# Environmental stress factors in the work with torture survivors

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## Introduction

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

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

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

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

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

## Multiaxial classification

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

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

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

## Stress-factors

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

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

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

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

1978) indicate that social support may protect against the emergence of a disorder in case of stressful situations. The subjective role of the social support perceived more than the factual one seems decisive in relation to the long term consequences.

## The codification of psychosocial stressors

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

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

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

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

## I. ICD-10 Classification

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

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

We shall in other words be furnished with a possibility to code the existence of traumatic events of relevance for the present condition, including violations of human rights such as torture. With the aim to facilitate the rating of the environmental factors a careful selection of the Z-codes will take place. These may naturally be divided into:

a) environmental factors including all relevant events of a psychosocial nature with a further subdivision into recent or chronic difficulties, and
b) life style/life management problems including problems related to the personality and life style of the individual.

## II. DSM-III and DSM-IV Classification

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

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

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

The judgement how an *average* person in similar circumstances and with similar socio-cultural values would react to a specific stressor is strenuous unless the eval-

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

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

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

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

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

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

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

## Specific problems for torture survivors

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

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

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

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