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Cognitive-behavioral treatment of tortured asylum seekers: a case study

Metin Başoğlu[a,*], Solvig Ekblad[b], Sofie Bäärnhielm[c], Maria Livanou[a]

[a]*Section of Trauma Studies, Institute of Psychiatry, Division of Psychological Medicine, University of London, 38 Carver Road, London SE24 9LT, UK*
[b]*Unit for Immigrant Environment and Health, The National Swedish Institute of Psychosocial Factors and Health, Stockholm, Sweden*
[c]*Transcultural Center, Stockholm County Council, Stockholm, Sweden*

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Abstract

The present study examined results of cognitive-behavioral treatment (CBT) in a 22-year-old, male, tortured asylum-seeker living in Sweden. The patient received 16 sessions of CBT involving mainly self-exposure to trauma-related cues. Clinical measures (assessor- and self-rated) were completed at pre-treatment, weeks 6, 8, 12, and 16, post-treatment and at follow-up (1-, 3-, and 6-month). Treatment led to significant improvement across all measures of post-traumatic stress disorder, anxiety, and depression. The improvement was maintained at 6-month follow-up. The results suggest that CBT could be useful in treating tortured asylum-seekers and refugees despite the additional stressors experienced by asylum-seekers and refugees.

Keywords: Asylum seekers; Torture; Post-traumatic stress

1. Introduction

Current psychological treatments for survivors of torture include psychodynamic approaches (Bustos, 1992) 'insight therapy' (Vesti & Kastrup, 1992),

* Corresponding author. Tel.: +44-207-738-4967; fax: +44-207-733-7028.
E-mail address: m.basoglu@iop.kcl.ac.uk (M. Başoğlu).

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'testimony' method (Agger & Jensen, 1990; Cienfuegos & Monelli, 1983), cognitive therapy (Somnier & Genefke, 1986), and cognitive-behavioral treatment (CBT) (Başoğlu, 1992). Lack of controlled studies makes it difficult to judge efficacy of these treatments in torture survivors (Başoğlu, 1993). Most reports of effective treatment do not provide a sufficiently detailed description of the method; many appear to be a mixture of various psychotherapeutic elements and not based on a consistent theory (Başoğlu, 1992). Outcome evaluations are not based on systematic measurement of problem areas with adequate follow-up.

The behavioral model of PTSD posits that neutral stimuli present at the time of the trauma become conditioned and can then evoke high levels of arousal. Moreover, they can be paired with other neutral cues, which then become conditioned to evoke anxiety responses. Through stimulus generalization, the trauma survivor can face daily a variety of trauma reminders that elicit intense emotional or physiological responses. Escape or avoidance develops, to decrease or ward off the discomfort, which is brought on by the conditioned stimuli (Keane, Zimmering & Caddell, 1985). To reverse the effects of psychological traumatization, the behavioral model proposes prolonged exposure to trauma cues until anxiety subsides, which is a method of "de-conditioning." CBT is the treatment of choice in anxiety disorders (Andrews, 1993; Marks, 1987). There is consensus among trauma researchers that CBT is also the treatment of choice in PTSD (Foa et al., 1999).

Numerous studies in animals and humans have shown that prolonged exposure to conditioned stimuli in the absence of the unconditioned stimulus lead to the extinction of fear and anxiety responses (Marks, 1987; Mineka, 1979). In addition to earlier controlled and uncontrolled studies of trauma survivors, there are recent controlled studies that have demonstrated the efficacy of behavioral treatments in post-traumatic stress disorder (PTSD) (Foa & Meadows, 1997; Livanou, 2001). Given that PTSD is the most common diagnosis in torture survivors (Başoğlu et al., 1994c), it could also be effective in treating PTSD in torture survivors. There is indeed some preliminary evidence based on case studies (Başoğlu, 1998; Başoğlu & Aker, 1996) and an open clinical trial (Paunovic & Öst, 2000) to support this point.

In this report, we present a case study to examine the efficacy of CBT in a tortured asylum-seeker living in Sweden. A previous study (Başoğlu & Aker, 1996) had obtained good results with CBT in a non-refugee torture survivor living in her own country. The purpose of this study was to investigate whether this treatment would also be effective in an asylum-seeker who had fled into exile. Flight into exile, asylum-seeking and refugee status involve additional stressors (Baker, 1992) that may further complicate the effects of torture and make treatment more difficult.

2. Method

The patient was a 22-year-old, male, single Kurdish asylum-seeker from Turkey. He was selected from among the referrals to the Spånga psychiatric

out-patient clinic, which provides psychiatric treatment for asylum seekers from the northern and western part of Stockholm. He was the first asylum seeker who met inclusion criteria for the study, which were a history of torture, knowledge of the Turkish language, age between 18–65, absence of severe depression with serious suicidal intent, and willingness to receive CBT. Knowledge of the Turkish language was required because this would enable the first author (who speaks Turkish) to participate in the first interview with the patient and later to supervise his treatment during the course of the study (by telephone and e-mail communication with the therapist).

The patient had arrived in Sweden in 1997 and reported a history of persecution, arrest, detention, imprisonment, and torture in Turkey. He had been detained and ill treated on eight separate occasions between 1994 and 1997. On one occasion he was imprisoned for 18 months. He reported having been subjected to various forms of torture, including severe beatings, falaqa (beating of the soles of the feet), electric torture in the genitals, blindfolding, being burned by a cigarette, hanging by hands, 'Palestinian hanging' (hanging by the wrists with hands tied behind), fondling of genitals, near-suffocation caused by his face being subjected to high pressure water from a hose, isolation, deprivation of food, water, and sleep, exposure to cold showers, exposure to bright light and loud military music, threats of death (having a loaded gun against the head), threats against family, sham executions, prevention of personal hygiene, verbal abuse, mockery/humiliation, being stripped naked, prevention of urination/defecation, and deprivation of medical care. Soon after his release from 18-month long imprisonment he was re-arrested and detained for an additional five days. He left the country after this last detention.

Soon after his arrival in Sweden in 1997 he was seen by a nurse in primary care and referred to his local psychiatric team at the Spånga psychiatric out-patient clinic for assessment. He was given antidepressants (Nafazodon, 400 mg per day), which he used for 6 months with some benefit but then discontinued. He contacted the clinic again in June 1998 as he continued having psychological problems. He was then offered a course of CBT as part of the present study, which he accepted. Treatment started in October 1998.

In psychiatric examination he reported recurrent flashbacks and nightmares relating to his torture, distress when faced with reminders of the torture (e.g., particular sounds), fear of having a nightmare, disrupted sleep, distress when thinking or talking about his torture, problems with concentration, increased irritability, anxiety, fatigue, headaches, pains in the chest, and feeling that he was still under threat from the Turkish authorities although he knew that he was safe in Sweden. He avoided social interactions and had difficulty in forming close relationships. His social avoidance and concentration difficulties made it difficult to attend language courses and learn Swedish. He tried to reduce his anxiety and irritability by using alcohol, pacing up and down in his room, and occasionally by engaging in a self-harming behavior that involved burning himself with cigarettes. The self-harming behavior seemed to be related to his torture experience, which

involved being burned by cigarettes. Pacing was a habit, which he found useful in alleviating anxiety while he was in prison.

The patient was provided information about the purpose of the study and written informed consent was obtained. The patient was reassured about confidentiality by emphasizing that information would not be made available to a third party without his permission and that it would only be used for publication in professional journals. Confidentiality was also observed by modifying some of the case details to avoid identification of the patient.

A single case experimental design was used to examine treatment outcome. To control for the possible effects of time and therapist contact, two baseline assessments (Baseline 1 and Baseline 2) were conducted in 4 weeks. Treatment started after Baseline 2 and subsequent assessments were carried out at post-treatment and 1-, 3- and 6-month post-treatment. The therapist conducted the assessments because an independent assessor was not available. The third author conducted the treatment after a training course in CBT that was organized by the first author, who also provided regular supervision throughout the treatment. The study was carried out at the Spånga psychiatric out-patient clinic in Stockholm.

2.1. Treatment

At Baseline 1 the patient was first given information on the nature of his symptoms and their connection with his torture experience. He was then given explanation about the treatment and its rationale. Actual exposure instructions were given after the second baseline assessment. The treatment involved 14 sessions, mostly once a week but on some occasions with longer between-session intervals. Sessions were conducted with the help of an interpreter.

The patient was first asked to identify the trauma-related activities that he feared and avoided and grade them in a hierarchical fashion, from the least to the most distressing. He avoided sleeping because of fear of nightmares about the torture. He had difficulty socializing because he felt anxious with people and also feared that he might lose control and assault someone. He avoided traveling on buses because this triggered flashbacks of a past incident when the police had boarded a bus he was on and arrested some people. He did not watch TV and films because certain news or scenes of violence reminded him of his torture experience. He avoided dealings with the Swedish immigration office and his lawyer because this meant having to talk about his torture experience.

The patient was then asked to carry out self-exposure to distressing situations until he no longer felt anxious. These tasks or 'treatment targets' were determined in consensus with the patient. Live exposure started with the least anxiety-evoking situations and continued with more distressing ones. Environmental circumstances or cues that contributed to the distress at the time of each exposure task were identified and discussed with the patient. Anxiety associated with each situation was rated by the patient on a 0–8 scale before, during and after each exposure task. When a rating of 2 or less (minimal anxiety or distress) was

achieved and maintained during a particular task, exposure was terminated. The patient was asked to practise self-exposure daily and to keep a diary, recording the details of homework tasks and subjective anxiety ratings before, during and after each session.

The treatment started with exposure to buses. The first session was carried out with the help of the therapist because the patient was initially reluctant to carry out this exercise on his own. The patient continued with this task until his anxiety subsided. He then moved on to other treatment targets, which he tackled by himself. These included meeting with people regularly, watching TV and reading newspaper articles, and dealing with Swedish Immigration authorities regarding the asylum application. The sessions, which lasted one hour on average, were conducted daily. After all treatment targets had been achieved during treatment, the patient continued practising exposure in a structured way during follow-up. The amount of time devoted to exposure homework tasks was on average one hour per week.

The treatment focused more on behavioral than cognitive interventions. Cognitive interventions were limited to information about traumatic stress symptoms and their connection with the torture. No systematic attempts were made to identify anxiety-evoking thoughts or beliefs and challenge and replace them with more adaptive ones. Beliefs or interpretations relating to the torture were not discussed during treatment. The patient was told that prolonged exposure to trauma cues would lead to reduction in distress and increased sense of control over traumatic stress problems. He was given verbal praise for each achievement in treatment and encouragement for subsequent exposure tasks.

The patient's application for political asylum was rejected by the Swedish authorities after the fourth week in treatment. This led to a temporary worsening in his symptoms. He felt more depressed, irritable and had increased difficulty with sleep and concentration. There was also an increase in his distress related to exposure tasks so he stopped practising exposure for a week. He was then encouraged to contact his solicitor and immigration authorities, which he managed to do. Approximately two weeks later, with encouragement from the therapist, he resumed treatment and continued practising exposure to buses and social situations. The patient was granted political asylum during the 16th week in treatment.

2.2. Assessment

Psychiatric status was assessed using the Structured Clinical Interview for DSM-IV (SCID) (First, Gibbon, Spitzer, & Williams, 1996). The Clinician-Administered PTSD Scale (CAPS) (Blake et al., 1996) was used to assess PTSD in the last month. The Structured Interview for Survivors of Torture (SIST) (Başoğlu et al., 1994c), was used to elicit information about (a) demographic features and personal history, (b) events leading up to torture, and political activities leading to arrest and detention, (c) details of the torture experience, and (d) post-trauma adjustment.

A measure of Main Problems (Marks, 1986) was used to monitor progress in the patient's problems. This was a single item that measured the patient's overall presenting problems on a 0–8 scale (0 = not at all a problem/does not interfere with my life, and 8 = extremely severe problem/interferes with my life all the time). Other measures included the Work and Social Adjustment Scale (WSA) (Marks, 1986), the modified Mississippi Scale for Combat-Related PTSD (PTSD-RS)(Keane, Caddell, & Taylor, 1988), State-Trait Anxiety Inventory (STAI)-(Spielberger, Gorsuch, & Lushene, 1970), General Health Questionnaire (GHQ) (Goldberg & Hillier, 1979), and Beck Depression Inventory (BDI) (Beck, Ward, Medelson, Mock, & Erbaugh, 1961). The Turkish-language versions were used for the BDI (Hisli, 1987), the STAI (Öner & LeCompte, 1982) and the GHQ-28 (Kiliç, 1996). Clinician's Global Impression–Improvement (CGI) and Patient's Global Impression–Improvement (PGI) were used to measure overall clinical improvement. These measures (Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998) ranged from 1 (very much improved), through 4 (no change) to 7 (very much worse). The assessments using all study measures were conducted at Baseline 1, Baseline 2, week 20 (post-treatment), and 1-, 3-, and 6-month follow-up. Improvement during treatment was measured at weeks 6, 8, 12, and 16 using the CAPS and the BDI.

The patient met the SCID criteria for PTSD, major depression and dysthymia at both Baseline 1 and Baseline 2.

3. Results

Table 1 shows the treatment outcome on the clinical measures. The scores on the main outcome measures showed no reduction from Baseline 1 to Baseline 2 suggesting that there was no improvement related to time, therapist contact or the detailed assessment conducted at Baseline 1. On the other hand, substantial improvement was noted on all measures from pre- to post-treatment. The treatment gains were maintained at 6 months follow-up. The patient did not meet the criteria for diagnosis of PTSD at post-treatment and follow-up.

Treatment achieved a patholytic effect with reduction in PTSD, depression, anxiety, and social disability. Improvement continued after treatment on most measures and this was particularly distinct in the WSA scale. Similar improvement was noted on both assessor- and self-rated scales. This is important given that the assessor-ratings were not carried out by an independent assessor. An exception was the PGI, which showed minimal improvement at post-treatment, 1- and 3-month follow-up when the CGI was rated as 'much improved' at the respective assessment points (Table 1). The CGI was more consistent with the other measures, which suggested substantial improvement in traumatic stress problems. This discrepancy may be due to validity problems of the PGI, which has not yet been validated in Turkish. A more recent study (Başoğlu et al., unpublished data) of earthquake survivors showed that some Turkish people tend to rate

Table 1
Scores on clinical measures at pre- and post-treatment and follow-up

	Baseline 1	Baseline 2	Post-treatment	Follow-up (month)		
				1	3	6
GHQ-28 (range 0–56)	52	46	9	3	0	0
STAI						
State anxiety (range 20–80)	77	69	49	47	43	41
Trait anxiety (range 20–80)	77	74	56	53	51	45
PTSD-RS (range 35–175)	148	148	110	97	80	88
WSA: Ability to work						
Self	6	8	4	3	–[b]	1
Assessor	6	7	3	2	–[b]	0
WSA: Home management						
Self	8	8	4	7	–[b]	2
Assessor	6	7	3	6	–[b]	0
WSA: Social life						
Self	8	8	4	3	–[b]	1
Assessor	7	7	4	3	–[b]	0
WSA: Private leisure						
Self	8	8	4	3	–[b]	2
Assessor	7	7	4	3	–[b]	0
WSA: Family relationships						
Self	8	8	4	3	–[b]	2
Assessor	6	7	3	3	–[b]	0
Main problems						
Self	8	8	3	2	2	2
Assessor	6	8	2	2	2	2
CGI[a]	–	–	2	2	2	1
PGI[a]	–	–	3	3	3	2

GHQ: General Health Questionnaire; PTSD-RS: Civilian Mississippi Scale (modified version); STAI: Spielberger State and Trait Anxiety Inventory; WSA: Work and Social Adjustment Scale; CGI: Clinician's Global Impression–Improvement; PGI: Patient's Global Impression–Improvement.

[a] 1 = very much improved, 2 = much improved, 3 = slightly improved, 4 = no change, 5 = slightly worse, 6 = much worse, 7 = very much worse.

[b] Data unavailable at 3-month follow-up.

themselves on the PGI as 'minimally improved' when there is over 60% reduction in their traumatic stress reactions, particularly when they are experiencing stress related to current life problems. At 6-month follow-up, however, the PGI rating (much improved) became more consistent with the other ratings.

Results of treatment on the CAPS and BDI scores are presented in Figs. 1 and 2. The improvement in these measures was consistent with the change in the other clinical ratings. As the patient was granted political asylum just before the week 16 assessment, some of the improvement observed that week might have reflected

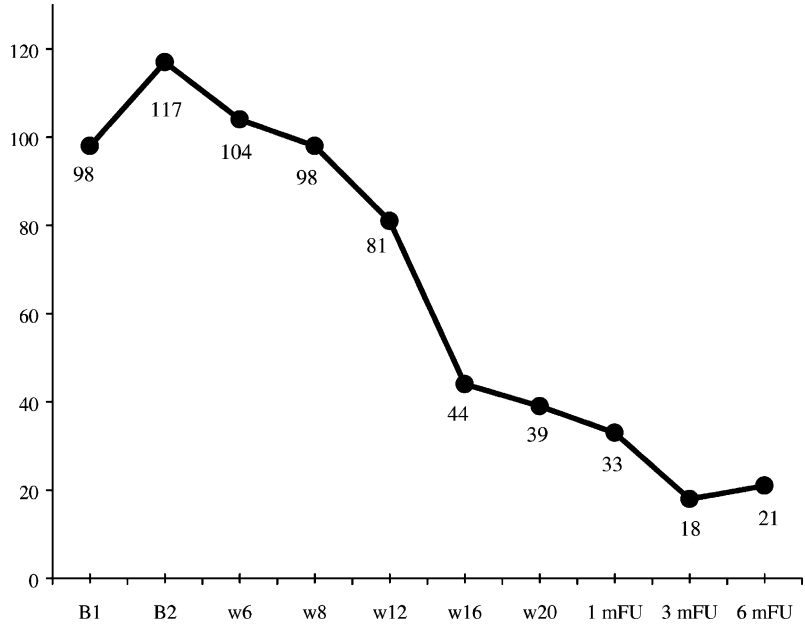

Fig. 1. Improvement in PTSD symptoms (CAPS). CAPS: Clinician Administered PTSD Scale (sum of frequency and intensity scores, range 0–136); B1: Baseline 1, B2: Baseline 2; w6, w8, w12, w16, w20: weeks 6, 8, 12, 16, and 20; w20: Post-treatment; 1-, 3-, and 6-mFU: 1-, 3-, and 6-month follow-up.

the positive impact of this event. Both the BDI and the CAPS, however, showed an improvement at week 12, suggesting that the patient had already begun to improve before he heard about the granting of his asylum application.

4. Discussion

CBT was useful in reducing symptoms of PTSD, depression, and anxiety in our patient. Improvement was achieved in a relatively short period of time (14 sessions), maintained at 6-month follow-up and generalized to all areas of social functioning. This case study provides further evidence that CBT may be effective in treating torture survivors who are refugees or asylum-seekers. This is consistent with the results of an open clinical trial (Paunovic & Öst, 2000) involving 16 tortured refugees in Sweden who were successfully treated with CBT and other studies showing that CBT achieves lasting improvement in various anxiety disorders (Marks, 1987), including PTSD (Foa & Meadows, 1997; Livanou, 2001; Marks et al., 1998).

Part of the improvement during follow-up might be due to the fact that the patient was granted political asylum towards the end of the treatment. Although

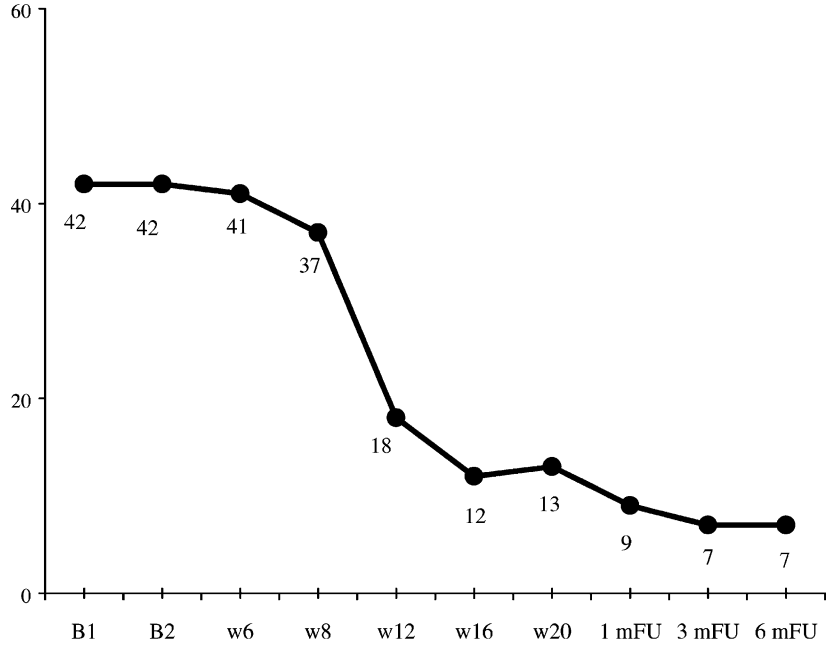

Fig. 2. Improvement in symptoms of depression (BDI). BDI: Beck Depression Inventory (range 0–63); B1: Baseline 1, B2: Baseline 2; w6, w8, w12, w16, w20: weeks 6, 8, 12, 16, and 20; w20: Post-treatment; 1-, 3-, and 6-mFU: 1-, 3-, and 6-month follow-up.

we cannot rule out this confounding factor, reduction in the CAPS and BDI scores before this event at week 16 suggests that the patient had already begun to improve, despite the possibility of repatriation. This is consistent with our earlier work with non-refugee torture survivors (Başoğlu and Aker, 1996), which suggest that behavioral interventions can reduce PTSD despite an environment that carries realistic threats to safety. Indeed, interventions that enhance sense of control over traumatic stressors may reduce PTSD, even in a situation of ongoing traumatic stress (Başoğlu & Mineka, 1992).

The CAPS scores showed a slight increase after the first baseline assessment (see Fig. 1). While it is difficult to ascertain the reasons for this increase, it might reflect either ordinary fluctuations in PTSD symptoms or the effects of the first detailed assessment during which the details of the traumatic events were discussed. Thinking and talking about the traumatic events might indeed be construed as imaginary exposure. Exacerbation of symptoms in the early stages of behavioral treatment is often observed, not only in torture survivors (Başoğlu & Aker, 1996), but also in assault victims (Kilpatrick, Best, & Connie, 1984) and other phobic and agoraphobic patients (Marks et al., 1993). Such effects of behavioral treatment are not harmful and subside with continuation of the treatment (Shipley & Boudewyns, 1980). Informing the patient of this possibility

before treatment often helps the patient to go through this process without much difficulty.

This case study was conducted as an extension of the first author's work with non-refugee torture survivors who are currently living in their home country. The research question was whether the good results obtained with CBT in non-refugee torture survivors (Başoğlu & Aker, 1996) could be replicated with refugee torture survivors. Compared with non-refugee torture survivors, refugees or asylum-seekers might experience more psychological problems because of the additional problems of uprooting, flight into exile, and resettlement in a host country. Although such problems could conceivably interfere with positive response to CBT, our results suggest that this need not necessarily be the case. This might be explained by some research findings, which suggest that torture and subsequent life stressors lead to different types of psychological problems. A previous study (Başoğlu, Paker, Özmen, Taşdemir, & Şahin, 1994b) has shown that torture is associated with PTSD but not depression whereas lack of social support is related to depression but not PTSD. Refugee status, which often involves deprivation of social support networks, might therefore contribute to depression but not to PTSD. Comorbid depression need not necessarily impede successful treatment of PTSD with CBT, provided that the depression does not undermine the patient's motivation for treatment. With successful exposure treatment, depression improves with improvement in PTSD (Marks et al., 1998) as well as in other anxiety disorders (Başoğlu, Lax, Kasvikis, & Marks, 1988; Başoğlu et al., 1994a).

As noted earlier, treatment had more of a behavioral than cognitive focus. Nevertheless, treatment achieved significant clinical improvement. This is consistent with the results of a recent treatment study in Sweden (Paunovic & Öst, 2000), which compared the efficacy of CBT and exposure treatment in 16 refugees. Exposure treatment and CBT achieved similar percentages of reduction in PTSD symptoms (49 vs. 53%, respectively). The fact that significant clinical improvement can be achieved with a predominantly behavioral approach has important implications in work with refugees. Language and cultural barriers often pose serious problems in work with refugees. Treatment often needs to be conducted through an interpreter, which makes communication with the patient a difficult and time consuming task. This problem often makes cognitive interventions difficult, because, compared with behavioral interventions, they require more lengthy communications and discussions about the details of the traumatic events and the beliefs associated with them (Başoğlu, 1992, 1998). Exposure treatment, on the other hand, requires relatively less verbal communication with the patient (often centering around the issues of task setting) once the treatment rationale is explained and understood by the patient. Thus, compared with other forms of psychological treatment, behavioral interventions are more easy and practical to administer with patients who have language problems.

CBT is sometimes regarded as a 'superficial' form treatment that deals only with symptoms and not the 'essence' of the patient's psychological problems. Because this misconception may lead to some refugees being deprived of

effective psychological care, it deserves some attention here. There is abundant evidence in the anxiety disorders literature that improvement achieved by CBT generalizes to all areas of functioning, including social, work, family and marital adjustment (Marks, 1987; Marks et al., 1993, 1998). The fact that reduction in torture-related stress symptoms in the present study as well as in two previous case studies (Başoğlu, 1998; Başoğlu & Aker, 1996) has also improved social adjustment and enhanced quality of life provides further support for this point.

In conclusion, there is some preliminary evidence that CBT is a promising treatment in the rehabilitation of tortured asylum-seekers and refugees. Clearly, results from a case study have limited generalizability and there is need for controlled studies to ascertain the efficacy of CBT in tortured asylum-seekers and refugees. A more systematic study of this issue is in the interest of both refugees and the host countries that are faced with the challenge of providing mental health care to large numbers of refugees. This is indeed a serious problem given that according to recent reports there are approximately 11.5 million refugees and asylum seekers worldwide (United Nations High Commissioner for Refugees, 2000) and 5 to 35% of them are estimated to have a history of torture (Baker, 1992).

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