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Belief systems as coping factors in traumatized refugees: a prospective study.

Francisco José Eiroá Orosa[1], Michael Brune[2], Katrin Huter[3], Julia Fischer-Ortman[2], Christian Haasen[3]

1. Community Action Group, Madrid, Spain
2. University Medical Center Hamburg Eppendorf, Hamburg, Germany
3. Haveno Psychotherapy and Intercultural Communication, Hamburg, Germany

Corresponding Author:
Christian Haasen, Department of Psychiatry, University Medical Center Hamburg Eppendorf, Martinistr. 52, 20246 Hamburg, Germany
Email: haasen@uke.uni-hamburg.de

Abstract

Belief systems have been considered to be coping factors for traumatized refugees. We present a prospective and extended version of a previous retrospective study reviewing the importance of different coping factors such as belief systems, previous traumatization and social integration in the treatment of traumatized refugees. A longitudinal design was used in order to analyze the treatment of 49 refugees, finding that amelioration of posttraumatic symptomatology is related to social and intellectual factors; namely education, living with a partner, a secure resident status and the use of medication. The previous level of traumatization did not present an obstacle to the therapy. Although non-significant, those patients who had strong belief systems showed better improvement. The importance of sociocultural and beliefs as coping and therapeutic factors is discussed.

Key words

Refugees - Posttraumatic Stress Disorder – Belief systems – Coping – Religiosity – Ideology

Introduction

Displaced individuals living as refugees in developed Western countries suffer not only from posttraumatic reactions due to the experience that led them to flee from their country of origin, but also from a broad range of difficulties when trying to adjust to their new environment. Their well being is a matter of serious concern for mental health practitioners particularly in Europe and North America, where different support services exist. Social and cultural factors affecting the course of posttraumatic reactions in refugees have been reviewed. Wenk-Ansohn (2007) suggests that safety and social support are basic factors to avoid retraumatization at the arrival to the country of asylum. Lie (2002) points at unemployment and unresolved family reunion as risk factors in settled refugees after severe life threatening trauma. Carlsson, Olsen, Mortensen, & Kastrup (Carlsson, Olsen, Mortensen, & Kastrup, 2006) confirm unemployment and add difficulties in interpersonal relationships as predictors of mental health symptoms and low quality of life in a sample of tortured refugees.

Despite the fact that a large amount of research on treatment of traumatized refugees has been centered on symptoms of the aftermath of trauma in the form of Post Traumatic Stress Disorder (PTSD), an approach focusing on the amelioration of specific reactions of traumatic experiences in refugees usually centers around psychosocial interventions. Kinzie (2007) reviews different psychosocial therapeutic approaches including psychoanalytic, behavioral and cognitive, testimonial and trauma focused therapy. The testimony method (Cienfuegos & Monelli, 1983) was developed as a result of experiences with victims in Chile and is a narrative approach consisting in integrating fragmentary experiences in a life-story and thereby giving them meaning. Subsequently, different Latin-American authors have pointed the importance of testimony as a therapeutic tool after political violence (Lira, Becker, & Rodríguez, 1989) and the meaning each person gives to the experience (Rojas, 1996).

Beliefs systems as coping factors for traumatic experiences

Giving meaning to traumatic experiences has been a topic of mayor interest since the inauguration of the logotherapeutic approach by Viktor Frankl (1964). Logotherapy is regarded as the Third Viennese School of Psychotherapy and one of its core assumptions is that people cope with difficult situations by giving them a meaning, which can therefore be used as a therapeutic tool. Frankl derived this work from his experiences in the concentration camp of Auschwitz, where he was imprisoned during the II World War. Bruno Bettelheim (1943 cited in Pünamaki, 1996) also prisoner during the war, wrote from an existentialist point of view about different coping patterns between prisoners in the Dachau concentration camp. He found that both committed communists and religious Jews could give a clear explanation for why hardships happened to them.

Further research on trauma has been centered on the concept, that the shattering of basic assumptions is a framework for understanding the assimilation of traumatic experiences into basic belief systems (Epstein, 1991; Janoff-Bulman, 1992). According to this perspective, traumatic events precipitate psychosocial transitions raising questions about the purpose of life, the nature of suffering and the meaning of justice, as people struggle to answer the questions of why the event occurred and which implications it will have in the future (Parkes, 1971; Emmons, Colby, & Kaiser, 1998). Research on loss shows how one of the most significant tasks in grief is to reconstruct faith or philosophical systems (Doka, 1993).

Following the idea of Frankl and Bettelheim, research has focused on victims of more modern conflicts in order to confirm spiritualism and political commitment as resilient factors among survivors. Political commitment (among other factors such as social support, previous exposure and previous knowledge and preparation) has been shown as a protective factor among tortured activists in Turkey (Basoglu et al., 1994). Research among Palestinian children yields similar conclusions. Pünamaki (1996) shows how political hardships increase ideological commitment that is related to a

low level of psychosocial problems in this collective. Along the same lines, Quota, Pünamaki & El Sarraj (1995) show how children dissatisfied with the peace treaty of 1993 are more psychologically vulnerable than their satisfied counterparts which were involved in the struggle before. Similarly, passive response to Intifada violence predicted PTSD among Palestinian children (Pünamaki, Qouta, & El-Sarraj, 2001).

Religious beliefs and ideological commitment, as well as social cohesion were found to be protective against posttraumatic symptomathology in terrorism exposed populations in Israel (Kaplan, Matar, Kamin, Sadan, & Cohen, 2005). Moderate religious respondents reported more posttraumatic symptoms than their traditional (considered a middle point between secular and religious) or secular peers in a large sample of pupils of Israeli schools (Laufer & Solomon, 2006). Likewise, religiosity had a curvilinear effect in a study carried out among Jews and Arabs exposed to terrorism (Hobfoll et al., 2008). Traditional Jews had clearly higher rates of PTSD than secular, religious or ultra religious Jews. Ideological commitment was also found to be a protective factor against symptom development in adolescents facing terrorism, although it also was found to be a possible factor contributing to the cycle of violence (Laor et al., 2006).

The possibility of giving meaning and controlling the political environment has been shown to be a protective factor in other contexts. Zimmerman, Ramirez & Maton (1999) show how believing that own actions in the social and political system can lead to desired outcomes (called sociopolitical control by the authors) is a resilience factor among young black people in deprived areas of the USA.

Objectives of the study.

This study is a prospective and extended version of a previous retrospective study carried out by the study group about the impact of belief systems as coping factors in the outcome of psychotherapy with traumatized refugees (Brune et al., 2002). The patients in the previous study were found to be

more able to cope with their traumas when they had profound and firm beliefs systems, which was an important predictor for a better therapy outcome. Belief systems had been defined as political ideology or religiousness of central importance in the patient's lives. Therapy outcome had been analyzed within groups of patients with or without belief systems of central importance using as covariates treatment characteristics which could be considered confounding factors (education, duration of treatment, second language competence and additional psychopharmacological treatment) finding that only group membership predicted amelioration of depressive symptoms and global severity. The present study looks at religion or ideology using a different sample and additional measures in a prospective design. The aim of this study is to check which factors are determinant in the refugee's psychotherapeutic treatment. Following the design of the former study, the role of beliefs systems as important coping factors is specifically analyzed.

Method

Participants.

The study was carried out using a convenience sample consisting of 49 traumatized refugees, 29 men and 20 women, between 15 and 63 years of age (M= 34.37; S.D. =10). In this study a traumatized refugee was a person, who in the country of origin suffered torture, wrongful detention, experienced events of war or other forms of political repression, and subsequently sought asylum in Germany.

The diagnosis of each patient was made following DSM-IV criteria (American Psychiatric Association, 1994). The main diagnosis among most patients was PTSD (77.5%, two of them with secondary diagnoses, namely severe depressive episode without psychotic symptoms and borderline personality disorder), only 4 (8.2%) were diagnosed with an adjustment disorder, 3 (6.1%) with dysthymic disorder, 2 (4.1%) with enduring personality change after catastrophic experience, 1 with

severe depressive episode without psychotic symptoms and another one with somatization disorder. The symptoms which lead patients to seek therapy can be seen in table one.

Table1 Distribution by gender, beliefs group and countries of origin

Country of origin	Male	Female	CBS	No CBS	Total
Ex-Yugoslavia	8	5	3	10	13
Kurdistan	9	3	6	6	12
Chechnya	3	5	4	4	8
Africa	5	4	7	2	9
Other	4	3	4	3	7
Total	29	20	24	25	49

Procedure.

All subjects in the sample were treated in an out-patient clinic offering psychotherapy for traumatized refugees in Hamburg between 2001 and 2007, for an average period of 23.59 months (range=12-48, S.D.=8.72). The therapies were patient-centered and used a therapeutic program according to Van Der Veer (1992) and Basoglu (1992). Due to the different origin of the patients, cultural influences in treatment response were taken into consideration as outlined by Morris and Silove (1992). Additional psychopharmacology was prescribed if indicated. 31 patients (63%) did not receive any kind of pharmacological treatment, 12 (24.5%) received antidepressants and 6 (12.2%) received other forms of pharmacological treatment (antipsychotics or mood stabilizers). When belief systems, namely political ideology or religion, where of central importance for the patients, they were used as a supporting therapeutic element.

Measures.

The data of each patient was registered in a chart including information on country of origin, social integration (including housing, marital status, job possibilities in Germany, status of residence, German language proficiency and social contacts); frequency and duration of the extreme experiences; centrality, relation with the extreme experience and evolution in exile of religious and ideological convictions and medical and psychiatric history. The countries of origin were classified according to the conflict which led the patient to seek asylum. 13 persons (26.5%) came from Ex-Yugoslavian countries, 12 (24.5%) from Kurdistan (Turkey or Syria), 9 (18.4%) from Sub-Saharan African countries, 8 (16.3%) from Chechnya in the Russian Federation, and 7 (14.3%) from other countries (Algeria, Azerbaijan, Chile, Iran, Russia, Syria and Turkey).

Depressive symptoms were assessed at the beginning and the end of the therapy using the 21-item version of the *Hamilton Rating Scale for Depression*, HAM-D 21 (Hamilton, 1967). The HAM-D has been a standard instrument for the assessment of depression since the seventies, testing severity of depressive symptoms in individuals. It includes a broad range of symptoms. According to a revision carried out by Bagby (2004) internal reliability of the instrument measured by Cronbach's alpha is over .70 reaching .97. Interrater reliability ranges from .82 to .98 and test-retest reliability from .81 to .98 Pearson's r. Convergent validity has been carried out with a large number of instruments. The correlations with the Beck Depression Inventory, for example, range from .48 to .89 Pearson's r.

Overall clinical severity was evaluated using the *Severity of Illness* item form the *Clinical Global Impression Scale, CGI (Guy, 1976)*. This item requires the clinician to assess severity of psychopathology according to his clinical experience within a particular population. The item ranges from 1 to 7: normal (not at all ill); borderline mentally ill; mildly ill; moderately ill; markedly ill; severely ill; or extremely ill. According to a validation study carried out by Zaider, Heimberg,

Fresco, Scheiner and Liebowitz (2003), concurrent validation of this scale with the Seehan Disability Scale ranges from .55 to .77 and from .48 to .56 Pearson's r with the Beck Depression Inventory.

For posttraumatic symptomathology, which had not been assessed in the previous study, the Eight-item *Treatment Outcome Post-traumatic Stress Disorder Scale, TOP-8* (Davidson & Colket, 1997) was used. This scale was developed as a brief, clinician-administered scale to assess treatment responses in patients with PTSD. It is composed of 8 items that measure the 3 clusters of PTSD: avoidance/numbing (4), reexperiencing (2) and hyperarousal (2). Internal consistency of the scale indicates a Cronbach alpha of .73. Test-retest reliability gave a value of .88 Pearson's r, convergent validity ranges from .82 to .98 Pearson's r with other post-trauma instruments and from .56 to .72 with the Eysenk Neuroticism Scale. (Kathryn, Connor, Jonathan, & Davidson, 1999).

Their experience of political violence was classified according to the number of times it occurred and the length of the extreme experience. Torture was experienced by 49% of the sample. Of these 66.7% experienced torture longer than 6 months and 62.5% more than 5 times. 63% of the sample experienced wrongful detention, 54.8% of them between 2 and 5 times, 54.8% longer than 6 months. 46.9% were present in war scenarios, 73.9% of them longer than 6 months. The following categories created for the preceding study (Brune et al., 2002) regarding type, duration and frequency of trauma were used:

– Extreme traumatization (ET): experience of organized violence at least five times *and* for a duration of at least 6 months, 10 patients (20.4%);

– Very severe traumatization (VST): experience of organized violence at least five times *or* for a duration of at least 6 months, 12 patients (24.5%);

– Severe traumatization (ST): experience of organized violence fewer than five times *and* for a duration shorter than 6 months, 27 patients (55.1%).

Eleven persons (22.4%) reported political ideology as a central belief system, while fourteen (28.6%) described religion as a central belief system; only one patient was both ideologically and religiously committed. The rest (25 persons) did not have a central belief system. Following the design of the main study (Brune et al., 2002) based in the different ways of giving meaning to experiences outlined in the introduction, two groups were built according to this information: those with no central belief system (Non-CBS) and those with a central belief system (CBS). All members of the CBS group with ideology as central belief (ten persons, including the patient who was both ideologically and religiously committed) lived an extreme experience connected with their beliefs, while only two (14.3%) of those with religious beliefs lived an extreme experience connected with their beliefs.

Table two shows the distribution by gender, central belief system and country of origin. The sociodemographic and treatment characteristics within the two subsamples can be seen in table three. Significant differences between groups were only found for gender (χ^2=4.871, p<.05) due to a predominance of men in the CBS group. Also the CBS group had a higher proportion of extreme traumatized patients (70.8% versus 40.0% in the Non-CBS group; χ^2=4.705, p<.05).

Table 2 Sociodemographic characteristics according to belief system group

	No CBS (n=25)	CBS (n=24)	Significance
Female gender (n, %)	14, 56.0	6, 25.0	χ^2=4.871, p=.027
Age at beginning of treatment (Mean, SD)	35, 8.73	33.71, 11.34	t=.448, n.s.
Secure residence permit status (n, %)	3, 12.0	5, 20.8	χ^2=.699, n.s.
Living with partner (n, %)	12, 48.0	13, 54.2	χ^2=.186, n.s.
Stable housing (n, %)	15, 60.0	14, 58.3	χ^2=.014, n.s.
Employed (n, %)	7, 28.0	9, 37.5	χ^2=.503, n.s.
Completed vocational training (n, %)	9, 36.0	5, 20.8	χ^2=1.38, n.s.
German Proficiency in a range from 0 to 4 (Mean, SD)	2.04, 1.10	2.08, 1.02	t=.143, n.s.
Good social network (n, %)	7, 28.0	11, 45.8	χ^2=1.676, n.s.
Treatment assisted by an interpreter (n, %)	13, 52.0	14, 58.3	χ^2=.199, n.s.
Pharmacological treatment (n, %)	11, 44.0	7, 29.2	χ^2=1.159, n.s.

Table 3: Initial symptoms leading patients to seek therapy

	PTSD		Other diagnosis		Total	
	n	%	n	%	n	%
Depressive symptoms	26	53.06	8	16.33	34	69.39
Anxiety	19	38.78	4	8.16	23	46.94
Intrusive symptoms	7	14.29	1	2.04	8	16.33
Increased arousal	6	12.24	2	4.08	8	16.33
Corporal complaints	4	8.16	1	2.04	5	10.2
Avoidance	2	4.08	0	0	2	4.08
Attempted suicide	1	2.04	1	2.04	2	4.08
Compulsive symptoms	1	2.04	0	0	1	2.04
Total	38	77.55	11	22.45	49	100

Analysis

The initial, final and improvement scores of HAMD, CGI and TOP-8 were calculated. Furthermore, scores of improvement were calculated for the three clusters of PTSD symptomatology: avoidance, reexperiencing and hyperarousal. Two tailed Pearson's correlations were used to assess relation of score reductions. T-tests were calculated to compare between people with and without strong beliefs systems and between patients whose extreme experience was related to their belief system and those without relation. Analysis of variance (ANOVA) was carried out in order to compare initial score and reduction in the three traumatization groups.

To control for the influence of all additional factors and the variable of primary interest (centrality of belief systems) in treatment outcome avoiding type one errors; stepwise regression analyses were carried out using improvement scores as dependent variables, and centrality of beliefs, grade of traumatization, sociodemographic (gender, age, secure residence status, living with partner, stable housing, employment, completed vocational training and good social contacts) and treatment characteristics (treatment duration, use of medication and treatment assisted by an interpreter) as independent variables.

Results

Average HAM-D score was 21.69 (range=11-45, S.D. = 7.41) at the beginning and 10.18 (range=2-24, S.D. = 4.91) at the end of the therapy. The average HAM-D reduction was 11.51 (range 2-28, S.D. = 5.43), corresponding to a 52.66% reduction. CGI mean varied from 5.39 (range 4-6, S.D. = .57) at the beginning and 3.06 (range 1-6, S.D. = 1.22) at the end of the therapy, thereby showing a 2.33 average reduction (range 0-5, S.D. = 1.21), corresponding to a 43.13% reduction. TOP-8 score average was 19.53 (range 10-30, S.D. = 4.809) at the beginning and 8.59 at the end of the therapy

(range 3-18, S.D. = 3.446), with an average reduction of 10.94 (range 1-19, S.D. = 3.96) corresponding to a 55.59% improvement.

There were significant two tailed Pearson correlations between reduction of HAM-D, CGI and TOP-8 scores (HAM-D with TOP-8: r = .399, p<.005; HAM-D with CGI: r= .480, p<.0001; CGI with TOP-8: r = .448, p<.001).

T-tests showed no significant differences between belief groups in initial scores or therapy outcome, although those with a firm belief system (CBS group) had non-significant better outcomes in the three measures and in the three PTSD clusters. ANOVAs within traumatization groups showed significant higher initial (F=9.934, p<.0001) and better TOP-8 outcome (F=7.480, p<.005; reexperiencing: F=2.580, p<.05; avoidance: F=4.561, p<.05; hyperarousal: F=8.331, p=.001) in the ET group, but no significant differences were found in CGI or HAMD outcome, although the ET group had higher improvement in these two scores (see table four).

Table 4. Comparisons between traumatization and belief system groups in therapy initial and outcome scores.

	Initial HAM-D	HAM-D reduction	Initial CGI	CGI reduction	Initial TOP-8	TOP-8 reduction
No CBS	22.04±7.68	11.00± 5.28	5.24±.52	2.04± 1.31	19.00±5.20	10.04± 4.16
CBS	21.33±7.26	12.04± 5.65	5.54±.59	2.63± 1.06	20.08±4.40	11.88± 3.59
Significance	t=-.331, p=.742	t=-.667, p=.508	t=-1.889, p=.064	t=-1.720, p=.092	t=-.785, p=.436	t=-1.655, p=.106
Severe traumatization	22.30±10.60	10.80± 6.29	5.10±0.57	1.80±1.23	17.80±5.75	9.70± 3.74
Very severe traumatization	18.50±4.21	9.83± 3.01	5.33±0.49	2.33±1.30	15.83±3.16	8.17± 3.88
Extreme traumatization	22.89±6.96	12.52± 5.87	5.52±0.58	2.52±1.16	21.81±3.76	12.63± 3.26
Significance	F=1.534, p=.226	F=1.128, p=.332	F=2.130, p=.130	F=1.293, p=.284	F=9.934, p=.000***	F=7.480, p=.002*

No CBS- No Central Belief System, CBS- Central Belief System, * p<.05, *** p<.0001

No significant differences in score reduction were found between those whose extreme experience was related to their belief system compared to those where extreme experience was not related to belief system.

Stepwise regression analyses indicated that the use of pharmacotherapy (standardized β=.342, p=.009), completed vocational training (standardized β=.313, p=.013) and living with a partner (standardized β=.296, p=.024) had a positive influence on the reduction of HAM-D scores. A secure residence status had a positive effect on reduction of CGI (standardized β=.293, p=.041). Finally, the level of traumatization (standardized β=.347, p=.006) had positive effect on reduction of TOP-8 scores in contrast with the use of an interpreter, which had a negative effect (standardized β=-.279, p=.037).

When analyzed by PTSD clusters, the level of traumatization had a positive effect on every cluster (re-experience: standardized β=.306, p=.032; avoidance/numbing: standardized β=.318, p=.019; hyperarousal: standardized β=.305, p=.033) but the use of an interpreter only remained a significant difficulty in the overcoming of avoidance/numbing symptoms (standardized β=-.316, p=.020).

Discussion

Psychotherapy with traumatized refugees is a complex task for therapists. Psychosocial factors seem to be of major importance in the development of the therapeutic process. Although these factors are usually out of the control of the therapist, they must be considered in the progression of the therapeutic process. Ideological and religious elements seem to be an important field to be explored with the patients, especially when they can be helpful in the development of a new conceptualization of the experiences which lead them to leave their country of origin.

The aim of the present prospective study was to validate results found in a previous retrospective study, which found an impact of belief systems on the outcome of therapy. The results do not clearly

confirm previous findings despite some evidence of a positive aspect of a central belief system for therapy outcome. Therefore, even if central belief systems may be an important topic that can be used in therapy of traumatized refugees, we should not forget that sociocultural factors and living conditions of refugees are key factors for their recovery.

Methodological difficulties also hampered the possibility to validate results of the previous retrospective study. The sample of the present study was smaller and very different than the one used in the previous study. In this study most of the patients escaped from armed conflicts (mainly Ex-Yugoslavia, Kurdistan and Chechnya), whereas in the previous study many of them had escaped from countries with a severe lack of freedom (mainly Iran and Latin America). Nevertheless, new and important results must be considered. Therefore, the use of a convenience sample including refugees as they come into treatment, reflecting a research design adapted to actual treatment situations, instead of a research design with power and sample size calculations and inclusion criteria for the recruitment of refugees for treatment, hamper a comparison of the two studies. Nonetheless, the present study delivers important evidence that will help future therapists in their work with traumatized refugees.

Education, living with a partner, a secure resident status and the use of medication were positive factors in treatment outcome. The use of medication, level of education and living with a partner helped to overcome depressive symptomatology. Those with a higher level of traumatization and who could complete therapy without an interpreter had a positive influence on PTSD symptoms. A secure resident status had a positive influence in the overall outcome of severity.

Furthermore, the higher the level of previous traumatization, the greater is the amelioration in posttraumatic symptomatology. This higher improvement shows the validity of psychotherapy also with severe traumatized patients.

This study shows better outcome for patients with strong belief systems although, in contrast with the previous study, psychopharmacology, sociocultural factors and living conditions showed a greater explanatory power. The greater improvement in patients who have strong beliefs systems can be explained both by the greater capability of them to give meaning to their experiences and by the use of belief systems in the therapeutic process. Nevertheless, context shapes the process of providing meaning to traumatic experiences and determines outcome.

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