POST TRAUMATIC STRESS DISORDER AMONG SURVIVORS OF AFGHAN TORTURE AND CONCENTRATION CAMPS

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Thirty Afghan refugees who had survived torture and concentration camps experience were subjected to thorough psychiatric search. All of them met the DSM-III R Criteria for post- traumatic Stress Disorder. Their main symptoms were avoidance of the past recall, intrusive thoughts and nightmares that were persistent. These findings give cross-cultural validation of post-traumatic stress syndrome in general while with a difference that (i). Younger patients of our study group showed better prognosis and minimum suicidal tendencies, (ii). Duration of stay in concentration Camps was significantly less as compared to Western studies.

INTRODUCTION

The practice of state organized violence including torture, constitutes a worldwide epidemic[12]. Its purpose is more often to degrade, to damage the personality, to erode ego functioning, to engender dependence and to destroy the victim's belief in humanity. It encourages the development of what Barduv[3] calls a repressive ecology, a state of generalized insecurity, terror, lack of confidence and rupture of social relations.

Over the last decade, the physical and psychological effects of torture have become more clearly defined[1] \ Initially focusing on the relevance of largely discredited concept of torture syndrome, the debate has now shifted to the relative importance of Post-traumatic stress disorder (PTSD). Allodi[6], has stressed the central importance of making a diagnosis of PTSD in survivors of torture. Others have argued that whether PTSD is a meaningful diagnostic category in other (non-Western) cultures'.

A Psychiatric syndrome resulting from Massive Stress led to the DSM-III-R diagnosis of Post-Traumatic Stress Disorder. The salient features described arc:

i. Re-experience of trauma and painful recollections
ii. Recurrent nightmares.
iii. Social withdrawal.
iv. Hyperactive startle reaction.
v. Sleep disorder.
vi. Guilt.
vii. Memory impairment.
viii. Intensification of symptoms by exposure to similar events.

A review of literature suggests that in almost all concentration camp survivors the above mentioned symptoms were present. Chodoff[8] and Trautmam[9] Have blamed the massive, prolonged psychological trauma in Nazi Camps.

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Arthur[10] studied the combat and prisoner of war (POW) experience and found that the subjects had similar symptoms, although the trauma had not been as severe and prolonged. The POWs showed generally fewer universal symptoms and less psychiatric disturbances than concentration camp victims. Other investigators such as Archibald[11], Buck[12] and Wilmer H. A[13]. discussed the delayed stress in detail. Allodi and Cowgill[14] described the torture experience followed by a cluster of psychiatric symptoms and physical evidence comparable with history', in a group of Latin American Refugees who arrived in Canada after having being subjected to torture and political execution.

Before Russian invasion Afghanistan was a peaceful country with no political upheavals. Most Afghans lived in villages and highlands. Traditional values included a strong tribal identity, religious conformity and cohesive extended family structure. Freedom fighters had organized Guerilla war after the Russian invasion. We report here on thirty Afghan Refugees who survived the torture camps of Afghan army aided by Russian occupied forces.

MATERIALS AND METHODS

Since 1980, Horizon (NGO) has been looking after Afghan Refugees, when necessary through admissions in Hayat Shaheed Teaching Hospital and Lady Reading Hospital Peshawar. The present study was carried out in 1994 and the time duration was one year.

The thirty patients in this report revealed their histories after reassurance and relationship with the therapist. The symptoms of these patients were clearly different from those of other refugees and were more persistent. Their problems could not be explained merely as the effects of Refugees status. A systematic review of these patients was done through an initial diagnostic interview and all of them were hospitalized for a period of three to six weeks.

TABLE - 1: Summary of 11 Patients.

Patient No.	Sex	Age	Diagnosis	Precipitating Events	Symptoms
1	M	24	Depressive Illness	3 month physical torture, starvation, social isolation.	Hyperactive startle reaction, vivid dreams, apathy and irritability.
2	M	31	Depressive Illness	Unknown where about of the family, execution of brother, starvation one year forced labour.	Suicidal and homicidal thoughts, extreme guilt, memory impairment. Startle reaction.
3	M	26	Agitated Depression With Bronchial Asthma	Execution of family members, death of friends during escape, sexual assault, 9 month forced labour.	Irritability and anger, avoidance of past experience. Recurrent nightmares. Recollections of past experience.
4	M	52	Multiple Somatic Complaints with Depression	Torture and execution of son, starvation, death of wife.	Pains and aches body, intrusive thoughts, feeling on guard while thinking about the repetition of the episode.
5	M	35	Depressive psychosis	One year forced labour starvation, isolation minimum physical violence.	Nightmares, intrusive thoughts, poor concentration, avoidance of past recalling fear mixed with paranoid ideas.
6	M	29	Agitated Depression	Three months torture with electrical instruments, cigarette bums, induced fractures of hands.	Anger and hostility towards family, avoidance of thoughts of the past feelings " as though" secret Afghan police chafing hyperactive startle reaction.
7	M	24	Depersonalization Syndrome with Depression	Observation of frequent torture of friends and freedom fighters execution of male family members.	Emotional coolness, poor concentrations startle reaction avoidance of past, depersonalization and derealization.
8	M	57	Depressive Illness	Execution of only daughter, (schoolteacher) forced labor 6 months.	Anger, guilt about being alive. Intrusive thoughts and nightmares. Frequent prayers, crying.
9	M	30	Hysteric neurosis dissociative	Watching frequent terror in the village infidelity of wife and 3 months forced labour.	Mimicking every physical disease. Double personality, loss of memory' for stressful events. Startle reaction. Intrusive thinking strong guilt.
10	M	42	Agitated Depression	Death of only son due to lack of medical aid. A month's stay in torture camp isolation, starvation, deprivation of clothes.	Intrusive thinking, guilt feeling " better if was killed in Afghanistan" symptom reduction after second marriage.
11	M	23	Agitated depression	Physical torture in concentration camp. Rape scenes of young women in the target village. Forced labour 3 months.	Recurrent thoughts and nightmares. Hyperactivity marked intensification of symptoms while recalling past. Suicidal attempt with knife.

Table 2: - Distribution by Age, Sex and Marital Status

Age in Years	Male	Female	Total	%	Married	Marital Status % Unmarried		%
21 -30	17	1	18	60.0	15	83.0	3	17.0
31 -40	4	-	4	13.3	3	75.0	1	25.0
41 -50	3	-	3	10.0	3	100	-	-
+ 50	5	-	5	16.7	5	100	-	-

Their specific traumatic experience and post-traumatic stress disorder symptoms were particularly searched.

RESULTS

A summary' of the 11 important cases is shown in Table 1. Following features were common in all cases.

1. All of them did not receive any psychiatric assistance before this study.
2. Discussion about the past traumatic events was very painful for these patients and most of them tried to avoid discussion initially.
3. Almost all of them refused accepting the treatment at tire first interview.
4. There was strong intrusive thinking about the past, usually regarding death of family members and torturing experience. Most of these patients had frequent nightmares and some had episodic nightmares. Description of events caused more distress.
5. Threshold to noise was decreased and they were hypersensitive to noise and in crowds they showed exaggerated psychomotor agitation.
6. Half of the studied population demonstrated guilt and shame of being alive while their relatives arc dead.
7. Memory problems, poor concentration and sleep disturbance was common to all.
8. One patient attempted suicide while suicidal thinking was not a distinct feature.
9. The patients of younger age group showed relatively better prognosis after 2-3 months of treatment. They were highly motivated and wanted to go back to fight.

Distribution according to age, sex and marital status is shown in Table 2. Occupation of patients in Table 3, distribution of symptoms in Table 4, psychiatric diagnosis in Table 5, analysis of direct physical torture and distribution of precipitation stressors are shown in Table 6 and 7 respectively.

Table 3: - Occupation of Patients

Occupation	No.	%
Skilled Workers	12	40.0
Unskilled workers	10	33.3
Agriculturists	6	20.0
Doing nothing	2	6.7
Total	30	100

DISCUSSION

This study gives a cross-cultural validation for the diagnosis of post-traumatic stress disorder. The ICD diagnostic categories such as Depressive illness, Manic-Depressive Psychosis and Paranoid Psychosis could not fit these symptoms.

There were frequent similarities such as the one given in the introduction of this article.

Table-4: - Distribution of Symptoms (n=30)

Symptoms	No	% out of 30
Hyperactive startle reaction	15	50.0
Suicidal and Homicidal thoughts	2	6.7
Irritability and Anger	18	60.0
Pain and aches body Nightmares/ Intrusive thoughts	3	10.0
Poor concentration/Memory impairment	15	50.0
Extreme guilt	10	33.3
Suicidal attempts with knife	12	40.0
Depersonalization and derealization	1	3.3
Avoidance of past recalling	3	10.0
	15	50.0 1

Table 5: - Psychiatric Diagnosis (Present and Past) n=30

Diagnosis	No.	%
Depressive Illness	21	70.0
Manic depressive psychosis	2	6.7
Hysteric neurosis dissociative	2	6.7
Paranoid psychosis	4	13.3
Schizophrenia	1	3.3
Total	30	100

Table 6: - Analysis of direct physical torture (n=21)

Event	No.	% out of 21
Burning of sensitive parts	7	33.0
Chilli enema	9	43.0
Electric shock	12	57.0
Lashing	3	13.0

Table 7: - Distribution of Precipitating Stressors (n=30)

Events	No.	%
Physical torture	21	70.0
Starvation	27	90.0
Social isolation	9	30.0
Sexual assault e g. rape of wife/daughter	3	10.0
Execution of family members	15	50.0
Death of wife	1	3.3
Deprivation of clothes	2	6.6
Death of only son due to lack of Medical aid	1	3.3

Zilbirg et al[15] and associates, described both "frozen avoidance" and persistent intrusive thoughts as features of a post-traumatic stress syndrome. This was substantiated in our study. For instance, any reminder of the past would cause avoidance reaction. This also means that there was not therapeutic benefit by discussing the event with patients.

The hyperactive startle reaction is also noteworthy and is self-explanatory' in line with concentration camp experiences mentioned in the literature. There were following differences. The prognosis was better in those young patients after treatment who were either related to the freedom fighter or were living in their vicinity. No such similarity was found in Western or other Asian references. This is probably due to high motivation for freedom of land and religion. Similar findings were shown in a different study done about the psychiatric problems in Afghan Refugees by Mufti[16]

In our study the severity of physical and mental torture was prominent, while the duration of study in concentration camp was much less as compared to other cross-cultural studies.

The attempted suicide and suicidal tendencies were significantly lower in this group. It has been observed in this study that treatment of torture survivors is greatly complicated in the bicultural setting. Majority of patients was Pushto speaking, those with Persian language were unable to speak the language of his or her migrated country, and the interpreter or (preferably) the bicultural worker became essential components in the process of assessment and treatment. They should act not as translators, but as culturally appropriate and empowered agents operating with therapist (interpreter) or independently (bicultural worker), allowing a clearer understanding of both verbal and nonverbal communication and evaluating the cultural significance of what is being said.

Also therapy should take place as far as possible in a setting of physical and emotional safety. At all stages careful explanation and education is required, and anything resembling interrogation should be avoided. Though full consideration is required before performing physical examination or investigation, as procedure such as venipuncture, electrocardiography or electroencephalography may provide uncontrolled reminders of the torture syndrome.

Though sexual torture does not stand out prominent in this sample, sexual torture is widely perpetrated against both sexes, although it is commonly not disclosed initially and may even be denied. There are often pronounced feelings of shame and humiliation. Treatment must take into account the confusion and threat to sexuality it represents. Even where specific sexual torture has not taken place, sexual difficulties appear to be common.

Despite the extent of the problem there is no adequate controlled research on the assessment, treatment and clinical outcome of torture survivor. Ethical research in this field should be coupled with increasing public awareness of torture and attempts to develop and foster mechanism by which it can be prevented.

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