Psychological Assessment and Diagnosing of Traumatized Refugees

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Introduction

The purpose of this article is to review a number of difficulties that appear when evaluating the treatment of traumatized and tortured refugees. The starting point is that treatment is planned and based on systematically collected information. Without this starting point, treatment will be more casual and somewhat difficult to evaluate.

Recently, the demand for systematic assessments has grown with an increasing knowledge of the extent of traumatization in particular groups of refugees. This knowledge (of the extent of traumatization) increases the need for treatment and efficiency of treatment. When interdisciplinary treatments of long duration are called for, naturally the granting authorities require documentation as to the magnitude of the clients' problems and the effects of the treatment.

In traditional analytic treatment an isolated, neurotic symptom can be regarded as a mysterious riddle for the psychologist to solve, like a kind of detective. An assessment of the client's condition is part of the total information of the case, which forms the basis of solving the riddle. With severely traumatized clients, the problem is not the isolated and well-defined symptom, but rather a great amount of symptoms and known causes stemming from abuse and violent attacks. The treatment is complicated by cultural differences, the number of losses and living in exile, which are

factors that normally maintain the traumatization or even reinforce the adversive condition. In many cases, treatment may last several years and imply an intense and coordinated effort from physiotherapists, social workers, psychologists, doctors, and cultural workers. When it comes to traumatization, few professionals have been trained at college with regard to the effects of severe psychical traumatization, diagnosing traumatization, and traumatization treatment, as these fields are relatively new. Since 1992, the author has been teaching these three topics as an integrated part of a two-year "crisis-programme" at the Department of Psychology at the University of Aarhus, and for a number of years I have supervised several Danish treatment centres for traumatized and tortured refugees.

Difficulties in assessing trauma as part of ordinary clinical practice

The starting point is that fundamental traumatic reactions are quite consistent regardless of culture (cf. Carlson & Rosser-Hogan, 1994), although a few distinct symptoms may be specific for a certain culture. In order to prevent misunderstandings, misjudgement, and wrong treatment, a good quality of interpretation is of vital importance when evaluating and treating people from different cultures.

The various treatment centres have different referral and assessment procedures. In some cases, the waiting time is so long that the condition of the clients may have changed significantly and a new assessment must be made at the beginning of treatment. Some clinicians will use the first session(s) to assess the size of the problems and to make a treatment plan together with the client, while others will concentrate on building-up alliance, motivation and on adjusting the expectations of the client (e.g. as to family reunification and chances of recovery).

Some studies indicate that in many cases the magnitude of the problems is underestimated during initial assessment. A Danish study of young Bosnian refugees (Tibor, Nørregaard & Packness, 1995) showed that the medical doctor only found symptoms of traumatization in about half of the population and only one or two traumatic events per person. A follow-up study (Elklit, Nørregaard & Tibor, 1999) of the same population showed that 97% had traumatic experiences with an average of six types of direct traumatic exposure per person and additionally seven types of witnessing people close to them being exposed to traumatic events. This considerable under-reporting is of great importance in targeting the need for treatment and is probably an expression of unacknowledged and unprocessed counter transference. Additionally, the clinician may only want his client to open up to a limited extent, in order for the client to pull him-/herself together at the end of the session. This strategy is reasonable when it comes to treatment, but is not sufficient when it comes to assessment.

The clients' wish, ability, and will to describe problems and symptoms can be limited. Some clients give wrong or misleading information, because they wish to achieve something in particular. However, this is normally discovered during treatment, when the client is not cooperating. In some cases, the client is not aware that specific symptoms can be essential to the planning of treatment. The client is hardly to blame for this; in this case, we as clinicians must take the responsibility – for not being thorough enough and having settled for too restricted problem definitions. Here, the interplay between the psychologist's *knowledge* about the relation between trauma, culture and symptoms and her *interrogative method* is important. Insufficient basic knowledge easily results in insufficient information. In other cases, the client is reluctant to reveal symptoms out of fear that the psychologist might conceive them as signs of mental disease; sometimes re-experiencing and flashbacks are hidden to avoid condemnation and stigmatization. The differential diagnostic

problems between PTSD and psychotic states are reviewed by Elklit (2004). Central marks are the content of hallucinations and delusions, which are meaningful in relation to the traumatic events, a relatively intact reality testing, lack of response of antipsychotic medicine, and the level of the plasma dopamine beta hydrolaxe level (ibid.). An active and comprehensive examination is experienced as a relief by many clients, as they would feel recognized by an expert "who knows how I feel and think".

Willis & Gonzalez (1998) strongly recommend the use of standardised instruments in assessing traumatised refugees. Their main argument is that the recognition of relevant response alternatives, which is the task in self reporting, is a considerably easier cognitive and emotional task than the active recall of concrete episodes, which is typical of the clinical interview. In addition, self reporting is preferred by clients when it comes to situations that contain elements of socially shameful events.

Important experiences may be repressed or not available. Other experiences may be available, but linked with shame (and the risk of social expulsion). In these cases, some parts of the clients' story do not emerge during the initial assessment, but only later on in the treatment. Finally, there are symptoms, which are conceived by some clients as so ordinary that they will be regarded as ego-synton traits, while other clients regard them as possible consequences of traumatization – cf. the diagnosis "personality changes following catastrophic experiences" (F62.0) in ICD-10 (WHO, 1992). It is my experience that an active and comprehensive examination reduces the amount of withheld information. When the client experiences the clinician's interest and thoroughness, the meta-communication is, (1) that the information is important and constitutes a pattern in the problem analysis, and (2) that treatment is governed and part of an overall scheme.

Is traumatization diagnosable through ordinary psychological testing?

In many ways it would be easier if ordinary psychological testing could be used with traumatized refugees. But on the whole, one must say that the most commonly used psychological tests are not suitable for diagnosing chronic Posttraumatic Stress Disorder (PTSD) or other traumatic sequelae. Usually, the purpose of applying projective tests, like Rorschach, the TAT, or Rotter's sentence completion tests, or self-reporting questionnaires like the Minnesota Multiphasic Personality Inventory (MMPI), Symptom Check List 90 (SCL-90), or Millon's Clinical Multiaxial Inventory (MCMI-III), is to give insight into the personality dynamics. Several researchers are working on the development of special PTSD-subscales or PTSD-indexes for some of the above tests, but up till now the results have not been satisfactory. The MMPI has a PTSD-subscale (the PK-scale) that was constructed by Lyons & Keane (1992), who have chosen 46 MMPI-2 items for measuring PTSD-symptoms. Among the 46 items no items describe intrusive re-experiencing symptoms or the particular kind of emotional numbing, which is characteristic for PTSD. Solomon, Keane, Kaloupek, & Newman (1996) found the PK-scale unsuitable for PTSD diagnosing. Wetzel et al. (2003) concluded in line with earlier studies that the PK scale primarily is a measure of general dysphoria and that it is not able to discriminate between clients with and without PTSD in populations with a considerable amount of psychopathology. Also, as evidenced by Carlson & Armstrong (1994), the F-scale of the MMPI (the so-called lie scale) is elevated with PTSD. The reason for this is that some normally rare symptoms are frequently found with traumatized people ("Every other night I have nightmares"; "I think my sins are unforgivable").

The PTSD scale (scale R) of the MCMI-III has recently been assessed in studies of US combat veterans (Craig & Olson, 1997; Hyer, Boyd, & Stanger, 1997). Although a low internal consistency

was noticed, in both studies the R-subscale successfully differentiated between PTSD and non-PTSD cases.

Trauma history

Although it is important to know the personal dynamic of the client when planning treatment, this knowledge cannot replace a more precise trauma specific knowledge, i.e. a survey of specific assaults and losses and the subsequent symptoms. In the case of one single trauma the clinician will normally begin with a relatively detailed questioning in order to understand the incident in detail. With traumatized refugees, a systematic survey of different kinds of assaults and losses and of arrests, imprisonments, flight and living in exile by means of a horizontal timeline is a natural starting point. For this purpose, a number of tools have been developed especially for refugees and torture victims.

The most commonly used instrument for assessing trauma exposure is the Harvard Trauma Questionnaire Part I (HTQ-I) (Mollica et al., 1992) which was designed to measure war related trauma events in refugees who have survived civil war and ”ethnic cleansing”. The first part of the HTQ consists of 17 trauma events historically reflecting common Indochinese refugee experiences, Some revisions of the HTQ-I has been reported (Tibor et al., 1996, Elklit et al., 1998), as several aspects of e.g. a European civil war and ethnic cleansing that was not included in the original HTQ (e.g. threats on life, physical violence, psychological violence, loss of home, forced labor etc.). In the calculation of traumatic events, the questions that reflect intrapsychic reactions should be excluded because they correspond to DSM-IV PTSD stressor criteria A2, i.e., the person's response involved intense fear, helplessness or horror. The remaining items in the first part of the HTQ covers the A1 PTSD stressor criteria, i.e., the person experienced, witnessed, or was confronted

with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

The modified HTQ-I mentioned above also differed from the original HTQ-I which has three positions: a) ”exposed to”, b) ”witness of/has this happened to your family or friends”, and c) ”heard of”. It is debatable if the third position can be conceived as traumatogenic, but both the first and second position reflect situations that might be traumatogenic and therefore should be counted separately.

A number of lists of specific methods of torture are described in the literature (Allodi & Cowgill, 1982; Goldfeld, Mollica, Pesavento, & Faraone, 1988; Hougen, 1988; Kosteljanetz & Aalund, 1983; Ramsay, Gorst-Unsworth, & Turmer, 1993; Rasmussen, 1990; Turner, Van Velsen, & Gorst-Unsworth, 1990; Vesti, Somnier, & Kastrup, 1992). The development of one scale based on expert consensus is recommended; for clinical purposes a medical examination is often an integrated part of a comprehensive treatment and the clinician will often have this information before the psychological treatment begins.

The systematic questioning (or self-reporting) implies that (a) the client is aware (and is aware that the therapist is aware) that listed events are of importance to the suffering, (b) that during the assessment one will not go into detail with the assaults and losses, but prior to treatment it is important to have an overview of the experiences of the client, and (c) that during treatment a more detailed processing will take place.

Traumatization effects

In the diagnostic interview, focusing on relevant diagnoses and asking questions based on the criteria in the diagnosing manuals achieve an optimal examination of traumatization effects. The most common possible diagnoses for refugees at rehabilitation centres are chronic PTSD, personality change after catastrophic events (F62 in ICD-10), DESNOS (Disorder of Extreme Stress Not Otherwise Specified in DSM-IV), depression (MDD), anxiety (GAD), phobia, abuse, and somatoform disorders. Neither of the two extensive diagnosing systems (DSM-IV and ICD-10) is fully developed to include effects of severe traumatic events. The DSM-IV is far more suitable for describing PTSD than the ICD-10, but on the other hand the DSM-IV has no fully qualified diagnosis for long-term personality changes following catastrophic events. The DSM-system is preferable to ICD-10 in diagnosing PTSD because (a) it is based on a psychological and not on a normative sociological stressor criterion, (b) it is well-researched, (c) to a high degree it specifies the avoidance criteria, which are not specified in the ICD-10, (d) it allows several, simultaneous diagnoses, and (e) it invites one to consider whether the disorder is influenced by somatic conditions (Axis III) and psychosocial stressors (Axis IV) and to see the personality structure (Axis II) in conjunction with the symptom disorder (Axis I). Likewise, the DSM system also makes it possible to work with levels of PTSD instead of defining the condition in a categorical way. As PTSD is a serious condition that can be difficult to treat, sub-clinical degrees of PTSD also often warrant treatment.

Figure 1 Problem Areas, Tools and Potential Diagnoses in Assessing Traumatised Refugees

Problem field	*Instruments*	*Diagnosis*
Dissociation; Reexperiencing; Avoidance behaviour; Hypervigiliance	Diagnostic interview *combined with:* HTQ	Degree of chronic traumatisation PTSD, F62, DESNOS Adjustment Disorder
Personality structure/disorder	Diagnostic interview *combined*	Personality changes

	with: SCID; MCMI; Rotter's Sentence Completion Test	
Symptom disorder Social functioning	Diagnostic interview *combined with:* GHQ; TSC; BDI; SCL-90; GAF	Comorbid psychological disorders MDD, GAD, fobia, Somatoform disorder, Addiction

As mentioned, the primary symptoms should be examined on the basis of a diagnosis manual, a structured interview (SCID, CAPS or the like) or a self-reporting questionnaire like Harvard Trauma Questionnaire – Part IV (HTQ-IV), or a similar questionnaire, PTSD Symptom Scale (PSS), Posttraumatic Diagnostic Scale (PDS), Posttraumatic Stress Disorder Check List-Civilian Version (PCL-C) which all follow the DSM diagnosing manual. Today the use of the Impact of Event Scale (IES) or the Posttraumatic Symptom Scale (PTSS-10) is not recommendable as far more precise tests are available. In addition to the diagnostic items, the HTQ contains 14 questions about guilt, hopelessness, insanity, fear, betrayal, and other typical reactions to traumatic events and is definitely the most suitable questionnaire for refugees. An important detail is which load makes a single symptom count. For instance, in the PDS the second lowest items on a 4-point Likert scale are included, and in the HTQ only items with no less than the second highest value, corresponding to the symptom occurring "quite a bit", are included.

The Harvard Trauma Questionnaire-Part IV (HTQ), (Mollica, Caspi-Yavin, Bollini, Truong, Tor & Lavelle, 1992) is a simple and reliable screening instrument that is culturally sensitive, has a good internal consistency, a good concurrent validity, and is more efficient than e.g. HSCL-25 in identifying PTSD. Part four consists of 30 items, of which 16 correspond to the PTSD diagnosis in DSM-III-R, covering the three main clusters of PTSD: Reexperiencing, avoidance and hypervigilance. The answers are reported on a 4-point Likert scale, ranging from: "extremely",

"quite a bit", "a little", and "not at all". The three subscales can be scored separately or the average for all 30 items can be added and a cut-off value can decide the diagnosis. A threshold of 75 (corresponding to a mean score of 2.5) was suggested by the authors (ibid.), which for a refugee population of 91 persons resulted in a sensitivity for PTSD of .78 and a specificity of .65. More recent studies (e. g. Fawzi et al., 1997) have suggested lower threshold values of 1.17 in a study of former Vietnamese prisoners of war. Hereby a sensitivity of .98 and a specificity of 1.0. was achieved. The categorial scoring, although, is preferable, because in this way one approaches the specific weight of symptoms that DSM-IV prescribes for PTSD.

In a Danish study of the HTQ based on more than 4200 persons (Bach, 2002) the internal consistency was also satisfying; Cronbach's alpha for the three subscales was .77- .84 and for the total scale .94. Mollica et al. (1996) found a test-retest reliability of r = .92.

Moreover, several comparative studies have shown high concordance between self-report and interview measures of PTSD (Foa, Riggs, Dancu, & Rothbaum, 1993; Solomon, Benbeinstry, Neria, Abrahamowitz, Ginzburg, & Ohry, 1993; Norris, Perilla, & Murphy, 2001).

Comorbidity is high with PTSD; many studies show that together with this the prevalence of anxiety and depression is about 70-80% (Kessler et al., 1995). The breakthrough in the treatment of PTSD has been the understanding of the PTSD symptoms as being primary and anxiety, depression and other symptoms as being secondary. When treatment focuses on the primary symptoms a lasting improvement is achieved, whereas focusing on the secondary symptoms does not entail great change.

Due to the high degree of comorbidity, in the diagnosing interview, depression and other sequelae should be evaluated on the basis of the Present State Examination (PSE), the SCID or via self-reporting questionnaires like the Trauma Symptom Checklist (TSC-35), the SCL-90 (or its short form: the BSI), or the GHQ (cf. Figure 1). Depression and anxiety can be measured by means of the Beck Depression Interventory (BDI) (Beck & Steer, 1993), the depression and anxiety subscales of the MCMI-III, the Hopkins Symptom Checklist (HSCL) and others. It is important to not focus only on anxiety and depression as comorbid conditions. Aggression, difficulties in relation to others, somatisation, dissociation, and sleeping difficulties are examples of other common symptoms. The most suitable questionnaire covering these symptom areas is the TSC (Briere & Runtz, 1989; Elklit, 1990; Duel & Krogh, 2003, Elgaard, 2004), which is especially developed to uncover psychological traumatic consequences. In connection with the TSC-35 a Danish norm set is available from the author. The dissociative symptoms can be studied more in depth with Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986; Spindler & Elklit, 2003).

As many victims of torture have been beaten, kicked and thrown around, it would be natural to examine if there has been head injuries with organic impairment. The Trail Making Test (Reitan, 1958; Elklit, 1992) is a very practicable screening tool used to decide if torture victims should have referral to a more detailed neuropsychological examination.

The personal luggage of the client

The planning of assessment and treatment should take issues like culture and personality into consideration. Having a cultural worker as part of the treatment team is often advantageous. This implies that the cultural workers are informed about the treatment and actively take part in the initial assessment and the evaluation of the treatment process, and that their specific cultural

knowledge is respected. All too often the cultural staff, working as interpreters, are not treated equally with the other staff (Holmgren, Søndergård, & Elklit, 2003).

Torture not only hits 'a carrier of a culture' but also a personality with a life history and a socialising that we need to know (Thrane & Elklit, 2002). The personality can be either vulnerable or strong when torture strikes. It is important for therapists to learn about the personality before the trauma in addition to the present personality. Therefore, an essential task in the initial assessment is to get a picture of the "old" and the "present" personality. In therapy with traumatized refugees, the traumatic events often overshadow the personality and not until later the therapist realizes how the original personality was. Early personal damage demands another kind of treatment than personal structures that have reached a high functional level.

A clinical interview with focus on adolescence and family relations is commonly used for the assessment of the early personality. Rita-Leena Punamäki, the Finnish psychologist, has developed a special systematic form especially for refugees. This form has certain features in common with the Bell Object Relation Inventory.

The present personality is assessed by analysing manner and behaviour during the interviews, by complaints and worries, and through the details of the told experiences and level of functioning. A more systematic approach could be to use the MCMI-III, which analyses the personality structure based on an interpersonal perspective that is very predominant in present day's understanding of psychopathology, and which constitutes the basis for the DSM-IV axis II. A positive characteristic of the MCMI is the dimensional thinking – namely, that the quantity of personality traits and problems varies and is likely to change under the influence of biological factors and social

circumstances. Apparently, projective tests are more imprecise due to cultural differences and for this reason they are not recommended.

The working method in general

In the assessment, the first task is to create an atmosphere where the client cooperates in giving the clinician adequate description of his background and the traumatic events. This process stresses the client, and some may be reminded of former interrogation situations and feel great pressure. In this case, it is important that the psychologist is aware that the best help is being thorough and precise as to reality (the historical and the present) and to avoid misinterpretations and overlooking facts. Alternatively to the initial assessment, one can work with the most salient problems (maybe of the physical or social kind, where we as clinicians are not experts) with no overview, background or direction.

Many clients conceive the systematic assessment method as reassuring. They feel that they and their experiences are taken seriously and that the clinician tries to get a comprehensive view in a short time and that we have a working scheme. This scheme implies that the assessment is finished, before treatment begins, and that the clinician helps the client to let go of pressing problems reassuring that they will be looked at when treatment begins.

The communicated attitude is as follows: “I will try to make an assessment of the type and magnitude of your problems; I would like to get a comprehensive view, so that I can plan the right treatment and avoid overlooking any material, that is presently important”.

Finally, it is worth underlining that self-reporting cannot stand alone as a basis for diagnosing, but has to be confirmed by means of interview, observation, and other information. The multimodal principle is central to all clinical assessment, because clients might withhold information or be unaware of certain circumstances that we find relevant, and because we clinicians also have blind spots. It is particularly difficult to make assessments of avoidance phenomena by means of interviews (self-reporting questionnaires are likely to be more reliable). Self-reporting may become more commonly used simultaneously with the development of more relevant test norms for traumatized refugees. This line of assessment holds promises for increasing and securing the quality of treatment of traumatized refugees, because as proper assessment is carried through, a sound base for a subsequent assessment of treatment effects is created, and this follow-up will be an expected outcome.

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