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ORIGINAL ARTICLE

Belief systems as coping factors for traumatized refugees: a pilot study

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Summary – The severity of traumatization seems to correlate with a more severe course of post-traumatic stress disorder (PTSD) (and other post-traumatic disorders), while firm belief systems have been found to be a protective factor against post-traumatic disorders. This study sought to determine the role of belief systems in the outcome of psychotherapy for traumatized refugees. The charts of 141 consecutively treated refugees were evaluated retrospectively. A firm belief system was found to be an important predictor for a better therapy outcome. The importance of a firm belief system as a coping factor, which should be used as an instrument in therapy, is discussed. © 2002 Éditions scientifiques et médicales Elsevier SAS

Post-traumatic disorders / PTSD / Organized violence / Belief systems / Coping

INTRODUCTION

Traumatized refugees differ from many other persons suffering from post-traumatic disorders in at least two fundamental aspects: their traumas are generally prolonged, repeated and consciously caused by other human beings and further, they have been forced to live in exile. Herman [27] describes why traumatic experiences caused by intentional actions of other humans ("man made disaster"), e.g., all kinds of organized violence,[1] mostly lead to a more severe course of post-traumatic disorders, than other kinds of traumatic experiences. The life in exile represents further stressors, the importance of which the refugee is unprepared for [22]. Especially difficult is the situation for traumatized asylum seekers with time-limited residencies. Even worse is the situation for those whose asylum application has been rejected and thereafter do not dare to go back to their countries and instead choose to live "illegally" in exile, where they once had sought protection. These difficulties very often represent traumatizing and retraumatizing living conditions [17,36,38]. For refugees who had experienced torture, the problems of exile often are a second traumatic burden, which complicates the elaboration of the traumatic torture experience [30,35,40]. Investigations of trau-

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[1] Organized violence is defined by the WHO as "The interhuman infliction of significant, avoidable pain and suffering by an organized group according to a declared or implied strategy and/or system of ideas and attitudes. It compromises any violent action which is unacceptable by general human standards, and relates to the victims feelings" (Van Geus, 1986 [44]).

matized asylum seekers show that unfavorable life conditions lead to an aggravation of symptoms of anxiety disorders, depression and post-traumatic stress disorder (PTSD) [39].

Many authors have observed the importance of belief systems among persons suffering from post-traumatic disorders, but the considered aspects do not always fully coincide and sometimes can seem partly contradictory. An evaluation of Latin-American women living in Canada, who had been traumatized by torture [1], showed a correlation between political convictions and the severity of the suffered torture: The more the women were politically involved, the more brutal was the torture they had suffered. Ideological conviction to a cause and being prepared for possible torture due to one's political activity have been shown to be protective factors against PTSD among torture victims [4,6]. However, there also is the risk that political ideology leading to torture or other politically motivated violence can be an obstacle in the elaboration of the trauma: by only seeing the political aspect of their own traumatic experience, the personal aspects of the trauma might be avoided, denied or misinterpreted [23].

The risk of a person with traumatic experiences developing a post-traumatic disorder increases with the number of traumas in his or her life history because the traumas have a cumulative effect [47]. Repeated experience of torture leads to clear elevation of the probability that the affected person develops PTSD or a post-traumatic depression [31].

A traumatized person can develop post-traumatic disorders in different ways. PTSD is a common possible consequence of traumatization, but dissociative disorders, somatization disorders and affective disorders can also follow traumatizing experiences. Quite frequently the traumatized person in different phases of his or her "post-traumatic" life is affected by different disorders [43]. Depressive symptoms are very common among persons who are suffering from post-traumatic disorders. Bleich et al. [9] found 95% of those diagnosed with PTSD to have a lifetime comorbidity for major depressive disorder (MDD), while Kessler et al. [29] described a comorbidity of 90% with other psychiatric disorders, mainly depressive disorders and drug addiction. PTSD and depression after traumatic events have many common and overlapping symptoms [8]. Especially common are depressive symptoms in torture victims as they often have experienced important losses in their lives [45]. A significant correlation between the number of traumatic events in the life story in survivors of massive violence in Cambodia with PTSD and the presence of depressive symptoms is reported by Mollica et al. [32]. Depressive symptoms in the first months after a traumatic event are an important mediator of chronicity of PTSD [21].

Many different methods are used in the treatment of post-traumatic disorders. Psychopharmacological treatment has been shown to be effective [14,15], yet it was not the object of research in this study. Psychotherapy with different theoretical inputs has been shown to be effective in the treatment of PTSD caused by different events [34,37]. For a refugee, who has suffered a new trauma or a retraumatization, a crisis intervention provides the most adequate help. Considering the pressure of poor living conditions among many traumatized asylum seekers, often the only adequate interventions are supportive psychosocial measures [42]. Psychodynamic psychotherapy with traumatized refugees can be indicated, depending on motivation and personality structure of the refugee, which limits its use for all traumatized refugees [10]. Working with groups of traumatized refugees with similar backgrounds, where patients give each other support and exchange experiences, can be very helpful for some groups [3]. For a therapy for traumatized refugees to be successful, it needs to be accompanied by supportive social measures and sometimes legal consultation—especially considering asylum laws [36]. The problems of living in exile also have to be a main theme in therapy [13].

The social environment of a person traumatized by organized violence is important for the effectiveness of his therapy. Basoglu et al. [5], describing former political prisoners in Turkey, showed not only the severity of torture and jail conditions, but also social circumstances after leaving prison to lead to a more severe course of mental disorder of the traumatized person.

An effective therapy concept for traumatized refugees requires also that the existential questions of life are taken into consideration [38]. This explains why relying on the principle of Will to Meaning, as used in the logo therapy developed by Frankl, is reported to be effective for persons traumatized by war events [12]. A central aspect in the recovery after severe traumatization is to give painful events a meaningful place in the life story of the affected person [46]. In this respect, Calhoun et al. [11] found rumination on religious questions to be associated to positive outcome after experiencing traumatic events.

Viktor Frankl [20] quoted Nietzsche "If man knows the WHY for his existence, man will be able to bear

nearly any HOW" to explain how it was possible for a human being mentally to survive the horrors of the Nazi concentration camps. This corresponds to a frequently described clinical impression of persons, who have been victims of torture or other kinds of organized violence. Belief systems can be seen as a coping strategy according to Folkman and Lazarus [19]: a redefinition of the actual circumstances in a threatening situation, where the threatened person fights for his rights or sees an emotional difficulty as a rationally solvable problem. In this study, we hypothesized a positive correlation between the extent of belief systems in the lives of the traumatized refugees and response to therapy, independent of treatment form. Belief systems could therefore represent a possible coping mechanism, which can be used as a tool in treatment.

MATERIALS AND METHODS

This study was a retrospective analysis of therapy outcome. Included were all refugees treated by the first author between 1990 and 1999 for at least a period of 3 months (in those cases where refugees were seen for a shorter period, the character was more of a consultation and did not involve a therapeutic process). In general, the therapies were patient centered psychotherapies, which often were accompanied by other therapeutic, medical and social supportive measures. For most of the patients, the first author was the main therapist, 11 patients had another therapist and the first author was viewed as a medical doctor. All therapies lasted between 3 months (inclusion criteria) and 6 years. The average treatment time was 21.5 months.

Chart review was done using a standardized data abstraction form, carried out only by the first author, who had also written extensive chart notes during the therapy periods. These chart notes contain an initial assessment with a detailed and systematic description of symptoms and life events as well as follow-up notes for each session and an extensive final evaluation of treatment outcome. The standardized data abstraction form included information on demographic variables, medical history, trauma and migration history and data concerning belief systems. To avoid a bias in data abstraction, a random sample of 10 charts was independently evaluated by the second author—no differences were found with respect to the main variables. Data were analyzed using SPSS for Macintosh, version 6.1.1.

A traumatized refugee in the context of this study was a person, who in the country of origin suffered organized violence, involuntarily left the country and during the time of the therapy lived in Sweden or in Germany. The study included 141 consecutively treated refugees in several therapy centers (133 in Sweden: Red Cross Center for Torture Victims in Stockholm, Red Cross Treatment Centers for Refugees in Skövde and Stockholm, IPIK in Stockholm; eight in Germany: Freihaven in Hamburg, Refugium in Stade), who were in therapy for at least 3 months between 1990 and 1999 and appeared for at least 10 therapy sessions. Traumatization was defined as having directly experienced torture, imprisonment, and other forms of persecution or war events. The aggravation of posttraumatic disorders by prolonged and repeated trauma is frequently described, but no literature was found, where it was quantified as to when trauma should be considered prolonged and repeated. From the author's own experiences, the following categories regarding type, duration and frequency of trauma were considered as indicated:

– extreme traumatization: experience of organized violence at least five times and for a duration of at least 6 months;
– very severe traumatization: experience of organized violence at least five times or for a duration of at least 6 months;
– severe traumatization: experience of organized violence fewer than five times and for a duration shorter than 6 months.

All persons included in the study received therapy as a consequence of traumatic experiences following organized violence. All psychiatric diagnoses were made according to DSM-IV [2]. Since depression is the most common syndrome among traumatized refugees and often rated in studies on traumatization [4,41], patients were assessed at the beginning and end of therapy with the Hamilton-Depression Scale (HAM-D [26]), which is applicable on persons coming from different cultural contexts [24], while overall outcome was rated with the Clinical Global Impressions Scale (CGI [33]). Second language competence was categorized in accordance with other studies [25]. Coherent belief system (corresponding to the German philosophical term "Weltanschauung" according to Jaspers [28]) was defined as a stated conviction—either political or religious in nature—including all the complex human concepts about the structures and meanings of the world and the human existence. Since there is no instrument for operationalization of the term belief system, three categories were chosen:

Table 1. Distribution of gender and countries of origin.

	Female	Male
Iran	14	43
Latin America	7	18
Iraq	1	14
Ex-Yugoslavia	7	7
Turkey	2	8
Africa	1	5
Other countries	3	11
Total	35	106

– no belief system: person had no specific religious or political conviction;
– belief system of marginal importance: a religious or political conviction was present, but did not influence the lifestyle or behavior of the person in any major way;
– belief system of central importance: a religious or political conviction was present and influenced the lifestyle or behavior of the person in a major way.

RESULTS

Description of sample

The sample consisted of 141 persons from different countries of origin (see *Table 1*), between 18 and 64 years of age (mean age = 36.5, S.D. = 8.8). Their experience of organized violence differed; they had been exposed to torture, imprisonment, other forms of persecution, and/or war. Those having suffered under the category of "extreme traumatization" formed 64.5% (91 persons), 17.7% (25 persons) formed "very severe traumatization" and 17.7% (25 persons) formed "severe traumatization".

The most frequent main diagnosis was PTSD (see *Table 2*). Among patients with PTSD, 11 had a second diagnosis of major depression (MDD) and two dysthymia. In total, 32 (22.7%) had a depressive disorder as main or second diagnosis. *Table 3* shows the initial symptoms, which led the patients to therapy.

Table 2. Distribution of main diagnosis.

Main diagnosis	Frequency
PTSD	One hundred and eight patients (77.1%)
Dysthymia	Sixteen patients (11.3%)
Somatization disorder	Seven patients (5.0%)
Anxiety disorder	Five patients (3.5%)
Major depression	Four patients (2.8%)
Delusional disorder	One patient (0.7%)

PTSD: post-traumatic stress disorder

Table 3. Initial symptoms, leading patients to seek therapy.

	PTSD	Other diagnosis
Depressive symptoms	56	21
Somatic symptoms	27	9
Intrusive symptoms	12	0
Anxiety	9	2
Concentration disorder	1	0
Sleep disturbance	1	0
Reactive psychosis	1	0
Paranoid symptoms	0	1
Attempted suicide	1	0
Total	108	33

PTSD: post-traumatic stress order

Therapy outcome

The average HAM-D-score was 14.0 (S.D. = 4.0; Max = 27; Min = 6) at initiation of therapies and 7.1 (S.D. = 4.6; Max = 24; Min = 0) at the end. The average HAM-D reduction during the therapy was 6.9 (S.D. = 4.6; Max = 21; Min = –5), which corresponds to a 49.4% reduction. The initial CGI score was 5.3 (S.D. = 0.7; Max = 6; Min = 3), while the final CGI score was 2.5 (S.D. = 1.2; Max = 6, Min = 1). The average reduction of the CGI was 2.8 (S.D. = 1.4; Max = 5; Min = 0). There was a high correlation between reduction of HAM-D and reduction of CGI ($r = 0.76$, $P < 0.001$).

Between the forms of therapy—crisis intervention, short-term or long-term therapies—there were no significant differences in the outcome of therapy in the reduction of the HAM-D score ($F = 0.2$; n.s.) and the CGI score ($F = 0.4$; n.s.). There was no correlation between the duration of treatment and HAM-D reduction ($r = 0.03$, n.s.) or CGI reduction ($r = –0.07$, n.s.). There was also no correlation between second language competence and HAM-D reduction ($r = 0.07$, n.s.) or CGI reduction ($r = 0.14$, n.s.), as well as no correlation between the level of education and HAM-D reduction ($r = 0.08$, n.s.) or CGI reduction ($r = 0.14$, n.s.).

Those who received additional psychopharmacological treatment (antidepressants for $N = 12$, tranquilizer for $N = 39$) did not have a significantly better outcome, neither in the reduction of the HAM-D score ($F = 0.6$; n.s.) nor in the reduction of the CGI score ($F = 2.2$; n.s.). The duration of treatment did not differ between

Table 4. Severity of traumatization related to initial HAM-D- and CGI-scores.

	Extreme traumatization	Very severe traumatization	Severe traumatization	Significance
Initial HAM-D	14.5	13.5	12.6	$F = 2.8$, $P < 0.1$
Initial CGI	5.4	5.1	5.0	$F = 6.4$, $P < 0.05$

HAM-D: Hamilton Depression Scale; CGI: Clinical Global Impressions Scale

those receiving antidepressants and those without medication ($F = 2.3$; n.s.).

The HAM-D and CGI scores for the three categories of traumatization are shown in *Table 4*. There was no difference between the three groups with respect to HAM-D reduction ($F = 1.2$, n.s.) or CGI reduction ($F = 1.4$, n.s.).

Of the subjects, 78.7% (111 persons) reported that in their country of origin they had had a political ideology as a belief system, 7.8% (11 persons) were religious and 13.5% (19 persons) said they never had any belief system. Of those with a belief system, 64.6% (78 persons) described it to be of central importance in their lives, while 35.3% (44 persons) said it was of lesser importance. Therefore, 55.3% (78 persons) had a belief system of central importance and 44.7% (63 persons) had a belief system of lesser importance or no belief system, with no correlation to the severity of traumatization ($r = 0.15$, n.s.). The importance of belief system for the outcome of therapy is shown in *Tables 5 and 6*.

Those who had a belief system of central importance had a significantly better education ($\chi^2 = 20.6$; $P < 0.001$) and also had significantly better competence in the language of the country of exile ($\chi^2 = 14.2$; $P < 0.001$). There was no significant difference in the duration of therapy ($\chi^2 = 6.4$; n.s.) between persons with a firm belief system and the others. Even though there was no correlation between education, language competence, duration of treatment or additional psychopharmacological treatment and therapy outcome, these can be confounding factors when analyzing the effect of belief systems on outcome. Therefore, two analyses of variance were completed, with HAM-D reduction or CGI reduction as dependent variables, belief system as an independent factor and possible confounding factors (education, duration of treatment, second language competence, additional psychopharmacological treatment) as covariate variables. In both analyses, covariate variables showed no significant effects. With HAM-D reduction as the dependent variable, a belief system was the only predictor of outcome ($F = 5.55$, $P < 0.05$), and with CGI reduction as the dependent variable, a firm belief system again was the only predictor of outcome ($F = 20.38$, $P < 0.001$).

DISCUSSION

The main limitation of the study is its retrospective nature. This pilot study was meant to confirm the intuitive feeling of most clinicians treating PTSD patients and generate hypotheses for future prospective studies. A future prospective study could also allow for external independent evaluation of treatment outcome, to avoid a further limitation of this pilot study. The validity of assessing therapy outcome using the CGI can be questioned, considering that the CGI was developed for medication outcome studies for schizophrenia. However, the possibility of using the CGI to measure global outcome of other disorders and treatment methods is explicitly stated [33]. Therefore, the use of the CGI in this study is warranted, considering the lack of established outcome measures in PTSD treatment studies. Nonetheless, for future follow-up studies, the use of a PTSD scale such as the one by Davidson and Colket [16] can serve as a good comparison to the results of this study. This would also allow a

Table 5. Importance of belief system for therapy outcome measured by reduction of HAM-D- and CGI-scores.

	Initial HAM-D	HAM-D reduction	Initial CGI	CGI reduction
Belief system of central importance	14.2	8.1 (55.9%)	5.6	3.4 (60.6%)
Belief system of low/no importance	13.7	5.5 (41.0%)	5.0	2.0 (41.1%)
Significance	n.s.	$P < 0.001$	$P < 0.001$	$P < 0.001$

HAM-D: Hamilton Depression Scale; CGI: Clinical Global Impressions Scale

Table 6. The effect of the loss of belief system of central importance on therapy outcome.

	HAM-D reduction	CGI reduction
Belief system preserved	8.2 (56.2%)	3.2 (58.5%)
Belief system reduced or lost	6.1 (44.0%)	2.7 (50.0%)
Significance	$P < 0.05$	$P < 0.05$

HAM-D: Hamilton Depression Scale; CGI: Clinical Global Impressions Scale.

more detailed evaluation of partial improvement within the symptom profile.

The addition of a rating scale for the most important syndrome—depression—allows outcome to be evaluated from a symptom perspective. A depressive mood is an important symptom among many traumatized persons, even though it sometimes is not the most obvious symptom. Refugees, who became victims of organized violence and had to leave their home country, nearly always experienced severe losses. All evaluated persons in this study showed depressive symptoms at the beginning of therapy, and in all cases, depressive symptoms were associated with the traumatization. This justifies the use of the HAM-D in measuring therapy outcome.

This sample of refugees shows little difference in comparison with those in other centers for traumatized refugees in Western Europe [7,18] with respect to origin as well as duration of therapies and therapy methods, so that the sample can be considered representative for traumatized refugees in northwestern Europe. With respect to the duration and frequency of suffered torture and distribution of diagnosis, the sample showed results similar to those of Van Velsen et al. [45]. As in the study by Basoglu et al. [5], our study showed a correlation between extent of traumatization and severity of disorder.

A general problem for scientific evaluations of the work with traumatized refugees in the western world is that the patients are a very heterogeneous group and their categorization into different subgroups by cultural, social and educational criteria could be made. But in spite of this fact, the actual sample—by being traumatized by organized violence and living in exile in cultural context of the western world—had enough in common to justify an evaluation of them as one sample.

The study's main results are that a belief system only has a relevant positive influence on treatment outcome when it is of central importance in the life of the torture victim. The type of conviction—religious or political belief system—had no influence on the outcome. However, the number of persons with a religious conviction was relatively small, so that possible conclusions are limited.

The sample showed some sociodemographic differences between those who had a belief system of central importance vs. those who did not. Those with a belief system were better educated and were more fluent in the language in the country of exile. Despite the fact that these seemed to be confounding factors with respect to treatment outcome, the covariate analysis clearly showed only a firm belief system to be a predictor for treatment outcome. Nonetheless, belief systems are tied into a complex social context, which can affect therapy outcome by way of a complex coping strategy.

A reduction of intensity in a patient's belief system correlated with less therapy improvement, so that a loss or diminution in a patient's belief system can be seen as a fact obstructing the potential of therapy. For patients with such a loss, therapy needs to focus on regaining the constructive cognitive capacity, which their belief system once had given them. However, a very rigid belief system can also obstruct the potential outcome of therapy. Three patients in the sample showed that intellectualization as a defense mechanism in ideologically very rigid persons can be a massive obstacle in a therapy. It seemed impossible for these patients to reflect on events of their life except from a political or religious angle.

CONCLUSION

This study indicates strongly that a profound and firm belief system, whether based on faith or politics, makes it possible for many traumatized persons to better tackle their traumas. Belief systems can therefore function as coping strategies [19]. Working with traumatized refugees who had a clear belief system calls for the therapist to utilize such systems in conducting the therapy and to interpret the trauma in the context of the patient's particular belief system. Understanding the importance of a firm belief system and the application of this as a tool in therapy therefore have important clinical implications in the work with traumatized refugees. Work with traumatized refugees necessitates an integrated approach, including philosophical, psychological, sociological and political aspects, in order to understand and ameliorate the social, existential and ideological situation of these refugees.

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