

Long-Term Mental Sequelae of Torture in Iran—Who Seeks Treatment?

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In this study, we investigated long-term mental sequelae of torture in Iran and explored differences between treatment seekers and nontreatment seekers. Thirty-four torture victims suffering from enduring mental sequelae and now living in Germany were examined. According to DSM-III-R, depressive, anxiety, and somatoform disorders were diagnosed with a high degree of comorbidity and with posttraumatic stress disorder (PTSD) being the most frequent diagnosis. Treatment seekers had a higher level of psychopathology, particularly the PTSD symptoms of intrusion and increased arousal, and a poorer knowledge of German. They reported different ways of coping. The differences found between the two groups may reflect more or less successful adaptation to conditions in the host country and contribute to the motivation to seek treatment.

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In Iran, people who are purported to be opponents of the political system may be detained or even executed with or without a formal trial. Torture, beating, and intimidation of political prisoners is reportedly widespread, both during pretrial detention and after sentence. Physical and psychological measures of torture are often used to extract confessions or information from prisoners (Amnesty International 1988, 1990, 1994). When they were released from prison, many of the former political prisoners tried to leave Iran and to seek political asylum in western countries.

Empirical research has shown that torture may lead to enduring psychiatric disorders that can often be classified as posttraumatic stress disorder (PTSD). Depressive, somatoform, and anxiety disorders have also been found to occur as mental sequelae of torture alone or along with PTSD. Several authors report that posttraumatic stress victims—even those with severe symptoms—often show resistance to seeking professional help (Eaton et al., 1982; Priebe et al., 1993). In a survey among Israeli veterans, Solomon (1989) found that subjects who had sought treatment reported more severe symptoms, a lower degree of self-efficacy, and fewer negative life events before the war than those who had not. In torture victims that have escaped to foreign countries, other factors than those seen in veterans may also be assumed to influence treatment seeking behavior: A lack of social skills that are required in the host culture, an insufficient knowledge of the language of the host country, a general mistrust toward doctors and institutions, and a culturally differ-

ent attitude toward medical and psychotherapeutic treatment might pose barriers to seeking or to finding treatment (Lee and Lu, 1988; Mollica et al., 1990; Motta, 1993). There is, however, hardly any empirical research on variables that differ between torture victims who do seek treatment and those who do not and that may account for treatment seeking behavior.

This study had two purposes: first, to assess long-term mental sequelae of torture in Iran, and second, to explore differences between treatment seekers and nontreatment seekers. Therefore, we examined 37 persons, who had been exposed to torture for political reasons in Iran, who were suffering from enduring psychiatric disorders because of their traumatic experiences during imprisonment, and who now lived in Germany. Two subgroups were compared: 12 patients were in specialized psychiatric treatment, and 22 were not in any sort of medical or psychological treatment and were not seeking any. We hypothesized that patients in treatment would show more severe psychopathology, have a better knowledge of German, and report fewer coping strategies than the nontreatment seekers.

Method

The study was carried out by the Department of Social Psychiatry at the Freie Universität Berlin, Germany. We included patients who had been imprisoned for political reasons in Iran for at least 2 months, who had been exposed to torture during imprisonment, and who were found by a research psychiatrist to be suffering from enduring mental sequelae of that traumatic experience. Patients with organic disorders, functional psychoses, or substance dependencies were excluded. Ten patients were recruited through therapy centers for torture

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victims in which they were receiving specialized treatment. The other 24 persons were contacted through Iranian refugee groups in Germany. Two of them were being treated in psychiatric private practice because of their posttraumatic disorder. The other 22 patients had never been in any such treatment nor were they seeking any at the time of the interview.

The interviews were carried out in Persian. The interviewer was familiar with the historical and political background in Iran. He was not involved in any treatment. Participation in the study was not associated with any immediate advantage for the patients. Patients' history and current living situation were investigated in a structured interview. Complaints were self-rated on the full 65-item version of the von Zerssen Complaints Check List (von Zerssen, 1986). Observer ratings of psychopathology were made on the Hamilton Rating Scale for Depression (HAMD; Hamilton, 1960) and on the Hamilton Rating Scale for Anxiety (HAMA; Hamilton, 1959). PTSD-symptoms as defined in DSM-III-R were investigated in the PTSD-interview by Watson et al. (1991). In this interview each symptom of the B-, C-, and D-criteria for PTSD is assessed and quantified on a rating scale from one ("no" or "never") to seven ("extremely" or "always"). Diagnoses were made according to DSM-III-R (American Psychiatric Association, 1987). Finally, patients were asked a standardized question about how they would be able to cope with memories of traumatic experiences and with current psychological symptoms.

Statistical significance of differences between the treatment and the nontreatment group was tested two-tailed.

Results

Sample and Living Situation

In the treatment group (A) were 5 women and 7 men, and in the nontreatment group (B) were 11 women and 11 men. The ages ranged from 28 to 47 years (mean \pm SD, A: 35.6 \pm 5.7, B: 34.8 \pm 4.5 years). All patients had completed A-level school education, and ten held university degrees. At the time of the interview, 13 were employed, 4 dependent on unemployment benefits, 6 on social welfare, 8 on scholarships, and 3 had other sources of income. Nineteen patients were living alone, 14 with a partner, and 1 within a family. There was no statistically significant difference between the two groups on any of these variables. Furthermore, both groups had been living in Germany for a similar period of time (A: 5.2 \pm 3.3, B: 6.1 \pm 6.7 years). The groups differed, however, in their knowledge of German: In

the treatment group, five patients showed very poor knowledge of German, three patients had moderate, and four patients had good knowledge of German; in the nontreatment group, there were no patients with very poor knowledge, 3 patients had moderate, and 19 patients good knowledge of German ($\chi^2 = 14.58, p < 0.001$).

Imprisonment and Torture

Twenty-six of the patients (A: 12, B: 14) were held in prison without sentence, and 8 (A: 0, B: 8) were formerly sentenced ($\chi^2 = 8.26, p < 0.01$). The length of imprisonment varied between 2 months and 10 years (A: 36.0 \pm 24.4, B: 49.7 \pm 36.1 months). Twenty-two patients (A: 10, B: 12) spent between 7 and 19 days out of this time in solitary confinement (A: 33.5 \pm 31.7, B: 28.0 \pm 33.9 days). Up to 17 prisoners were put into one cell with far less than a square meter of space for each person. Sixteen patients were kept in cells without light. All patients had been physically and psychologically tortured. Physical violence was applied to each prisoner by between two and seven different interrogators. Twenty-seven patients were beaten with cables, 21 were suspended, 11 received electrical shocks, 13 were burned on different parts of the body, and 7 were sexually assaulted. During torture 12 patients lost consciousness, 33 were wounded, 11 lost teeth, and 9 received bone fractures. Psychological torture included threats to prolong imprisonment (all patients), threats of execution (29), or mock executions (11), sexual assault on family members (3), detainment of family members (24) or of friends (7), and removal of children (18). At the end of interrogations, patients had to renounce their ideals and to say that they would now support the official state ideology. Nine patients reported having suffered from physical symptoms after imprisonment that they had not known before, and all patients stated that they had experienced psychological complaints after imprisonment that had been unknown before. Apart from the frequency of formal sentencing, there was no significant difference between the treatment and the nontreatment group in the reported features of imprisonment and torture. In both groups, approximately 8 years (A: 8.3 \pm 5.2, B: 7.9 \pm 3.3) had elapsed between the time of release from prison in Iran and the interview.

Symptoms and Diagnostic Classification

On the von Zerssen complaints list, the following symptoms were most frequently rated by the patients as moderate or severe: inner restlessness (82%), back ache (77%), worries (74%), inner tension

TABLE 1
Mean scores of HAMD, HAMA and Watson Scale for the
Treatment and for the Nontreatment Group

	Treatment group N = 12	Nontreatment group N = 22	t	p
HAMD	20.8 ± 7.0	15.0 ± 6.1	2.47	< 0.05
HAMA	26.3 ± 5.2	20.1 ± 7.1	2.63	< 0.05
Watson Scale	64.3 ± 7.9	37.2 ± 13.0	7.51	< 0.001

(68%), restless legs, pain in joints and muscles (62% each), irritability, heavy legs (59% each), forgetfulness, exhaustion, anxiety (56% each), and sleeplessness (53%). Of these symptoms, only anxiety (83% versus 41%, $\chi^2 = 6.08$, $p < 0.05$) and inner tension (92% versus 55%, $\chi^2 = 5.61$, $p < 0.05$) were reported significantly more often by the treatment group than by the nontreatment group. A similar tendency that did not reach statistical significance was found for inner restlessness, forgetfulness, and exhaustion. There was no significant difference concerning the other most frequent symptoms. The sum of all moderate or severe symptoms was 27.2 ± 4.5 in the treatment group and 19.2 ± 13.1 in the nontreatment group ($t = 2.59$, $p < 0.05$).

Table 1 summarizes the mean scores of HAMD and HAMA as well as of the Watson Scale for the two groups.

Observer ratings of psychopathology and the sum score of the PTSD-interview were significantly higher in the treatment group. This difference was particularly marked in PTSD-symptoms. In the treatment group, each symptom of the PTSD B-criterion and of the D-criterion as well as symptoms C3, C6, and C7 occurred significantly more often or to a more severe extent (B4, C7, D1, D2, D3, D5: $t = 4.52$ to 6.04 , $p > 0.001$; B2, B3, C3, C6, D4: $t = 2.90$ to 3.70 , $p > 0.01$; D1, D6: $t = 2.52$ to 2.66 , $p < 0.05$). A similar but not significant tendency was found for symptoms C4 and C5, so that just symptoms C1 and C2 did not differ in any significant way.

Table 2 shows the diagnoses of the two groups.

Comorbidity was frequent with 26 patients receiving more than one diagnosis. PTSD was diagnosed more frequently in the treatment group than in the nontreatment group ($\chi^2 = 7.36$, $p < 0.01$). Differences in other single diagnostic categories were not significant.

Ways of Coping

Patients' answers to the question as to how they coped with their memories and symptoms fell most frequently into the categories "talks with friends," "studies and sport" (56% each), "political activities" (50%), "talks with family members and children"

TABLE 2
Psychiatric Diagnoses According to DSM-III-R in the
Treatment and in the Nontreatment Group

	Treatment group N = 12	Nontreatment group N = 22
Major depression	6	6
Dysthymia	2	7
PTSD	10	8
Panic disorder	4	5
Generalized anxiety disorder	4	2
Anxiety NOS	0	2
Somatoform disorder	6	8

18 patients received 2 diagnoses, 7 patients 3 diagnoses, and 1 patient 4 diagnoses.

(47), and "contacts with other former prisoners from Iran" (29%). Although the number of reported ways of coping did not differ between the two groups, the nontreatment group stated more often that they would cope by "studies and sport" (73% versus 25%, $\chi^2 = 7.38$, $p < 0.01$). In the treatment group, "political activities" were more often stated as a way of coping (83% versus 32%, $\chi^2 = 8.80$, $p < 0.01$).

Discussion

The symptoms of long-term mental sequelae of torture in Iran are similar to those found in other studies on psychiatric disorders in torture victims. If ethnic, cultural, or other specific factors lead to any characteristic differences in psychopathology, the methods applied in this study did not reveal them. Although there was a high degree of comorbidity, all diagnoses fell into the categories of depressive, anxiety, or somatoform disorder. PTSD was the most frequent single diagnosis but clearly not the only enduring disorder occurring as a result of traumatic experience during torture (Eaton et al., 1982; Mollica et al., 1987; Allodi, 1991; Bauer et al., 1993).

For an interpretation of the differences between the treatment group and the nontreatment group, it should be taken into account that none of the two compared groups was in any way representative. Both groups were selective and small so that multivariate statistical analyses could not be applied. Furthermore, we investigated a special group of torture victims from Iran who now live in Germany, and it remains unclear to what extent the results may be generalized to torture victims from other countries. Although the two groups were small and some of the methods used to reveal differences were simple and tentatively applied, some significant differences between the two groups were

found, some of which are consistent with the hypotheses and some are not.

As hypothesized, the level of psychopathology was higher in the treatment group. Yet, the extent of the difference varies depending on which symptoms are considered. Although just a few of the non-specific complaints were more frequent in the treatment group, differences were marked and significant on each of the specific symptoms of intrusion and increased arousal as defined in B- and D-criteria of PTSD. These symptoms might especially influence motivation to seek treatment.

Contrary to our hypothesis, treatment seekers showed a poorer knowledge of German and not a better one. A poor capability to speak the language of the host country may impair the forming of new social contacts and the acquisition of new skills in the host country and, at the same time, may be a result of the lack of contacts and skills. Torture victims that do speak German can talk about their problems with German friends and are more likely to find nonprofessional help. Thus, there is a plausible explanation for the difference found, although it was not expected.

Patients in the treatment group did not—as hypothesized—report more ways of coping, but different ones. They regarded “political activities” as helpful more often and “studies and sport” less often compared to patients in the nontreatment group. Political activities of the examined patients are carried out in refugee groups and deal with the political situation in Iran. Such activities might increase their memories of the traumatic experience and intrusion symptoms, while dealing with studies and sport may be a sign of successful adaptation in the host society, and of personal problem solving.

Despite the naturalistic and exploratory approach of this study, the findings indicate that treatment seekers and nontreatment seekers among torture victims significantly differ in various respects. This conclusion is relevant not only for an understanding of motivation factors in seeking and in accepting treatment but also to advance the concept of PTSD,

which has mainly been based on findings in treatment seeking patients. Systematic studies in post-traumatic stress victims who do not seek treatment seem necessary, although they may be difficult to carry out.

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