual experience, with survivors of torture scoring the highest negative self, they did not remain negative over time. The results from the Repertory Grid analysis confirm that torture changes the cognitive perception of self to a much more negative one but over time there appears to be some adjustment resulting in a more positive view of self.

These results are indicative of the conflict that arises when a person experiences trauma, where they can see no change within the confines of their present, limited world (self at the time of the traumatic experience) that has forced a shift away from their view of their original reality (Kira, 2002; Wilson, 2004). This study demonstrates that immediately following the experience, a small shift occurred for all survivors, including torture survivors, as they attempted to reconnect with other people and circumstances where decisions had to be made. This shift could be explained by the notion proposed by Kelly (1955) that the person given his/her circumstances of life begin to construe the world anew, and their place in it. Clearly by the time of the interview, when they were able to tell their stories and further processing had taken place, participants, irrespective of group membership, recognized that

they had developed fresh, new ways of seeing themselves within the new life, which would be supported by Kelly's theory (Kelly, 1955). They were integrating their view of the experience into the recovering self and at the same time they were anticipating that this new life in Australia would continue positively into the future.

These findings not only refute Hypothesis 3 (Section 1) proposed by this study, that torture survivors would have a negative view of self in the future, but they are also inconsistent with Kordon's et al. (1992) view that, because torture aims to take away the individual's identity, the victim's surrender brings about the complete fragmentation of the self. Instead, the results support the view that torture can result in the fragmentation of self but equally survivors can retain a sense of autonomy coherency, connection, continuity, energy resulting in a positive view of self (Keenan, 1993; Lindy & Lifton, 2001; Lira & Castillo, 1991; Thornton, 1989; Wilson, 2004). The results support the conclusion of Reid and Strong (1987) in their review of literature on the service needs of torture survivors and refugees arriving in Australia, that torture did not seem to achieve its aim of destroying the person's identity. The point where the tortured disassociated and began their survival, could be explained by Wilson's (2004) proposition of self, where he states that, during the traumatic experience, the self does not fully surrender and the will to live is maintained. The results from the current study could lead to the interpretation that at one point during the torture the survivor made a conscious decision to survive, to maintain their self integrity. This was depicted in some accounts given by participants who were survivors of torture:

I felt I was a nothing, just nothing. At one point in the torture I thought I had to make a choice between life and death, madness or sanity. I felt I was travelling in time. I saw my mother's eyes, that look from my mother that penetrated me as the militaries took me. I felt her touch in my damaged body...From that point on I can't remember

what they did to me...All I remember was my mother's 'eyes. In my mind I chose life and sanity...I needed to see my mother's eyes again...This is what kept me alive...Still does today (Participant, 1995).

Torture survivors, irrespective of their country of origin, shared similar stories in relation to maintaining self integrity during the ordeal. This internal conflict leads to an internal dialogue with himself/herself and/or significant others creating a process whereby the survivor makes a choice to maintain control of his or her life and mentally fight for it (Cason et al., 2002; Frankl, 1984; Kelly, 1955).

The individual takes control over their mind during torture through creating images of significant others, of loved ones, of cultural and religious significance or other important life experiences. These images which give moments of comfort do not establish the will to live unless they help the survivor make meaning out of their senseless suffering (Frankl, 1984). The process of reconnecting with self and those significant others provides the strength to survive (Kelly, 1955; Kordon et al., 1992; Wilson, 2004). Some participants in their testimony explained in detail their inner conflict between surrender and life. This process of reconnection was elegantly explained by Allport (1984) in his review of Frankl's book (1984) *Man's Search for Meaning*:

... to live is to suffer; to survive is to find meaning in suffering. If there is a purpose in life at all, there must be a purpose in suffering and in dying. But no one can tell another what the purpose is. It is in this last level of suffering where individuals find their last human freedom. Allport (1984, p.9).

This process of re-connecting with significant aspects of their life and finding meaning and purpose in life was observed repeatedly amongst the participants. One account is as follows:

I was waiting in a queue, there were many of us, all women, I was calling my husband's name because we were both taken together. A friend recognised my voice. She yelled out my nickname, "Flaquita" it is me Aurora, Hey Flaquita remember that you are pregnant, look after your guaguaita (baby). At that point I did not know how significant this would become for my own survival and that of my baby. I find it very difficult to recall all the different types of torture I went through. Every time they came to get me I put my focus on the baby, I would hold my baby by putting my arms under my belly, when eventually they gave me a blanket I would wrap myself in it. Then I would feel as if I was inside my own womb, floating in the water, together with my baby ... we both survived ... I gave birth to a baby girl. (Participant, 1995)

Başoğlu and Mineka (1992) emphasized that those survivors who had strong political commitment and who could have predicted what could happen to them, were better prepared to psychologically fight or maintain a level of control during torture. Similarly, Başoğlu et al. (1994), when comparing survivors of torture who were politically committed and survivors of torture who had no political commitment, found that prior knowledge and preparedness for torture and a strong commitment to their struggle, protected the survivor from the total disintegration of self. That understanding allowed the survivors to process the experience in a positive manner where PTSD, anxiety or depression did not develop to a level where the survivor could not function or have a positive view of the future.

A political activist in the current study claimed to have maintained control:

My worst experience was in jail for 40 days...that dark room...The meaning of torture became my own struggle to choose between madness or sanity. I chose sanity so I began my own journey by creating an imaginary mirror, a mirror into my own self, which depicted the past and the future. How did I survive?...By having a political belief, sharing, talking with other prisoners, myself strength to live..in this dark room I saw an image of a mirror where I could see myself..I talked to myself, pretended I combed my hair...shaved. I remember the white towel on my shoulder..I can see myself doing it now...yes...I did this everyday...Then there were times I felt I was going crazy. I felt I wanted to end my life many times in this isolated room... But how?... there was nothing in this room but me...just me... I thought of bashing myself against the wall until I died, but I could not do it, I tried but I realised there was another prisoner next door...I wanted then to hang myself but I had nothing to use so I was forced to survive. Then I realised that as long as I had control of the image...the mirror...when I turned that mirror on and off like a light switch ...then I was in control of my life...this became my survival and my struggle between madness and sanity... I used to cry, a lot even now I feel very emotional when I recall everything...After my release I left and ended in a refugee camp. The conditions were bad...I lived there for 5 years...the worst thing in human life that can only make people lose their mind is torture...the system and powerful people hungry for money are responsible for this... As long I chose when to switch on and off the mirror I was in control of my own life and this allowed for the meaning of my own existence that is just being, this gave me the strength to want to live.

(Participant, 1996).

The ultimate decision, or as Kelly (1955) would say, an ultimate ‘choice’, is made where the survivor decides to stay sane and fight for his life. The varied experiences in the participants’ pre-torture, their belief systems, their relationship with significant others, could explain why the results of this study did not clearly support Hypothesis 3 that torture survivors would report a higher negative view of self ‘now’ and in the ‘future’. The insights they had gleaned from earlier experiences could have held together a coherent self view that gave them the ability to define and redefine personal constructs. Some of these constructs related to religious beliefs and the survivors’ role in society. This would be consistent with conclusions presented by Sachs et al. (2008) showing that religion was a strong coping mechanism for Tibetan Buddhists following torture and other systemic abuse.

Summary.

Torture and other types of systemic abuse constitute a severe assault on the individuals' mental wellbeing; however, people who have been tortured are likely to have endured other traumatic experiences associated with their oppression and these add significantly to the complexity of the torture survivors' vulnerability, as well as to their strength (Hollifield et al., 2011; Kira, 2002). The results also indicated that survivors of other types of systemic abuse are affected by these experiences, in some cases to a lesser degree of distress compared to the torture survivors as demonstrated by the PTSD last 4 weeks, the IES and the SCL-90-R. Even though survivors of other types of systemic abuse show a level of distress slightly lower than torture survivors, they are also in a vulnerable position. These complexities have led to the suggestion by other researchers that such a variety of psychopathology should be classified as a more 'Complex PTSD' or 'Torture Syndrome' (Allodi & Cowgill, 1982; Herman, 1992).

The Psychological Consequences According to Residential Status: Permanent Residents, Asylum Seekers in the Community and in Detention

Increasingly, Australian studies maintain that post-migration factors, such as seeking asylum or being placed in a detention centre, can have detrimental effects on refugees' mental health (Coffey et al., 2010; Johnston et al., 2009; Murray et al., 2008; Sinnerbrink et al., 1996; Silove et al., 1996, 1997, 1998). The results from Section 2 of this study clearly confirm that seeking asylum in Australia has a detrimental impact, irrespective of whether the participant was an asylum seeker living in the community or in detention.

The main effect results for residency supports studies presented in Chapter 4 that demonstrate the negative psychological consequences of asylum seeking (e.g., Coffey, 2010; Johnston et al., 2009; Silove et al., 1998; VFST, 1998). A surprising aspect of the results was that people in detention centres did not present with higher levels of psychiatric symptoms compared to asylum seekers living in the community. This is opposite to the prediction made in Hypothesis 1 (Section 2). Based on the SCL-90-R there was no statistical difference between asylum seekers living in detention and those living in the community on three out of the nine dimensions. On the remaining six dimensions there was a significant difference with the mean scores being higher for asylum seekers living in the community. In addition, there was no significant difference between asylum seekers in detention and permanent residents on seven of the nine SCL-90-R dimensions. Hypothesis 2 (Section 2) was supported in that asylum seekers living in the community showed greater levels of psychiatric symptoms than permanent residents. The GSI from the SCL-90-R, indicated that the total mean score was statistically higher for asylum seekers living in the community ($M = 1.64$, $SD = .95$) followed by asylum seekers in detention ($M = 1.2$, $SD = .44$) and the permanent residents ($M = .90$, $SD = .64$). This was contrary to expectations given the significant amount of literature documenting

the mental health problems associated with detention (e.g., Carswell et al., 2011; Johnston et al., 2009; Silove, 2004; Steel et al., 2009). These results confirm that the process of seeking asylum is distressing, whether the person is in detention or not. It could be speculated that asylum seekers in the community, who are living without security or control of their future, may present as distressed as, or worse than, asylum seekers in detention because of constant exposure to a new life style and its many demands. Those who are in detention do not have to cope with the same pressures and have the support of their peers and possibly a sense of comradeship with a common goal of release from detention.

The psychopathology amongst asylum seekers living in the community may reflect the findings of Johnston et al. (2009), Sinnerbrink et al. (1996) and Silove et al. (1997) who describe post-migration experiences as including fear of being sent home, frustration at delays in processing, no access to medical services and long-term separation from family. However, those concerns are shared by asylum seekers living in detention but, as suggested above, being among peers may help to alleviate the anxiety of the detainees compared to those living in isolation in the community.

There was a statistically significant difference between permanent residents and asylum seekers in detention on the two SCL-90-R dimensions, depression and somatization. Somatization includes symptoms such as headaches, pain in the heart or chest nausea or upset stomach (Derogatis, 1983). Some of these physical symptoms could have been related to the unmet medical needs of detainees. Many asylum seekers in detention complained of not having a medical examination which incorporated a detailed history of their torture. This process fails to meet the standards of the Istanbul Protocol (UNHCHR, 2004) which provides clear guidelines on assessments which include structured interviews and medical

assessments. Steel and Silove (2001) and Steel et al. (2009) have raised concerns regarding the inadequacy of the Immigration Department to meet the medical, psychological and social needs of asylum seekers. Due to the lack of comprehensive assessment, it is difficult to tease out those symptoms associated with somatization and physical pain resulting from torture or other medical conditions. For example, three of the survivors interviewed in detention complained of stomach pain. The researcher, following the interview, insisted on an independent medical examination because of the mistrust that existed between the immigration doctor and the detainees. The external examination revealed major issues relating to stomach ulcers. These three participants had shared the common experience of being forced to digest bags of chili powder and excrement during their torture, and one of the three required hospitalization. Asylum seekers in the community equally presented with higher mean scores than permanent residents on somatization, suggesting asylum seekers whether in detention or in the community present with physical symptoms. Access to appropriate medical services is similarly essential for community asylum seekers who have not had the same rights as permanent residents.

Depression was the other dimension where there was a significant difference between asylum seekers in detention and permanent residents. This is consistent with the findings of the two case studies of participants in detention reviewed in Chapter 4 (Mares et al., 2002; Steel et al., 2004). Also, the non-significant but slightly higher level of depression among asylum seekers living in detention compared to those living in the community, confirms the concerns of clinicians about the deterioration of mental health resulting from detention (Carswell et al., 2011; Coffey et al., 2010; Johnston et al., 2009; Murray et al., 2008; Silove, 2004; Silove et al., 2007). This finding also supports the Australian studies reported in

Chapter 4 which indicated the high level of distress resulting from asylum seeking (Johnston et al., 2009; Silove et al., 1998; Silove, et al., 1999; Steel et al., 1999). Silove et al. (1998), using the HSCL, reported that asylum seekers presented with three times the risk of high levels of depression, anxiety and PTSD compared to a migrant group. Depression mean scores for asylum seekers was 1.92 (SD=0.65), for refugees (people who have had the experience of seeking asylum) 1.65 (SD=0.59), and for migrants 1.45 (SD=0.49). The results from this study present a similar pattern with the SCL-90-R results where the mean score for depression for asylum seekers in detention was 2.15 (SD=.91) and for asylum seekers in the community 2.12 (SD=1.07). The overriding finding from the present study would support the literature that asylum seekers (whether in detention or not) experience high levels of distress as indicated by the GSI.

Hypotheses 1 and 2 (Section 2) also predicted a poorer level of functioning as measured by the GAF in asylum seekers in detention followed by asylum seekers in the community and permanent residents, respectively. The result found no significant difference although the trend was in the expected direction. The finding shows that irrespective of residential status and any psychopathology resulting from pre-migratory experiences, people were able to function without significant difficulties as measured by the GAF. The mean scores for all three residential categories was of mild impairment (61-70), suggesting mild symptoms such as depression, impairment in social or work functioning but retaining the ability to have meaningful interpersonal relationships (APA, 1987; Hall, 1995).

A result of significance for discussion in this section was the interaction between group and residency for IES, intrusion and avoidance. Both group and residency influences 'the current subjective distress' resulting from the traumatic event as measured by the IES

(Horowitz et al., 1979). Intrusion relates to the vivid memories of the participants' traumatic experiences. The results found a significant difference between asylum seekers and permanent residents on intrusion. There was no significant difference between asylum seekers in detention or living in the community. This does not support Hypothesis 1 (Section 2). The results also found a significant difference between torture survivors and survivors of other types of systemic abuse among the permanent resident and asylum seekers living in the community categories. There was no significant difference within the detention centre category when the interaction between residency and group was explored further. Asylum seekers were affected by increased intrusive thoughts compared to the permanent residents. This supports the literature that asylum seeking impacts on the level of distress following a traumatic experience. The process of seeking asylum itself, with constant interviews by various Immigration Department officials and lawyers, the continuous change of policies regarding immigration and refugees can add to the emotional trauma by triggering intrusive thoughts from past and present experiences. An asylum seeker living in the community stated:

...the bad experiences from my country and the way I escaped it, I will never forget. This part of my life will never completely go away. Australia, I thought was a free and beautiful country. But I didn't feel free when I arrived here, I feel like a prisoner in Australia. I am a bird, dying in a cage, without any hope. The Immigration Department takes a very long time because they don't understand my problem. They always push me down. My thoughts are always about being sent back, about what would happen to me, about my past experiences...torture. Sometimes I think the bird will be free, do you think the bird would fly free one day? (Asylum seeker participant living in the community December, 1997).

The results for avoidance are similar to those described above for intrusion except there was no significant difference between asylum seekers in detention and permanent residents. This does not support Hypothesis 1 (Section 2). Gorst-Unsworth (1992), Horowitz et al. (1979), and Turner (2000) suggested that avoidance acts as a coping mechanism which can manifest in numbness, and evading any communication and recognition of the experience. In detention, the constant interviewing of asylum seekers, as well as the imprisonment itself, can trigger intrusive thoughts, which forces them into an avoidance mode. This is likely to lead to inconsistency in their stories and lack of emotional affect in their presentation which means they are likely to be misunderstood.

The other measure of distress resulting from the systemic abuse endured by participants was PTSD ‘worst ever’ and ‘last 4 weeks’. All survivors reported similar ratings of ‘worst ever PTSD’ irrespective of their current residency status and asylum seekers were higher in their severity ratings than permanent residents for ‘last 4 weeks’. On PTSD caseness the three residential categories were very similar (average 76%) for reported ‘worst ever’. Interestingly, the PTSD ‘last 4 weeks’ caseness was highest in permanent residents (40%), followed by detention (35%), and community asylum seekers (25%). This finding is contrary to Hypotheses 1 and 2 (Section 2). The prevalence of PTSD is significant and enduring and adds to the literature on reported prevalence of PTSD (e.g. Steel et al., 2009). It is difficult to postulate as to why the permanent residents were presenting with a higher prevalence. This result is similar to the finding that avoidance scores on the IES were not different between permanent residents and asylum seekers in detention; this raises questions for further investigation and adds to the complexity of findings when exploring the consequences of systemic abuse.

Using multiple regression analysis traumatic experiences were explored as predictors of intrusion, avoidance and PTSD. As identified in the Results chapter, for intrusion the most significant predictors were: rape, captivity, torture, asylum seeking living in detention and living in the community. For avoidance, torture and asylum seeker living in detention were the most significant predictors. The significant predictors for PTSD were rape, seeing loss of life, torture and asylum seeking living in detention. Asylum seekers in detention and torture were constants across these three measures. Steel et al. (2009) stated that pre-traumatic experiences are not the only contributors to symptoms of PTSD but that ongoing experiences also contribute to these symptoms, such as in this study, living in detention and seeking asylum while living in the community. This means that the vulnerability of survivors to further, lengthy processing of their refugee status and their incarceration whilst seeking asylum has the potential to add to further deterioration of the survivors' mental health.

The consequences of systemic abuse and seeking asylum are complex which is further illustrated by changes in personality. All of the asylum seekers in detention met the criterion for personality change (as measured by the ICD-10 EPC). This compared to 73% for asylum seekers in the community and 42% for the permanent residents. Where predictors could be explored (detention was excluded as all participants endorsed change, i.e., 100%) torture was found to be the only significant contributor to personality change. This indicates that torture and detention are major contributors to personality change. This is consistent with the above results for PTSD and also consistent with the findings of Başoğlu et al. (2007) and Somnier and Genefke (1986) who claim that torture is a major contributor to personality change. This finding augments the view that, when considering the implications of seeking asylum, the torture experience must at all times be in the forefront of the discussion.

The impact of these experiences on personality is also supported by the self-ratings measured by the Repertory Grid. Asylum seekers rated themselves more negatively than permanent residents. Asylum seekers in detention rated self more negatively as an 'asylum seeker' compared to asylum seekers living in the community, and compared to permanent residents 'as migrants'. This trend supports Hypotheses 3 and 4 (Section 2). Interestingly, asylum seekers living in detention demonstrated a significantly more positive view of self in the future compared to asylum seekers living in the community and the permanent residents. Whilst asylum seekers in detention have been shown to present with significant psychopathology, again there are factors at play that influence the results contrary to expectations. The asylum seekers in detention presented with higher optimism for the future compared to those living in the community. This may be based on factors such as those discussed in regards to the SCL-90-R results, such as not yet experiencing the hardships of resettlement. Kelly (1955) would propose that the individual tries to make sense of their present and past experience by re-construing events and rebuilding their view of the world, as a way of coping they choose greater possibilities. An example of creating an alternative view of a present situation is provided by a detainee who remarked "This is five star compared to where I've been" [referring to where he was held whilst being tortured] (Participant in detention, August 1998).

What we would regard as a better residential status, living in the community, does not translate into a more positive sense of self view for asylum seekers. The uncertainty of the asylum seeking process and the consequences resulting from systemic abuse may directly impact on self view. Coffey et al. (2010) found that people who had been in detention had a negative self view, with a sense of helplessness and feeling of failure. The results in the

present study would suggest that there is no difference between asylum seekers in the community and in detention in this regard.

Summary.

The asylum seeking process has a detrimental impact on the mental health of survivors whether living in detention or not. This was demonstrated by the results from the SCL-90-R, the PTSD severity symptoms and the IES. Regardless as to whether participants were survivors of torture or other types of systemic abuse detention impacted on equally as demonstrated by the two IES subscales. These findings support previous research where they concluded that PTSD, depression, anxiety and a sense of helplessness was present in asylum seekers living in the community and those survivors who had experienced detention (Coffey et al., 2010; Hosking et al., 1998; Johnston et al., 2009; Mares et al., 2002; Silove et al., 1996, 1997, 1998, 1999; Sinnerbrink et al., 1996; Steel et al., 1999, 2004; VFST, 1998). The variability of the results in this section does not fully support the hypotheses, thereby making the interpretations more complicated. The lack of uniformity in the results regarding the level of distress across the three residential categories reinforces the complexity of the consequences of torture and seeking asylum (Başoğlu et al., 1997; Quiroga & Jaranson, 2005; Silove, 2004) and may be more appropriately named 'Complex Refugee Trauma'.

The Strengths and Contributions of This Study

This study contributes significantly to the research literature into the psychological consequences of torture and the impact of seeking asylum in Australia. It contributes by providing a comprehensive methodology for research in this field. Further, this study adds new knowledge in understanding the impact these experiences have on the ‘self’ as explored through Kelly’s (1955) theory. The introduction of the Repertory Grid (Kelly, 1955) as a measurement of change in ‘self’ over time following the experience of torture, other types of systemic abuse or as an asylum seeker, has not been previously adopted in this area of research. The Repertory Grid as an assessment of changes in ‘self view’ pre-, during and post- a traumatic experience such as torture, provides support for the view that researchers need to explore changes in personality resulting from a traumatic experience as measured by the ICD-10 (Beltran & Silove, 1999; Turner, 2000). The results from the PTSD measures add weight to the arguments that the PTSD diagnosis has limitations and that symptoms are more complex and varied than suggested by a diagnosis of PTSD. On the other hand, the results are unable to substantiate a specific ‘Torture Syndrome’ because other people who survive systemic abuse and have not experienced torture, also experience varied and complex symptoms. In addition, the asylum seeking process appears to accentuate levels of psychopathology, which arguably might be specific to refugee trauma.

The current study contributes to the already established knowledge resulting from previous research, that the consequences of torture are complex and at times debilitating resulting in depression, anxiety and PTSD. It confirms the previous results of the negative psychological effects of torture but extends previous research by comparing three groups: torture survivors, survivors of other types of system abuse and a control group (Başoğlu et al., 1994; Thompson & McGorry, 1995).

The results did not show that torture survivors present with higher levels of distress than survivors of other systemic abuse as was predicted across all measurements. The non-significant difference between torture survivors and survivors of other types of systemic abuse as measured by the PTSD severity score 'last 4 weeks' and the IES two sub-scales (intrusion and avoidance) does not support the argument for a 'Torture Syndrome' as proposed by a number of researchers (Allodi & Cowgill, 1982; Doerr-Zegers et al., 1992; Elsass, 1998). The results demonstrate the complexity and inconsistency in measuring the level of distress and other consequences resulting from torture. Torture survivors were shown to experience personality change and change in view of self as well as experience a higher level of distress as measured by the GSI in the SCL-90-R. Such differences will continue to give support for the conceptualisation of a specific syndrome resulting from torture. However, the results from Sections 1 and 2 showed that on many of the measures of psychopathology the survivors of systemic abuse reported equally or higher levels than torture survivors. This finding does not assist in validating a proposed 'Torture Syndrome' as explored by some researchers (Allodi & Cowgill, 1982; Doerr-Zegers et al., 1992; Elsass, 1998).

The study emphasises the need for researchers to include both a second group exposed to systemic traumatic events which differs from the first group (torture) as well as a control group not exposed to any type of systemic abuse. The operationalisation of definitions of these three groups has contributed a framework to alleviate concerns in the literature in regards to the difficulties in distinguishing which traumatic event, resulting from systemic abuse, impacts on psychopathology. Hollifield et al. (2011) adopted the same classifications as originally developed by Thompson and McGorry (1995) and used in the present study as a confirmation of objective torture criteria for distinguishing the three groups. By including all

three groups, differentiation can be made as to the level of distress resulting from torture and other systemic abuse. In the current study, the level of distress resulting from the experience of torture and other types of systemic abuse was apparent when contrasted with that of the control group.

Further, the study clearly indicated that seeking asylum, whether living in the community or in detention, can have detrimental effects on the psychological wellbeing of survivors. This study compared the results from standardized psychiatric scales across three residential categories (permanent residents, asylum seekers living in the community and asylum seekers living in detention). The aim of this was to better understand the implication of the asylum seeking process on the psychological wellbeing of survivors. This study extends our knowledge about the implications of seeking asylum amongst survivors of torture and other types of systemic abuse in Australia. This section of the study provided a new systematic comparison between the three residential categories by establishing clear criteria to distinguish these three categories. The results from this section of the study contribute to further knowledge in this area of psychology in Australia as it offers sound statistical data about the mental health status of asylum seekers.

The results from the comparison between the residential categories provide sound evidence that the process of seeking asylum has implications on the psychological wellbeing of asylum seekers. The interaction between group and residency was significant for participants in detention. Regardless of group membership detention had an impact on the level of 'intrusion' and 'avoidance' as measured by the IES. The results from the SCL-90-R indicated that asylum seekers in detention and in the community presented with high levels of psychological distress. The ICD-10 EPC also provided clear indication of personality

change for participants in detention. These findings contribute to the current debate about mandatory detention and reflect the significant support needs of asylum seekers generally. While the data for this research was gathered pre-2001, it is disturbing to realize, from media reports and from professional visits to detention centres, that there has been little policy development.

Yet, the results from the Repertory Grid also indicated clearly that participants in detention centres hold a sense of hope for the future, consistent with survivors of the Holocaust (Frankl, 1984, Valent, 1999) who stated that hope and will to survive can be achieved in the most extreme circumstances. As discussed in Chapter 4 there is much debate as to the present mandatory detention laws in Australia and the impact of detention yet research has not included a comparative methodology as presented in this study, that is, a comparison between permanent residents who have never experienced seeking asylum, asylum seekers living in the community and asylum seekers living in detention.

This research also contributes to the concerns raised in reviews about the adequacy of the PTSD diagnosis (McNally, 2004; Turner, 2000; Watters, 2010). PTSD changes over time, as demonstrated also by Başoğlu et al. (1994) and the prevalence of PTSD varies (Steel et al., 2009), and both raise questions about the diagnosis. The present research confirms the view that it cannot be assumed that all survivors of torture or other systemic abuse will have a PTSD diagnosis. In the current study, the assessment of PTSD was undertaken at two distinct times. The first was following the traumatic experience, torture or other type of systemic abuse, and based on a structured interview following the testimonial account of the participant's experience. The second time was on the basis of the 4 weeks prior to the research interview. The results from this assessment indicated a change in the number of

participants meeting the criteria for PTSD and the severity level. Başoğlu et al. (1994) is the only other study that included these two points in time measurement. The findings are interpreted as confirming the views that belief systems such as religious, political, social and commitment to significant others contributes to a level of resilience which allows the survivor to deal with the experience and gives them the strength and ability to be able to function and gain a sense of self integrity in everyday life (Başoğlu et al., 1994; Paker et al., 1992; Sachs et al., 2008; Shrestha et al., 1998; Watters, 2010).

No other study, nationally or internationally, has included assessments of self-constructs from the Repertory Grid (Kelly, 1955) in order to determine how survivors evaluated the impact of the traumatic experience on their view of self. The Repertory Grid is a unique instrument that can assist researchers in furthering their understanding of the participant's view on 'self' given a particular situation. In this research the Repertory Grid was administered following the in-depth interview. This allowed the participant to self assess and summarise where they had been 'before experience' 'at the time', 'post experience', 'now' 'as a migrant/refugee or asylum seeker' and 'in future'. This subjective measurement, which was constructed by survivors, adds an insight into the commonality of the meaning of language used to describe the 'self' from the perspective of the survivor, based on their most traumatic experience at different times in their life. Often participants commented that this was a good way of finishing the interview as it allowed them to review themselves and reflect on their own life. An important observation was the participants' ability and enthusiasm to complete the grid, making this instrument a useful tool for future research.

The study is unique in Australian research in this field by incorporating an in-depth interview structure and interview style with a large cohort. The participant's life experiences including the torture experience was recorded using a testimonial format which is explained in Chapter 3. Testimonies, as explained in Chapter 3, have been used as a psychotherapeutic process for treating torture survivors since the 1970s, and they also allow documentation and possible gathering of evidence against those who perpetrated the abuse (Agger & Jensen, 1990; Cienfuegos & Monelli, 1983). The Repertory Grid added a new dimension to the research and a new approach to the type of information gathered in regards to the level of impact the experiences had on the participant.

A key factor in the success of the research was the assistance of the cross-cultural workers. This approach has been unique in Australian research of this type as it moves away from having to stipulate the criterion that participants speak English. Having the same cross-cultural worker adds to the consistency of the language, the ability to establish trust and rapport and adds validity to the research methodology. The diversity of participants' background and circumstances meant that the researcher had to remain flexible, to know the structure of the interview well, to appreciate the flow of the interview and ensure that all questions were covered without it becoming an interrogation. Trust was built as the interview proceeded. The interviewer needed to be flexible with time; sometimes the interview had to continue into another day. The styles of research proved to be successful in being able to assist the interviewer establish rapport with participants. Participant cultural rituals and the environment they chose for the interview were always respected. The rituals related to prayer times, washing of hands, sharing a cup of tea or coffee. To accommodate participant requests involved interviewing some people in temples if that was where they felt at peace to answer questions; other participants insisted interviews be conducted at mealtimes, within the

security of their own home. Naturally, there were limitations for people in detention, but some participants still needed time for their prayers and fasting. This style of interview challenges conventional research formats and settings and adds to the establishment of research protocols and recommendations at an international level when studying the impact of torture and other systemic abuse (Quiroga & Jaranson, 2005; UNHCHR, 2004).

This study confirms that the continuing practice of torture and the reported torture techniques are consistent with those reported in Chapter 2. The torture techniques have only become more sophisticated with technological advances. Techniques appear to be universal. These torture techniques were consistent with those reported by Başıoğlu et al. (2007), Cathcart et al. (1979), DeZoysa and Fernando (2007), Doerr-Zegers et al. (1992), Knight (2006), and Paker et al. (1992).

Limitations of the Current Study

As with much research in the social sciences, populations accessed are rarely ideal. The use of a snowball technique whereby volunteers are obtained is not a random selection process. People who are willing or wanting to participate may not represent the broader cross-section of torture survivors and survivors of other systemic abuse. Due to restraints in research funding and the lack of government and agency support for research, the study was limited in regard to accessing a broad range of participants, in particular those living in detention. Researchers have repeatedly sought approval to access detention centres without receiving support from immigration authorities (Mares et al, 2002; Steel & Silove, 2001).

Due to the number and breath of the interviews conducted, the information gathered required extensive time to enter all the testimonies and the quantitative data. The qualitative

data collected was under-utilised and is yet to be fully explored. There are 259 individual stories that have not been adequately told or reflected on in this study. The qualitative material available in the testimonies is worthy of further reporting and examination. This qualitative data would assist in further understanding the needs of survivors and the changes migration itself causes in areas of employment, education and social status.

Başoğlu et al. (2007) reported that it is difficult to determine which factors primarily contribute to psychopathology, the torture event itself or the subsequent physical suffering resulting from the permanent physical damage resulting from torture. Therefore, a holistic and thorough assessment, which incorporates physical examination based on the history of torture, is crucial soon after arrival. While much has changed in the treatment of torture survivors since this research was undertaken, there is still need for considerable improvement. Physical consequences of torture are not always obvious, which is why appropriate medical assessment and support is required. Where individuals have suffered severely prior to migration and are in need of specialist support, there is a priority for assessments to be of a professionally high standard to maximize early intervention and support.

A physical assessment would provide further information on the consequences of the person's experience, validating their stories, and allow for appropriate referrals for treatment to take place. The physical consequences of torture were observed but, as stated in the methodology, it was not possible to assess participants medically as part of the research due to funding limitations and lack of official interest at the time this research was conducted. Those physical consequences, however, which were obvious or spoken of, were: scars on the skin from cigarette burns, hearing problems, lower back pain, gynaecological problems, and

pain from the soles of the feet (many survivors showed thick scars on their heels resulting from beatings to the soles of their feet). Examples of these physical complaints were based on obvious physical scars which survivors referred to in their statement during the interview. A survivor still had very complicated scars in his mouth resulting from a bullet wound when the torturers were 'playing' Russian roulette. He had a lot of difficulties in speaking and experienced pain.

The researcher found it difficult to comprehend that, given the medical examination before coming to Australia for permanent residency by an Australia medical official, this aforementioned person had not been referred immediately on his arrival to a specialist. The participant stated that no one had asked him if he required a specialist or recommended further support. The participant was then referred along with a detailed report to the Royal Melbourne Hospital maxillofacial specialist and underwent major surgery which resulted in improved speech, reduced pain and the ability to eat properly again. One participant presented with major damage due to caustic acid having been forced down his throat. His mouth, throat, vocal cord and oesophagus had been burnt so he could not speak or eat. His wife had also been tortured. Much time was spent by the researcher investigating appropriate surgeons to treat this case as he was in desperate need of specialised services.

When reviewing the literature on the psychological impact of torture (Chapter 3), and of seeking asylum (Chapter 4) it was noted that in most studies the majority of participants were male; for example, Domovitch et al. (1984), reported on 91 male and 13 female survivors; Allodi et al. (1985) on 37 male and 7 female survivors; and, Rasmussen et al. (2007) on 249 male and 150 female refugees (without specifying the number of torture survivors within the group in their study). Other research has involved only males; e.g.,

Carlsson et al. (2006), and Schweitzer et al. (2006) and some researchers have not specified the gender of the participants, e.g., De Zoysa & Fernando (2007), and Sachs et al. (2008). The gender imbalance was the only significant demographic difference observed in Section 1 across the three groups and in Section 2 across the three residential categories where the majorities were male.

A consideration of the smaller number of female survivors was that during this research, anecdotal comments were made by many survivors of torture of both genders that torture would often involve the forced witnessing of females being tortured at the same time as the participant. In some cases they witnessed the female being tortured to death and participants have recorded that they believed many tortured women did not survive. This might go somewhere to explain the discrepancy between males and females, along with the greater tendency of men to be taking part in political action. If the survivors escaped, their families would have been more likely to encourage young males to seek refugee status abroad.

A limitation of the reporting and self rating assessment by survivors is that it is based on memory which could be affected by the passing of time (Silove & Kinzie, 2001). Further, as suggested by Kelly (1955), events are constantly being re-constructed and this changes the way individuals view self within the experience they are living. For example, the Repertory Grid is dependent on participants' recall of their re-constructing of their experiences at different stages of their life. Therefore, one limitation of the Repertory Grid (and indeed other self report scales) is that it is reliant on retrospective self report.

Another methodological issue worth noting was the administration of the SCL-90-R. This was completed by participants prior to the commencement of the in-depth interview.

Perhaps a more reliable assessment may have been to administer it prior to, and after, the interview, to allow for changes as the interview elicited feelings and thoughts that might have been suppressed prior to the interview. As the interview progressed the participants did become more relaxed and open with their views, thoughts and feelings about the impact of their traumatic experience. However, the interview was lengthy and heavily weighted with scales. The use of too many psychiatric scales runs a risk of overwhelming the participants and such scales need to be incorporated with the full consent, understanding and trust of participants for the measurement outcome to be valid and reliable (Marsella, 2001).

Inter-rater reliability analysis could not be obtained for the PTSD interviewer-assessed rating as there was only one rater for each participant. The interviews for Spanish-speaking participants were undertaken with assistance from other research assistants. There was training and supervision for initial interviews with the principal researcher, to ensure consistent ratings and interpretations. However, inter-rater reliability was not undertaken to substantiate consistent ratings. Ideally, the interviews would have been more reliable if assessments were rated by two interviewers; however, this was prohibited by the lack of financial resources.

Another statistical limitation relates to Type I errors; due to the large number of tests that were conducted there is a possibility that a number of tests were significant by chance (Pallant, 2005). Nevertheless, in general interpretation of the results emphasises patterns of results rather than being reliant on a few specific and isolated findings.

Implications of this Research: Recommendations

Torture is an extreme act of violence inflicted upon an individual. Research has clearly demonstrated the psychological consequences of torture and the resilience of survivors who do not present with long-term mental health problems. The need to report the brutality of torture and its techniques is essential for continuing the fight against such practices. Specific areas of abuse are open to further investigation. For example, sexual abuse such as the use of women as sexual objects, personal objects of the torturer, needs to be denounced and their psychological and physical consequences may mean the survivors have unique needs. To illustrate, three women in this study reported having become pregnant as a consequence of their torture experience and significant emotional issues resulted in regards to acceptance of the child. The sexual abuse during torture often makes discussion painful. This research reported men were sexually abused during torture. The psychological consequences of this are not clearly recognized and it is often under reported and most likely under reported in this study.

A sound assessment must include a medical examination and appropriate reporting should be incorporated in any future research. The assessment must continue to include qualitative data obtained in a testimony format. This information would assist in further understanding the way survivors view self, and it gives the researcher a better insight into how people survive the experience of torture, other types of systemic abuse and the asylum seeking process. It is these data that assist researchers and clinicians alike, to further understand the needs of survivors and adaptation concerns in areas of employment, education, family structure and social status.

Detention and living in the community as asylum seekers both carry risks of further deterioration in mental health for those who have suffered torture or other forms of systemic abuse. Findings from the current study strongly suggest that all the processes of seeking asylum should be reviewed so as to reduce the likelihood of re-traumatization. Asylum seekers commonly report that there is limited sensitivity and openness to hearing their stories and it is recommended that the nature of the questioning needs to be more empathic, particularly in order to validate the asylum seekers' history. A comprehensive assessment of asylum seekers must include their history of abuse and its implications; that, after all, is what they are escaping from (Marsella, 2001; Quiroga & Jaranson, 2005). These recommendations are supported by Murray et al. (2008) who stated that, given the nature of pre-migration history of persecution, the treatment of asylum seekers in Australia is anti-humanitarian. Murray et al. (2008) stated: "Future Governments need to ensure that applications are processed quickly and that immediate access to appropriate support services is always available for these people." (Murray et al., 2008, p. 12).

One essential need is an appropriate timely assessment of physical and mental health, legal and social requirements of all asylum seekers. To ensure a reduction in stress-related trauma the survivor needs to have their whole story told (Quiroga & Jaranson, 2005). Likewise for practical reasons, the authorities need to have a full assessment of the asylum seekers' circumstances (Murray et al., 2008). Improved communication between all parties involved (e.g., immigration department staffs, solicitors, detention centre staff, welfare and health supports staff) would facilitate a more accurate processing of the asylum seekers application for protection in Australia.

The assessment of asylum seekers in general needs to be revised. It should be prompt, efficient and comprehensive. All parts of the assessment should be coordinated and the results shared for maximum effectiveness. A holistic assessment of survivors on arrival is required to assist in reducing the future consequences of their experiences of abuse. The physical health of asylum seekers must be determined promptly, not only to establish whether or not their health is of concern to authorities, but so that any effects of their pre-migration abuse can be found and dealt with. These examinations need to be carried out by independent general practitioners who are trained in the diagnosis of such conditions. Further, their mental health must be assessed by appropriate and experienced professionals. Assessment instruments should be consistent across Australia so that reliable data are available throughout the country. Innovative tools that allow for subjective measurements of psychopathology should be included, such as the Repertory Grid. The reports of these assessments should be available to the survivors for future reference. It is necessary that specialized treatment is then made available to those in need.

The remote location of most of the detention centres militates against the prompt application of the recommendations above. So do the constantly changing policies. Bipartisan approaches to the treatment of all asylum seekers would relieve many of the stressors inflicted on the asylum seekers and would ultimately reduce the costs of their incarceration and management from the Australian taxpayer. The findings from the Grid, that survivors of torture and systemic abuse can integrate their experiences in positive ways over time, is an important statement about people's resilience and their ability to heal. All the policies relating to asylum seekers should be designed to facilitate their healing.

Future Directions

Ongoing research into the consequences of torture is necessary to continue the reporting of such atrocities and its consequences and condemn the use of intentional psychological and physical infliction of pain. Research into these long-term consequences of torture can provide valuable knowledge to argue against the practice of torture when authorities are justifying their practice during times of war or insurgence (Donnelly & Diehl, 2011).

Further research into the consequences of asylum seeking could identify health concerns specific to refugee trauma. Research in this area would have substantial benefits if the government allowed access to detention centres without feeling threatened by research and provide assistance to detainees with the view of preventing further harm.

As commented in regards to the SCL-90-R the sequence of psychometric scales and the timing within an interview package may influence participants' reporting. Future research could test this hypothesis by using the same scale twice to test for differences following an in-depth interview.

Further substantive research is needed into the validation of the entire assessment package adopted for the interviews conducted in this research. This will assist in validating further the findings of this research and assist with other research studies. It could also provide a reliable and valid process for assessing general health needs of refugees. This is urgently needed as at present there is no standardized procedure or assessment used across clinicians in Australia.

Future research must continue to include clear group classification as conducted in this study and adopted by Hollifield et al. (2011). Similarly, future research will benefit from distinguishing between residential categories as applied in this research. It was this clear distinction between these categories that allowed us to identify that asylum seekers living in the community are in as much need as asylum seekers living detention. Whilst detention can cause further harm, all survivors require the focus of adequate health support.

The uniqueness of using the Repertory Grid adds to our understanding of the impact on self-view following a traumatic experience such as torture. Further research in this area should combine aspects of self-view and the relationship to coping and resilience which allows the survivor to regain a positive view of self later in life as demonstrated by this research. Watters' (2010) argues that people in non-Western societies have their traditional means of dealing with extreme experiences. Within 'modern Western culture the idea of PTSD is that of a broken spring in a clockwork brain' (Watters, 2010 p. 120). However, earlier generations found other meanings, from which to draw on, like religion, patriotism or moral values which are now replaced with the 'biomedical' (Watters, 2010). Watters (2010) sees PTSD as emphasising vulnerability while failing to acknowledge the resilience of the self. As suggested by Wilson (2004), rather than assuming limited integration or fragmentation, we should examine more carefully the connections between the self over time in relation to the descriptors in their constructs and the meaning survivors seek within their experiences. Kelly stated: "It is not what happens around him that makes a man experience; it is the successive construing and re-construing of what happens, as it happens, that enriches the experiences of his life" (Kelly, 1955, p. 73).

Conclusions

An obvious conclusion to be drawn from the discussion at this point is the degree of complexity presented by the findings in both Section 1 of the Results chapter comparing survivors of torture, survivors of other types of systemic abuse and a control group as well as in Section 2 which involved comparisons between the three residential categories. These complexities lie in the diverse findings resulting from the psychiatric scales, the Repertory Grid and the structured interview which included measurements of severity of symptoms based on the PTSD criteria and the percentage of survivors meeting such criteria.

The process of seeking asylum adds to the complex consequences of systemic abuse where the constant interviewing of asylum seekers can undermine their recovery and reduce their ability to cope by reinforcing the notion that they are not believed and hence denies their experience of systemic abuse. PTSD is not a concept that can provide sufficient understanding as to what happens to survivors in their continuing struggle for security and freedom. The continuing stress places them in a vulnerable position leading to consequences that are more complex than a simple diagnosis of PTSD, perhaps better described as 'refugee trauma' or 'refugee syndrome' - a group of symptoms specific to refugees who have a history of torture or other types of systemic abuse which might include the added factor of being an asylum seeker, that is, a refugee looking for a safe home. Auden in March 1939 wrote:

"Refugee Blues" |

Say this city has ten million souls.
Some are living in mansions, some are living in holes:
Yet there's no place for us, my dear, yet there's no place for us.

Once we had a country and we thought it fair.
Look in the atlas and you'll find it there:
We cannot go there now, my dear, we cannot go there now.

In the village churchyard there grows an old yew.
Every spring it blossoms anew:
Old passports can't do that, my dear, old passports can't do that.

The consul banged the table and said.
"If you've got no passports you're officially dead":
But we are still alive, my dear, but we are still alive.

Went to a committee; they offered me a chair;
Asked me politely to return next year:
But where shall we go to-day, my dear, but where shall we go to-day?

Came to a public meeting, the speaker got up and said;
"If we let them in, they will steal our daily bread":
He was talking of you and me, my dear, he was talking of you and me.

Thought I heard the thunder rumbling in the sky;
It was Hitler over Europe, saying, "They must die":
O we were in his mind, my dear. O we were in his mind.

Saw a poodle in a jacket fastened with a pin.
Saw a door opened and a cat let in:
But they weren't German Jews, my dear, but they weren't German Jews.

Went down the harbour and stood upon the quay.
Saw the fish swimming as if they were free:
Only ten feet away, my dear, only ten feet away.

Walked through a wood, saw the birds in the trees:
They had no politicians and sang at their ease:
They weren't the human race, my dear, they weren't the human race.

Dreamed I saw a building with a thousand floors.
A thousand windows and a thousand doors:
Not one of them was ours, my dear, not one of them was ours.

Stood on a great plain in the falling snow:
Ten thousand soldiers marched to and fro:
Looking for you and me, my dear, looking for you and me'.

WYSTAN H. AUDEN 1939

Although the data for this research were collected during the period between 1993 and 1998 like this poem of Auden written in 1939, they both equally apply today. It is hoped that the findings of this research will add to and assist researchers and clinicians in Australia to further our understanding of the ongoing struggle of survivors of torture and the complexity of refugee trauma.

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Appendix A

Country of Birth by Residential Status and Group Membership

Country	Permanent Resident Torture Survivors	Permanent Resident Other Trauma	Permanent Resident Control	Asylum Seekers Torture Survivors	Asylum Seekers Other Trauma	Asylum Seeker Detention Torture Survivors	Asylum Seeker Detention Other Trauma	Total
Algeria	0	0	0	0	0	1	1	2
Argentina	3	1	2	0	0	0	0	6
Bhutan	0	0	0	2	0	0	0	2
Bulgaria	0	0	0	1	0	0	0	1
Chile	1	5	2	0	0	0	0	8
Colombia	0	2	2	0	0	0	0	4
Cuba	0	0	1	0	1	0	0	2
East Timor	0	0	0	3	4	0	0	7
El Salvador	16	10	17	1	1	0	0	45
Ethiopia	12	16	5	0	3	0	0	36
Guatemala	13	15	11	0	0	0	0	39
Iran	0	0	0	2	0	0	0	2
Iraq	0	0	0	0	0	1	2	3
Nicaragua	0	0	1	0	0	0	0	1
Paraguay	0	0	1	0	0	0	0	1
Peru	6	14	11	0	0	0	0	31
Somalia	4	3	2	1	0	3	3	16
Sri Lanka	0	0	0	11	2	14	17	44
Turkey	0	0	0	2	0	0	0	2
Uruguay	1	3	3	0	0	0	0	7
Total	56	69	58	23	11	19	23	259

Appendix B

Letter Sent to Agency Manager and Research Summary for Agencies

Appendix B1

Letter Sent to Agency Manager

Manager
Agency Name

May 24 1993

Dear Sir /Madam

I am writing to you in the hope of establishing your support for a study being undertaken by the University of Melbourne, Department of Psychiatry.

The study is about the effect of repression, systemic abuse, torture and migration process itself. It aims to explore the impact migration and pre-migration experiences have had on people from the more recent migration flow into Australia which includes people from Latin America, Ethiopia and Somalia, and East Timor.

Specifically, the study requires the participation of males and females from the ages of 18. You do not need to assess whether they have experienced torture or other types of systemic abuse. That will be assessed through the process of an interview that will take approximately 3-4 hours to complete and that will include self report questionnaires. Rest assured all the information will be confidential. Interviews are conducted in the participants own native language.

It is hoped that this study will lead to an understanding and awareness of migrants from these diverse backgrounds and specifically the migrants who have survived organised violence. Hopefully this study will help to develop better health services which are urgently required.

I would be grateful if you could forward my name and telephone number to anyone who is interested in participating or would like more information. We would like to contact your agency or organization and organize a meeting time and discuss the study and the procedures with your service further. Also to assist in coordinating referrals it would be appreciated if we could have one person as a contact officer in your agency. Your assistance in this process is essential.

Should you have any queries or need any assistance on this matter, please do not hesitate to contact me on 93892536 between 9.30am and 3pm Tuesday to Friday.

Attached to this letter is a brief Summary of the research. I will be more than happy to bring a more detailed research proposal to a meeting and discuss this in more detail.

Thank you for your support

Maritza Thompson
Researcher

Appendix B2

Research Summary for agencies

Research into the Psychological Impact of Torture and Other Types of Systemic Abuse amongst Refugees Living in Victoria.

A pilot study was undertaken in 1989 to investigate the psychological sequelae of torture amongst Chilean and Salvadorian migrants (Thompson and McGorry, 1995). This study suggested that individuals who survived torture presented with higher levels of PTSD, depression and anxiety than those who survived other types of systemic abuse. This pilot work established the basis for a research protocol in assessing the psychological impact of torture. It was found to be feasible to access and interview survivors from a clinical research perspective without causing additional psychological distress.

This research project continues this early work and aims at extending to include refugees from a diverse cultural background including people from Ethiopia, Somalia, Iran, East Timor, and Turkey. Based on literature regarding these countries many people have been forced to leave as a result of having experienced systemic abuse including torture, many, also, have left for economic reasons. This research aims at interviewing a diverse group regardless of their reason for leaving their country.

The research is divided into two stages: The first is interviewing people who have come to Australia with permanent residency status. However there is no need to identify this by the agency as we will do this in our assessment.

The second stage is interviewing people who have come to Australia seeking asylum, and are presently living in the community or asylum seekers living in a detention centre.

The methodology of the study is complex. A semi-structure interview was developed where it explores pre-migration and post-migration history of the individual exploring the complexity of the numerous traumatic events and stress caused by migration in the host country. It also explores survival mechanisms. The interview includes a structure interview assessing the severity of Post Traumatic Stress Disorder (PTSD) symptoms. Also included are three psychometric scales: The SCL-90 which assesses the overall mental health state of the individual including psychiatric symptoms related to depression, anxiety, psychosis, substance abuse, psychosomatic symptoms; The Impact of Event Scale which further assesses post-trauma symptoms such as intrusion and avoidance and The Grid, a measurement of changes in 'view of self'.

Ethical standards are considered at all times and based on protocols set by international standards. I will be more than happy to meet with you and your staff to further discuss previous research findings and the purpose and need for further research.

Maritza Thompson
Researcher
Contact Number: 9392536

Appendix C

Training Program for Interviewers

This training aimed at achieving competence in conducting interviews in the area of Torture and Trauma. It provided training in the areas of assessment, communication and debriefing techniques. The training looked at methodological issues in research with particular focus on issues specific to research in the area of torture and other systemic abuse. It covered cultural issues; language, politics, beliefs and values, as essential information to understand the population sample to which this research focused. Training was provided to ensure consistency and effective interviews. The training aimed at reaching a common understanding of the aims, purpose, research questions and procedure of this study. It also incorporated theoretical background in areas related to post traumatic stress disorder, history of torture and trauma.

The training took place over a 3 day period. The following was the outline of the program:

PROGRAM:

DAY 1

- * Introduction: Overview
- * Definition of Terms: Torture/Organised violence/Systemic abuse
- * Definition of PTSD, depression, anxiety, psychosis
- * Aims of research and need for research
- * Role and Expectations of research assistants
- * Role and expectations of cross-cultural workers
- * Ethiopia - Culture and Politics
- * Profile in Melbourne
- * Somalia - Culture and Politics
- * Profile in Melbourne
- * Latin America: Culture and Politics.
- * Profile in Melbourne.
- * Asylum seekers: definition, population profile

* Language: The complications of translation and back-translation, the importance of understanding the concepts and ability to communicate using simple terminology.

DAY 2

* Interview techniques

* Semi-structured Interview: step by step review of the structured interview and definitions of terminology

* Scales

* Procedure for Reliability Test

* Pilot Interview

* Observation

* Discussion

DAY 3

*Briefing and Debriefing: the meaning of these concepts and support to be provided to all workers: Presented by Monica Manton

*Revision of Material from day before

Emphasis was placed on the following aspects of procedure which became the research methodology undertaken in the study:

Interview

Interviews were to be conducted with participants at a space where they felt most comfortable. That meant interviewing them at their apartment or house, in their back garden, in a public park in the researcher's office, at a temple or church. Interviewers were trained to view the process as an exploration into the individual's life. For the journey to occur the interviewer was to take the individual slowly through their life history to the present. In this process the interviewer had to be focused, to listen and to respond appropriately to what was being heard without engaging in counselling.

Due to the sensitivity of the topic and the mistrust entrenched within many torture survivors it was essential that the researcher was open and sensitive to the participants needs. Interviewers

were required to warn participants that the interview may evoke distressing feelings and that they were free to withdraw their consent/terminate the interview at any point. At no stage was any pressure to be applied upon the participants to complete the interview and scales.

Assessment Sequence:

General Information and Consent Form

The interview session commenced with explaining the research aim and procedure, as well as answering any questions the person might have. A consent form was signed. The form included the researcher's name and contact details if they wanted to re-contact the researcher for any information or queries. Interviewers were required to inform participants of complaints format if they felt they needed to complain about any concerns regarding the interview. Confidentiality of materials was outlined with no personal identification recorded on the interview materials. They were further informed that the information from the research might be published, that the information would be used for teaching purposes and that it was also part of the researcher's post graduate studies.

Interview sequence:

The consent form agreement was administered first followed by the SCL-90-R. The SCL-90-R was first administered for the following reasons:

- a) The subsequent interview and measures may influence the subject's mood, which would in turn affect the participants reporting about how they have been feeling in the last two weeks.
- b) The scale allowed for a rapport to commence between the interviewer, cross cultural worker and the interviewee.

c) The scale is very general and individuals were invited to generally review their mental health and physical health.

Participants were introduced to the interview by starting with general demographic questions. Each question was not necessarily used in the order which they appeared as it was felt necessary to be flexible.

The interviewer had to be very familiar with the interview so questions could be asked in a timely manner as the participants story unfolded. The participants were supported to express their entire life up to the point of the interview. Parallels can be drawn with the approach used with the testimony method. This method developed in Chile during the 1970s . The principal objective of this method is to get the individual to tell their story from the beginning of the experience. Originally this method was introduced as a way of keeping records so that in later years denunciations could be made about the atrocities that were taking place in Chile (Cienfuegos & Monelli, 1983). With time this method was viewed as a therapeutic technique. It allowed for a reconstruction of the events in a way that is meaningful to the individual.

Following the interview the subject was asked to complete the Impact of Event Scale. This was given at this time as it was like a summary of symptoms which had already been discussed in the PTSD section of the interview. The Repertory Grid was then completed.

Referral to Counselling

At the end of the interview, time would be made available to discuss any issues arising and appropriate referral and advocacy was provided. Participants were also informed of services available for them if they wished to have ongoing support or counselling as well as a

summary of their history was available to participants if requested in a report format written by the researcher (MT).

Data Handling

Each participant's file was given a number. Then revision of the whole interview was conducted. Where it involved a cross-cultural worker clarifications would be made if needed in any cultural issues or name of places, spelling of places or words that were used to describe a feeling or a thought that was felt important to keep in their language.

Data was divided into qualitative and quantitative data.

Debriefing

A support network was organised for debriefing and to provide assistance to the interviewers and cross-cultural workers. A group meeting was conducted once a week to discuss interview problems and queries that the interviewer encountered during the week. It was also a space to discuss new interviews organised. Group debriefing was conducted every fortnight. This became essential to deal with the frustrations of interview cancellations, the emotional impact of stories heard, referrals organised for participants, personal issues related to identifying with the interviewee and their experience. Debriefing became a space to be listened to, to letting go of the person and clarifying boundaries and role of the interviewer as an active compassionate listener. As stated by Egendorf (1995) to listen to pain can make the listener not want to continue or come back to it again, therefore attention must be given to how much the interviewers and the cross-cultural workers are affected by this phenomenon.

Appendix D

**Semi-structured interview (Including the PTSD structured
Interview, the GAF, and ICD-10 EPC) and Self Report Scales
(SCL-90-R, IES, GRID)**

Appendix D1

Interview Number: _____

SEMI-STRUCTURED INTERVIEW FOR THE PSYCHOLOGICAL ASSESSMENT OF THE PSYCHOLOGICAL IMPACT OF TORTURE AND OTHER TYPES OF SYSTEMIC ABUSE

Brief description

The interview and accompanying scales are to assess the general well-being of people who have migrated to Australia from different parts of the world. The interview is divided into 3 sections. Firstly, a 90 question scale is completed (The SCL - 90) which addresses present life situation and problems. Secondly, an interview examines pre-migration trauma if present. Thirdly, a short series of self-report sales are completed. The process in all takes approximately 3-4 hours with rest breaks.

Date _____

Interviewer _____

Location (e.g. Interviewer's house, referring agency, Detention Centre)

Total time taken for interview and scales

_____ hrs _____ minutes

Department of Psychiatry
Melbourne University
Royal Park Hospital
Parkville

Interview format and check list:

1. Ensure consent form is signed by the interviewee.
2. Ensure all questions have been answered.
3. Interviewers should be extremely familiar with all questions and flexible in sequence of questions.
4. Answers can be completed whilst the interviewee is completing the scales if it is inappropriate to be writing all the details during the interview.
5. If the client cannot read the scales then the interviewer should read the instructions and questions, writing down the answers.
6. If the interview becomes too distressing for either parties then the interview should cease making sure that there is a space for debriefing and appropriate referral if require for the participant. In case of the interviewer please make sure you contact the researchers.
7. Remember to complete the GAF scale and the ICD-10 Personality change.
8. On completion check that the following have been given:

- | | |
|---------------------------------|-----|
| * Participant Information Sheet | [] |
| * Participant Consent Form | [] |
| * SCL - 90 | [] |
| * Interview | [] |
| * GAF | [] |
| *ICD-10 Personality change | [] |
|
 | |
| * Impact of Event Scale | [] |
| * Grid | [] |

SEMI-STRUCTURED INTERVIEW

SECTION I

1) AGE _____

2) SEX

Female = 1

Male = 2

3) COUNTRY OF BIRTH _____

4) ETHNIC BACKGROUND _____

5) RELIGION _____

6) LANGUAGE _____

6b) WHERE DID YOU LIVED BEFORE ARRIVING IN AUSTRALIA?

7) LOCATION

Rural = 1

City = 2

8) LENGTH OF STAY IN AUSTRALIA 1) Years _____

2) Months _____

8b) LENGTH OF STAY IN DETENTION 1) Years _____

2) Months _____

9) SUBURB YOU LIVE IN _____

10) MIGRATION STATUS:

- 1) Family Migration
- 2) Skill Migration
- 3) Humanitarian Program
- 4) Refugee Program
- 5) Asylum Seeker (if yes, please answer questions 10b - 10e)
- 6) Women at Risk
- 7) Other

10 b) HAVE YOU LODGED A REFUGEE STATUS APPLICATION?

YES []1

NO []2

10 c) HAS IT BEEN APPROVED ?

YES []1

NO []2

10 d) IF NO, IS IT UNDER REVIEW ?

YES []1

NO []2

10 e) IF YES, HOW LONG HAS IT BEEN UNDER REVIEW?

11) MARITAL STATUS

- 1) Single
- 2) Married
- 3) Defacto
- 4) Divorced
- 5) Separated
- 6) Widow/Widower

12) NUMBER OF CHILDREN

13) DO YOU HAVE ANY RELATIVES OR CLOSE FRIENDS LIVING IN AUSTRALIA?

YES = 1

NO = 2

13 b) IF YES , SPECIFY (Tick appropriate categories)

- | | |
|-------------------------|-------|
| 1) Mother | 1[] |
| 2) Father | 2[] |
| 3) Brother | 3[] |
| 4) Sister | 4[] |
| 5) Friend | 5[] |
| 6) Son | 6[] |
| 7) Daughter | 7[] |
| 8) Aunt | 8[] |
| 9) Uncle | 9[] |
| 10)Other(Specify) _____ | 10[] |

13 c) IF CHILDREN IN DETENTION, WHAT IMPACT DO YOU THINK LIVING IN DETENTION MAY HAVE HAD ON YOUR CHILDREN?

13 d) DO YOUR CHILDREN GO OUT OF THE CENTRE ?

YES []1 NO []2 _____

13 e) IF YES, HOW OFTEN?

14) WHAT IS THE HIGHEST LEVEL OF EDUCATION THAT YOU HAVE COMPLETED?

- 0 None
- 1 Primary
- 2 Secondary
- 3 Technical
- 4 Tertiary
- 5 Postgraduate
- 6 Other (Specify) _____

15) WHAT WAS YOUR LAST OCCUPATION IN COUNTRY OF ORIGIN?

-
- 1) Upper professional
 - 2) Lower professional
 - 3) Large scale employer and manager
 - 4) Smaller scale employers and manager
 - 5) Self-employed
 - 6) Intermediate non-manual worker
 - 7) Clerical and related worker
 - 8) Foreman and supervisor manual
 - 9) Skilled manual worker
 - 10) Semiskilled or unskilled worker
 - 11) Farmer
 - 12) Home Duties
 - 13) Student
 - 14) Unemployed
 - 15) Non-Specific

16) WHAT IS YOUR CURRENT OCCUPATION IN AUSTRALIA?

-
- 1) Upper professional
 - 2) Lower professional
 - 3) Large scale employer and manager
 - 4) Smaller scale employers and manager
 - 5) Self-employed
 - 6) Intermediate non-manual worker
 - 7) Clerical and related worker
 - 8) Foreman and supervisors manual
 - 9) Skilled manual worker
 - 10) Semiskilled and unskilled worker
 - 11) Farmer
 - 12) Home Duties
 - 13) Student
 - 14) Unemployed
 - 15) Non-Specific

16 b) HOW HAS LIVING IN DETENTION IMPACTED ON YOUR LIFE?

**16 c) WHAT ARE THE LIVING CONDITIONS LIKE IN THIS CENTRE?
PLEASE COMMENT ON: FOOD, SPACE, ROOM ACCOMMODATION, CENTRE
PERSONNEL, HEALTH CARE, WELFARE, COUNSELLING ETC.)**

17) HAVE YOU DONE ANY ENGLISH COURSES SINCE YOU ARRIVED IN AUSTRALIA?

YES = 1 NO = 2 _____

18) OTHER COURSES?

YES = 1 NO = 2 _____

18 b) IF YES, SPECIFY:

19) ARE YOU CURRENTLY STUDYING?

YES = 1 NO = 2 _____

19 b) IF YES, ARE YOU :

1) Full-time

2) Part-time

3) Other (Specify)

20) ARE YOU RECEIVING ANY BENEFIT?

YES = 1

NO = 2

20 b) IF YES, SPECIFY

- 1) Job Support Allowance
- 2) New-Start Allowance
- 3) Sickness Allowance
- 4) Old Age Pension
- 5) Disability Support Pension
- 6) Special Benefit
- 7) AUS Study
- 8) Other (Specify) _____

20 c) SPECIFY THE REASON FOR RECEIVING SICKNESS ALLOWANCE OR THE DISABILITY SUPPORT PENSION

20 d) ARE YOU RECEIVING ANY INCOME?

YES = 1

NO = 2

20 e) IF YES, SPECIFY

21) BEFORE YOU LEFT YOUR COUNTRY, DID YOU:

- 1) Live with relatives
- 2) Own your own flat
- 3) Own your own house
- 4) Rent a house
- 5) Rent a flat
- 6) Other (specify) _____

22) DO YOU CURRENTLY:

- 1) Live with relatives
- 2) Own your own flat
- 3) Own your own house
- 4) Rent a private flat
- 5) Rent a private house
- 6) Rent a ministry of housing flat
- 7) Rent a ministry of housing house
- 8) Detention
- 9) Other (specify) _____

23) WHAT WERE THE REASONS FOR LEAVING YOUR COUNTRY?

- 1) Political & Economic
- 2) Political
- 3) Economic
- 4) Family reunion
- 5) Family reunion & Economic
- 6) Other

24) WHAT IS YOUR ASSESSMENT OF YOUR PHYSICAL HEALTH?

- 1) Very good
- 2) Good
- 3) Not so good
- 4) Bad
- 5) Don't know _____

25) WHAT HEALTH PROBLEMS HAVE YOU HAD?

26) ARE YOU PRESENTLY TAKING ANY MEDICATION?

YES = 1

NO = 2

26 b) IF YES SPECIFY:

27) HAVE YOU MADE USE OF ANY OF THE FOLLOWING PROFESSIONALS DURING THE LAST 12 MONTHS (Tick appropriate categories):

- | | |
|--|--------|
| 1) Dentist | 1 [] |
| 2) Psychologist | 2 [] |
| 3) Psychiatrist | 3 [] |
| 4) Social worker | 4 [] |
| 5) Family counsellor | 5 [] |
| 6) Public health nurse | 6 [] |
| 7) Minister, priest, rabbi or any other religious person | 7 [] |
| 8) Spiritualist, psychic | 8 [] |
| 9) Acupuncturist | 9 [] |
| 10) Herbalist | 10 [] |
| 11) Chiropractor | 11 [] |
| 12) Medical practitioner | 12 [] |
| 13) Other | 13 [] |

28) HAVE YOU MADE USE OF ANY OF THE FOLLOWING AGENCIES DURING THE LAST 12 MONTHS (Tick appropriate categories):

If in detention, ask if they are aware of any of these organisations:

- | | a) Use | b) Aware of |
|---|---------------|--------------------|
| 1) Community Health Centre | 1 [] | 1 [] |
| 2) Migrant Resource Centre | 2 [] | 2 [] |
| 3) Health Clinics | 3 [] | 3 [] |
| 4) Public Hospitals | 4 [] | 4 [] |
| 5) Ethnic Organisations | 5 [] | 5 [] |
| 6) Mental Health Facilities (e.g. Transcultural Psychiatric Unit) | 6 [] | 6 [] |
| 7) Victorian Foundation for Survivors of Torture | 7 [] | 7 [] |
| 8) Other | 8 [] | 8 [] |

29) HAVE YOUR NEEDS BEEN MET?

YES = 1

NO =2

Please elaborate:

SEMI-STRUCTURED INTERVIEW

SECTION II

A: EXPERIENCE OF TRAUMA

1) DID YOU EVER EXPERIENCE ANY OF THE FOLLOWING EVENTS BEFORE LEAVING YOUR COUNTRY?

- | | |
|---|-------|
| 1) * Serious physical injury (accident or natural disaster) | 1[] |
| 2) * Systematic physical & psychological torture | 2[] |
| 3) * Combat | 3[] |
| 4) * Rape | 4[] |
| 5) * Witnessed the rape of family members, friend or other among themselves forced by officials | 5[] |
| 6) * Witnessed the rape of family members, friend or other done by officials | 6[] |
| 7) * Assault | 7[] |
| 8) * Captivity | 8[] |
| 9) * Being kidnapped | 9[] |
| 10) * Natural disaster: earthquake, tornado, drought | 10[] |
| 11) * Seeing loss of life | 11[] |
| 12) * Threat to life of self, family, friend, other | 12[] |
| 13) * Witnessed violence in mass demonstrations | 13[] |
| 14) * Witnessed the killing of a member of your family, friend, other | 14[] |
| 15) * Experienced the disappearance of relative or friend | 15[] |
| 16) * Relative in jail as a political prisoner | 16[] |
| 17) * Search as a result of organised violence in your home or place physically nearby | 17[] |
| 18) * Forced displacement | 18[] |
| 19) * Lived in refugee camps | 19[] |
| 20) * Exile | 20[] |
| 21) * Other | 21[] |

1b) WHICH OF THESE EXPERIENCES WAS THE WORST FOR YOU?

2) WHAT DO YOU REMEMBER ABOUT IT ?

3) HOW LONG WERE YOU IN THAT SITUATION?

- 1) Months
- 2) Weeks
- 3) Days
- 4) Hours
- 5) Minutes

4) HOW OLD WERE YOU AT THE TIME OF THIS EVENT?

(If more than one event, score the event that appears to be most closely related to symptoms, but also record age at which other trauma occurred.)

5) *DO YOU EVER TALK ABOUT THIS EXPERIENCE?

6) *HAVE YOU EVER FELT THE NEED FOR ASSISTANCE TO DEAL WITH THE ABOVE SITUATION?

PLEASE SPECIFY: _____

7) *WERE YOU ABLE TO LEARN OR GAIN ANYTHING FROM THE EXPERIENCE?

8) *WHAT HELPED YOU TO COPE DURING THE EXPERIENCE (BELIEFS: RELIGIOUS, POLITICAL, SELF-STRENGTH, ETC)

9) *WHAT MADE IT DIFFICULT TO COPE WITH THE EXPERIENCE?

10) *WERE YOU AFRAID AT ANY PARTICULAR TIME DURING THE EXPERIENCE OF LOSING CONTROL?

YES = 1

NO = 2

11) *HOW DID YOU RESPOND EMOTIONALLY TO THE EXPERIENCE? (E.G. ANGER, DESPAIR, SADNESS, FRUSTRATION, CRYING, SCREAMING, FEAR)

12) *IF YOU WERE FORCED TO LEAVE THE PLACE WHERE YOU WERE LIVING, WHERE DID YOU GO AND WHAT WERE YOUR LIVING CONDITIONS LIKE?

13) *IF YOU LIVED IN A REFUGEE CAMP WHERE WAS IT AND WHAT WERE YOUR LIVING CONDITIONS LIKE ?

13 b) HOW LONG DID YOU STAY IN THE REFUGEE CAMP ?

14) *IF YOU LIVED IN EXILE (OTHER THAN AUSTRALIA) WHERE WAS IT AND WHAT WERE YOUR LIVING CONDITIONS LIKE ?

15) *HOW WOULD DEFINE TOTURE AND WHAT DO YOU THINK ABOUT ITS IMPLEMENTATION?

16) *WHO DO YOU THINK ARE RESPONSIBLE FOR YOUR EXPERIENCE?

If the participant reports having been tortured but does not discuss this as the worst experience, please complete questions 17 to 26. Proceed to Section 3 if participant reported torture as the worst or has not been tortured.

17) WHAT DO YOU REMEMBER ABOUT IT ?

18) HOW LONG WERE YOU IN THAT SITUATION?

- 1) Months
- 2) Weeks
- 3) Days
- 4) Hours
- 5) Minutes

19) HOW OLD WERE YOU AT THE TIME OF THIS EVENT ?

(If more than one event, score the event that appears to be most closely related to symptoms, but also record age at which other trauma occurred.)

20) *DO YOU EVER TALK ABOUT THIS EXPERIENCE?

21) *HAVE YOU EVER FELT THE NEED FOR ASSISTANCE TO DEAL WITH THIS EXPERIENCE?

PLEASE SPECIFY: _____

22) *WERE YOU ABLE TO LEARN OR GAIN ANYTHING FROM THE EXPERIENCE?

23) *WHAT HELPED YOU TO COPE DURING THE EXPERIENCE (BELIEFS: RELIGIOUS, POLITICAL, SELF-STRENGTH, ETC)

24) *WHAT MADE IT DIFFICULT TO COPE WITH THE EXPERIENCE?

25) *WERE YOU AFRAID AT ANY PARTICULAR TIME DURING THE EXPERIENCE OF LOSING CONTROL?

YES = 1

NO = 2

26) *HOW DID YOU RESPOND EMOTIONALLY TO THE EXPERIENCE? (E.G. ANGER, DESPAIR, SADNESS, FRUSTRATION, CRYING, SCREAMING, FEAR...)

SEMI-STRUCTURED INTERVIEW

SECTION III

Interviewer to complete A.1 & A.2 on completion of the interview.

A.1 Did the participant experience an event outside the range of usual human experience, and which would be markedly distressing to almost anyone?

YES []1

NO []2

A.2 Define the event. (Identify by the numbers below; narrative comment may be added.)

1 = Torture

2 = Physical assault/attack

3 = Seeing someone killed or hurt

4 = Natural disaster

5 = Personal injury in accident

6 = Complicated bereavement

7 = Threat to your life by officials

8 = Captivity

9 = Other

A.3 Did the participant's response involved intense fear, helplessness or horror(DSM-IV)

YES[] No[]

B. RE-EXPERIENCING THE TRAUMATIC EVENT

After it was over, did you find yourself remembering the events over and over again?
No _____ Yes _____

Which events do you refer to?

Did this happen even when you weren't trying to remember?
No _____ Yes _____

This may have taken the form of disturbing nightmares, recurrent painful recollection during the daytime, or a reliving of the event with behaviour as if it were recurring (e.g. hiding in the dark room.)

Which of these did you experience?	No	Yes
Nightmares	_____	_____
Flashbacks	_____	_____
Acting as though it was happening again	_____	_____

How long after the event did these first appear ? (months) _____

B.1 RECURRENT INTRUSIVE RECOLLECTIONS (DSM-III/DSM-III-R/DSM-IV)

Have you experienced painful images or memories of torture or other trauma experience which you couldn't get out of your mind, even though you may have wanted to?

Have these been recurrent?

- 0 - not at all**
- 1 - mild** rarely and/or not bothersome
- 2 - moderate** at least once a week, and/or rare but produces significant impairment of function or distress
- 3 - severe** at least 4 times a week
- 4 - extremely severe** daily or produces so much impairment that the participant cannot work or enter social situations
- 9 - no information**

Rate worst ever _____
Rate past 4 weeks (or other designated period) _____

B.2 DREAMS (DSM-III/DSM-III-R/DSM-IV)

I'd like to ask you about your dreams.

Have you had repeated dreams of violence, torture, refugee camps, death, rape, or other theme related to trauma?

Were these of actual scenes you were involved in?

Do you recognise people in the dream?

Are these dreams of the event?

How frequent are these dreams?

Do you wake up sweating or shouting? Trembling ? Palpitating ? Do you have trouble breathing?

Are the nightmares so bad that your spouse (partner) does not sleep in the same bed, or in the same room?

0 = no problems

1 = mild infrequent, or not disruptive

2 = moderate

3 = severe at least once a week or sleep in separate bed, same room as partner

4 = extremely severe more than 3 times a week; partner does not sleep in the same room because of ongoing nightmares

9 = no information

Rate worst ever _____

Rate past 4 weeks (or other designated period) _____

B.3 ACTING OR FEELING AS IF (DSM-III/DSM-III-R/DSM-IV)

At times have you reacted to something as if you were back in **the torture setting/scene (or other relevant trauma)**? Has it seemed that the event was recurring or that you were living through it again?

What was it?

Do you try to escape from the reminder (sound, documents about your community, etc.)?

Do you hide, shout, attack someone, or act as if you were being attacked/tortured ?

0 = not at all

1 = rarely

2 = sometimes

3 = often, or one instance of obvious significance

4 = every week, or more than one instance of serious significance

9 = no information

Rate worst ever _____

Rate past 4 weeks (or other designated period) _____

B.4 INTENSE PSYCHOLOGICAL DISTRESS OR EXPOSURE TO REMINDERS OF EVENT (DSM-III-R/DSM-IV).
DSM-III code as D.8)

Do any of the symptoms occur, or get worse, if something reminds you of the stressful event? Ask about TV programs, weather conditions, news, about their country, recent disaster involving the loss of life, loss of good friends, etc. (Feel angry, sad, irritable, anxious, frightened?)

0 = not at all

1 = a little bit: infrequent, or of questionable significance

2 = somewhat: one or two symptoms occur

3 = significantly: several symptoms occur or one symptom with much distress

4 = marked: very distressing, may have activated an episode of the illness, resulting in hospitalization, different treatment, etc.

9 = no information

Rate worst ever _____

Rate past 4 weeks (or other designated period) _____

B.5 Has the participant experience physiological reactivity on exposure to internal or external cues. (Ref to D.6 for coding this question for DSM-IV only).

C. AVOIDANCE OF STIMULI ASSOCIATED WITH THE TRAUMA

C.1 Do you try to avoid thoughts feelings, conversations about the trauma? How? Have you used alcohol or drugs to block thoughts or feelings? Ask about staying busy/transient life-style. (DSM-III-R/DSM-IV).

0 = no avoidance

1 = mild: of doubtful significance

2 = moderate: definite effort is made, but is able to function at work or socially

3 = severe: definite avoidance which affects life in some way (keeps moving from place to place/cannot work/works excessively/or episodic substance abuse because of need to avoid thoughts or feelings)

4 = very severe: dramatic effect on life (frequent substance abuse or inability to work or form relationships attributed to need to avoid thoughts or feeling)

9 = no information

Rate worst ever _____

Rate past 4 weeks (or other designated period) _____

C.2 AVOIDANCE OF ACTIVITIES THAT AROUSE RECOLLECTION OF THE EVENT (DSM-III-R/DSM-IV) DSM-III code as D.9

Do you avoid places, people, or occasions that remind you of the event?

Movies? Noisy places? Community organisations, political events related to your country ?
Airports? Other places?

0 = No avoidance

1 = mild: of doubtful significance (uncomfortable, but doesn't avoid)

2 = moderate: definite avoidance of situations

3 = severe: very uncomfortable and avoidance affects life in some way

4 = extremely severe: goes beyond reminders of combat; house-bound, cannot go out to shops and restaurants

9 = no information

Rate worst ever _____

Rate past 4 weeks (or other designated period) _____

C.3 PSYCHOGENIC AMNESIA (DSM-III-R/DSM-IV)

Is there an important part of the event that you cannot remember?

Even if the events are clear, do they seem unreal to you? Are the feelings you had at the time of the trauma difficult to recall?

0 = no problem

1 = mild: remembers most details

2 = moderate: some difficulty remembering significant details

3 = severe: remembers only a few details

4 = very severe: claims total amnesia for an important aspect of the trauma

9 = no information

Rate worst ever _____

Rate past 4 weeks (or other designated period) _____

C.4 LOSS OF INTEREST - HAVE YOU EXPERIENCED LESS INTEREST(PLEASURE) SINCE YOUR TRAUMATIC EVENT, IN THINGS THAT YOU USED TO ENJOY? (DSM-III/DSM-III-R/DSM-IV)

What things have you lost interest in? What do you still enjoy?

0 = no loss of interest

1 = one or two activities less pleasurable

2 = several activities less pleasurable

3 = most activities less pleasurable

4 = almost all activities less pleasurable

9 = no information

Rate worst ever _____

Rate past 4 weeks (or other designated period) _____

C.5 DETACHMENT/ESTRANGEMENT (DSM-III/DSM-III-R/DSM-IV)

Do you have less to do with other people than normal? Was it different before?

0 = no problem

1 = less contact or more avoidance

2 = sometimes avoids contact that would normally participate in

3 = definitely and usually avoids people with whom would previously associate

4 = absolutely refuses or actively avoids all social contact since the stress

9 = no information

Rate worst ever _____

Rate past 4 weeks (or other designated period) _____

C.6 RESTRICTED RANGE OF AFFECT (DSM-III-R/DSM-IV)

Can you have warm feelings/feel close to others? Do you feel numb?
Was it different before?

0 = no problem

1 = mild: of questionable significance

2 = moderate: some difficulty feeling close to people

3 = severe: definite problems feeling close to people

4 = very severe: estranged from family

9 = no information

Rate worst ever _____

Rate past 4 weeks (or other designated period) _____

C.6x CONSTRICTED AFFECT (OBSERVED) (DSM-III only)

Interviewer to complete.

Note expressions of happiness, sadness, anger, suspicion, etc.

0 = full range and appropriate

1 = mild constriction, but fluctuates slightly with appropriate content

2 = moderate constriction with only slight fluctuation in response to active efforts by interviewer

3 = severe constriction

4 = extremely severe constriction without any change in affect

9 = not recorded

Rate at interview _____

C.7 FORESHORTENED FUTURE (DSM-III-R/DSM-IV)

What do you see happening in your future?

What do you visualise as you grow old?

What are your expectations of the future?

0 = describes positive or realistic future

1 = mild: describes pessimistic outlook at times, but varies from day to day depending on events

2 = moderate: pessimistic much of the time

3 = severe: constantly pessimistic

4 = can see no future views early death as likely (but without adequate medical basis)

9 = no information

Rate worst ever _____

Rate past 4 weeks (or other designated period) _____

D. INCREASED AROUSAL

D.1 SLEEP DISTURBANCES (DSM-III/DSM-III-R/DSM-IV)

We spoke earlier about nightmares - what about other aspects of sleeping?

Have you had trouble sleeping? No____ Yes_____

Falling asleep? (initial insomnia) No Yes

Do you wake in the middle of the night? (middle insomnia) _____

Are you unable to go back to sleep after waking? (terminal insomnia) _____

0 = no loss of sleep

1 = mild: occasional difficulty but no more than two nights/week

2 = moderate: difficulty sleeping at least three nights/weeks

3 = severe: difficulty sleeping every night

4 = extremely severe: less than 3 hours sleep/night

9 = no information

Rate worst ever _____

Rate past 4 weeks (or other designated period) _____

D.2 HAVE YOU BEEN MORE IRRITABLE OR MORE EASILY ANNOYED THAN USUAL? (DSM-III-R/DSM-IV)

How did you show your anger? Have you had angry outbursts?

0 = not at all

1 = mild: occasional feelings of annoyance or anger which may go unnoticed by others

2 = moderate: increased feelings of annoyance, becomes snappy or argumentative (at least once every 2 weeks); others may have commented

3 = severe: almost constantly irritable or angry, often loses temper or has significant impairment in ability to relate to others as a result of this

4 = very severe: preoccupied with anger or feelings of retaliation, overly aggressive or assaultive, marked impairment in function

9 = no information

Rate worst ever _____

Rate past 4 weeks (or other designated period) _____

D.3 IMPAIRMENT IN MEMORY/CONCENTRATION (DSM-III/DSM-III-R/DSM-IV)

Have you noticed any trouble concentrating?

Is it hard to keep your mind on things?

Can you pay attention easily?

What about reading or watching TV?

Are you forgetful?

0 = no difficulty

1 = serial subtraction, 1 mistake out of 5; or patient acknowledges slight problem

2 = serial subtraction, 2 mistakes out of 5; or patient describes definite difficulty

3 = serial subtraction, 3 mistakes out of 5; interferes with daily activities, job, etc.

4 = serial subtraction, 4 or 5 mistakes; or will not even attempt subtraction; constant problems, unable to do simple tasks

9 = not recorded

Rate worst ever _____

Rate past 4 weeks (or other designated period) _____

D.4 HYPERVIGILANCE (DSM-III-R/DSM-IV)DSM-III select either D.4 or D.5

Do you have to stay on guard?

Are you easily distracted?

Do you feel on edge?

0 = no problem

1 = mild: occasional/not disruptive

2 = moderate: causes definite discomfort/feels on edge or watchful in most situations

3 = severe: causes extreme discomfort and alters life (feels constantly on guard/must keep back to wall/socially impaired because of feeling on edge)

4 = very severe: preoccupied with need to maintain vigilance

9 = no information

Rate worst ever _____

Rate past 4 weeks (or other designated period) _____

D.5 STARTLE (DSM-III-R)

Do you startle easily?

Do you have a tendency to jump?

Is this a problem after unexpected noise?

If you hear or see something that reminds you of the original trauma?

0 = no problem

1 = mild: occasional but not disruptive

2 = moderate: causes definite discomfort or an exaggerated startle response at least every 2 weeks

3 = severe: causes avoidance of places, makes others comment, happens more than once a week

4 = extremely severe: so bad that patient cannot function at work or socially

9 = no information

Rate worst ever _____

Rate past 4 weeks (or other designated period) _____

D.6 DOES EXPOSURE TO AN EVENT THAT REMINDS YOU OF, OR RESEMBLES THE TRAUMA, CAUSE YOU TO HAVE ANY PHYSICAL RESPONSE? (SWEATING, TREMBLING, HEART RACING, NAUSEA, HYPERVENTILATING, FEELING FROZEN, DO NOT INCLUDE NIGHTMARES.) (DSM-III-R).

0 = not at all

1 = a little bit: infrequent or questionable

2 = somewhat: mild response

3 = significantly: causes much distress

4 = marked: very distressing or has sought help from doctors because of the physical response (eg. chest pain so severe that patient was sure he or she was having a heart attack)

9 = no information

Rate worst ever _____

Rate past 4 weeks (or other designated period) _____

D.7 BEHAVIOUR/SURVIVAL GUILT (DSM-III only)

	Yes	No
Are you troubled by feelings of guilt or shame for what you did in torture ? (or another situation)?	_____	_____
Do you feel that you did not deserve to survive?	_____	_____
Have you felt guilty about surviving ?	_____	_____

0 = no guilt

1 = mild: sometimes feels guilty, but basically takes the view of "I did my job"

2 = moderate: expresses some distress because of these feelings, or feels guilty much of the time

3 = severe: constant feelings of guilt, which may evoke

4 = extremely severe: preoccupied with these feelings

9 = no information

Rate worst ever behaviour guilt	_____
Rate past 4 weeks (or other designated period)	_____
Rate worst ever survival guilt	_____
Rate past 4 weeks (or other designated period) survival guilt	_____
For how long has this condition lasted?(months)	_____

E. Duration of disturbance symptoms in criteria B,C & D more than one month

Yes[] No[]

F. The disturbance causes clinically significant distress or impairment in social in social, occupational, or other important areas of functioning

Yes[] No[]

Acute: If duration of symptoms is less than 3 months

Yes[] No[]

Chronic: If duration of symptoms is 3 months or more

Yes[] No[]

Delayed onset of symptoms: If onset of symptoms is at least 6 months after the stress.

Yes[] No[]

SCORE SHEET FOR STRUCTURED PTSD INTERVIEW

Total worst-ever score for all appropriate B,C, D items (ignore ratings of 9).

DSM-III-R _____
total

Total present (past 4 weeks or other designated period score for all appropriate B,C,D items (ignore ratings of 9)

DSM-III-R _____
total

Score **No** as **1**, **Yes** as **2**, to all answers below:

DSM-III-R diagnosis

	Past	Present
Traumatic event definitely present	_____	_____
At least one item from category B with score > 2	_____	_____
At least three items from category C with score of > 2	_____	_____
At least two items from category D with score of > 2	_____	_____
All items (categories B,C & D) present at least 1 month	_____	_____

Thank participant for participation in the intensity of interview questions. Introduce new theme of life now in Australia.

SEMI-STRUCTURED INTERVIEW

SECTION IV

PRESENT SITUATION

1 *HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING EVENTS IN AUSTRALIA?

- | | |
|--|-------|
| 1) * Serious physical injury | 1[] |
| 2) * Systematic physical & psychological torture | 2[] |
| 3) * Rape | 3[] |
| 4) * Assault | 4[] |
| 5) * Jail | 5[] |
| 6) * Being kidnapped | 6[] |
| 7) * Natural disaster: earthquake, flood, fire | 7[] |
| 8) * Seeing loss of life or your own life being threatened | 8[] |
| 9) * Witnessed violence in mass demonstrations | 9[] |
| 10) * Threats to your closest relatives (mother, father, son, daughter, partner, grand-parents, husband, wife, brother, or/and sister) | 10[] |
| 11) * Witnessed the killing of a member of your family or a friend | 11[] |
| 12) * Experienced disappearance of a relative or friend | 12[] |
| 13) * Witnessed organised violence in your home or physically close by | 13[] |
| 14) * Relative or friend in detention centre | 14[] |
| 15) * Search in your home by migration authorities | 15[] |
| 16) * Forced displacement | 16[] |
| 17) * Lived in a detention centre | 17[] |
| 18) * Other | 18[] |

1b) WHAT EFFECTS HAS THIS HAD?

2. HOW DO YOU FEEL ABOUT BEING HERE IN AUSTRALIA?

3. DO YOU LIKE PARTICULAR ASPECTS ABOUT AUSTRALIA?

Yes = 1 ____

No = 2 _____

4. IF YES, WHAT ARE THEY?

5. IF NO, WHAT ARE THEY?

7. DURING THE LAST 12 MONTHS HAVE ANY OF THE DIFFICULTIES LISTED BELOW BEEN A PROBLEM FOR YOU IN AUSTRALIA?

NO at all [1] A bit of a problem [2] Moderately [3] A serious problem [4]
A very serious problem [5]

- | | | |
|-----|--|-----|
| 1. | Communication difficulties | [] |
| 2. | Discrimination | [] |
| 3. | Separation from family | [] |
| 4. | Worries about family back home | [] |
| 5. | Unable to return home in Emergency | [] |
| 6. | No permission to work | [] |
| 7. | Not being able to find a job | [] |
| 8. | Bad job condition | [] |
| 9. | Being in detention | [] |
| 10. | Interviews by immigration | [] |
| 11. | Delays in processing your application | [] |
| 12. | Conflict with immigration officials | [] |
| 13. | Fears of being send home | [] |
| 14. | Worries about not getting treatment for health problems | [] |
| 15. | Poor access to emergency medical care | [] |
| 16. | Poor access to long term Medical care | [] |
| 17. | Poor access to dentistry care | [] |
| 18. | Poor access to counselling services | [] |
| 19. | Little government help with welfare | [] |
| 20. | Help from charities e.g. Red Cross | [] |
| 21. | Poverty | [] |
| 22. | Loneliness and Boredom | [] |
| 23. | Isolation | [] |
| 24. | Poor access to the food that you like. or traditional food | [] |

7. DO YOU EVER THINK OF RETURNING?

Appendix D 2

The GAF

The GAF is described as follows (DSM-III-R criteria):

- 90 Good functioning in all areas, interested and involved in a wide range
81 of activities, socially effective.
- 80 No more than slight impairment in social and occupational functioning (e.g.,
| missing a few deadlines or appointments) or school functioning (e.g.,
71 temporarily falling behind in school work)
- 70 Some difficulty in social or occupational functioning (e.g., frequent work
| absences, work occasionally incomplete or judged "not up to standards") or
| school functioning (e.g., occasional truancy, or theft within the household) but
| generally functioning pretty well; has some meaningful interpersonal
61 relationships
- 60 Moderate difficulty in social, occupational, or school functioning (e.g., few
| friends, conflicts with co-workers, unable to complete work assignments,
51 unsatisfactory work performance)
- 50 Serious impairment in social, occupational, or school functioning (e.g.,
41 no friends, unable to keep a job at expected or prior level of performance)

- 40 Major impairment in several areas, such as work or school, family relations,
| judgement (e.g., Avoids friends, neglects family, is unable to work; child
31 frequently beats up younger children, is failing at school)
- 30 Inability to function in almost all areas (e.g., stays in bed all day; no job,
21 home, or friends)
- 20 Occasionally fails to maintain minimal personal hygiene (e.g., smears faeces)
11 unable to function independently
- 10 Persistent inability to maintain minimal personal hygiene; unable to function
| without harming self or others or without considerable external support
01 (e.g., nursing care and supervision)

Select section and give a score based on the information following the interview

Appendix D3

ICD-10 Enduring Personality Change

The ICD-10 (WHO, 1992, 1993, 2010) includes in its diagnosis a category on enduring personality change after catastrophic experience (EPC). These changes are attributed to an extreme stress such as having lived in a concentration camp, torture, disaster, or prolonged exposure to a life threatening situation e.g. torture. This explores any change on the individual related to his personality. This includes:

	1=YES	
2=NO		
A hostile or mistrustful attitude towards the world	1[]	2[]
]		
Social withdrawal	1[]	2[]
]		
Feeling of emptiness or hopelessness	1[]	2[]
]		
A chronic feeling of being "on edge", as if constantly threatened	1[]	2[]
]		
Estrangement	1[]	2[]
]		

Another criteria is that the change in the individual's personality should have been present for two years

Appendix D 4

SCL-90-R[®] SIDE _____

INSTRUCTIONS:

Below is a list of problems people sometimes have. Please read each one carefully, and circle the number to the right that best describes HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. Circle only one number for each problem and do not skip any items. If you change your mind, erase your first mark carefully. Read the example below before beginning, and if you have any questions please ask about them.

SEX

MALE

FEMALE

NAME _____

LOCATION _____

EDUCATION _____

MARITAL STATUS: MAR ___ SEP ___ DIV ___ WID ___ SING ___

DATE		
MO	DAY	YEAR

ID. NUMBER

AGE

EXAMPLE

HOW MUCH WERE YOU DISTRESSED BY:

	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Bodyaches	0	1	2	3	4

HOW MUCH WERE YOU DISTRESSED BY:

		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Headaches	1	0	1	2	3	4
2. Nervousness or shakiness inside	2	0	1	2	3	4
3. Repeated unpleasant thoughts that won't leave your mind	3	0	1	2	3	4
4. Faintness or dizziness	4	0	1	2	3	4
5. Loss of sexual interest or pleasure	5	0	1	2	3	4
6. Feeling critical of others	6	0	1	2	3	4
7. The idea that someone else can control your thoughts	7	0	1	2	3	4
8. Feeling others are to blame for most of your troubles	8	0	1	2	3	4
9. Trouble remembering things	9	0	1	2	3	4
10. Worried about sloppiness or carelessness	10	0	1	2	3	4
11. Feeling easily annoyed or irritated	11	0	1	2	3	4
12. Pains in heart or chest	12	0	1	2	3	4
13. Feeling afraid in open spaces or on the streets	13	0	1	2	3	4
14. Feeling low in energy or slowed down	14	0	1	2	3	4
15. Thoughts of ending your life	15	0	1	2	3	4
16. Hearing voices that other people do not hear	16	0	1	2	3	4
17. Trembling	17	0	1	2	3	4
18. Feeling that most people cannot be trusted	18	0	1	2	3	4
19. Poor appetite	19	0	1	2	3	4
20. Crying easily	20	0	1	2	3	4
21. Feeling shy or uneasy with the opposite sex	21	0	1	2	3	4
22. Feelings of being trapped or caught	22	0	1	2	3	4
23. Suddenly scared for no reason	23	0	1	2	3	4
24. Temper outbursts that you could not control	24	0	1	2	3	4
25. Feeling afraid to go out of your house alone	25	0	1	2	3	4
26. Blaming yourself for things	26	0	1	2	3	4
27. Pains in lower back	27	0	1	2	3	4
28. Feeling blocked in getting things done	28	0	1	2	3	4
29. Feeling lonely	29	0	1	2	3	4
30. Feeling blue	30	0	1	2	3	4
31. Worrying too much about things	31	0	1	2	3	4
32. Feeling no interest in things	32	0	1	2	3	4
33. Feeling fearful	33	0	1	2	3	4
34. Your feelings being easily hurt	34	0	1	2	3	4
35. Other people being aware of your private thoughts	35	0	1	2	3	4

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HOW MUCH WERE YOU DISTRESSED BY

	0	1	2	3	4
36. Feeling others do not understand you or are unsympathetic	0	1	2	3	4
37. Feeling that people are unfriendly or dislike you	0	1	2	3	4
38. Having to do things very slowly to insure correctness	0	1	2	3	4
39. Heart pounding or racing	0	1	2	3	4
40. Nausea or upset stomach	0	1	2	3	4
41. Feeling inferior to others	0	1	2	3	4
42. Soreness of your muscles	0	1	2	3	4
43. Feeling that you are watched or talked about by others	0	1	2	3	4
44. Trouble falling asleep	0	1	2	3	4
45. Having to check and double-check what you do	0	1	2	3	4
46. Difficulty making decisions	0	1	2	3	4
47. Feeling afraid to travel on buses, subways, or trains	0	1	2	3	4
48. Trouble getting your breath	0	1	2	3	4
49. Hot or cold spells	0	1	2	3	4
50. Having to avoid certain things, places, or activities because they frighten you	0	1	2	3	4
51. Your mind going blank	0	1	2	3	4
52. Numbness or tingling in parts of your body	0	1	2	3	4
53. A lump in your throat	0	1	2	3	4
54. Feeling hopeless about the future	0	1	2	3	4
55. Trouble concentrating	0	1	2	3	4
56. Feeling weak in parts of your body	0	1	2	3	4
57. Feeling tense or keyed up	0	1	2	3	4
58. Heavy feelings in your arms or legs	0	1	2	3	4
59. Thoughts of death or dying	0	1	2	3	4
60. Overeating	0	1	2	3	4
61. Feeling uneasy when people are watching or talking about you	0	1	2	3	4
62. Having thoughts that are not your own	0	1	2	3	4
63. Having urges to beat, injure, or harm someone	0	1	2	3	4
64. Awakening in the early morning	0	1	2	3	4
65. Having to repeat the same actions such as touching, counting, or washing	0	1	2	3	4
66. Sleep that is restless or disturbed	0	1	2	3	4
67. Having urges to break or smash things	0	1	2	3	4
68. Having ideas or beliefs that others do not share	0	1	2	3	4
69. Feeling very self-conscious with others	0	1	2	3	4
70. Feeling uneasy in crowds, such as shopping or at a movie	0	1	2	3	4
71. Feeling everything is an effort	0	1	2	3	4
72. Spells of terror or panic	0	1	2	3	4
73. Feeling uncomfortable about eating or drinking in public	0	1	2	3	4
74. Getting into frequent arguments	0	1	2	3	4
75. Feeling nervous when you are left alone	0	1	2	3	4
76. Others not giving you proper credit for your achievements	0	1	2	3	4
77. Feeling lonely even when you are with people	0	1	2	3	4
78. Feeling so restless you couldn't sit still	0	1	2	3	4
79. Feelings of worthlessness	0	1	2	3	4
80. The feeling that something bad is going to happen to you	0	1	2	3	4
81. Shouting or throwing things	0	1	2	3	4
82. Feeling afraid you will faint in public	0	1	2	3	4
83. Feeling that people will take advantage of you if you let them	0	1	2	3	4
84. Having thoughts about sex that bother you a lot	0	1	2	3	4
85. The idea that you should be punished for your sins	0	1	2	3	4
86. Thoughts and images of a frightening nature	0	1	2	3	4
87. The idea that something serious is wrong with your body	0	1	2	3	4
88. Never feeling close to another person	0	1	2	3	4
89. Feelings of guilt	0	1	2	3	4
90. The idea that something is wrong with your mind	0	1	2	3	4

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Appendix D 5

Impact of Event Scale

Many people experience unusually stressful events from time to time in their lives. This includes such things as car accidents, rape, death of close family member, assault, floods, tornados, fires, airplane accidents, near drowning, witnessing a life threatening event, torture, incarceration, child abuse (sexual, physical or both), wife beating, sexual assault, robbery, being with someone who is critically ill, etc.

Below is a list of comments made by people after stressful life events. Please check each item indicating how frequently these comments were true for you DURING THE PAST SEVEN DAYS. If they did not occur during that time, please mark the “not at all” column.

		1	2	3	4
		Not at all	Rare	Sometimes	Often
1	I thought about it when I did not mean to				
2	I avoided letting myself get upset when I thought about it or was reminded of it				
3	I tried to remove it from my memory				
4	I had trouble falling asleep or staying asleep				
5	I had waves of strong feelings about it				
6	I had dreams about it				
7	I stayed away from reminders of it				
8	I felt as if it had not happened or it was not real				
9	I tried not to talk about it				
10	Pictures about it popped into my mind				
11	Other things kept making me think about it				
12	I was aware that I still had a lot of feeling about it, but I did not deal with them				
13	I tried not to think about it				
14	Any reminder brought back feelings about it				
15	My feelings were kind of numb				

Appendix D6

GRID: SELF VIEW

Circle the number between 1 and 7 that indicates how you view yourself according to each of the descriptions below, that is do you see yourself closer to the 7 (unhealthy person) or middle, 4 or closer to 1 (healthy person)

Self before having lived through the most stressful (traumatic) experience									SCORE
Healthy	1	2	3	4	5	6	7	Unhealthy	
Happy	1	2	3	4	5	6	7	Sad	
Knowledgeable	1	2	3	4	5	6	7	Ignorant	
Patient	1	2	3	4	5	6	7	Impatient	
Not lonely	1	2	3	4	5	6	7	Lonely	
Dreamer	1	2	3	4	5	6	7	Realist	
Romantic	1	2	3	4	5	6	7	Un-romantic	
Enthusiastic	1	2	3	4	5	6	7	Un-enthusiastic	
Open-person	1	2	3	4	5	6	7	Closed-person	
Ambitious	1	2	3	4	5	6	7	Un-ambitious	
Not-vulnerable	1	2	3	4	5	6	7	Vulnerable	
Optimistic	1	2	3	4	5	6	7	Pessimistic	
Relaxed	1	2	3	4	5	6	7	Tense	
Secure	1	2	3	4	5	6	7	Insecure	
Not-bitter	1	2	3	4	5	6	7	Bitter	
Intelligent	1	2	3	4	5	6	7	Stupid	
Independent	1	2	3	4	5	6	7	Dependent	
Unfearful	1	2	3	4	5	6	7	Fearful	
Fighter	1	2	3	4	5	6	7	Non-fighter	
Trustful	1	2	3	4	5	6	7	Mistrustful	
Free	1	2	3	4	5	6	7	Imprisoned	

Self at the time of your most stressful (traumatic) experience									SCORE
Healthy	1	2	3	4	5	6	7	Unhealthy	
Happy	1	2	3	4	5	6	7	Sad	
Knowledgeable	1	2	3	4	5	6	7	Ignorant	
Patient	1	2	3	4	5	6	7	Impatient	
Not lonely	1	2	3	4	5	6	7	Lonely	
Dreamer	1	2	3	4	5	6	7	Realist	
Romantic	1	2	3	4	5	6	7	Un-romantic	
Enthusiastic	1	2	3	4	5	6	7	Un-enthusiastic	
Open-person	1	2	3	4	5	6	7	Closed-person	
Ambitious	1	2	3	4	5	6	7	Un-ambitious	
Not-vulnerable	1	2	3	4	5	6	7	Vulnerable	
Optimistic	1	2	3	4	5	6	7	Pessimistic	
Relaxed	1	2	3	4	5	6	7	Tense	
Secure	1	2	3	4	5	6	7	Insecure	
Not-bitter	1	2	3	4	5	6	7	Bitter	
Intelligent	1	2	3	4	5	6	7	Stupid	
Independent	1	2	3	4	5	6	7	Dependent	
Unfearful	1	2	3	4	5	6	7	Fearful	
Fighter	1	2	3	4	5	6	7	Non-fighter	
Trustful	1	2	3	4	5	6	7	Mistrustful	
Free	1	2	3	4	5	6	7	Imprisoned	

Self just after having lived through the most stressful (traumatic) experience									SCORE
Healthy	1	2	3	4	5	6	7	Unhealthy	
Happy	1	2	3	4	5	6	7	Sad	
Knowledgeable	1	2	3	4	5	6	7	Ignorant	
Patient	1	2	3	4	5	6	7	Impatient	
Not lonely	1	2	3	4	5	6	7	Lonely	
Dreamer	1	2	3	4	5	6	7	Realist	
Romantic	1	2	3	4	5	6	7	Un-romantic	
Enthusiastic	1	2	3	4	5	6	7	Un-enthusiastic	
Open-person	1	2	3	4	5	6	7	Closed-person	
Ambitious	1	2	3	4	5	6	7	Un-ambitious	
Not-vulnerable	1	2	3	4	5	6	7	Vulnerable	
Optimistic	1	2	3	4	5	6	7	Pessimistic	
Relaxed	1	2	3	4	5	6	7	Tense	
Secure	1	2	3	4	5	6	7	Insecure	
Not-bitter	1	2	3	4	5	6	7	Bitter	
Intelligent	1	2	3	4	5	6	7	Stupid	
Independent	1	2	3	4	5	6	7	Dependent	
Unfearful	1	2	3	4	5	6	7	Fearful	
Fighter	1	2	3	4	5	6	7	Non-fighter	
Trustful	1	2	3	4	5	6	7	Mistrustful	
Free	1	2	3	4	5	6	7	Imprisoned	

Self as a migrant/ refugee/ asylum seeker/ asylum seeker in detention									SCORE
Healthy	1	2	3	4	5	6	7	Unhealthy	
Happy	1	2	3	4	5	6	7	Sad	
Knowledgeable	1	2	3	4	5	6	7	Ignorant	
Patient	1	2	3	4	5	6	7	Impatient	
Not lonely	1	2	3	4	5	6	7	Lonely	
Dreamer	1	2	3	4	5	6	7	Realist	
Romantic	1	2	3	4	5	6	7	Un-romantic	
Enthusiastic	1	2	3	4	5	6	7	Un-enthusiastic	
Open-person	1	2	3	4	5	6	7	Closed-person	
Ambitious	1	2	3	4	5	6	7	Un-ambitious	
Not-vulnerable	1	2	3	4	5	6	7	Vulnerable	
Optimistic	1	2	3	4	5	6	7	Pessimistic	
Relaxed	1	2	3	4	5	6	7	Tense	
Secure	1	2	3	4	5	6	7	Insecure	
Not-bitter	1	2	3	4	5	6	7	Bitter	
Intelligent	1	2	3	4	5	6	7	Stupid	
Independent	1	2	3	4	5	6	7	Dependent	
Unfearful	1	2	3	4	5	6	7	Fearful	
Fighter	1	2	3	4	5	6	7	Non-fighter	
Trustful	1	2	3	4	5	6	7	Mistrustful	
Free	1	2	3	4	5	6	7	Imprisoned	

Self Right Now (time at interview)									SCORE
Healthy	1	2	3	4	5	6	7	Unhealthy	
Happy	1	2	3	4	5	6	7	Sad	
Knowledgeable	1	2	3	4	5	6	7	Ignorant	
Patient	1	2	3	4	5	6	7	Impatient	
Not lonely	1	2	3	4	5	6	7	Lonely	
Dreamer	1	2	3	4	5	6	7	Realist	
Romantic	1	2	3	4	5	6	7	Un-romantic	
Enthusiastic	1	2	3	4	5	6	7	Un-enthusiastic	
Open-person	1	2	3	4	5	6	7	Closed-person	
Ambitious	1	2	3	4	5	6	7	Un-ambitious	
Not-vulnerable	1	2	3	4	5	6	7	Vulnerable	
Optimistic	1	2	3	4	5	6	7	Pessimistic	
Relaxed	1	2	3	4	5	6	7	Tense	
Secure	1	2	3	4	5	6	7	Insecure	
Not-bitter	1	2	3	4	5	6	7	Bitter	
Intelligent	1	2	3	4	5	6	7	Stupid	
Independent	1	2	3	4	5	6	7	Dependent	
Unfearful	1	2	3	4	5	6	7	Fearful	
Fighter	1	2	3	4	5	6	7	Non-fighter	
Trustful	1	2	3	4	5	6	7	Mistrustful	
Free	1	2	3	4	5	6	7	Imprisoned	

Self TEN YEARS FROM NOW									SCORE
Healthy	1	2	3	4	5	6	7	Unhealthy	
Happy	1	2	3	4	5	6	7	Sad	
Knowledgeable	1	2	3	4	5	6	7	Ignorant	
Patient	1	2	3	4	5	6	7	Impatient	
Not lonely	1	2	3	4	5	6	7	Lonely	
Dreamer	1	2	3	4	5	6	7	Realist	
Romantic	1	2	3	4	5	6	7	Un-romantic	
Enthusiastic	1	2	3	4	5	6	7	Un-enthusiastic	
Open-person	1	2	3	4	5	6	7	Closed-person	
Ambitious	1	2	3	4	5	6	7	Un-ambitious	
Not-vulnerable	1	2	3	4	5	6	7	Vulnerable	
Optimistic	1	2	3	4	5	6	7	Pessimistic	
Relaxed	1	2	3	4	5	6	7	Tense	
Secure	1	2	3	4	5	6	7	Insecure	
Not-bitter	1	2	3	4	5	6	7	Bitter	
Intelligent	1	2	3	4	5	6	7	Stupid	
Independent	1	2	3	4	5	6	7	Dependent	
Unfearful	1	2	3	4	5	6	7	Fearful	
Fighter	1	2	3	4	5	6	7	Non-fighter	
Trustful	1	2	3	4	5	6	7	Mistrustful	
Free	1	2	3	4	5	6	7	Imprisoned	

Appendix E

Participant Information Plain Language Statement and Participant Consent Form

Appendix E1

Participant Information Plain Language Statement

A study is being undertaken by the University of Melbourne, Department of Psychiatry. The study is investigating the consequences of systemic abuse including torture and consequences of migration and its process.

The study is presently seeking the participation of individuals who are living in Australia regardless of their residential status. The study aims to better understand the impact of migration and pre-migration experiences have had on people from different have come to Australia from different regions of the world. The research aims also to assist health services in providing appropriate support for survivors of torture and other types of systemic abuse.

The interview will take proximally 3-4 hours and includes the completion of self-report health questionnaires.

All information is **strictly confidential** and **no names** are recorded. Your consent to the study will be formally requested prior to undertaking the interview and this form is kept by you. A number will be given to each interview as they are entered for analysis, not your name. Information will be published and public presentations of research findings will be presented. Anonymity will be adhered to in any documentation. However we cannot guarantee how others may interpret and quote the findings.

We hope that the study will lead to better care for many people as well as publicising the situations that bring people to Australia. Your participation will be of significant value and greatly appreciated.

If you can assist in the research please contact Maritza Thompson on ph: 93892281 between 9.30am and 3pm Monday to Friday.

Appendix E2

Participant Consent Form

I understand the purpose of the research is to further understand the extent to which torture and other forms of systemic abuse have an effect on people and their families.

I understand the purpose of the interview and research and wish to participate. I give consent for the interview to be recorded for the sole purpose of this research. I do this on the understanding that if I find this interview to be distressing I can withdraw at any time. I understand that identification details such as name and address will be deleted.

Signature

Date

Researcher:

I have fully explained the aims, risks and procedures of the research to the participant and I agree with the conditions of the participant.

Signature

Date

Cross-cultural worker

I promise as a cross-cultural worker I am here to only facilitate the process of interview by assisting the participant with language issues and the researcher. I promise to keep all information confidential. I do not take any of the material with me and understand the agreements described above.

Signature

Date

Appendix F

Ethical Issues and Principles to Consider When Researching the Impact of Torture, Other Types of Systemic Abuse and Seeking Asylum

The research methodology adopted ethical principles to investigate the psychological impact of torture and other types of systemic abuse on refugees that were in accordance with the study by Thompson and McGorry (1995). Overall four main principles were adopted in this research: 1. a humanitarian approach to research; 2. a compassionate approach to interviewing and research overall; 3. a cross-cultural, sensitive approach; and 4. a psychotherapeutic approach to interviewing. These four principles are in accord with the International Rehabilitation Council for Torture Victims (2007); Gurr and Quiroga, (2001); Marsella, 2001; Quiroga and Jaranson (2005) and Watters (2010).

A humanitarian approach to research.

Some of the participants had been forced to leave their country due to political and social repression, war, and/or economic instability, some had been forced to choose between staying in their country and risk their lives or leave as a result of the political and/or economic instability. Others were forced to leave and ended up in refugee camps or were living temporarily in a host country. Those who left by force or voluntarily, resulting from the systemic abuse and threats to their life, leave with their trust towards systems and governments shattered (International Rehabilitation Council for Torture Victims, 2007; Gurr and Quiroga, 2001, Silove & Kinzie, 2001). They mostly leave looking for a better future in a safe environment. Some of the concern from the

participants might relate to; whether the researcher is representing a government organisation that they do not trust, whether this research might affect their immigration process or their life in general in a negative way (Marsella, 2001; Silove & Kinzie, 2001).

Participants must not be defined only by their recent traumatic experiences. They are individuals, each with a past that contributed to their present being. An approach adopted by constructivist researchers when investigating the impact of war on Vietnam veterans and exploring therapeutic intervention with traumatised survivors, is that of exploring the whole life history of the individual, defining who they were prior to the traumatic experience, during and after their traumatic experience (Klion & Pfenninger, 1996). The purpose of this process is to assist survivors in redefining their roles as individuals within a society other than just the 'war victim' or as in this case the 'torture survivor'. This will make the interview a more psychotherapeutic interview rather than a dry; question and answer type of interview which has the potential of becoming more like an interrogation (Gurr & Quiroga, 2001; Marsella, 2001).

Somnier et al., (1992) stated that some research in the area of torture failed to consider other traumas in the individual's life that might influence the person's presentation, as well as the cultural aspects that assist survivors with their coping mechanism. Some of the issues encountered in these studies are no different to research in the area of migrant mental health, where methodological problems are also present due to sample selection, language barriers and the use of limited interviews and instruments (Marsella, 2001).

A compassionate approach.

Compassionate interactions, confidentiality, empathy, are the most important elements in making an interview both possible and worth doing (Gurr & Quiroga, 2001; Marsella, 2001; Thompson and McGorry, 1995). In developing a model for interviewing participants in this study the methodology gives consideration to the mistrust survivors of torture and other systemic abuse have towards anything that might resemble an interrogation rather than an interview (Gurr and Quiroga, 2001; Marsella, 2001; Thompson and McGorry, 1995). Robertson (2000) reported the main principal in working with survivors of systemic abuse is the importance of respecting the survivor's history and the need of validating the survivors' life experience including the traumatic experience. It is essential that researchers have empathic and active listening skills so as to achieve a respectful relationship with traumatised survivors of systemic abuse and war (Gurr and Quiroga, 2001; International Rehabilitation Council for Torture Victims, 2007; Robertson, 2000). These skills were viewed as essential for interviewing survivors of torture or other systemic abuse in this study.

A cross cultural sensitive approach.

Participants in this research were from a variety of ethnic backgrounds representing a diversity of cultures with different political views, religious beliefs and traditional values on how they go about their everyday living. When researching the implication of torture and other systemic abuse on refugees it is important to avoid attributing behaviour or emotional responses necessarily to a cultural attitude alone and not to the actual trauma itself (Gurr and Quiroga, 2001; Ishisaka et al., 1985; Kinzie, 2011; Montgomery & Patel, 2011). The researcher must be cautious about the interpretation of behaviours and the symptoms presented by survivors. When exploring individual responses to torture or other forms of systemic abuse, the researcher must be open to learn from the participant and tease out what is culturally appropriate behaviour

and what is a real symptom resulting from these experiences which might place the person at risk of psychiatric disorder (Kinzie, 2011; Mollica and Lavelle, 1987; Watters, 2010).

Any research that neglects cross cultural issues runs the risk of serious misunderstanding. Watters (2010) quotes a representative of the World Health Organisation who witnessed the lack of cultural and language awareness among counsellors and researchers in the weeks following the Sri Lankan tsunami. He compared such failure to the issuing of wrong medication. The model adopted in this thesis attempted to take into consideration cultural appropriate behaviour as a response to everyday life situations and considers, with the participants, what might not be appropriate and explores their attitude, reactions and feelings about these experiences in relation to other life experiences they have encountered in their life journey. The refugees' life experiences, including the traumatic experience itself, is explored and the impact on their psychological wellbeing is conducted in a way whereby, both, the researcher and the participant process these experiences, eliciting what their impact had been on the wellbeing of the participant.

Australia faces the problem in research that there are so many different languages spoken that translation or interpreting is often beyond the cost estimated in research (Thompson and McGorry 1995). Often costs are not incorporated due to the lack of knowledge of the researcher about the need for interpreting resulting in a criterion for subject participation being based on the fact that they speak English. This immediately reduces the chances of meeting the person within their own culture, which allow them to express themselves in the language in which they had experienced the trauma, and give meaning to their experience. The cost, time requirements and compassion were key elements incorporated into this research. The empirical implications were considered at

all times but not at the cost of the individual; above all compassionate and cultural understanding were key factors in order to gain depth in understanding the implication of torture.

Therefore where needed, interpreters, in this research referred to as cross-cultural workers, were employed and trained on the psychometric scales and structured interview. The cross-cultural workers assisted in bringing cultural knowledge to the researcher giving a better understanding about what symptoms were related to the experience itself and what might be seen as normal in the participant's culture. This research employed the same cross-cultural workers throughout the research and they spoke the following languages: Farsi; Amharic, Oromo; Somali, Arabic; Turkish; Tamil. They all met with the researcher weekly and discussed outcomes of interviews and issues related to the interviews.

In creating this model the researcher and cross-cultural workers had to be clear of their own world view; that is, their own values and beliefs, so no pre-judgments were made when meeting the participants (Gurr and Quiroga, 2001; Montgomery & Patel, 2011). Also, the concept of universality needed to be constantly challenged, so that no assumptions are made that all people from a particular country would share the same family values or dominant traditions or similar history of repression. Similarly, we had to keep in mind that within one culture there are many subcultures.

The area of research relating to trauma raises the ongoing discussion around assessments and interventions in cross cultural environments and the need to understand culture when exploring psychopathology from the point of view of one dominant culture studying a non dominant culture when using psychometric instruments (Gurr and Quiroga, 2001; Montgomery & Patel, 2011). For example, instruments such as the

Global Assessment of Functioning, DSM-III-R criteria (APA, 1987) and personality change on the basis of the ICD-10 criteria (WHO, 1992, 1993, 2010) have both been influenced by a dominant western culture (Kinzie, 2011; Watters 2010). Therefore, the scales used in this project and the criteria for assessments, including the criteria for PTSD (Davidson et al., 1989), were to be seen as instruments that facilitated the communication with the individual rather than solely instruments that measured a specific construct such as depression or anxiety (Jaranson et al., 2001; Marsella, 2001). Each item on the scales must be seen as an exploration about symptoms and behaviours that ‘might’ be common to individuals, regardless of their global cultural background; this view should also be in keeping with the criteria used to give a particular diagnosis (Jaranson et al., 2001; Marsella, 2001; Thompson & McGorry 1995). Therefore, the meaning of an item must also be meaningful for the interviewee regardless of their culture, for example in the SCL 90-R item 30 “feeling Blue”, the Spanish translation for this expression is “melancolia”; the translation into English is “melancholic” meaning sad, nostalgic (Thompson & McGorry 1995). These idiosyncrasies and definitions were prioritised as essential when communicating with participants from such a broad language and cultural diversity in this project. The principle has been to remain consistent with the words and most importantly to find a ‘meaning’ appropriate to the interviewee.

A psychotherapeutic approach

Jaranson et al., (2001); Marsella, (2001); Thompson & McGorry (1995) and, Wilson (2004) are examples of clinicians and researchers who have emphasised the importance of the therapist or researcher having to deal with issues of trust between therapist or the researcher and the survivor of systemic abuse. It was essential in this study for the researcher to achieve a level of trust when interviewing survivors of torture or other types of systemic abuse including asylum seekers. At any given time the

participant might reveal the torture experience leading to an increase in the participant's symptoms of anxiety, feelings of powerlessness, fear of persecution, shame and guilt. This anxiety could lead to resistance to further disclosure or the opposite whereby the participant might feel the urge to disclose their life history requiring the researcher to listen and be equipped to contain resulting symptoms. At the same time the researcher is covering questions for study purposes without harming the participant (Gurr and Quiroga, 2001; Physicians for Human Rights 2003; Marsella, 2001; Montgomery & Patel, 2011; Thompson and McGorry, 1994). Flexibility of time allocated to the interview should always be considered. In this study the interview allowed for disclosure of the experience. No limitation was set in terms of time. As stated by the Physicians for Human Rights (2001) a four hour interview may be required to assess adequately the physical and psychological implication of torture, therefore flexibility of time is essential. A subsequent interview or two might be required and there must be the opportunity for referral to a follow-up service where necessary (The Physicians for Human Rights, 2001).

Jaranson et al., 2001; Kinzie, 2011; Marsella, 2001, The Physicians for Human Rights, (2001) and Wilson (2004) emphasise the need to keep in mind, at all times, the challenges that both therapist or researcher and survivor have in building an effective level of trust and maintain a collaborative relationship if therapy is to work. Given the mistrust and suspicion the participants in this research might have around the intent of the research, the challenges for the researcher and the participant is no different to those stated by for example Marsella, (2001) or Wilson (2004), in developing a therapeutic relationship.

The study attempted to provide a non-threatening, trusting interview with individuals who were willing to participate and who were aware of all aspects of the study,

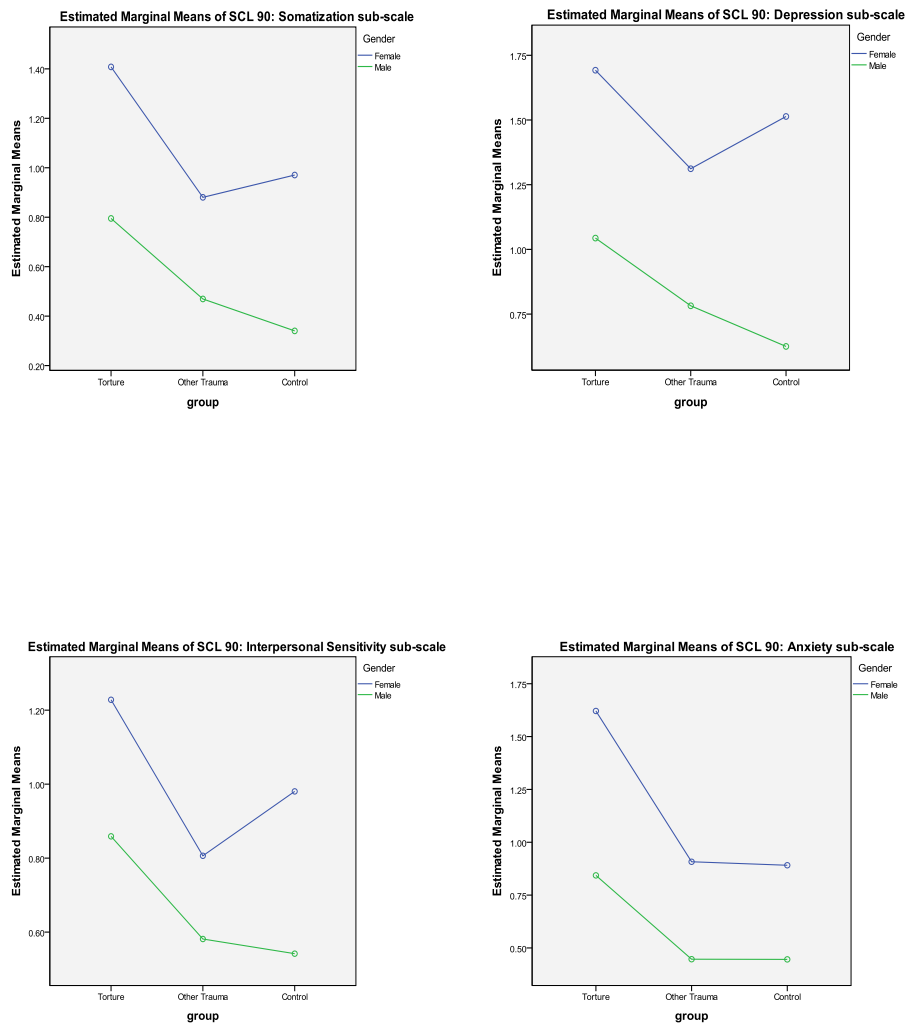
as was done by Thompson and McGorry (1995). The participants were at no time in doubt as to the purpose of the research or confused as to any benefits that might accrue (Watters 2010). It was important that the procedure did not resemble previous interrogations (Gurr, & Quiroga, 2001; International Rehabilitation Council for Torture Victims, 2007; Jakobsen, 1985, Thompson and McGorry, 1995). Participants were provided with the opportunity to terminate the interview at any stage and were referred to support services as required.

Appendix G

Interaction Between Groups (Survivors of Torture, Other Systemic Abuse and the Control Group) and Gender on the SCL-90-R, IES, GAF and PTSD

Figure G.1

SCL-90-R nine dimensions and the GSI



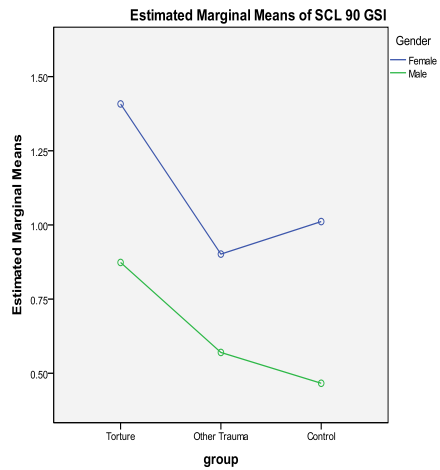
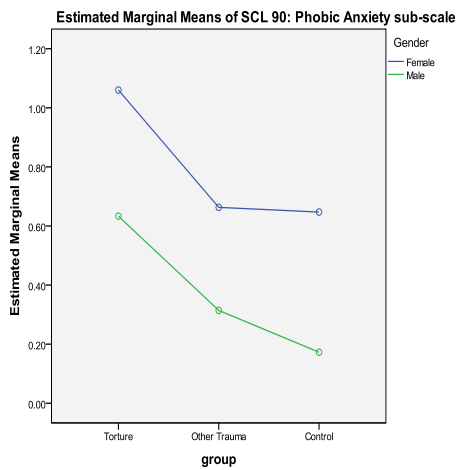
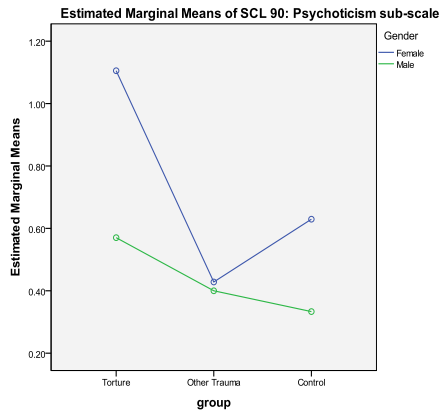
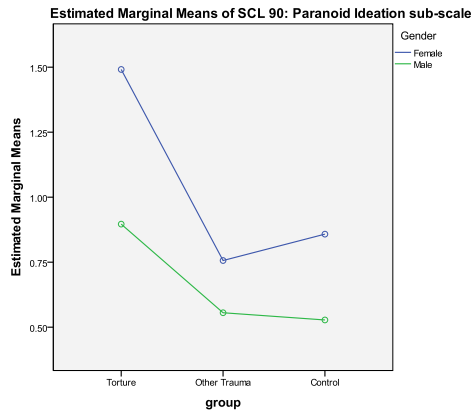
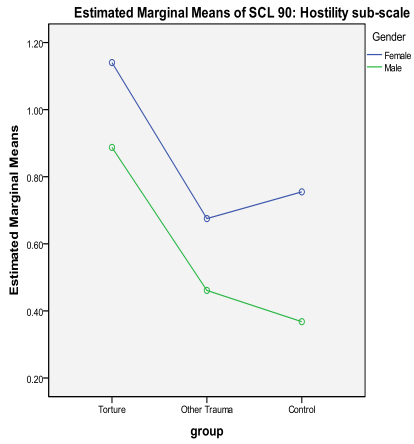
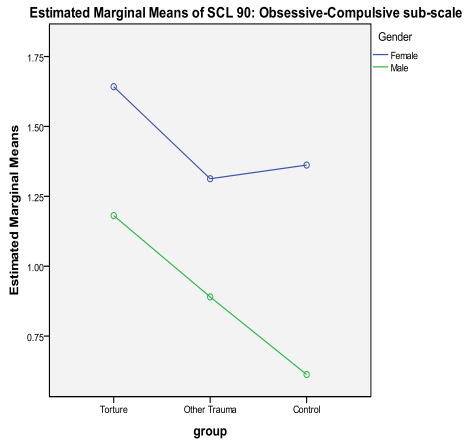


Figure G.2

IES Intrusion and Avoidance

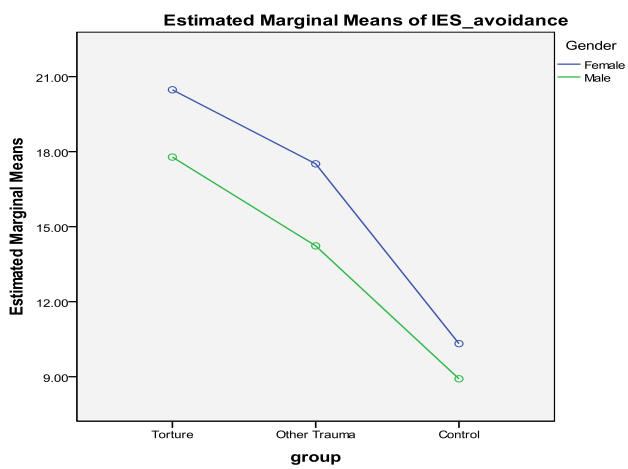
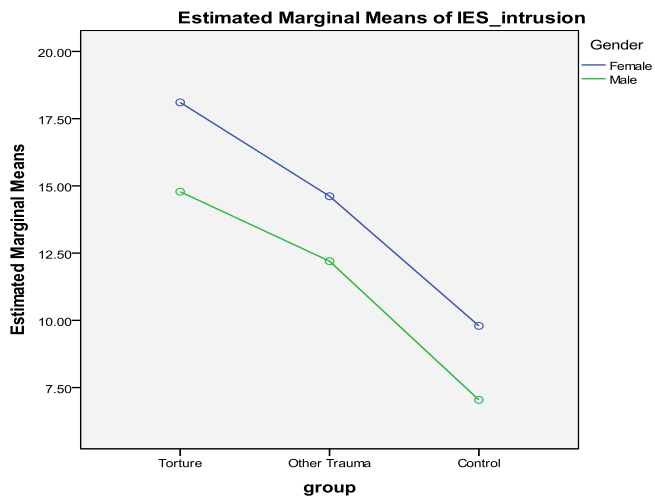


Figure G.3

PTSD Worst Ever and PTSD Last 4 Weeks

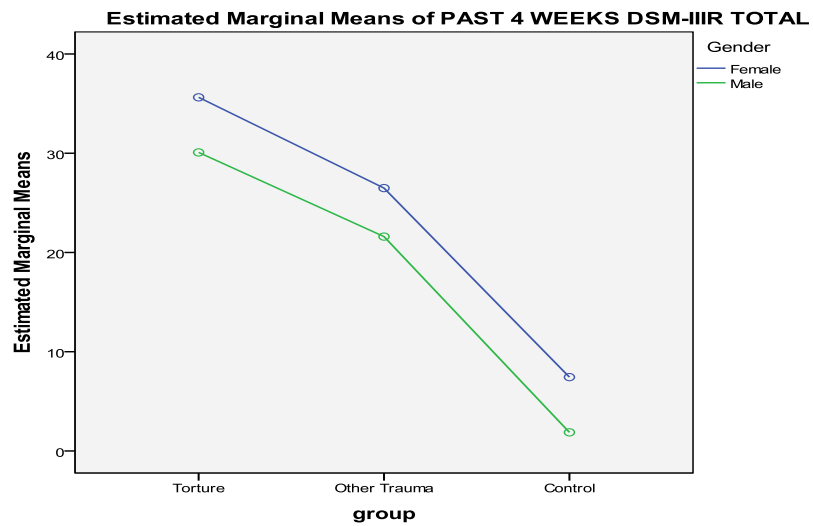
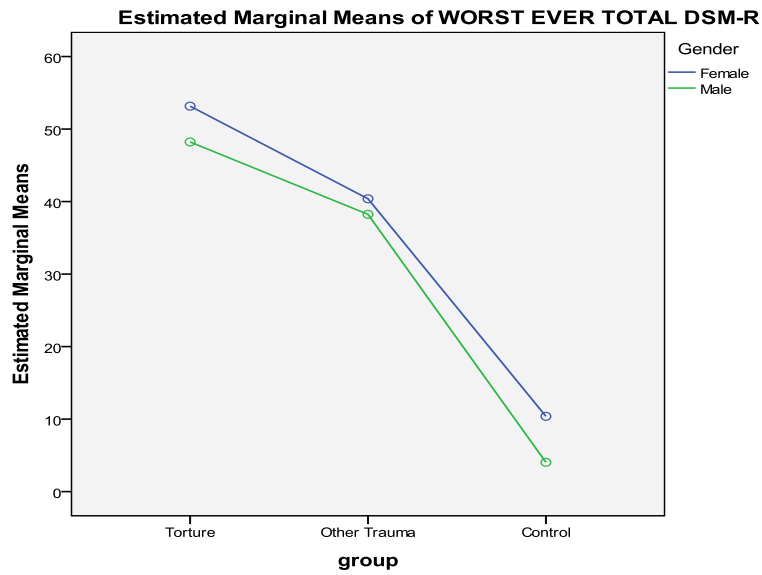
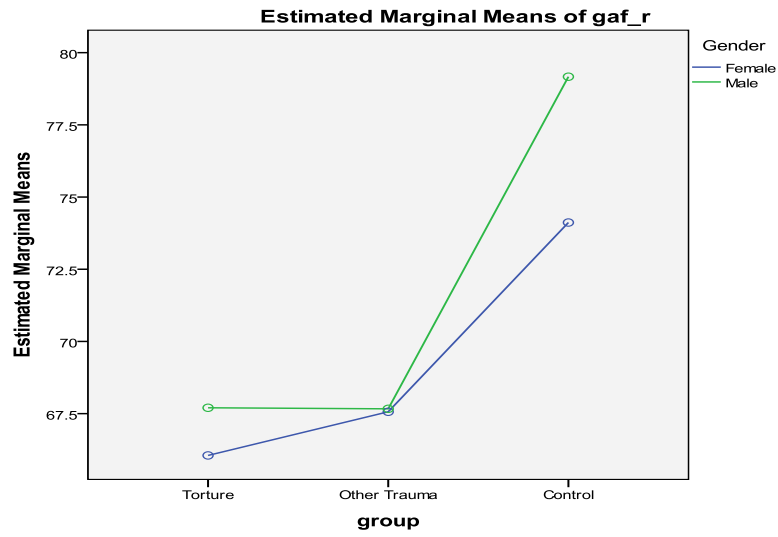


Figure G.4

GAF-R



Appendix H

Torture Techniques Reported by Torture Survivors

Torture techniques	Percentage of torture survivors reporting each torture technique n=98
Head trauma including 'Telefono'	95.9% (94)
Falanga/Falaka/Basinado	49.0% (48)
Insertion of instruments	26.5% (26)
Suspension (Various type)	69.4% (68)
Cross	38.8% (39)
Butchery suspension	38.8% (38)
Reverse butchery suspension	21.4% (21)
Suspension by the fore arm	42.9% (42)
Parrot perch	55.1% (54)
Application of electric shock/Parrilla/Picana	76.5% (75)
Deprivation	99.0% (97)
Asphyxiation/'Submarino/Water Boarding	98.0% (96)
Sexual torture	57.1% (56)
Beatings	99.0% (97)
Dental torture	33.7% (33)
Psychological torture	99.0% (97)
Verbal abuse	99.0% (97)
The use of animals to torture	26.6% (27)
Forced eating of excrement or use of chemicals in food	76.5% (75)

Note: For definition of torture techniques see Chapter 2

Appendix I

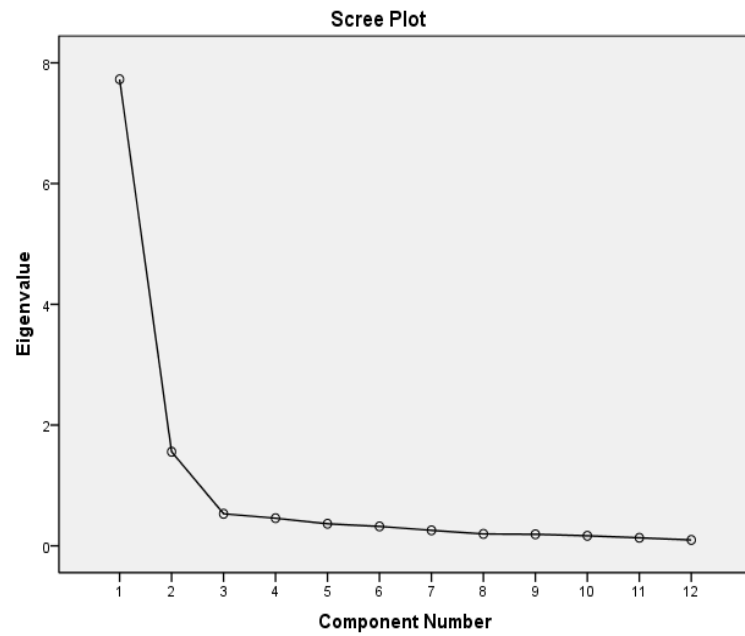
Factor Analysis: Correlation Matrix for all Measurements and Screen Plot

Appendix I1

Factor analysis: correlation matrix for all measurements

	SCL 90: Somatization	SCL 90: Obsessive-Compulsive	SCL 90: Interpersonal Sensitivity sub-scale	SCL 90: Depression sub-scale	SCL 90: Anxiety sub-scale	SCL 90: Hostility sub-scale	SCL 90: Phobic Anxiety	SCL 90: Paranoid Ideation sub-scale	SCL 90: Psychoticism sub-scale	IES_intrusion	IES_avoidance	PTSD last 4 week mean total
SCL 90: Somatization sub-scale	1.000	.725	.656	.792	.845	.633	.691	.687	.662	.558	.400	.495
SCL 90: Obsessive-Compulsive sub-scale	.725	1.000	.766	.765	.768	.665	.688	.728	.758	.486	.408	.428
SCL 90: Interpersonal Sensitivity sub-scale	.656	.766	1.000	.701	.761	.707	.702	.781	.799	.407	.346	.354
SCL 90: Depression sub-scale	.792	.765	.701	1.000	.807	.616	.611	.707	.651	.576	.386	.480
SCL 90: Anxiety sub-scale	.845	.768	.761	.807	1.000	.716	.809	.753	.785	.587	.444	.504
SCL 90: Hostility sub-scale	.633	.665	.707	.616	.716	1.000	.572	.725	.743	.371	.340	.367
SCL 90: Phobic Anxiety sub-scale	.691	.688	.702	.611	.809	.572	1.000	.633	.730	.472	.425	.444
SCL 90: Paranoid Ideation sub-scale	.687	.728	.781	.707	.753	.725	.633	1.000	.759	.454	.336	.425
SCL 90: Psychoticism sub-scale	.662	.758	.799	.651	.785	.743	.730	.759	1.000	.411	.346	.388
IES_intrusion	.558	.486	.407	.576	.587	.371	.472	.454	.411	1.000	.802	.724
IES_avoidance	.400	.408	.346	.386	.444	.340	.425	.336	.346	.802	1.000	.659
PTSD last 4 week mean total	.495	.428	.354	.480	.504	.367	.444	.425	.388	.724	.659	1.000

Appendix I2



Appendix J

Hierarchical Multiple Regression Analysis: Correlation Matrix for Intrusion, Avoidance and PTSD Last 4 Weeks

Intrusion

Avoidance

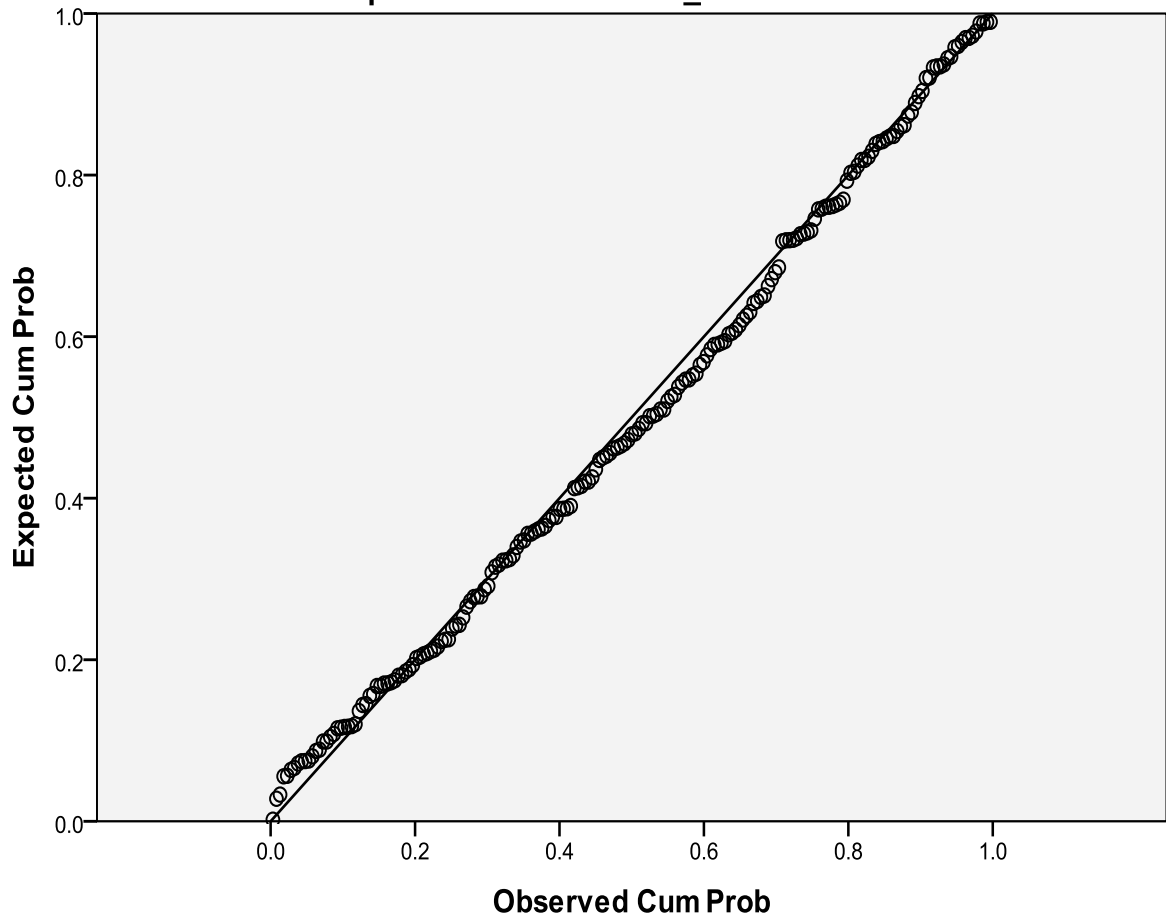
PTSD

Appendix K

**Regression: Standardised Residual; Normal Plot,
Scatter plot and Histogram for Intrusion, Avoidance
and PTSD (last 4 weeks).**

Appendix K 1

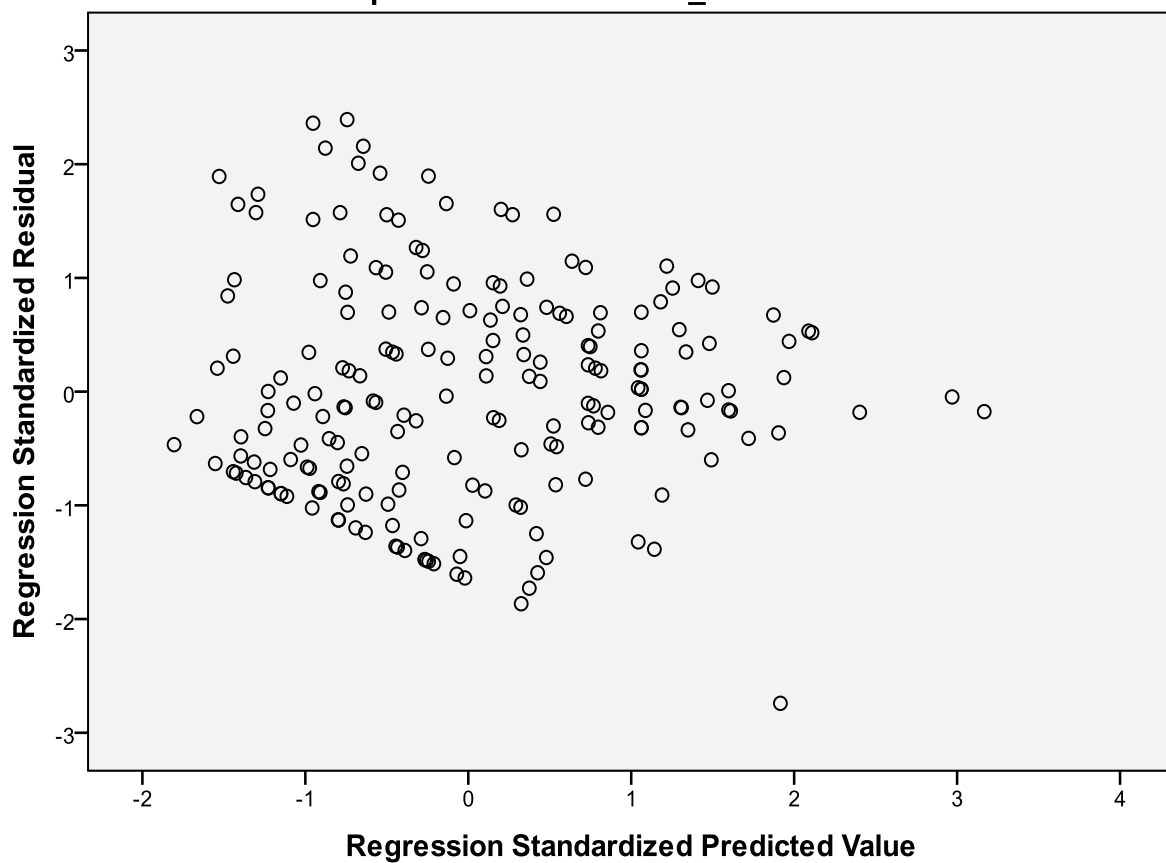
Normal P-P Plot of Regression Standardized Residual
Dependent Variable: IES_intrusion



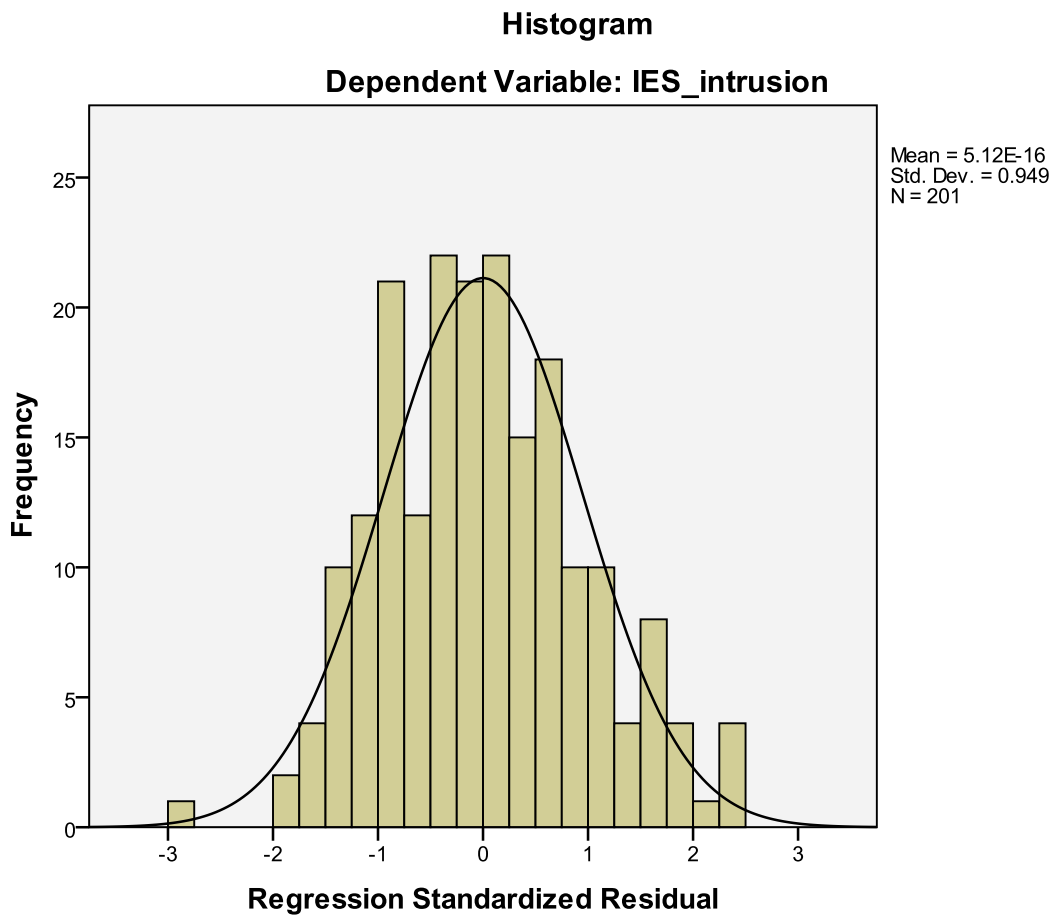
Appendix K 2

Scatterplot

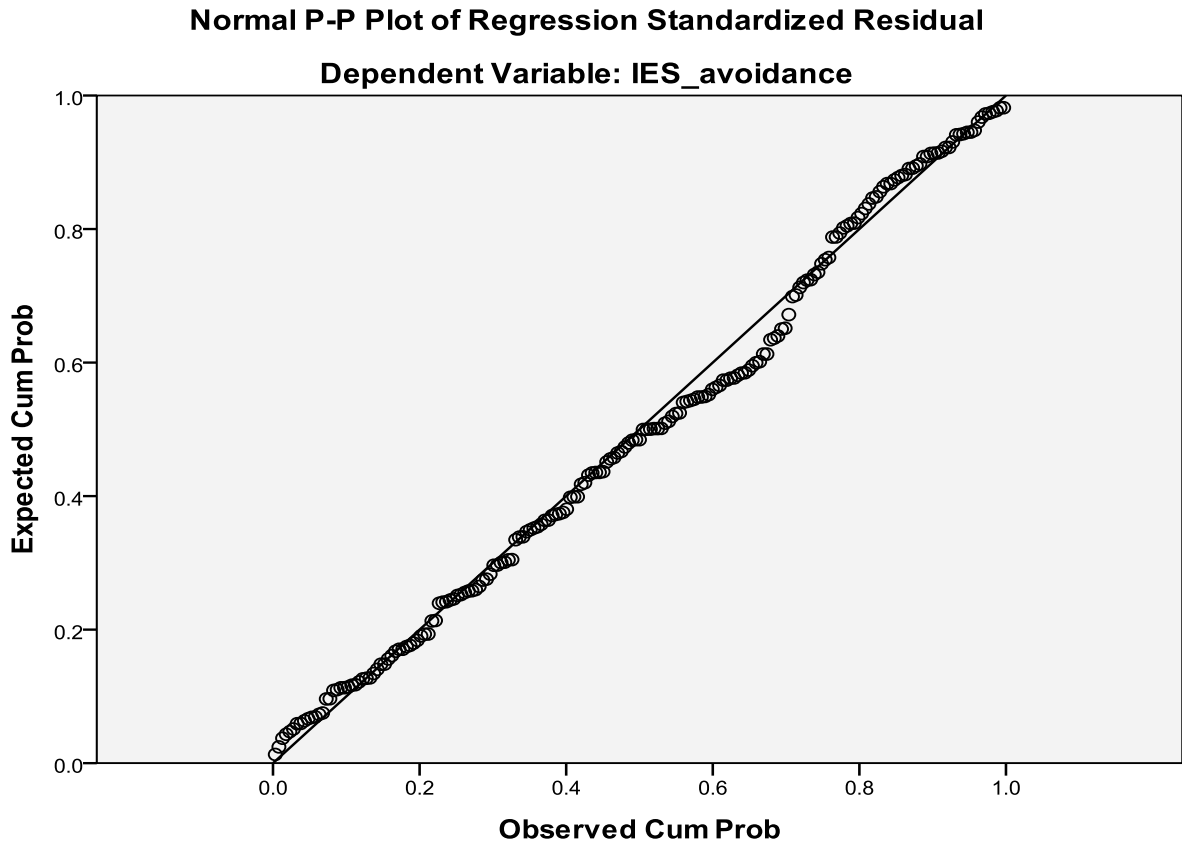
Dependent Variable: IES_intrusion



Appendix K 3



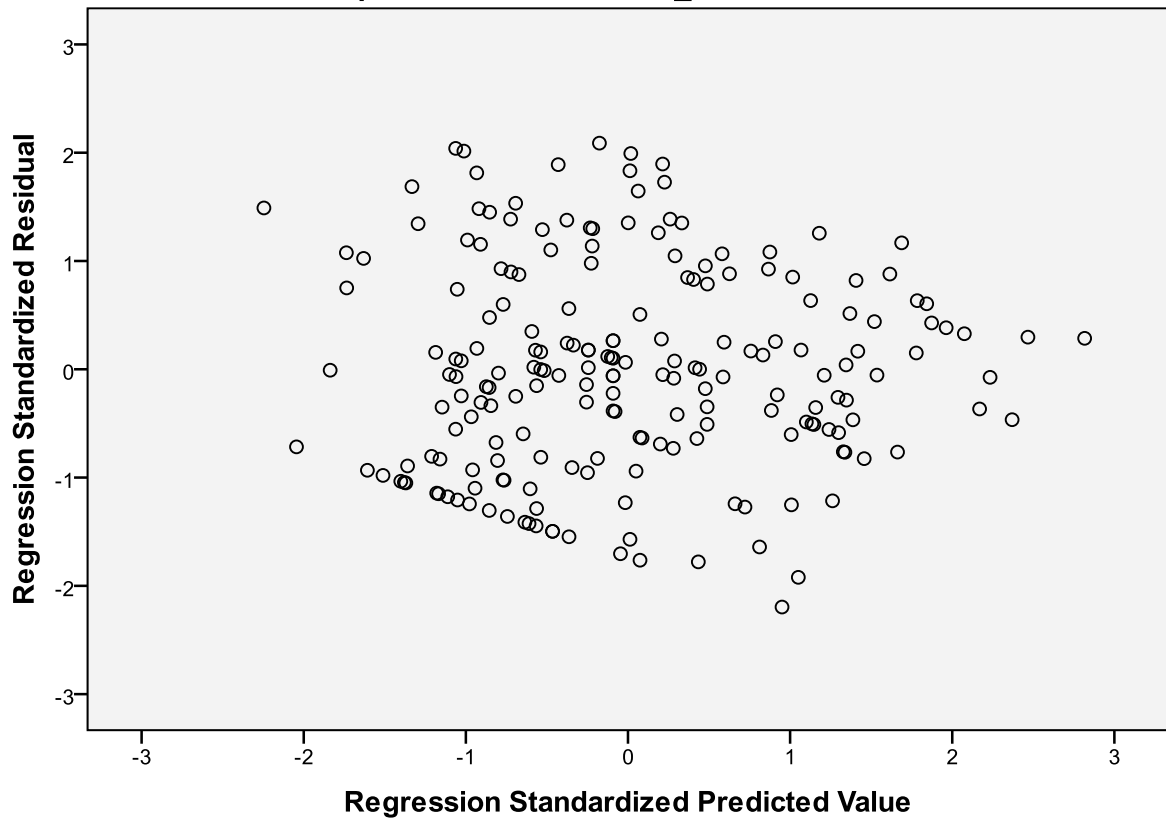
Appendix K 4



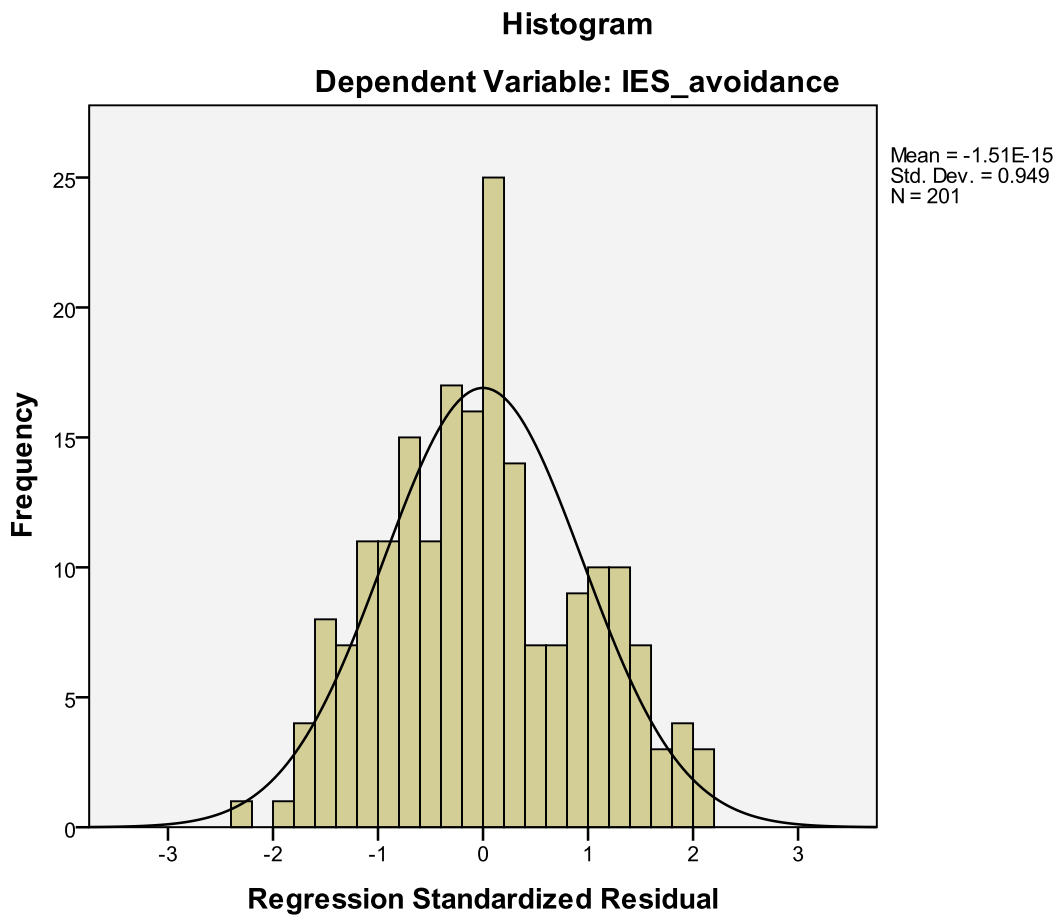
Appendix K 5

Scatterplot

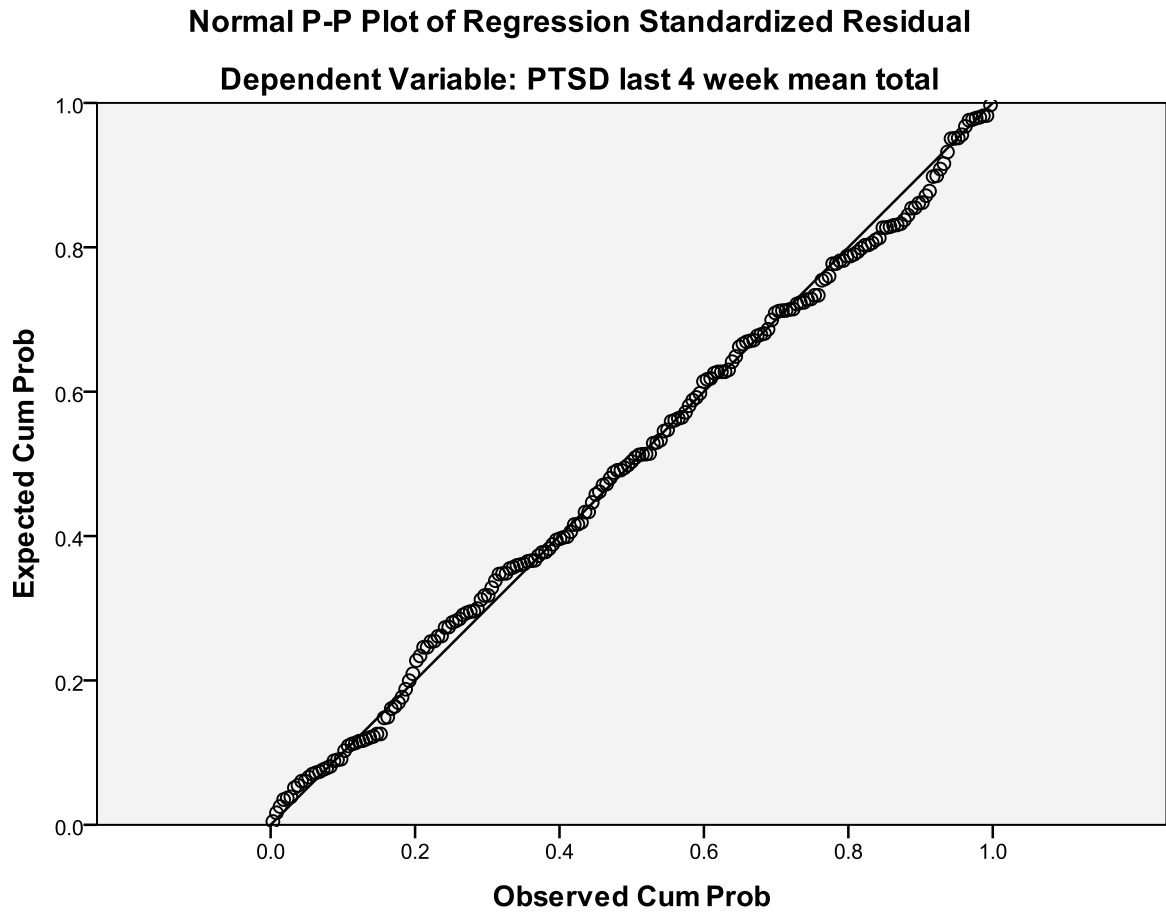
Dependent Variable: IES_avoidance



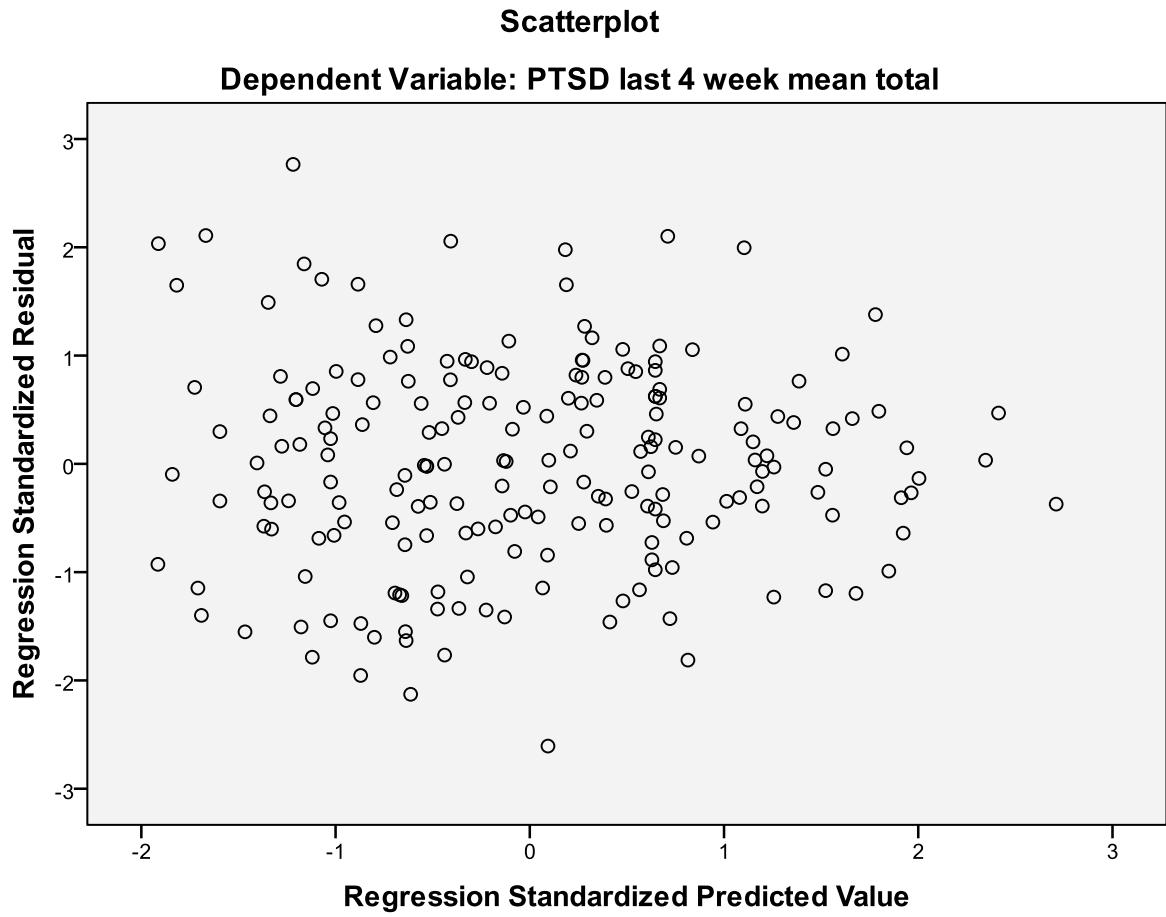
Appendix K 6



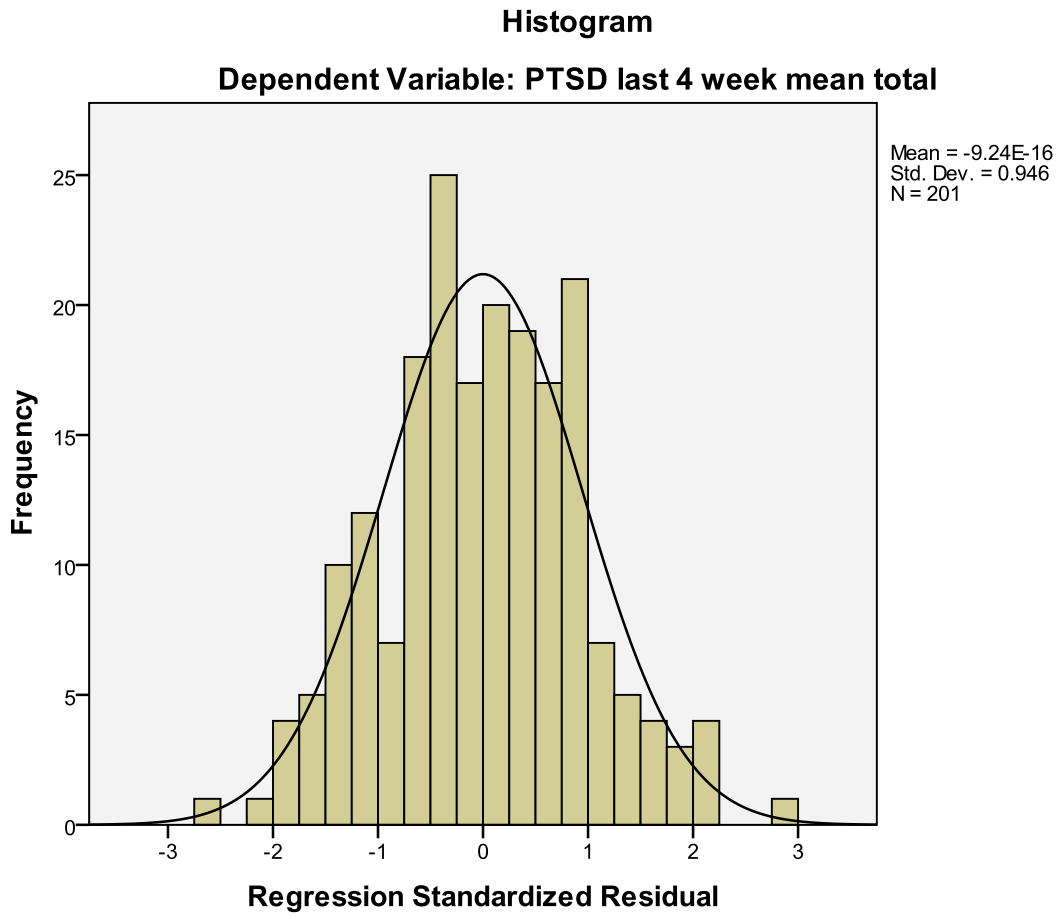
Appendix K 7



Appendix K 8



Appendix K 9



Appendix L

Traumatic Experiences Entered in Three Different Blocks for Hierarchical Regression

Traumatic Experiences			
1 Experienced serious physical injury	Block 1=18 traumatic experiences	Block 3=21 traumatic experiences	
2 Experienced Combat			
3 *Experienced rape			
4 Witnessed rape family (forced)			
5 Witnessed rape family (done by officials)			
6 Assault			
7 Captivity			Block 2=19 traumatic experiences
8 Being kidnapped			
9 Natural disaster			
10 Seeing loss of life			
11 Threat to life			
12 Witnessed violence in mass demonstrations			
13 Witnessed killing of family member			
14 Experienced disappearance of relatives or friends			
15 Relative in jail as political prisoner			
16 Search as result of organised violence			
17 Forced displacement			
18 Lived in refugee camps*			
19 Torture			
20 Living in detention in Australia			
21 Asylum seeker living in the community			