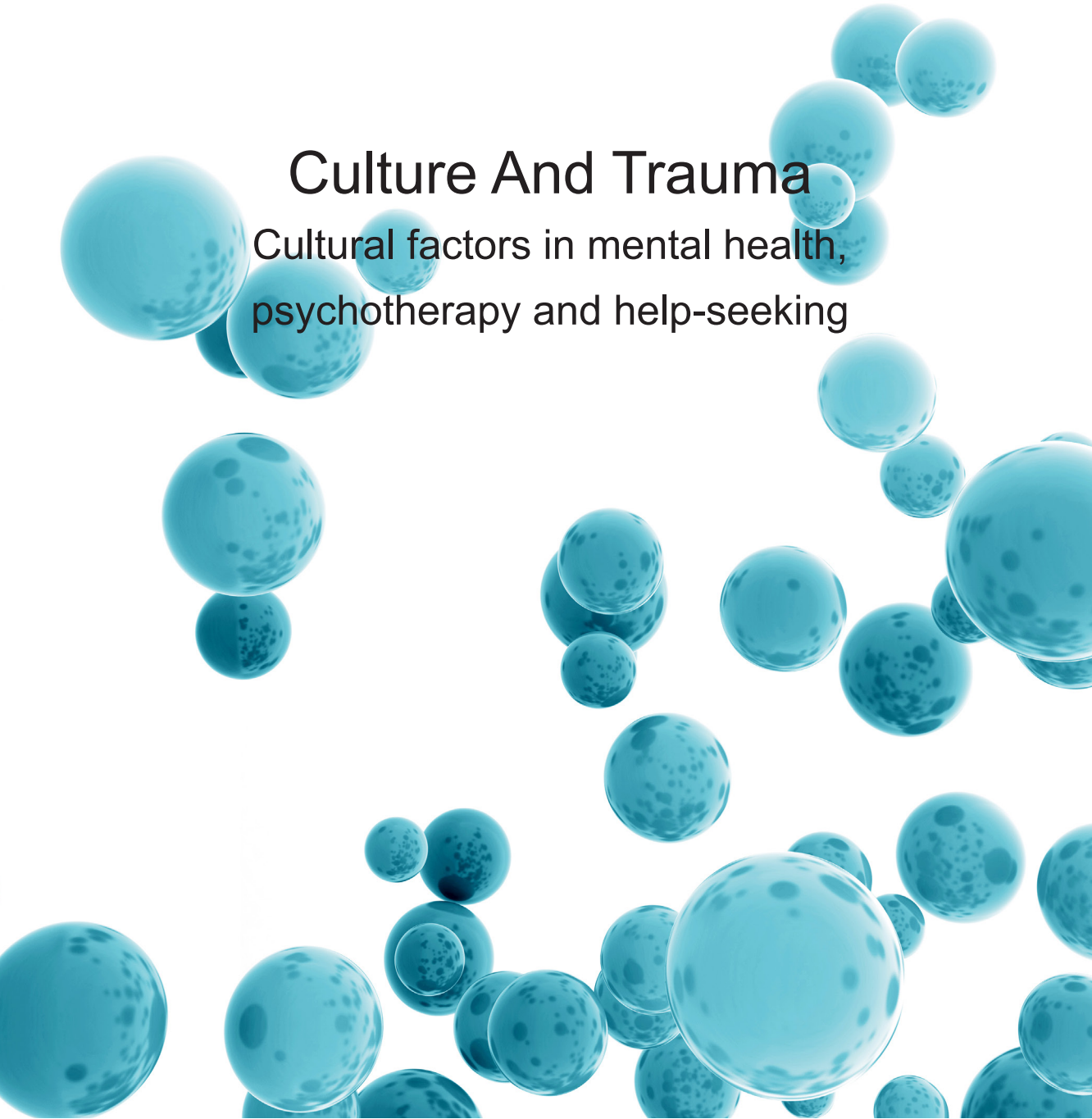
Acta Universitatis Tamperensis 2386

CARLA SCHUBERT

Culture And Trauma

Cultural factors in mental health, psychotherapy and help-seeking



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ACADEMIC DISSERTATION
To be presented, with the permission of
the Faculty Council of Social Sciences
of the University of Tampere, for public discussion
in the Väinö Linna auditorium of the Linna building,
address: Kalevantie 5, Tampere
on 15 June 2018 at 12 o'clock.

UNIVERSITY OF TAMPERE

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Tampere University Press
Tampere 2018

ACADEMIC DISSERTATION
University of Tampere
Faculty of Social Sciences
Finland

The originality of this thesis has been checked using the Turnitin OriginalityCheck service in accordance with the quality management system of the University of Tampere.

Cover design by
Mikko Reinikka

Acta Universitatis Tamperensis 2386
ISBN 978-952-03-0764-6 (print)
ISSN-L 1455-1616
ISSN 1455-1616

Acta Electronica Universitatis Tamperensis 1895
ISBN 978-952-03-0765-3 (pdf)
ISSN 1456-954X
http://tampub.uta.fi

Suomen Yliopistopaino Oy – Juvenes Print
Tampere 2018

"Yo llevo en el cuerpo un dolor
Que no me deja respirar
Llevo en cuerpo una condena
Que siempre me echa a caminar"
Manu Chao

"Think in the morning. Act in the noon.
Eat in the evening. Sleep in the night."
William Blake

ABSTRACT

The challenges in the mental health treatment of traumatized refugees include among others, differences in the definition of mental health and illness symptoms, and an unfamiliarity with mental health treatment embedded in Western cultural traditions. These matters may influence the quality of care, impede seeking services or access to them or lead to early drop out. More knowledge about the cultural diversity in the symptom presentation of posttraumatic stress, possible ways of adapting therapeutic tools in a culturally sensitive way for diverse cultural groups, and recognition of the barriers in mental health help-seeking of migrants from diverse cultures in Finland are needed to develop services adequately.

The first aim of the present study was to explore the influence of culture in the manifestation of symptoms of complex psychological trauma. The second aim was to examine the use of the universal human experience of dreaming as a tool in psychotherapy with traumatized non-Western refugees originating from diverse cultures. In the third study, the influence of cultural factors on the mental health help-seeking process in three diverse immigrant groups was explored using structural equation modeling. In addition, a comparison of women participants with men was attempted.

The dissertation study involves multiple settings and methods; statistical analysis of covariance to test main and interaction effects in a quantitative cross-sectional data (study I), a qualitative case study (study II) and structural equation modeling analysis (study III). In the first study, posttraumatic, depressive, anxiety and somatization symptoms of tortured refugees from different countries (N= 78) seeking mental health treatment were assessed and four cultural groups were compared for differences. In the second study, the mental health function of dreams and dream work in integrative culturally sensitive psychotherapy with two refugee women from different cultural backgrounds was examined. In the third study, structural equation modeling was used to explore the influence of cultural factors on the mental health help-seeking process in three diverse immigrant groups of Somali, Russian, and Kurdish origin (N=1356).

The first study highlighted the significant role of culture in influencing clinical symptom representation. The diverse cultural groups reported significant differences

in the experience of mental health symptoms. Somatic complaints were expressed more by South Eastern European subjects than Central African survivors. In the second study, dream work was found to be a successful additional element in the individual psychotherapies of two traumatized female torture survivors. In the third study, the three immigrant groups showed distinct culturally influenced dynamics in relation to help-seeking behaviour, while traumatic events were the main contributor for seeking help from mental health services. The differences in help-seeking between men and women depicted culturally anchored gender roles. The results of the three studies should be considered in the development of culturally sensitive health services for the immigrant and ethnically different populations.

TIIVISTELMÄ

Traumatisoituneiden pakolaisten mielenterveyshoidossa haasteita tuovat osin psyykkisten oireiden ymmärrys ja tunnistamisen vaikeus sekä hoidollisten menetelmien vieraus, jotka pohjautuvat länsimaiseen kulttuuriin. Nämä erot voivat vaikuttaa palvelujen laatuun, estää palveluihin pääsyn tai palveluihin hakeutumista tai ne voivat vaikuttaa hoidon ennenaikaiseen keskeyttämiseen. Palvelujen kehittämiseen tarvitaan enemmän tietoa kulttuurisesta monimuotoisuudesta ja posttraumaattisen stressin oireiden ilmenemisen muodoista, kulttuurisensitiivisistä hoidollisista menetelmistä, sekä hoitoon hakeutumisen esteistä, joita traumaattisten kokemusten takia hoitoa tarvitsevat pakolaistaustaiset henkilöt voivat kohdata Suomessa.

Tämän tutkimuksen ensimmäinen tavoite oli tutkia kulttuurin vaikutusta posttraumaattisten oireiden ilmenemismuotojen suhteen. Toisena tavoitteena oli tutkia unien sisältöjen käyttöä traumatisoituneiden ei-länsimaisesta kulttuuripiiristä tulevien potilaiden psykoterapiassa. Kolmannessa tutkimuksessa kulttuuristen tekijöiden vaikutus mielenterveyspalveluihin hakeutumisen suhteen tutkittiin kolmen kulttuurisesti erilaisessa maahanmuuttajaryhmässä, hyödyntäen rakenneyhtälömallia (SEM). Lisäksi kaikissa osatutkimuksissa sukupuolieroihin ja naisen näkökulmaan ja kokemukseen kiinnitettiin huomiota.

Tutkimus sisältää kolme aineistoa ja eri tutkimusmenetelmiä: tilastollisen kovarianssi-analyysin (study I), kvalitatiivisen tapaustutkimuksen (study II), sekä tilastollisen rakenneyhtälö-mallintamisen (structural equational modeling, SEM) kolmannessa osatutkimuksessa (study III). Ensimmäisessä tutkimuksessa kartoitettiin ja vertailtiin neljästä eri kulttuuripiiristä tulevien ja psykiatriseen hoitoon hakeutuvien kidutettujen pakolaisten (N=78) posttraumaattisia, masennuksen, ahdistuksen ja somatisaation oireita. Toisessa tutkimuksessa unien mielenterveydellistä funktiota ja unityön merkitystä kulttuurisensitiivisessä psykoterapiassa tutkittiin kahden eri kulttuurista tulevan kidutusta kokeneen naisen yksilöpsykoterapiassa. Kolmannessa tutkimuksessa kulttuuristen tekijöiden vaikutusta mielenterveyshoitoon hakeutumisessa tutkittiin rakenneyhtälömallin avulla kolmesta eri kulttuurista – Somali, Venäjä ja Kurdi – tulevien maahanmuuttajaryhmässä (N=1356).

Ensimmäinen tutkimus korostaa kulttuurin merkittävää roolia psyykkisten oireiden ilmenemismuodossa. Kulttuuripiirien välillä tuli esiin merkittäviä eroja oireiden kokema. Kaakkois-Eurooppalaiset yksilöt kokivat enemmän somaattisia oireita kuin Keski-Afrikasta tulleet kidutuksen uhrit. Toisessa tutkimuksessa kulttuurisensitiviinen unityö näytti merkittävästi vaikuttavan yksilöpsykoterapiaprosesseihin molempien traumatisoituneiden naispotilaiden yksilöpsykoterapioissa. Kolmannessa tutkimuksessa jokaisessa maahanmuuttajaryhmässä apuun hakeutumisen prosesseihin vaikuttivat kulttuurisesti omanlaiset dynamiikat. Kaikissa ryhmissä trauma vaikutti merkittävästi avun hakemiseen mielenterveyspalveluilta. Kulttuurisissa ryhmissä naisten ja miesten välillä oli havaittavissa eroja avun hakemisessa. Tutkimusten tuloksia olisi hyvä huomioida terveyspalveluiden kehittämisessä kulttuurisensitiivisempään suuntaan.

ACKNOWLEDGEMENTS

Writing this dissertation "throughout the years" would not have been possible without the help and the support of colleagues, friends and family. I would like to express my deepest gratitude to my supervisor Prof. Raija-Leena Punamäki. Thank you for the inspiring moments together, your never-ending enthusiasm in research matters and your resourcefulness. I am also indebted to my other supervisor Dr. Kirsi Peltonen who was there to help me whenever needed. I also would like to thank Prof. Liisa Keltikangas-Järvinen and Docent Laura Kauppinen for believing in me at the starting point of growing into a researcher and giving me a chance to prove my abilities. I am grateful to Prof. Katri Räikkönen especially for introducing to me the mystical world of SEM-modeling. I gratefully acknowledge the input and comments of the official reviewers of my dissertation, Dr. Edith Montgomery and Prof. Brigitte Lueger-Schuster. Your wise comments helped me to improve this work in the final stages. Docent Matti Huttunen I humbly thank for the ample provision of reading material and the good tips to improve my scientific writing skills. For the helpful comments at various stages of writing this thesis I am indebted and grateful to Docent Juhani Ihanus.

Dr. Asko Rauta helped me in developing a deeper understanding of the complex issues involved in the psychiatric care of refugees with a history of torture trauma. All my colleagues who worked with me at the Centre for Tortured refugees in Helsinki during the many years I was part of the team also deserve a big thank you. I am grateful to have been able to share important moments and benefit from your expertise and sincere commitment to make a difference in the lives of the Centre's clients. I also thank the team of the Tampere psychiatric clinic for immigrants for fruitful talks and discussions concerning refugee healthcare. The colleagues at the trauma center of the Osaka Kyoiku University, Dr. Takino Yozo and Prof. Motomura Naoyasu made me feel very welcome and helped me to advance in my research. With respect I also extend my thanks to my colleagues working in the field of cross-cultural psychology and/ or trauma research and rehabilitation in Finland and Germany (danke schön besonders an Dr. Norbert Gurris und Irmgard "Irma" Schrand) and around the world, who have helped me develop my abilities in research, and special thanks to Jaana Suvisaari, Anu Castaneda and the rest of the Maamu-

team at THL, who all deserve a big thank you. I am sincerely grateful to all my clients with immigrant background – from over 30 countries – who confided in me and shared their experiences with me. Writing this dissertation was enabled mainly by generous grants, awarded to me by the Oskar Öflund Foundation, the Jenny & Antti Wihuri Foundation, the Finnish Concordia Fund and the University of Tampere.

At this stage, writing these acknowledgements, I also reminded myself of my first contact with political oppression, torture trauma, and the life as a refugee through my Chilean friends in Austria, Marco Antonio, Pato, and many more. You initiated a spark in myself, which, years later became a more or less steady fire of interest in socio-political debates, the defense of human rights, and trying to be of use in helping survivors of torture trauma to a better life. Thank you Liisa and David Simons for advice in English writing, and Maija Salonius-Hatakka for many late-night coffees and lengthy talks about writing, mental health issues, yoga and life itself. Dear Antonia Roither-Voigt, thank you for your friendship little sister, and the many pep-talks in the last years, and dear Katharina Gugerell, I really do not know how I would have managed without your help during the last stages of this work! Last, I am sincerely grateful for my family, especially my mother Ritva, my son and musical inspiration Akseli, and my aunt and "esikuva" Kati in trying to do a bit of research every here and then when other work allowed it. I thank my brother Jan and his wife Maida who gave me insight into Bosnian life before and after the war and last, I want to thank also my "extended" family in Japan, especially Syusyu san, – gambaro! - and in Austria, thank you for the support and your understanding when there was "time pressure", you know how much I love and appreciate you all.

Helsinki, 9.5.2018

Carla C. Schubert

LIST OF ORIGINAL PUBLICATIONS

This thesis is based on the following publications, referred to in the text as study I-III.

I Schubert, C. & Punamäki, R-L. (2011). Mental health among torture survivors: cultural background, refugee status and gender. Nordic Journal of Psychiatry 65 (3): 175–182. doi: 10.3109/08039488.2010.514943.

II Schubert, C. & Punamäki, R-L. (2016). Posttraumatic nightmares of traumatized refugees: Dream work integrating cultural values. Dreaming, 26 (1): 10-28. dx.doi.org/10.1037/drm0000021.

III Schubert, C., Punamäki, R.-L., Suvisaari, J., Koponen, P., & Castaneda, A. (2018). Trauma, psychosocial factors and help-seeking in three immigrant groups in Finland. Journal of Behavioral Health Services & Research. 1–18. doi:10.1007/s11414-018-9587-x

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1 INTRODUCTION

The purpose of this dissertation is to deepen the understanding of the crucial role of cultural factors in the symptom representation after complex trauma (study I), in the rehabilitation (study II), and in the help-seeking paths of refugees settled in Finland (study III). A distinct trauma connected to the lives of many involuntary immigrants is torture, a human rights violation which has a substantial effect on mental health and life far from home. While torture and refugee trauma does not halt at women, they represent a minority in rehabilitation facilities in Finland and elsewhere. Another aim of this dissertation therefore is to provide information on gender differences and increase the knowledge concerning the symptomatology (study I), mental health rehabilitation of immigrant women with a history of torture trauma (study II), and women immigrant paths of help-seeking for mental health (study III).

Refugees are involuntary immigrants who have left their home countries because of difficult, strenuous or life-threatening circumstances. During the last decade, our World has witnessed a dramatic increase in refugee numbers. In 2015 and 2016 Europe received over 2.5 million applications for asylum (roughly equivalent to 45% of the current Finnish population). Finland received during the same time span more than 37000 applications (Finnish Immigration Service, 2018) compared to 4–6 thousand in earlier years. More than 65 million people were in need of protection worldwide because of forced displacement (European commission, 2017). While migration is all but a new phenomenon, this extreme increase in refugees who all carry their personal load of physically and mentally stressful experiences poses a challenge to the healthcare systems of host countries.

Involuntary immigrants undergo more hardship than native born residents of a host country after settlement. Language difficulties, as the official language of the host country has yet to be learned and may remain chronically on a low level, housing and financial problems, and a lack of social network add strain to daily life. Discrimination and prejudice act further as barriers to assimilation. In research studies conducted in Western countries investigating mental disorders of refugees and asylum seekers, the prevalence however varies substantially and is not necessarily higher than in native residents (Priebe et al., 2016). The heterogeneity of the results presented in studies is partly due to the vast variability in the group of refugees and

their life histories and life situation before leaving home, and partly to differences in study methodology and the framing of the samples. Posttraumatic Stress Disorder (PTSD) is however clearly more prevalent in involuntary immigrants (Priebe et al., 2016; Steel et al., 2009). Other mental health disorders that have been emerging in research with refugees are depression and anxiety disorders (Fazel, Wheeler, & Danesh, 2005, Priebe et al., 2010).

A history of torture can add a heavy weight to the mental health burden of many refugees. In the last report published by Amnesty International, torture as a form of governmental punishment still exists in more than 120 countries (Amnesty International, 2016), comprising almost two thirds of our World. The complex effects of torture on the body and especially the mind of the victim persist for a long time, for years or decades, or they can become even chronic in nature (Bradley & Tafwiq, 2006; Carinci, Pankai & Christo, 2010; Moisander & Edston, 2003). In many cases torture survivors experience additional stressors during and after the flight from their home country, on an intra-individual, a social, and an economical level (Li et al., 2016; Quiroga & Jaranson, 2005).

Approximately one third of refugees suffer of long-lasting mental health sequelae related to trauma (Bogic, Njoku, & Priebe, 2015), but research in Finland and elsewhere shows that only a small percentage of refugees in need of mental healthcare actually receive it (Silove et al., 2017; Castaneda et al., 2013). Further, traumatized refugees in psychotherapeutic treatment are at a high risk of drop out (e.g., McColl et al., 2010). In part, the attribution of symptomatology and illness explanations, and the subjective experience of mental problems may vary substantially between cultures and make Western psychiatric health services less amenable to immigrants. Omitted mental healthcare generates in the long run significantly more care costs (Priebe et al., 2009). In asylum seekers, psychological problems can make integration more difficult (Schick et al., 2016). Long and chronic histories of untreated mental health problems influence language learning needed for a good integration, work ability, and the quality of social relations with family and the surrounding social network in a negative way (Nickerson et al., 2011a). Further, individuals who experience traumatic events are more at risk of developing serious physical health problems later than those without trauma histories (Kendall-Tacket, 2009). Therefore, developing high quality mental healthcare to aid refugees get over their traumatic past and gather strength for life and its manifold issues in the new home country is urgently needed.

One of the typical sequelae after surviving a traumatic event is the experience of bad dreams or nightmares. As dreams typically do, they contain fictitious elements,

but they also contain images or sequences similar to the original trauma (Hartmann, 1998; Hinton & Lewis-Fernandez, 2011). Those trauma-related nightmares are not only included in symptom descriptions of PTSD, they also contribute to additional psychological distress (Campbell & Germain, 2016). Dreams seem to represent also a useful resource for rehabilitation endeavours. Research points to a mental health function in dreams by serving as a canvas for enactment and working through of problems encountered during the day (Cartwright et al., 2006).

Dreaming is a universal human experience and dreams linked to a traumatic experience occur across cultures (Eagle, 1998; Hartmann, 1996; Hinton et al., 2009; Grayman et al., 2009). However, the emotional impact on the dreamer seems to be influenced by cultural interpretation (Barrett, 1996). Interestingly, in many cultures dreams are appointed a significant role after distressing events. Especially traumatized refugees report a high occurrence of nightmares which affects sleep quality, mood and performance during the day (Hinton et al., 2009). As the provision of psychotherapy for this distinct group of potential clients is challenging because of unfamiliarity with the standard methods, trust issues (Fabri, 2001), cultural and language issues (Palic & Elklit, 2010), a focus on nightmare content could be of use.

Working with dreams in culturally sensitive psychotherapy could aid in reducing posttraumatic stress symptoms and improve the quality of sleep in clients. However, the trend in Western psychiatric healthcare treatment prefers evidence-based treatment options in which cultural factors are typically not considered (Lancaster et al., 2016). Psychotherapy methods used in the rehabilitation of refugee clients are strongly based on a Western individualistic cultural context, incorporating cultural beliefs about human nature and the view of the world. These basic assumptions are not necessarily shared with members of other cultures and can lead to a lack of common ground in psychotherapeutic work. In the attempt to help a trauma survivor to process his past, achieving a base of mutual understanding is vital. The meaning of dreams in different cultures can vary (Tedlock, 1991) and is regulated by diverse social practices. Bearing in mind that the attitude of the individual client towards dreams should be taken into consideration, they may provide a fruitful basis for a collaboration in cross-cultural psychotherapy. In today's favored evidence-based practices in trauma treatment, as for example, in cognitive-behavioural therapy dream work does not feature as a relevant method disregarding substantial evidence for the value of working with client's dreams in therapy (Eudell-Simmons & Hilsenroth, 2005; Pesant & Zadra, 2006). The present study seeks to contribute to the development of better working rehabilitation methods for non-Western individuals with a history of trauma. As the primary material in the attempt to achieve

this goal served the dream work in individual psychotherapy with refugee torture trauma survivors.

Research in help-seeking for mental health problems shows that immigrants use less health services than native populations (Kirmayer & Young, 1998). Especially refugees, who experience high levels of mental and somatic symptoms, seem to access health services less than natives (McCrone et al., 2005; Durbin et al., 2015). However, in first generation immigrants a generally higher risk of mental illness has been detected, with even higher levels of depression and PTSD prevalence in the subgroup of refugees (Close et al., 2016). Negligence of the long-term effects of mental health problems, shame or ignorance about available treatment options may hinder help-seeking in refugees with trauma histories (Hollifield et al., 2011). Another factor which may complicate a refugee's life after trauma and hinder help-seeking are the cultural differences a refugee torture survivor encounters in contacts with representatives of the host country's society (Marsella et al., 1996). It is possible that help-seeking from professional mental health facilities in the host country is not a favorable option because the concept of treatment may differ and seem strange in comparison to treatment traditions in other, non-Western cultures. Western treatment options may not feature as proper methods of dealing with the mental problems one encounters. Especially in cultures where mental health symptoms are not accepted and where help for mental health issues is not available from health professionals, one seeks help only for somatic symptoms. Psychological problems can then present only or partly via somatic complaints. In the present study, the relationships of trauma and psychosocial factors and help-seeking are examined and a model is tested concerning immigrant help-seeking behaviour in three ethnic groups.

The interest of psychological research in culture has resulted in diverse scientific approaches. Cross-cultural psychology studies the variations and differences between cultures in thought processes, emotions and behaviour, the main interest being in understanding human diversity. Cultural psychology targets an understanding of the interaction of mind and culture in diverse contexts and – at the same time – attempting not to compare and contrast those contexts (Lonner & Hayes, 2007). In this field of research, a holistic perspective of culture is taken, which does not pay attention to the imminent diversities between individuals, interpretations of research results should not be overgeneralized, as Poortinga has well emphasized (2015). Cross-cultural studies among torture victims are still rare. Research into psychological sequelae of traumatic events has shed light on single cultural groups more than on its effect on the whole group of refugees to Western

countries. To deepen the understanding of diversity in cultural groups regarding mental health problems and mental-health related help-seeking, a (cross)-cultural perspective is taken in the first (study I) and the last part (study III) of the present study. Study II attempts a more cultural psychological stance in examining culture's role in the mental life of the individuals featured in the distinct case studies.

Summing up, the present study aims at adding comprehensive knowledge of the impact of cultural variables influencing trauma manifestation, rehabilitation, and help-seeking of immigrants, with special considerations for the treatment of torture trauma. Through adding information on these topics, this research hopefully supports the development of psychotherapeutic rehabilitation methods. Through a better understanding of cultural variations in mental health symptoms and a deeper knowledge of culturally sensitive ways in psychotherapeutic work, healthcare providers can improve their services and immigrant clients will get a better chance to improve their health and well-being.

2 TORTURE – A NEGATIVE PHENOMENON

Definitions of torture by international organizations and political treaties vary depending on the situation and purpose. At the United Nations Convention against torture and other cruel inhuman or degrading treatment or punishment (1984) torture was defined as an intentional act directed at a person or someone close, causing severe hurt or suffering of physical or mental quality, in order to obtain from him or a third person information or a confession, or as a punishment. The acts are sanctioned or accepted by public officials or persons acting as official capacities. Pain or suffering arising only from inherent in, or incidental to lawful sanctions are excluded from this definition.

The intention and purpose have been emphasized as the most important criteria in defining torture acts, and not the severity of pain (Basoglu, 2012; Quiroga & Jaranson, 2005), which can only be measured subjectively. Every individual does experience pain in a different way and thus, an objective measurable threshold cannot be determined. Typical for torture is the lack of control over the torturer's actions and the duration of the situation, which leads to the targeted breaking of the victim's will. The torturer/victim relationship creates through its asymmetry a relationship of extreme dependency via psychological manipulation of the victim (Becker, 2001).

Torture is often directed against specific ethnic, religious, or sexual minority groups (Amnesty International, 2016; Messih, 2016; Barel et al., 2010). The torturers mostly act as part of a machinery and have an appointed role. They can be official agents of a government or they are members of a paramilitary group or representatives of a clandestine organization. Sadly, medical doctors, psychologists and nurses – notwithstanding their ethical and professional obligation to promote and protect human rights – have also taken actively part in torture (Lifton, 2004).

Torture techniques seem to vary according to geographical areas. The most prevalent form of physical torture worldwide is the beating of body parts (Carinci et al., 2010). Other physical torture methods contain the strapping of body parts with rope, wire or handcuffs, burning of or spilling acid on parts of the body, immersion into water, suffocation or asphyxiation, hanging, blows of electricity, stabbing, extraction of nails or teeth, immobilization in forced positions, serving contaminated

food or drink, sexual violence, genital beatings or cuttings or rape (Shrestha et al., 1998; Tata Arcel, Genefke, & Kastrup, 2013).

Psychological methods that leave no scars on the surface of the skin are for example exposing the victim to loud noises, strong light or darkness, isolation, deprivation of clothing, and denying healthcare services (Basoglu, 2009; Haney, 2003; Leaman & Gee, 2012; Schubert & Punamäki, 2015). Restriction of food and water and no or too much heating serve to manipulate and affect bodily functions. (Amnesty International, 2014). In addition, the humiliation or degrading treatment of the victim or family members, disfiguration or death threats and sham executions are a vital part of torture acts (Quiroga & Jaranson, 2005). In many cases physical and psychological torture methods overlap. Typically, false documentation about supposed crimes made by the victim or people near him or betraying information of others are signed by the victim in situations where there is threat of torture or torture acts.

Estimates of tortured refugees and asylum seekers worldwide vary according to the socio-geographical buildup of the sample. European studies show a variation of prevalence between 30% and 45% among refugee populations (Gäbel et al., 2006; Masmas et al., 2008; Clément et al., 2017). A meta-analysis based on five studies of refugees in the US suggested a quantity similar to the latter report with a prevalence of torture survivors of 44% in the general US refugee population (Higson-Smith, 2015). A recent review including forty-one peer-reviewed research articles on forced migrants reported a range of torture prevalence between one and 76% percent (Sigvardsdotter et al., 2016). In research on torture, data on the prevalence is however hard to establish because of the secrecy attached to human rights violating torture acts. Another challenge in sampling data concerning the impact of torture on victims forms the fact, that studying torture effects from a prospective viewpoint would be highly questionable from a humanistic ethical perspective.

It is known that both men and women are subjected to torture, even children and youth are not spared. The present study however concentrates on adult traumatized refugees and therefore, individuals under 18 years of age are not included in this research. Concerning women refugee torture survivors, studies centering on the experiences of women are scarce. A United Nation's report depicts a particular high risk for women and girls of being subjected to torture (Mendez, 2016). A study examining 63 female torture survivors indicated that women seemed to be often the victims of social and political circumstances with a smaller percentage of politically active individuals than men (Edston & Olson, 2007). In a group of Somali and Oromo refugees to the US, both the 605 men and 529 women had suffered torture

on an equal level (Jaranson et al., 2004). Evidence shows that sexual abuse and rape are among the most used torture methods in women (Allodi, 1990; Edston & Olson, 2007; Zlotnick et al., 2006), a finding discovered also in a study with torture survivors from the war in Ex-Yugoslavia (Spiric et al. 2010). In torture rehabilitation centers, women clients do however represent a smaller group in comparison to men (Al-Saffar, 2007; McColl et al., 2010; Spiric et al., 2010). The underrepresentation of women in special healthcare units cannot be taken directly as evidence that women are less victims of torture than their male counterparts. Looking at the societal role of women as mothers and caretakers of the household in most cultures, and her role as an emotional supporter of her husband, her mental health influences the well-being of her family members. A better knowledge of help-seeking barriers could help make services more accessible for women torture survivors and, in this way would contribute to the well-being of the whole family and the next generations.

2.1 Consequences of torture

It is a clear finding in research literature that torture carries a substantial risk for the development of complex, long-lasting and sometimes chronic sequelae in the survivor (Basoglu et al., 1994; Leaman & Gee, 2012; Leth & Banner, 2005; Williams, Peña, & Rice, 2010). The impairments and problems are complex and while an attempt is presented here to divide them into physical and mental health domains, clear consequences of specific techniques are almost impossible to outline (Quiroga & Jaranson, 2005; Williams & van der Merwe, 2013). The Istanbul Protocol (UN, 2004) contains precise guidelines for the evaluation and assessment of the consequences of torture on the victim, based on scientific research.

Physical problems after torture incidents are often nonspecific, which can be explained by the multitude of torture methods used during the time the victim was held prisoner. Characteristic torture sequelae are long lasting pains in different parts of the body, as for example back pain or headache, fractures or injuries that are chronic in quality (Olsen et al., 2007; Carinci et al., 2010). For some torture methods, clearly discernable physical sequelae have been demonstrated. For instance, beatings and crushing may lead to intracranial and spinal cord bleeding (Quiroga & Jaranson, 2005). Common consequences of blunt trauma to the head are chronic hearing loss (Bradley & Tawfiq, 2006; Rasmussen et al., 2007a) or neurological deficits as problems in attention span (Moreno & Grodin, 2002). The whipping of the soles of the feet is a typical torture method applied in diverse geographical areas – in the

Middle East it is called by the name Falanga – results in persistent and over the years increasing pain, foot dysfunction, sensory disturbance and abnormal gait (Amris et al., 2009).

Psychological torture and the extent of harm induced by it is of significant dimensions. Research with torture survivors from the area of Ex-Yugoslavia and from Turkey (Basoglu, 2009) and a study examining the psychological state of 279 tortured individuals from the former Yugoslavia still living in the area confirmed that psychological torture has similar or even more negative effects on the mind of the survivor than physical torture (Basoglu, Livanou, & Crnobaric, 2007). In Palestinian tortured male ex-prisoners, severe psychological torture led to both somatic and mental health problems (Punamäki et al., 2010), while for other torture methods no significant association with somatic symptoms was found. In a sample of 326 torture survivor refugees relocated in the USA, physical torture did not predict severe posttraumatic symptoms, contrary to witnessing torture or psychological torture methods (Kira et al., 2013).

Torture and cumulative exposure to possibly traumatizing events seem to have the most significant impact on the development of posttraumatic stress disorder (PTSD) (Steel et al., 2009) and torture survivors indeed show a high prevalence of PTSD. Traumatic stress after a potentially traumatizing event is in Western psychiatric clinical research and practice examined via a catalogue of symptoms to establish the presence of clinically significant PTSD. The American Psychiatric Association (APA) revised the diagnostic criteria for PTSD in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V, 2013) and placed the diagnosis, which was in earlier editions part of anxiety disorders in a new category of trauma-and stressor-related disorders. As a traumatic event the DSM-V (APA, 2013) lists direct exposure to, witnessing, or – in a more indirect way – being informed that someone close has undergone either death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence. Also, indirect exposure to details of a traumatic event through one's professional duties, are included. The diagnosis of PTSD demands at least one symptom of re-experiencing (e.g., flashbacks or nightmares), one symptom of avoidance of trauma-related stimuli, thoughts or feelings, two symptoms of hyperarousal or reactivity that began or worsened after trauma (e.g., irritability, hypervigilance or concentration difficulties), and two symptoms illustrating negative cognitions and mood (e.g., overly negative thoughts, exaggerated blame of self or others or negative affect) that began or worsened after trauma. The symptoms have to appear for a duration of more than 1 month after the traumatic event and should not appear due to another

illness, substance use or medication (APA, 2013). The diagnosis pays no attention to the particularities of the traumatic event, and it does not include sociological, historical or cultural factors. Further, the concept of PTSD does not include somatic and psychosomatic symptoms, typical sequelae clearly identified in torture survivors (Becker, 2001; Quiroga & Jaranson, 2005) and other trauma (Escalona et al., 2004). Research with traumatized patients has indeed demonstrated that PTSD rarely occurs alone, but is accompanied by many other psychological problems not fully captured by the catalogue in the DSM throughout its revisions (Yehuda & MacFarlane, 1995; Hoge et al., 2016).

In forced migrants, studies show a rate of PTSD between 18% and 40% (Ibrahim & Hassan, 2017; Steel et al., 2009; Vojvoda et al., 2008). In torture survivors attending mental health treatment the rate rises to around 90% (Moisander & Edston, 2003; Mollica et al., 1998). The strong association between torture and PTSD has been found across cultural groups. Research examining individuals still living in the Balkan area (n=3313) and refugees living in three Western countries (n=854) showed that torture was one of the highest predictors of PTSD out of 23 potentially traumatic experiences connected to the war in former Yugoslavia (Priebe et al., 2010). African tortured refugees of Somali and Oromo ethnicity settled in the US, showed a higher risk of PTSD and other psychological and physical problems than non-tortured individuals of the same ethnicities (Jaranson et al., 2004). In a group of 910 Bhutanese refugees living in exile in Nepal, l 418 torture survivors were compared to 392 non-tortured subjects. The torture survivors suffered significantly more of PTSD-symptoms (43%) than the subjects of the other group (4%) (van Ommeren et al., 2001).

Regarding psychological symptoms in the aftermath of having had to endure torture, a rather high comorbidity with other mental disorders has been reported, including depression, anxiety, dissociative disorders, personality disorders, adjustment problems and somatization (Avdibegovic et al., 2010; Gerritsen et al., 2006; Johnson & Thompson, 2008; Schubert & Punamäki, 2015; Van Ommeren et al., 2002). The rates of comorbidity of depression and anxiety in torture survivors show levels even higher than in victims of other traumatic events (Morina et al., 2013; Rytwinsky et al., 2013). To illustrate, a study by Rončević-Grzeta and colleagues in Croatia showed significantly higher depression in refugee torture survivors compared to refugees with other trauma history and local individuals with no trauma history (Rončević-Grzeta et al., 2001; see also Nickerson et al., 2017). Research by the Rehabilitation and Research Centre for torture survivors in Denmark also pointed out higher levels of depression and anxiety in refugee torture

survivors compared to patients with chronic pain and psychiatric in-patients (Harlacher et al., 2016). Research evidence highlights further insomnia, isolation, and feelings of loneliness (Bolton et al., 2013), concentration impairment, sexual dysfunction, alcohol- and substance abuse (Brady et al., 2012) and suicidality as sequelae of torture (e.g., Basoglu, 2001), which influence functioning in daily life, social relations and adaptation to working life in a profound and negative way (Kira et al., 2006).

Torture acts all have in common the total power of the torturer over the victim (Horowitz, 1976), which can however occur in other severe, prolonged interpersonal trauma. During torture, the victim has no control over the content of the acts or the amount of torture events yet to come. The victim is further not given information of the time passing between those events (Schubert & Punamäki, 2015). The keeping of victims in a non-informed situation of their near future makes their helplessness considerably stronger and the time in between torture sessions is experienced by survivors in retrospect as the worst (Becker, 2001). The experience of helplessness has been emphasized as a strong predictor of mental health sequelae in torture survivors (Basoglu et al., 2007). Linked to this state of helplessness are a loss of self-efficacy and coherence (Gurris & Wenk-Ansohn, 2009). Ehlers and colleagues have – in their research – specified mental defeat in relation to torture, a state closely related to helplessness. The victim finds him or herself in a situation where, no matter what he or she does, there is no possibility of controlling what will happen to oneself. This experience leads to mental defeat, defined as a perceived loss of all autonomy, in other words a state of giving up in one's own mind all efforts to retain one's identity as a self-determined human being (Ehlers, Maercker, & Boos, 2000, p. 45).

Regarding the social realm, the long-lasting effects found in the emotional experience of torture survivors and significant problems in arousal of rage and fear and anger management issues (Näätänen et al., 2002) influence relationships and add daily strain. The tortured individual may even experience severe personality changes, which derive from the complex interpersonal situations between the torturer and the victim. The considerably long-lasting influence on social bonds and attachment patterns is among the most devastating sequelae of interpersonal trauma, such as sexual assault and torture (Van der Kolk & Van der Hart, 1989).

Because of a biologically embedded need to maintain attachment bonds in stressful time periods, the torture victim may turn to the torturer in need of emotional attention and care. The development of emotional ties with the torturer(s) makes the denial and dissociation of the trauma stronger (Saporta & van der Kolk,

1992) and attachment style may change after torture or captivity (Solomon et al., 2008). On the cognitive-emotional level, consequences of torture trauma evolve as an extreme loss of trust and believe in the good-naturedness of other humans and have a severe negative influence on self-confidence (Quiroga & Jaranson, 2005). Further, the systematic humiliation inherent in all torture acts influences the development and strengthening of withdrawal from social contacts and paranoia. Subsequently, relating to others may be experienced as a threat, reminding the individual of previous extremely hurtful situations, which may present a risk also later in the psychotherapy relationship and ultimately endangers successful treatment (Varvin, 2016).

The influence on attachment bonds has been detected even in the next generations (Danieli, 1980; Daud et al., 2008). In research by Danieli and colleagues, adult children of Holocaust survivors filled out an inventory assessing multigenerational legacies of trauma. A clear finding was that the adaptional style of the survivors' Holocaust experiences significantly influenced their children (Danieli et al., 2016). The transmission of torture experiences from parents to their children can occur directly or indirectly, through speech, behavioural factors and affective reactions (Volkan, 2002; Leen-Feldner et al., 2013).

Research examining the impact of torture on mental health and gender differences has disclosed diverse results: in a sample of torture survivors in Ex-Yugoslavia, women torture survivors experienced a significantly higher level of PTSD, depressive and anxiety symptoms, interpersonal sensitivity, obsessive-compulsive symptoms and somatization than men (Spirić et al., 2010), while a study with Syrian Kurdish refugees with torture histories reported no gender differences in PTSD-levels (Ibrahim & Hassan, 2017). According to general research on PTSD, women are significantly more at risk in developing the disorder than men after a traumatic incident (Andrews, Brewin & Rose, 2003). This disproportion has been linked to psychosocial and biological differences between men and women (Olff, 2017; Kira et al., 2012). In stressful situations, women seem to use more emotion-focused strategies compared to the problem-focused coping men typically employ (Olff, 2017). Earlier research has pointed out that emotion-focused strategies are not very successful in the aftermath of trauma (Kanninen et al., 2002; see also Elklit & Christiansen, 2009). In a study with Danish bank employees who had experienced a bank robbery, women reported a higher experience of associated risk factors than men, as for example neuroticism, peritraumatic fear, negative posttraumatic cognitions about the self and the world, and feeling let down (Christiansen & Hansen, 2015).

Kira and colleagues have emphasized the influence of gender discrimination on women by parents and the society as a whole on the mental health of female torture survivors. They have proposed that being exposed to male dominance and continuous aggression enhances feelings of powerlessness and influences the self-concept, self-efficacy and sense of control in women, which are vital elements needed in processing traumatic events (Kira et al., 2012). Regarding biological influences, Olff and colleagues have examined the role of the hormone oxytocin in fear, social support and stress regulation and found sex differences in the way the administration of oxytocin influenced stress response (Frijling, 2017). Psychosocial factors are influenced by culture and may therefore present significant variations from one culture to another (Berry & Sam, 2007). Concerning future directions in mental healthcare for trauma survivors, more research on women and on individuals from other cultural backgrounds is needed to deepen the understanding of variations in psychosocial factors and to develop better working methods for those groups.

Being prepared to experience torture seems to act as a shielding factor against psychological sequelae. In a study by Basoglu and colleagues (1997) comparing 55 tortured political activists with 34 torture survivors who were not committed to a political cause and were not psychologically prepared for being arrested and tortured, political activity emerged as a shielding factor from posttraumatic stress symptoms. On the other hand, negative coping styles are associated with symptom formation (Emmelkamp et al., 2002), and a coping style embracing avoidance (Punamäki et al., 2004), emotion-focused disengagement coping (Hooberman et al., 2010), and emotion-focused strategies (Kanninen et al., 2002) after trauma seem to weaken resilience in trauma victims.

A substantial part in the life of a refugee is depending on the decision of the asylum process, if one is not a quota refugee. Not getting a decision means that any plans for the immediate future need to be postponed because a negative decision will make them null and void of meaning. Research on the rehabilitation of torture refugees has emphasized the role of a long or pending asylum process as a negative influence on mental health. Asylum seeking torture survivors who wait for a decision concerning residency status have been shown to suffer of a higher level of PTSD than those who have been granted legal asylum status or residency permit (Keller et al., 2006; Lindert et al., 2008), though research results are not consistent. In the present study the influence of the asylum status on the psychopathology of participants will be included in study I.

3 CULTURE AND MENTAL HEALTH

Greater awareness in cultural dynamics concerning mental health problems is crucial for the development of better mental healthcare. A deeper understanding of the influence of cultural factors could help build rehabilitation services that serve natives, immigrants and ethnic minorities with an equally high quality. The present study intends to examine cultural issues in connection to psychopathological symptom representation after trauma, dream work in culturally sensitive psychotherapy and help-seeking paths in immigrants from different cultures to Finland.

Culture can have a variety of meanings, but in the present study culture is understood as depicting the modus operandi of a group of people, and their shared values. While every person is singular in certain ways, culture is located in-between the individual and the surrounding social collective. An individual grows up surrounded by a unique environment consisting of other humans who share with each other a row of morals, values and habits that have been and are still formed through the generations. Through interaction with others the individual learns and internalizes the particularities of the cultural group. The way people share their lives with each other can be defined through the daily routines and rituals involved therein, the symbolic content and abstract ideals, which serve as a guideline or code of conduct (Hofstede, 1980; 1991). Cultural variations can be found between continents, from country to country, and even within countries from subculture to another subculture, formed by values, morals, religion, sexual or gender identities, political or lifestyle preferences (Williams, 2011).

Anthropological, psychological, socio-medical research on mental health beliefs, diagnostics and healthcare methods in diverse cultural settings depict a clear cultural and social shaping of the meaning and experience of illness and the complex role of relations with others and the community for an individual's perception of his world and inner experience (Conrad & Barker, 2010; Helman, 1990; Kleinman, 1982; Sturm et al., 2010). In all cultures, health and healthcare is based on and deeply embedded in the cultural environment, conveyed by symbols and metaphors, heroes, values and morals and distinguishing thereby one group of people from another (Hofstede, 1991). These factors can be depicted graphically as layers of a "cultural onion".

Symbols, representing the outer layer of the onion, make up the most visible differences in cultures. They can be defined simply as things that are representing something, e.g., a sign representing an idea, a process, or a function. Symbols are bound to the context they appear in and people decipher their meaning differently, depending on their own knowledge or literacy of the context. In healthcare, a symbol can designate a nurse's uniform, hospital furniture or a patient report. Familiarity with symbols makes it easier to understand them (Lee at al., 2014). To demonstrate, a study testing the comprehensibility of hospital symbols by North American, Turkish, and South Korean study participants showed that Americans understood the symbols created by a US institution better than the participants of Turkish or South Korean origin (Lee et al., 2014).

Metaphors are culturally embedded figures of speech, that make an implicit or hidden comparison between two things that are unrelated. The use of metaphors in language is considered universal, but shaped by cultural differences. Deeply tied to the history and development of a culture and its language, metaphors entail shared human experience, within one culture or even across cultures. For instance, ants creeping in parts of the brain designate a metaphor for distress in the somatic manifestations of a mental disorder in Nigerian African culture (Martinez-Hernaez, 2013). In Finland a common way of describing depressive emotions is "a mind" that is "on the floor", which closely resembles the English metaphor "feeling down". Heroes are role models to the people of a cultural group. They can be real persons, for example a famous sportsman or woman, or fictitious characters.

In the core of the cultural "onion" lie values and morals, shaping the everyday code of conduct in a society. They serve an evaluative function between the self and the society and influence the subjective construction of the meaning of illness in a person's life (Bury, 2001). Shared values, influenced by morals developed within a society are represented by stigma, meaning a strong feeling of disapproval that most people in a society have about something. Stigma influences among others access to treatment, help-seeking and one's identity, as shown in research on AIDS (Weitz, 1990). In Hong Kong, which represents a collectivistic and more interdependent society, stigmatization of mental illness led to nondisclosure of illness and failure to comply with treatment, as found in research on schizophrenia (Lee et al., 2005).

One basic psychological conceptualization of cultural differences that has been emphasized in research is the construct of individualism and collectivism. Hofstede took the construct as one of five dimensions in an endeavor to establish scientifically measurable variations in organizational cultures and work context across different countries (1980). Subsequent cross-cultural research highlighted the frequent

interaction of the sociocultural environment with the individual and its influence on the self-construal or how one defines oneself (Triandis, 1989). Through a process of constant interaction with the surrounding sociocultural world, variations of how a person thinks or what he believes of himself develop and are being incorporated in an individual's self-construal (Markus & Kitayama, 1991). The degree of individualism or collectivism the surrounding society represents, has a clear influence on the self-construal, which influences self-other related cognition, motivation, decision making, information processing and emotion appraisals (Markus & Kitayama, 1991). Western cultures, holding as core values individualism and independence, differ from cultures emphasizing collectivism and interdependence, such as Asian cultures or African cultures. An independent construal involves a view of the self as an independent, autonomous person, whose inner desires, preferences or abilities are significant in regulating behaviour (Triandis, 1989). Concerning social relationships, they are freely chosen and mostly not tied to obligations. Finland for example has been characterized as an individualistic culture, emphasizing personal freedom, self-reliance and achievement orientation (Hofstede, 2010).

In contrast, an interdependent construal has its base in the idea of the fundamental connectedness of human beings to each other. In interdependent, collectivistic cultures, one is connected to others stronger, but in a prearranged way and tied to more obligations concerning the community (Adams & Plaut, 2003). Group harmony is more appreciated than assertiveness and goal directedness. These differences have been found in a number of studies (Hofstede, 1980; Fernández et al., 2005) and can be traced also in factors related to mental health and mental healthcare. No culture though is only collectivistic or individualistic, but reflects degrees of both.

In an early medical anthropological research study on somatization and depression in the collectivist culture of China, substantial evidence was found for a tendency in patients to report vague somatic symptoms in absence of organic pathology. The study revealed that the patients were diagnosed according to their somatic symptomatology with neurasthenia, but met also the criteria for depression. The results emphasized existing variations in cultures regarding sanctioned idioms of distress (Kleinman, 1982). Also, gender seems to influence somatic symptom reporting and women generally experience more somatic or bodily distress than men (Barsky, Peekna, & Borus, 2001), but in association with a history of trauma this gender gap has been demonstrated rarely, in research with U.S. veterans (Rice et al., 2015). It certainly would add valuable information to examine differences in somatic experiencing post-trauma between men and women across cultures.

The conceptualization of illness is a cultural construct. The surrounding larger society around oneself influences personal views of health problems through established guidelines (Larsen, 2013), built on historically embedded traditions and beliefs. In the somatization of mental health problems, stigma clearly plays a role. While stigma attached to mental disorders affects individuals across cultures and societies, the degree of individualism or collectivism seems to shape the degree of influence. A stronger individualistic attitude is associated with a less stigmatizing mind-set (Papadopoulos et al., 2013). Attributions – assuming causal relationships – regarding the development of psychopathology are also depending on cultural factors. In the collectively oriented and (Sunni) Muslim religious tradition of Somali culture for example, exists considerable variability in illness attributions: a jinn, in other words a spirit, is named as one causal factor for mental illness (Carroll, 2004), but other causal attributions can be war or poverty or being subjected to a hard life (Kuittinen et al., 2017).

Keeping in mind that mental health symptoms do often involve strong emotional reactions, the socio-cultural aspects of emotional behaviour and differences therein across cultures should also be given attention. The experience of emotions is universal, but societies and cultures vary in their emotional practices, which describes the actual emotions individuals feel and express (Mesquita & Ellsworth, 2001). While it is clear, that not all members of one society behave in the same way, cultural models set the boundaries in each society for what is understood as an emotional reaction within the normal realm and what would be understood as mentally ill behavior (Mesquita & Walker, 2002). Considering reactions to traumatic stress, individuals from cultures with a more collective layout may express their emotions more in a manner that does not affect group harmony (Jayawickreme, Jaywawickreme, & Foa, 2013). The exact meaning of group harmony also varies between cultures: the externalization of affect, for example crying and shouting, is in some cultures (e.g., Iran) part of normal reactions in social interaction but in others considered out of the norm (e.g., Finland). In Japanese, expression of positive emotions like happiness is less emphasized than in Canadian culture (Safdar et al., 2009).

3.1 Torture trauma, PTSD, and culture

The bio-medical model, on which Western medical knowledge is based, assumes that diseases are universal and independent of time and place. It focuses on health from

a purely biological base and no attention is given to alternative understanding of signs and symptoms of diseases. The model neglects the significance of the interaction between an individual and the outside world in generating illness, the perception of illness and in the shaping and manifestation of symptoms and reaction patterns (Tseng, 2001). Psychological suffering is tied to culture and society. Still, throughout the health sector of the Western world, the mental health practice favors medical drug treatment which also strongly influences the research and development of psychological treatment options (Deacon, 2013).

The Western bio-medical concept has been criticized with reference to the construct of the posttraumatic stress syndrome. The diagnosis described in the DSM (APA) – including earlier versions – does not include particularities of and the sociocultural context related to the traumatic event. Because reactions to traumatic events in other cultures do not necessarily conform to Western cultural expectations, the applicability of the model in cross-cultural settings has therefore been questioned (Marsella et al., 1996; Marsella, 2010). Information derived from clinical work with trauma survivors of other cultures points to more varied sequelae which are not captured well enough through PTSD symptoms. Research centering on the aetiology of PTSD has emphasized the interaction between internal and external worlds in regard to the development of psychological sequelae. PTSD symptoms have been identified across many cultures (Hinton & Lewis-Fernandez 2011), but similar traumatic experiences do not necessarily lead to the development of similar symptoms (Young, 1997). Another attempt for a diagnosis was proposed with the Diagnosis of extreme stress not otherwise specified or in short, DESNOS, which emphasizes the changed self-perception of the victim. While DESNOS is not included in the DSM, it could be accurately described as a strong degree of PTSD. However, considering cultural groups, the ways in communicating distress – collective, spiritual, and metaphoric in nature – vary clearly and should be considered in healthcare, treatment plans and interventions. (Drozdek, 2007).

Cultural differences have also been found in the cognitive appraisal of the traumatic event of the individual affected. After trauma, appraisals of the self and others and the surrounding world can change and lengthen PTSD symptoms (Ehlers & Clark, 2000). In research by Jobson & O'Kearney, participants with exposure to trauma from independent cultures reported more alienation, mental defeat, permanent change and less control strategies in contrast to other, non-traumatized participants of independent cultural background. Trauma survivors from interdependent cultures differed from non-traumatized participants of the same cultural sphere only in alienation appraisals (Jobson & O'Kearney, 2009). Culture

affects also the way how the environment, the social network of a trauma survivor understands the event or chain of events. Becker (2001) has further emphasized that neither the character of the traumatic situation itself nor the time span in which the trauma erupts and the sociopolitical processes present are included as significant factors influencing the psychological state of the trauma victim (Becker, 2001).

At least in part, the society around the torture survivor influences the recovery from posttraumatic symptoms (Brewin et al., 2000). Maerker and Müller (2004) have in their research with ex-political prisoners of East Germany highlighted the protective quality of social acknowledgement of trauma survivors in their own community, which includes positive reactions, appreciation and acknowledgement of the victims' situation. While rape as a commonly used torture method during the war in Bosnia is a known fact, the women victims still seem to face serious problems with their social community if they come forward and tell their story. The acknowledgement of being a rape victim of war has led to separations of the men from the victim or even abandonment from the whole family (Husić et al., 2014). A study by Eichhorn and colleagues (2012) with German survivors of rape during World War II highlights the significance of the lack in social acknowledgement of the victims and the negative influence on their psychological recovery. While at least 20 000 women and girls were raped and suffered sexual violence during the war in Bosnia and Herzegowina, only 779 women had obtained the status of civilian victim of war until 2013, a status installed in 2006 entailing financial, health, housing, and employment support and schooling opportunities.

Regarding mental health sequelae to trauma, holding on to Western ethnocentric assumptions may lead to bias in diagnosis, assessment and treatment (Marsella, 2010). To illustrate, 19 Salvadorian women out of 20 developed bodily symptoms after a traumatic event not included in the criteria for PTSD in the DSM-IV-TR (APA, 2000), and were therefore not diagnosed with PTSD despite their culturally embedded reaction to trauma (Jenkins, 1999). A study with Tibetan refugees reported that the experience of the destruction of religious symbols in their home country was considered by the refugees more upsetting and traumatizing than prior imprisonment and torture. Further, anxiety and depression were described by the Tibetans in somatic terms significantly more than in psychological terms (Terheggen et al., 2001; see also Hinton & Otto 2006).

Evidence today points to the universality of PTSD despite cultural differences (Hinton & Lewis-Fernandez, 2011; Kohrt & Hruschka, 2010) as biological reactions to traumatic experiences are universal, e.g., activation of certain endocrine and neurotransmitter pathways, as also brain regions which regulate fear behaviour

(Sherin & Nemeroff, 2011), but interpreting and communicating sequelae of traumatic distress can take diverse shapes and the "idioms of distress" are local and culturally bound phenomena (de Jong, 2002). Yeomans and Forman emphasize as cultural factors in traumatic stress social and institutional support notions of personhood and familialism, cultural meaning of symptoms, social acceptance of expressed distress, and functional impairment (2009).

In the attempt to understand the complexity of torture and refugee trauma, Khan introduced - from a psychoanalytic viewpoint - the concept of "cumulative trauma" (1977). The concept includes as influencing factors in traumatization the dimension of time and the relationship and thus enables to understand trauma as a product of series of initially non-traumatic individual experiences. Eventually, the individual reaches a point of breakdown experiencing an accumulation of these experiences (Khan, 1977). Partly based on Khan's writings, Keilson developed the concept of "sequential traumatization", which incorporates different possibly traumatizing experience in time and explains in this way trauma as a continuing event, which influences the individual even after acute traumatic situations (Keilson, 1992). Based on his research of Jewish war orphans in the Netherlands Keilson identified three traumatic sequences in time. First, the time of occupation and the beginning of terror in the Netherlands by the Nazi-regime, second, a period of direct persecution including deportation of Jews and separation of children and their parents, hiding and direct experience of the atrocities in concentration camps, and third, the postwar period which for those orphaned children included the process of appointment of guardians (Keilson, 1992). Because it is not built on certain symptoms, but includes also social, collective, and socioeconomic factors as the political situation, poverty and literacy, Keilson's concept is applicable to different cultural and socio-political settings (Becker, 2001), and also gender-related factors can be embedded (Haldane & Nickerson, 2016).

At present, through increasing scientific interest in cultural aspects of mental health, the significance of cultural factors in shaping aspects of trauma-related mental disorders seems to be acknowledged by professionals and researchers working in the field (Drozdek & Wilson, 2007; Marsella, 2010). Still, more research is urgently needed to develop and implement well-functioning specialized mental health services to aid refugees with complex trauma. One fundamental aim of the present study is therefore to contribute to the defense of human rights and the socio-political debate concerning the provision of special mental healthcare services with its research on the mental health sequelae of trauma in refugee torture survivors of diverse cultural origin.

4 PSYCHOTHERAPY WITH REFUGEE CLIENTS

Psychotherapy is a form of mental health treatment which is based on Western cultural heritage. Across the numerous different schools of psychotherapy, the emphasis lies, roughly described, in the individual and his experience of himself and the social world around him, which he shares and reflects upon together with the psychotherapist (Kirmayer, 2007). As refugees come mainly from cultures outside the Western world, they may not be familiar with established psychotherapy methods. Their cultural and ethnic concepts may clash with the intrinsic values of traditional psychotherapies. The various schools of psychotherapy have been developed in a culturally, geologically, and historically different environment, and lack shared experiences with a client from another cultural sphere (Sue et al., 2009). Thus, the client and the psychotherapist have no ready-made common base for exploring narratives, meaning making and the promotion of change in therapy. At least in part through these shortcomings – especially if unrecognized – the commitment to a psychotherapy process may be endangered. Indeed, ethnic minorities do underutilize services and terminate them prematurely (Pole et al., 2008). Especially in the case of torture survivor refugees, findings show that those reporting a higher level of PTSD symptoms and would clearly need rehabilitation interrupt treatment earlier than those with less symptoms (McColl et al., 2010).

According to research studies, cultural groups differ in the psychotherapy method of choice. In some cultural settings, the treatment provider is seen as a person of authority, implying an assertive stance in the treatment process. For example, Chinese clients in therapy favor goal oriented, directive and time limited therapies (Chong & Liu, 2002). In a sample of Chinese immigrants to Canada, therapy clients preferred information sharing, homework assignments and solution offering (Ng & James, 2013). In contrast, a psycho-dynamic approach may provoke negative reactions as impatience or incomprehension in the client. However, South American patients, also representing, similarly to the Chinese, a collectivistic cultural stance, are according to research more receptive to psychodynamic psychotherapeutic approaches (Morris & Silove, 2006). This result indicates a historical influence and a familiarity with this mode of therapy, due to a wider dissemination of psychodynamic psychotherapy in the area of South America.

Nickerson and colleagues (2011b) part the models of psychotherapeutic practice with refugees suffering of PTSD in multimodal approaches, which address additionally to psychological functioning also social and cultural adaptation, physical health and the challenges in daily life, and trauma-focused interventions. Organizations offering psychological support and treatment to traumatized refugees mostly rely on multimodal interventions encompassing help in general resettlement issues, assistance with family reunion matters, acculturation issues, access to social services and medical care (Drozdek, 2015; Nickerson et al., 2011b). Studies on the efficacy of multimodal treatment programs are scarce and to date, rather little evidence has been presented of its' influence in improving mental health (Mollica et al., 1990; Stammel et al., 2017). Further, multimodal treatment does not automatically include culturally sensitive working methods, but these are highly recommended by clinicians working in this field (Kizilhan, 2017). In treatment centers specialized in helping traumatized refugees, a combination of still frequently applied multimodal treatment and trauma-focused group treatments have been suggested to reduce psychopathology in a more effective way (Drozdek, et al., 2014).

Psychotherapies most studied with randomized controlled trials and thus suggested as a golden standard for the psychological treatment of trauma victims and PTSD are prolonged exposure, cognitive processing therapy and cognitive psychotherapy. However, in recent years, research centering on real-world practice indicates a rather substantial drop-out rate (Najavits, 2015). Wampold and colleagues (2017) criticize meta-analyses of cognitive-behavioural psychotherapy, which has been suggested as the primary treatment for tortured refugees along with NET-therapy, developed especially to use in refugee populations (Neuner, et al., 2004: Hensel-Dittmann et al., 2011). This therapy method incorporates CBT and testimony therapy. It fits easily into the demands of empirical research and has therefore been featured in a high number of published studies (Neuner et al., 2008; Robjant & Fazel., 2010). However, while the narration of the trauma is for some victims the best way to alleviate PTSD-symptoms and help restore mental wellbeing, this may be too demanding for others. In the case of torture history, survivors with a strong internalizing structure might benefit more from traditional healing or supportive therapy (Perez-Sales, 2017).

Research literature on evidence-based practice in regard to PTSD has consistently excluded patients who are highly complex, or suffer of substance dependence, or experience homelessness, suicidality, are potentially violent, bipolar or psychotic, present with major cognitive impairment, live in circumstances prone to domestic violence, and other challenges (Najavits & Hien, 2013). Considering highly complex

patients, torture survivors who live as refugees or are stuck in an asylum-seeking process mostly fall into this category (e.g., Varvin, 2016).

Culturally competent psychotherapy includes having an understanding, appreciation, awareness and respect for cultural differences and similarities in the work with a client representing another culture (Wing Sue & Sue, 1999). Cultural belief systems of the client should be made visible and constitute part of the work process. Evidence-based therapies could profit from adding content which emphasizes and gives room to cultural sensitivity. Culturally modified CBT-techniques have indeed yielded good results with Cambodian and Vietnamese patients (Hinton et al., 2006).

A typical feature in psychotherapy and psychological treatment of refugees is to work with an interpreter because client and therapist do not have a mutual language to understand each other. The addition of an interpreter in a situation in which intimate details of the clients' life are shared, does present not without problems in trust building and proper translation of content (Herrel, 2004). The presence of a third person changes the development of the therapist-client relationship to a more gradual process than in traditional dyadic psychotherapy. The interpreter is in his role as a translator of the clients' narrative the first point of contact and thus it is common for clients to form first a stronger attachment to the interpreter than the therapist. Further, translation in a psychotherapy process is not free of problems on a technical and a conceptual level (Luk, 2008). As a positive side in adding an interpreter is the chance of providing cultural guidance by the interpreter, which can have a significant impact on the therapy process (Miller et al., 2005).

4.1 Processing traumatic experiences through dream work

Dreams, seen in certain phases during sleep and containing a row of visual images and narrative particles of diverse content from real life experiences to fictitious elements, and lacking volitional control of the sleeper, are a universal feature (Hobson, Pace-Schott, & Stickgold, 2000). They convey meaning and significance in many cultures and have drawn scientific interest in the Western world about their role since over a hundred years, beginning with Freuds' Interpretation of dreams (1900). Following this classical opus, the psychoanalytic view of dreams depicting the unconscious of the dreamer, repressed during daytime, was imprinted in the mindset of the Western World, only later to be rejected by behaviourists. For behaviourists dreaming was a subjective phenomenon and as such not empirically

verifiable mental activity (Revonsuo, 2018). With the discovery of neurophysiological correlates of dreaming, research has presented information on the neural basis of dreaming, but the content of dreams is still only accessible by reports of the dreamer (Nir & Tononi, 2010). Until recently, the definition and the function of dreaming elicited opposing opinions from researchers of diverse scientific fields (Hobson et al., 2000; Solms, 2000). Psychological research has shown that the content of dreams is influenced by many diverse aspects of a dreamer's daily life and contain among fiction parts of past events, present concerns, important issues and unimportant sequences experienced by the dreamer (Schredl & Hofmann, 2003).

Nightmares – dreams that frighten, disgust and awaken the dreamer – can be understood in various ways, influenced by one's cultural background. However, recurring nightmares are seen today as a common sequel and a typical symptom of PTSD across cultures. Nightmares after trauma have been reported by Cambodian (Hinton et al., 2009; Hinton et al., 2013), Finnish (Sandman et al., 2013), Indonesian (Grayman et al., 2009), Somali (Schuchman & MacDonald, 2004) individuals, and US-veterans of the Vietnam war (Neylan et al., 1998), among others. Evidence has been presented that in some cultural groups nightmares are even the most significant symptom after trauma (Hinton et al., 2009). If unwanted thoughts before sleep are tried to be suppressed, they seem to re-appear in dreams and make them disturbing (Kröner-Borowik et al., 2013). Among the functions of dreaming, the processing of stressful, traumatic events has been emphasized especially by Hartmann (1984; 1996; 2010), while Kramer (1993) and Cartwright and colleagues (1998; 2006) have in their studies presented prove of the processing of emotional events taking place in the life of the dreamer. Stressful or frightening situations may turn up in a more or less disguised form during dreaming and serve a therapeutic working through of the events of the day (Cartwright et al., 2006).

A change through distinct discernible phases has been documented. Immediately after the traumatic event, dreams contain rather clear images of the event itself. In the next phase, the dream features a central image which evokes in the dreamer strong emotions of fear, horror or terror. In the third phase, the dream content includes images and story particles, which arouse emotions of guilt, shame and self-blame. In the next phase, dreams have evoked feelings of grief or sorrow, followed later by dreams which seem to contain no connection to the initial traumatic event anymore (Hartmann, 1984). The changes of dream content in dreams of trauma victims have been observed also occurring naturally (Barrett, 1996; Terr, 1991) and in therapy (Coalson, 1995).

In some cases, the traumatized individual is tormented for years by recurring nightmares replicating the trauma and lacking the typical dreamlike features in their fragmentized and non-metaphoric or symbolized content, often repeating exactly the same content night after night (Hartmann, 1984). These dreams have been labeled PTSD-nightmares or posttraumatic re-enactments. Associations between substantial sleep loss (Germain, 2013), nocturnal awakenings (Germain & Nielsen, 2003) and impaired daytime functioning (Zadra & Donderi, 2000; Wittmann, Schredl, & Kramer, 2007) have been found. Because of this clear and profound impact on well-being, nightmares should be more attended to in psychotherapeutic interventions after traumatization. Further, because even frightening dream material is perceived less threatening than the waking life experiences they illustrate, trauma survivors seem to be more at ease working with their dreams compared to more direct approaches (Cohen, 1999).

Targeting nightmares linked to traumatic events in psychotherapies does lead to a reduction of nightmare frequency and an improvement of the mental health of the client (Burgess, Gill, & Marks, 1998, Grandi et al., 2006; Rothbaum & Mellman, 2001; Zadra & Pihl, 1997). Pharmacological treatment has been used to reduce PTSD-nightmares, but often complexly traumatized patients use multiple psychotropic medication which makes assessing the efficacy of a certain drug difficult (Aurora et al., 2010). Still, most evidence-based psychotherapies used to treat PTSD do not target nightmares directly and therefore those seem to persist after treatment (Belleville et al., 2011).

Cultural views vary, but dreams seem to have a significant, universal role in diverse life situations, as guidance, or in a mediating function between an ancestor or a recently deceased close person and the dreamer (Tedlock, 1991). Interestingly, dreams are in some, more traditional cultures and indigenous societies not understood as internally generated content reflecting the dreamer's inner world (Holy, 1992). The interpretation of dreams is in some cultures highly accepted and widespread custom (Rahimian, 2009). Dreams are used in healing and curing procedures and in spiritual life (Crawford & Lipsedge, 2004; Krippner, Bogzaran, & de Carvalho, 2002; Laughlin & Rock, 2014). In research by Hinton and colleagues the significance of nightmares after trauma in Cambodian refugees was studied. The study revealed the culturally embedded interpretation of the dream content after trauma in this cultural group and its complex significance for the dreamer. The dream content itself was interpreted by the dreamer as very upsetting. A deceased relative appearing in the dream could either apply for help or engage in an attack to destroy the dreamer. The information gathered in this research led to the

recommendation of always asking about dreams of the deceased when working with another cultural group (Hinton et al., 2013).

Immigrant clients who start treatment for traumatic symptoms may have cultural preconceptions about psychotherapy and the therapist himself, which may hinder the client to open up about the content of nightmares. The psychotherapist can also experience barriers in asking for dream material from the client during the session (Pope-Davis et al., 2001). Traditional belief systems and their appointed interpretations of content conveyed in dreams can sometimes worsen the mental health of an individual. For example, the content of the dream may be interpreted as accusing or punishing the dreamer. If a client is not supported in psychotherapy to share and reflect on the dream content with the therapist, the traditional cultural interpretation may significantly intensify mental distress (Eagle, 2005).

One treatment especially designed to help battle recurring nightmares is Imagery Rehearsal Therapy, IRT. In this particular therapy-method, the recurrent dream is told and in co-operation with the therapist, the part that evokes terror or fright is changed by the dreamer into a version that has a positive, empowering ending. The therapy has been used successively with survivors of other interpersonal traumatic events (Krakow et al., 2001). However, because the authors emphasize that the use of IRT implies the perception of the nightmare as a sleep disorder and thus learned behaviour (Krakow & Zadra, 2006), this view could be met with suspicion and lack of comprehension in individuals originating from cultures where dreams have particular culture-bound connotations.

Dreams deserve to be used more in psychotherapy and especially as a tool in therapeutic work with individuals from other cultures. Dream work may be used as an additional element in diverse psychotherapy methods. The present study contributes to strengthen the use of dream work as a therapeutic tool in psychotherapy with traumatized refugee patients. The study examines dream work in the individual psychotherapies of two torture survivor refugees, both from non-Western cultures. Further, the dream material and possible change in its content as a reflection of therapeutic improvement is examined.

5 MENTAL HEALTH HELP-SEEKING IN IMMIGRANTS

An important question that needs to be examined in the development of healthcare services for immigrants, concerns barriers in the paths of help-seeking. Considering the cultural heterogeneity of immigrants, the barriers to health services may differ between cultural groups. The differences can depend on the understanding and interpretation of symptoms, and can be influenced by an incorporated knowledge of traditional ways of help-seeking. Studies have concentrated mostly on single immigrant groups and therefore, results cannot explain the help-seeking behaviour of individuals with other cultural background. The reality in host countries is however different, and the refugees attempting to create a new life in this new environment originate from many diverse cultures. The present research tried to test a model of help-seeking in three culturally different immigrant groups.

Theoretical models of help-seeking behaviour emphasize the roles of health beliefs, attitudes and trust in services, as well as family and societal resources (e.g., social support), personal factors and a need for care (Andersen, 1995; Cramer, 1999). In single immigrant groups, acculturation, emigration context, distrust in health services, cultural values and illness explanations (e.g., Choi et al., 2015), cost of services and language difficulties (Wong et al., 2006) have been secured as special factors influencing health service use. Studies underline the influence of cultural variables not only on the manifestation of posttraumatic symptoms, but also on the engagement in psychological treatment (Campbell, 2007; Kirmayer, 2012).

As health conceptions are clearly culturally influenced, they predict health promoting practices and help-seeking in health matters (Levesque & Li, 2014; Fabrega, 1995). If mental health needs are in one's own culture not recognized as such, an individual suffering of mental health problems will not read his psychological state as one that needs help from healthcare services. This poor mental health literacy (in Western cultural terms) weakens recognition, adequate management and prevention of mental health problems (Jorm, 2012). Health beliefs of non-Western cultures adhere mostly to a holistic understanding of health, differing from the Western division of mind and body. Mental illness can further be

interpreted as caused by supernatural means or spirits or as a punishment from divine powers (Eagle, 2005; Kleinman, 1980; Kuittinen et al., 2017).

Distrust in healthcare policy and professionals of the host country seems to explain at least in part the low use of mental health services by immigrants. Research shows a preference of seeking help from traditional healers and religious elders who share one's own cultural background (Mölsä, Hjelde, & Tiilikainen, 2010; Moreno & Cardemil). The unfamiliarity with healthcare processes and treatment options can further construct a barrier to help-seeking in immigrants. In meetings with a health professional, difficulties in understanding arise, and important questions troubling the patients mind are not asked, out of fear (Betancourt, 2006). Interpreters used in the case of language problems can also awake distrust because a lack of confidence in the ability to translate correctly symptoms, evaluation and treatment options (Herrel et al., 2004) Distrust in healthcare can stem further from earlier negative experiences with healthcare professionals or institutions and feeling excluded or discriminated by healthcare personnel (Edberg, Clearly, & Vyas, 2010).

Acculturation as a process of adaptation into a new social and geographical environment is acknowledged to be stressful (Berry, 1997). If acculturation is successful, it has a positive influence on mental health and on help-seeking behaviour (Miller et al., 2006). Language acquisition is the strongest indicator of acculturation. Somali women resettled in the United Kingdom reported poor communication as a problem in help-seeking and distrust of a break of confidentiality as a limiting factor in the use of interpreters (Davies & Bath, 2001). Other acculturational factors are age of immigration, length of residence, generational status, and country of origin (Abraido-Lanza et al., 2006). It seems that also the educational level achieved in the home country has an impact on attitude to health help-seeking in resettlement countries (Fatahi & Krupic, 2016). Social relations with native citizens of the host country are critical in deepening acculturation (Fatahi & Økland, 2015).

Social and family resources play a significant role in help-seeking. Most people first seek help for evaluation and treatment options from the lay community outside the formal medical system (Stoller et al., 1993; Pescosolido, 2011). The family and close social relations feature in an important supportive role especially in collectivistic cultures. Among Asian American students and Chinese immigrant women, increased perceived social support was linked to more positive mental health help-seeking attitudes (Liao, Rounds, & Klein, 2005). However, the preferred quality of social support is in Asian cultural tradition a more implicit one, meaning feelings of connectedness and obligations to one′s community, in opposition to seeking social support through an intentional help-seeking effort (Taylor et al., 2007). A good

connection to one's own cultural community may influence help-seeking in the way that first, traditional ceremonies, healers, or remedies are used, before an attempt to access the healthcare system of the host country (Carroll et al., 2007). The social network in the home environment which is a major factor in building up and reflecting upon an adult person's identity is at the beginning lost for refugees and needs to be built up new again.

Regarding social acceptance, cultural stigma constitutes a possible barrier to help-seeking. In cultures laying high importance on collective harmony in place of autonomy and individualism (Hofmann, Asnaani, & Hinton, 2010), the notion of a mental illness as stigma affects the entire family. Hence, psychological distress seems to manifest strongly through somatic symptoms (Draguns & Tanaka-Matsumi, 2003). Research with Cambodian refugees to the US, who originate from a culture that strongly emphasizes collective harmony and saving face, shows this clearly through high levels of somatic disturbances along with cultural syndromes, in addition to high PTSD-levels (Hinton et al., 2013). Culturally, mental health problems are seen as a punishment for prior actions and represent a strong stigma. In another study, the understanding of mental health problems as a stigma was clearly delaying the acceptance of psychiatric referral in individuals of Asian background (Ng, 1997). However, somatization also appears in Western patients and thus, speaks against specific "somatizing cultures".

When there is a strong need for care, help-seeking from professional health care services may be tried. Refugees do experience – apart from possible torture – also other, sometimes traumatic violent events, during the flight and while having settled in the host country, in the form of interpersonal violence, harassment, or humiliation. Leaving one's home country carries with it at having to experience extensive losses, especially of the social realm. Further, resettling in a new environment and culture without the necessary language skills, social contacts and amenities most certainly adds stress. The often long and difficult process of asylum seekers to gain refugee status in a host country has a clear and by earlier research well documented influence on mental health (Silove et al., 2007). In cases of asylum detention, research shows increase in psychological symptoms correlating with its' length (Robjant et al., 2009). While not all asylum seekers have a torture history, many torture victims end up as asylum seekers and thus suffer of the additional stress entailed in the process best characterized by comprehensive insecurity. Considering the time after settling in a host country, conflicts in the family or between spouses, ethnic discrimination (Pascoe & Smart Richman, 2009), socioeconomic hardship, difficulties in language acquisition (Beiser & Hou, 2001), loss of one's status and

poor social support have been identified as common factors increasing psychological stress in refugees (Li et al., 2016).

Differences in the utilization rates of mental health services have been found not only between immigrants and native citizens, but between immigrant and ethnic groups (Tiwari & Wang, 2008). The growing diversity of Western cultural populations as for example in Finland, calls for changes to meet the specific needs of immigrants. To develop mental healthcare services in a generally accessible direction for all citizens equally, the varying needs of specific cultural groups in help-seeking deserve more thorough investigation. It would be useful for health policy-makers to have more information on differences between immigrant groups of diverse ethnic and cultural origin in the process of health help-seeking. The present study seeks to investigate the influence of cultural factors and mental distress in paths of health-care help-seeking and differences in culturally diverse immigrant groups.

6 AIMS OF THE STUDY

The present dissertation aimed to deepen the understanding of the influence of cultural factors on mental health symptom representation in the aftermath of the complex trauma of torture. Further, the use of a culturally sensitive model of dream work in the psychotherapeutic treatment of traumatized refugees was examined. Last, a model explaining paths of help-seeking in three ethnically different immigrant groups in Finland was tested.

6.1 Research questions

Tortured refugees: Considering tortured refugees the research questions were:

1. Does culture affect the manifestation of posttraumatic mental health symptoms?
2. Considering the additional stress of the asylum seeking process, do asylum seekers report a higher level of PTSD, depression and anxiety symptoms and somatic complaints than individuals with a granted refugee status?
3. Do gender differences feature in the level of psychiatric symptoms? Regarding PTSD, depression and anxiety, do women torture survivors experience more symptoms than men, and regarding somatic symptoms, do men report more symptoms than women?

Considering dream work in individual psychotherapy with torture survivors, the research questions were:

4. Do dreams feature a mental health function?
5. Do cultural factors influence psychotherapeutic dream-work? If so, how can they be addressed?
6. Do loss and death feature in the nightmares of trauma survivor refugees, and if so, in what way?

In study III, a model of multiple psychosocial factors associated with help-seeking behavior was tested in immigrants with Russian, Kurdish, or Somali background. The model hypothesizes that high levels of traumatic events are associated with

increased help-seeking through (a) weaker social network and/or (b) low levels of acculturation, which in turn are associated with (c) low trust in services and/or (d) high levels of mental health problems.

7. Does the proposed model fit and thus, are traumatic experiences associated with help-seeking from mental health services in all immigrant groups?

8. Does cultural background influence the path of help-seeking (a, b, c, d) for mental health problems from health services?

7 MATERIAL AND METHODS

1. Research questions 1, 2 and 3: The quantitative data consists of 78 clients of a specialized mental health clinic for tortured refugees in Helsinki area.
2. Research questions 4, 5 and 6: The qualitative data consists of the individual psychotherapies of two patients in treatment who both have a history of having endured torture and are refugees from a non-Western culture.
3. Research questions 7 and 8: The quantitative data is part of data gathered by the National Institute for Health and Welfare in Finland for the Migrant Health and Wellbeing study (Maamu) with a total N=3000.

The quantitative part of this research is analyzed with SPSS- statistical program. To answer research questions 1 to 3 one-way analyses of covariance (ANCOVA) is used, for research questions 6 and 7 a structural equation model (SEM) is used (AMOS), and research questions 4 and 5 are answered via the qualitative approach of case studies.

7.1 Participants and procedure

Participants in the first study were clients of a specialized mental healthcare unit for tortured refugees in Finland (I). In the second, qualitative study, the participants were two individual psychotherapy patients, both with a migrant history and different cultural background, and a history of complex psychological trauma (II). The participants of the third study (III) took part in the Migrant Health- and Wellbeing (Maamu) study, a large population based study of 3000 randomly selected migrants of three diverse cultural groups with either Russian, Somali, or Kurdish background and residing in Finland in six different city areas for at least one year (Castaneda et al., 2012). Of the 3000 participants, 545 Russian, 351 Somali, and 508 of the Kurdish group attended both the interview-part and the health examination of the study and were included in study III.

7.2 Measures

Participants reported demographic variables as marital status, education, socioeconomic status, household size, and work situation (Study I and III). In study I, Education was coded into five classes: no formal schooling, primary school, secondary school, vocational school, and higher education. In study III, education was coded into three classes: no education, vocational training/some courses, and academic / polytechnic education. In study II, a qualitative case study comprising two individual psychotherapies, demographics essential for the study were shared in the case description / were omitted due to guarantee anonymity of the psychotherapy clients. In study I, the asylum status of the refugee was coded into two classes: asylum seeker or refugee.

The Impact of Event Scale (IES) by Horowitz and colleagues (1979) was used in the extended version by Weiss and Marmar (1997) to measure posttraumatic symptoms (Study I and II). The extended version consists of 22 questions for the participant to answer after a traumatic event. The items cover intrusion, avoidance, and hyperarousal experienced during the past week. The questions could be answered on a scale from 0=not at all, 1=rarely, 3=sometimes, to 5=often, on behalf of the traumatic event and how the effect was felt. The sum score for the total scale was calculated and sums of subscales depicting intrusive, avoidant, and hyper-arousal symptoms. Relatively low internal consistency was observed (Cronbach's alpha 0.65). Following a recommendation of Weiss and Marmar, clinical cut-offs of 35 for the sum of the two subscales intrusion and avoidance was used (1997).

In study III, the personal experience of traumatic events was assessed with a checklist derived from the Harvard Trauma Questionnaire (Mollica et al., 1992), asking about experience of war, natural disaster, been witness to violent death or injury, experienced sexual violence, assault, kidnapping, torture, or another extremely violent act. The questions were responded yes (1) or no (0). A new variable was computed of the sum of traumatic events marked by the participant, ranging from 0 to 10. The amount of exposures to each trauma was not enquired.

Anxiety and depression symptoms were measured using the Hopkins symptom checklist (HSCL-25), a self-report questionnaire including 15 depression symptoms (e.g., "Feelings of worthlessness") and 10 anxiety symptoms (e.g., "Nervousness or shakiness inside"). Study participants evaluated their mood and behaviour regarding the checklist item questions during the previous week, using a Likert scale (0 not at all to 4 extremely often). For depressive and anxiety symptoms mean sum scores were calculated (Cronbach's alpha 0.86 for depressive and Cronbach's alpha 0.71 for

anxiety symptoms). As a clinically significant cut-off score +/= 1.75 was utilized (Ekblad & Roth, 1997).

Somatic complaints were collected in study I from the patient chart information reported by the client in the entrance interview, which was conducted by clinical professionals of the specialized mental healthcare unit. The clients were asked about somatic problems that had stayed unexplained in the medical assessment, and when needed, enquiries were made about symptom severity, occurrence and medication. The number of somatic problems mentioned was totaled. Participants also reported if they suffered of severe physical disability.

In study III, the somatic symptoms were assessed by the 10-item somatization subscale of the Symptom Checklist-90 (SCL-90) by Derogatis, Lipman and Covi (1973). Every item describes a distinct somatic experience (e.g., dizziness). The participants marked their own individual experience on a 5-point Likert scale (1=not at all to 5=very much).

Acculturation was measured in study III by five variables. (1) Participants reported the year arriving in Finland, and the according length of residency (years) was calculated. (2) Nationality status in Finland was coded as Finnish vs not Finnish citizen. (3) Language proficiency was indicated by the level of understanding Finnish/Swedish (ranging from 1=not at all, to 4= I understand well), and being able to "explain things in Finnish/Swedish (ranging from 1=not at all possible, to 4=I manage well). (4) The number of Finnish friends as raw numbers. (5) Social contacts with Finns was assessed by asking the amount of communication with Finns (1=almost daily, 2=weekly, 3=monthly, 4=a few times per year, 5=seldom, 6=never / does not apply).

The social network was assessed with five variables in study III: (1) Participants' responded to the question "How many good friends do you have?" a number, which was coded into a 5-point Likert scale (1=no friend, 2=1 friend, 3=2–3 friends, 4=4–6 friends, 5=7 or more). Loneliness indicated the subjectively experienced lack of a social network, assessed by one question "Do you feel lonely?" with 5 Likert response alternatives (1=not at all lonely, to 5=always lonely). The item was reverse scored. Further, contacts with (3) relatives, (4) members of own ethnic group, and (5) people abroad, was inquired with a 6-point Likert scale (1=almost every day, to 6=there are no friends/relatives).

7.3 Statistical analyses

Statistical analyses (Study I and III) were performed using SPSS 20.0 and – for study III – AMOS 15.0 software within SPSS Framework Version was used for structural equation modeling (SEM). Age, gender, and education were included as covariates in the models (Study I and III). In study III, Inverse Probability Weights (IPW) were calculated according to ethnic group, age group, gender, municipality, and marital status and used throughout the study in order to produce population level estimates representative of the Russian, Somali, and Kurdish populations in Finland and, in order to reduce bias due to non-response.

In study III, the use of SEM allowed to test multiple regression equations simultaneously and the inclusion of multiple psychosocial factors associated with help-seeking behaviour. The statistical method of SEM makes it further possible to evaluate the significances of direct and indirect (mediated) paths among the three ethnic groups. For a good SEM-model fit, the criteria were nonsignificant $\chi 2$ value, $\chi 2$ /df<2.00, Comparative Fit Index (CFI), Tucker-Lewis Index (TLI) above .90, and RMSEA under .06.

Analyses involved testing the measurement models of the latent constructs of social network, acculturation indices, mental health, trust in services, and help-seeking for mental and somatic/general health services in a multigroup procedure to show factorial invariances (whether the measurement models differ or are similar across the three groups). If the multigroup SEM analysis did not fit the data, the hypothesized model would be separately tested in the Russian, Somali, and Kurdish groups.

8 RESULTS

In the dissertation study, three different data sets were used for the three studies included in this research. The original publications of the dissertation study (studies I–III) display the exact results regarding each research question, including statistics. An overview of the results is displayed here. For more and thorough information, please see the original publications attached.

8.1 Study I

The present study investigated first, if cultural factors have an impact on the manifestation of mental health symptoms after traumatic events (study I). The sample of the study consisted of 78 refugee patients with a history of torture trauma. The participants represented 14 countries, categorized in four groups according to socio-geographical information. Of the sample, 31 (25 men, 6 women) participants were of Middle Eastern cultural origin, 23 (10 men and 13 women) of Central African origin, 13 (10 men and 3 women) of Southern Asian origin, and 11 (4 men and 7 women) were of South Eastern European origin. The results of the Pearson's chi-square tests revealed significant group differences in age, gender distribution, civic status, work situation, refugee status, and family reunification. 17% or the whole sample were employed, and the educational level was generally low with almost 50% having less than 10 years of schooling. Islam was the dominant religion in all groups but the Central African group. No group differences were found in educational level, exposure to trauma or physiological disability. In all groups, participants reported a history of more than five traumatic events. Women reported more events of having been raped (48% vs 6%) and other sexual trauma than men (69% vs 33%), whereas men reported more often long times (more than 12 months) of imprisonment (33% vs 10%) and more combat situations (49% vs 10%).

To examine associations of cultural background with PTSD, depressive, and anxiety symptoms, one-way analyses of co-variance (ANCOVA) were applied. After preliminary analyses of co-variances showed significant interactions between PTSD and gender, and depression and work situation, these were included in the

subsequent ANCOVA analyses. The results of the subsequent analyses reveal significant differences regarding mental health sequelae and the processing of trauma between clients representing diverse cultural areas. Cultural differences were found in PTSD-symptoms, depressive symptoms and in somatic complaints. Regarding research question 1, South Eastern Europeans reported higher levels of PTSD-symptoms than other groups. Regarding somatic complaints, those were higher in South Eastern Europeans than in clients originating from Central Africa. Refugee status had no significant influence in associating between culture and mental health in any of the cultural groups (research question 2). The interaction effects of the cultural group X gender on PTSD, and cultural group X gender and work situation-interaction effects were non-significant. This result indicates that in all cultural groups, male and female torture survivors were similarly vulnerable. Further, culture X employment status had no significant influence in the vulnerability, meaning that in all cultural groups it made no difference regarding PTSD-symptomatology if one was employed or not.

Regarding somatic complaints, no significant differences were found between men and women (research question 3). Concerning anxiety symptoms, no differences between cultural groups were found. However, a marginally significant interaction effect was found in anxiety symptoms ($F(2,64)=2.84$, $P<0.06$, $\eta^2=0.09$), indicating higher anxiety levels in the asylum seekers of the South Eastern European group compared to refugees. The legal status regarding asylum seeking procedures was not associated with anxiety in Middle Eastern and Central African groups. Regarding the sex of the participant, women suffered more from PTSD and depressive symptoms than men in all cultural groups. Further, age had no significant influence in the link between culture and mental health in all groups.

8.2 Study II

Regarding the psychotherapeutic treatment of refugee torture victims using dream work in two individual psychotherapy processes, a mental health function of dreams after trauma was established (research question 4). In both case reports, dream work consisted of exploring the content of the dreams and personal meaning to the client and enabled working through the emotions connected to the traumatic events in the client's past. The acknowledgment of emotions involved led the way to processing the traumas and an active mourning and grief regarding the losses in the life of the clients was made possible. Through a nonhierarchical approach a validation of the

client's cultural interpretations of nightmare content were made room for and a culturally sensitive stance in an integrative psychotherapy was achieved. In both case reports, the nightmare content changed as a function of psychotherapy, to less frightening images and a change in content, even to the point of complete disappearance of the post-traumatic nightmare. The interest in, respect towards, and validation of the client's cultural views about the content of the nightmare were of significance in both psychotherapies (research questions 5 and 6).

8.2.1 Case report 1

"Luisa" (the client's name and details of her family have been changed to protect her identity) is a West African woman and started therapy at the age of 33. She had come as a refugee to Finland from a war-tormented country after having lived seven years at a refugee camp in another country in Africa. In a military attack on her home village she had lost both her parents and siblings 9 years earlier. During the assessment phase, a range of PTSD-symptoms she suffered of, were detected. In addition, she had trouble sleeping, complained about various almost chronic pains and worried constantly about issues in her daily life.

In therapy, Luisa was supported in concentrating on those issues in her momentary life she felt confident to share. The context of the therapy sessions and the roles of her as a client and the therapist, and her thoughts on this kind of treatment and perceptions of the therapy as a specific situation were discussed, in a reciprocal way. Luisa's frequent use of alcohol to sooth herself emerged. The therapist wanted her to monitor her drinking which she did not do. In session No 8, Luisa confided to the therapist that she was worried what the therapist would think of her and therefore, she could not monitor her drinking. Writing it down made it more real and her therapist would disapprove of her behavior. The therapist suggested they examine the reason for her drinking, and Luisa felt relieved. She said she drank because it made her forget. In session 13, Luisa was encouraged to examine the content of her nightmares and her pain experience through the appointed meanings embedded in the traditions of her cultural upbringing, succeeding in mutual reflective collaboration with the psychotherapist and making way to working through the emotions connected to her trauma history. Death featured in the dreams in concrete images of dead people, first through strangers and later in the process through dead

members of her family, activating a row of negative emotions (Table 1). The first nightmare was a dream the client saw almost every night. There were dead people in the dream, people she knew who had died years earlier. In this first narrated dream she saw a man who had been famous in her village. He was with his son and seemed alive and they were harvesting peanuts. The man came towards her and asked her what she was doing. She felt the need to tell this man that she was not stealing the peanuts they were harvesting and she woke up feeling horror. In later dreams she felt guilt. In the therapy process she began to verbalize those feelings for the first time. The psychotherapist invited the client to share her views about the content and the emotions activated through the dreams. Luisa felt the dreams were a punishment for her, as in her culture ancestors send messages to the dreamer through the content. Especially the fact that she had not buried her relatives was hard for her to admit and accept (research question 5). Further in the process a culturally valid form of expressing grief and mourning was established and implemented by the client, in the form of a traditional ceremony. This enactment made the processing of the feelings of shame and guilt possible and led to a decrease of psychiatric symptoms (research question 6). During the therapy, the IES-R-score, which was at the start of therapy 57 points, went down considerably, to 39 points, measured at the last, the 30th session.

In the integrative psychotherapy, the psychodynamic elements used in case study I were the accessing and reviewing of unpleasant emotions attached to painful, traumatic experiences that the client had not formulated before, and were nonverbally represented in the body and mind. Luisa concentrated in the first sessions of therapy on her bodily pains, which worried her immensely. Her feelings, thoughts and actions attached to them revealed a pattern that could be reflected upon mutually. Cultural transference and countertransference phenomena in addition to personal transference were examined and interpreted. Cognitive-behavioural elements used were education about posttraumatic stress symptoms, homework assignments, monitoring of dysfunctional activities used by Luisa to cope with the trauma sequelae. Luisa's adaptive coping skills were strengthened and supported, and negative attributions altered. A clear discussion and the suggestion to make an own decision of the therapeutic aims of the therapy at the beginning gave Luisa a feeling of being in control. A respectful and non-judgmental attitude towards Luisa's cultural worldview and the cultural conceptualizations of health and illness, and cultural treatment options were central elements throughout the therapy.

Table 1. IES-Scores, dream content, emotions and actions resulting from the dream work in Luisa's psychotherapy work in psychotherapy.

	Session 13	Session 14–15	Session 16–19	Session 20	Session 30
Dream content:	Nightmare "Peanut-dream" with a dreamlike narration, but repetitive in content "I find myself in my hometown and I meet people who I know are dead".	"Peanut-dream" goes on "I did not steal your peanuts".	Dream is richer and changes in narrative *"I went to the bed and looked at him and I saw he was dead."*	"Escape-dream": "I am running away from a man and I hit on doors, they are closed. A door opens and a woman signals me to come in. She grabs my hand."	The nightmares have stopped.
Repetitive elements:	Dead people, peanuts	Dead people, peanuts	Dead people	–	
Dominant emotion:	Horror	Guilt	Shame, Worry, Self-blame	Anxiety	
Actions done by the patient inspired by dreamwork				Luisa decides to perform a burying ceremony for her dead family members at her home.	
IES-Score	57				39

8.2.2 Case report 2

In case report 2, "Shirin" (the client's name and details of her family have been changed to protect her identity) is a woman from a Middle Eastern country. She was at start of the therapy 41 years old and had lived as a refugee in Finland for almost seven years. She had experienced imprisonment in her home country, which was a total surprise for her. She had not been politically active but was imprisoned because of accusations of political activity. During several months in prison she was constantly tortured. She had been in therapy once before but had stopped it, all of a sudden. At the assessment session, she suffered in addition to posttraumatic stress from anxiety symptoms, a fear of high places, heavy back-pains, sleeping problems and nightmares. She also experienced a fear of dying and leaving her children as orphans. At the first sessions, the IES-R-score was with 73 points very high.

Shirin desperately wanted to get help to get over her torture trauma, but until session 43 she did not talk about it, and complained instead of the many strains in her daily life as a single mother and a refugee. She criticized herself regarding her role as a mother and she felt she made the lives of her children worse. She experienced language problems but managed most errands and things she needed to do on her own. During the first half of therapy she canceled sessions every once in a while, and upon attending again the next session she would criticize the ineffectiveness of the treatment. In the therapy, during the first part of the sessions the strengthening of Shirin's resources and psychoeducation and information were provided to help her identify maladaptive ways of coping and to improve her parenting skills. In the second part of therapy, the sharing of cultural metaphors of death with the psychotherapist helped Shirin connect with her trauma history. For example, in the first dream she shared with the psychotherapist, her dead uncle came to her parent's home and tried to take her with him, which made her wake up screaming (for other dream content, please find the research article attached, study II). She said that this dream meant, according to cultural traditional belief, she herself would also die soon (research question 6).

Through a validation of the significance of cultural meaning of the nightmare content by the psychotherapist the client started to develop hopefulness and to process the dream content and the emotions evoked by it. By actively reflecting on the content and an examination of associations brought to mind in the following sessions, a reassignment of emotions felt in the dreams into her real life was enabled. Subsequently, this reassigning process led to a decrease of PTSD-symptoms and a disappearance of nightmares containing dead people.

In the integrative therapy of client Shirin (Table 2), a psychodynamic stance served to explore Shirin's attempts to avoid topics or hinder the progress of therapy, identification of the client's mental defence mechanisms and revealing them, helping the client become aware of her hidden feelings. Her emotions towards traumatic content were explored and validated. Shirin's health problems were given time in sessions to validate her somatic experience. Nightmare content and its cultural conceptualization in Shirin's home country was shared with the therapist and a respectful and appreciative attitude was an essential element throughout therapy (research question 5). Cognitive elements used were the identification of maladaptive beliefs and thoughts regarding her role as a mother, the development and reinforcement of coping skills as a parent, monitoring her pain, and the recognition and decrease of behaviour which influenced her pain level in a negative way. Dream work was loosely based on the Focusing technique (Gendlin, 1986). Thus, both

psychotherapies highlight the importance and relevance of a culturally sensitive therapeutic attitude and the value of dream with refugee torture survivors originating from Non-Western cultures (study II).

Table 2. Table 1. IES-Scores, dream content, emotions and actions resulting from the dream work in Shirin's psychotherapy.

Dream content:		Nightmare "Uncle-dream": with a dreamlike narration, repetitive element: "My dead uncle came and took my hand, leading me away. Nobody helped me."	"Hometown-dream": "I was in my hometown with my mother, a dead neighbour comes close."	"Dog-dream": "A huge dog fletches his teeth, wanting to eat me. I fight back, my children are behind me."	Nightmares featuring dead people have stopped.
Repetitive elements:		Dead person	Dead person	–	–
Dominant emotion:		Horror, fear	Anger	Relieve	
Actions done by the patient inspired by dreamwork			Shirin starts to write down a narrative of the traumatic events.		
IES-R score	73				40

8.3 Study III

Regarding help-seeking paths of Russian, Kurdish, and Somali origin immigrants in Finland, in the demographic information the three cultural groups differed in all characteristics. In the Russian immigrant group were more women (64%) than in the Kurdish (45%) or the Somali (56%) group. A work permit based residence status was found more often in Russian immigrants (54%), whereas about a half of Somali (56%) and Kurdish (54%) participants had a refugee status. Russians were older (40% vs. 23% 45–64-years) than the participants of the other two cultural groups, and were better educated, as 79% had high school basic education, in comparison to 42% among Kurds and 22% among Somalis. The Kurdish immigrants had lived a shorter time in Finland (average 10.82 years) than the other groups (11.66–11.85).

Experiences of traumatic events were reported highest by Kurdish immigrants. In Kurds, 21% reported more than six events, while among Russian and Somali immigrants only a very small number of participants (n = 4–7) reported as many traumatic events. Earlier research based on the same data has revealed variations in the representation of mental health problems between the three cultural groups: Kurds reported depression, anxiety and somatic symptoms, members of the Somalian cultural subgroup reported mainly somatic symptoms, and participants with a Russian background reported a generally lower level of those symptoms (Rask et al., 2015).

Measurement models of the latent constructs of mental health, acculturation indices, social network, trust in services, and help-seeking mental and somatic health services were tested in a multigroup procedure to check the factorial invariances (whether the measurement models differ or are similar across groups). Then, by multigroup procedure, it was tested whether the hypothesized model with direct and mediated effects between traumatic events as the exogenous variable and help seeking from mental (four manifest variables) and somatic health services (four manifest variables would fit. Social networks (represented by five manifest variables), and acculturation indices (five variables), and trust in services (three variables) and mental health (three variables) were tested for their mediating role regarding help seeking in the model. Covariates included in the model were education, gender, and age. It was expected that the latent variables of psychosocial factors on help-seeking (Figure 1) would fit similarly in the data of the three individual groups. In the case that the multigroup SEM analysis would not fit the data, the hypothesized model was separately tested in the Russian, Somali and Kurdish groups.

The multigroup measurement model showed an acceptable fit to the whole data (CFI = .90, TLI = .90, RMSEA = .027 (90% CI .026–.027)), although the $\chi 2$ -statistic indicated misfit ($\chi 2$ (992) = 3927.51, p G .0001; χ/df = 3.96). This was due to the large sample size (Yuan, Hayashi, & Bentler, 2007). The groups differed in the significances of the loadings of manifest variables on the latent constructs (standardized regression weights), except on mental health. The measurement model of mental health was complete in all ethnic groups (i.e., the manifest variables of depression and anxiety, somatization, and life satisfaction showed significant loadings on the latent construct of mental health) (research question 7). Regarding social networks, the manifest variable of loneliness did not achieve significance in the Russian or in the Kurdish subgroups. The latent variable acculturation did load significantly in those two subgroups but one of the acculturation indices, the variable Finnish friends, did not load in the Somali subgroup. The indices for seeking mental

help were relatively complete in all three cultural groups, whereas seeking help from somatic healthcare services was problematic in Russian and Somali groups.

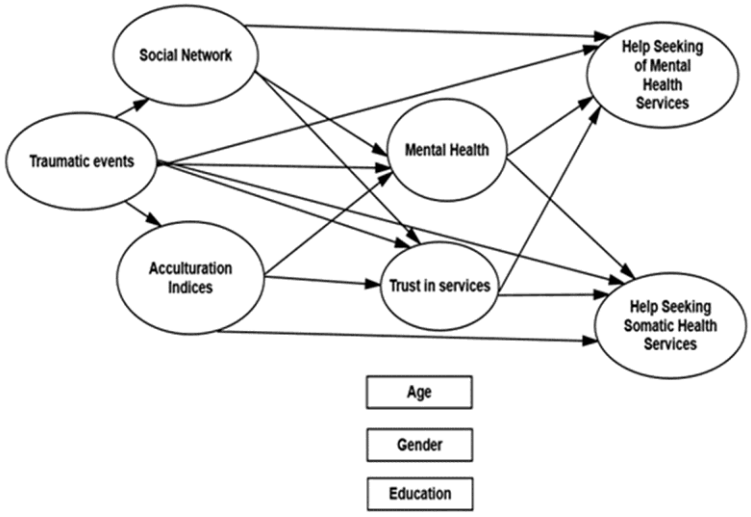

Figure 1. Schematic Model of Psychosocial Factors to Help-Seeking Behavior.

Concerning pathways to help-seeking for mental health problems associated with trauma in Somali, Russian and Kurdish origin immigrants in Finland, past traumatic events were clearly associated with seeking more mental health services in all groups. Help-seeking in individuals with past trauma was indirectly mediated through increased risk for mental health problems in all three ethnic groups (research question 7). In Russian immigrants (Figure 2), a larger social network was significantly related to a higher trust in services ($\beta = .36$, CR=3.39, $p < .02$), and through mental health symptoms to help-seeking behaviour. Lower education in Russians was associated with seeking more somatic healthcare services ($\beta = .22$, CR = -3.04, $p < .01$).

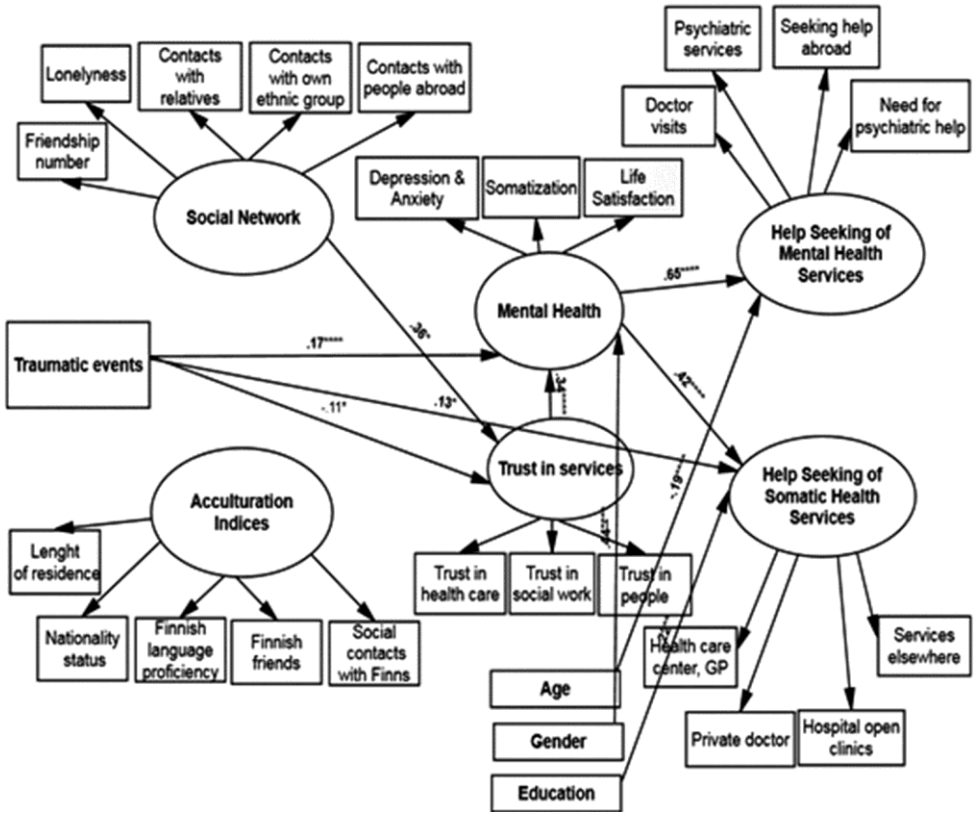

Figure 2. Results of the Help-Seeking Model of Psychosocial Factors in the Russian Immigrant Group (Structural Equation Model).

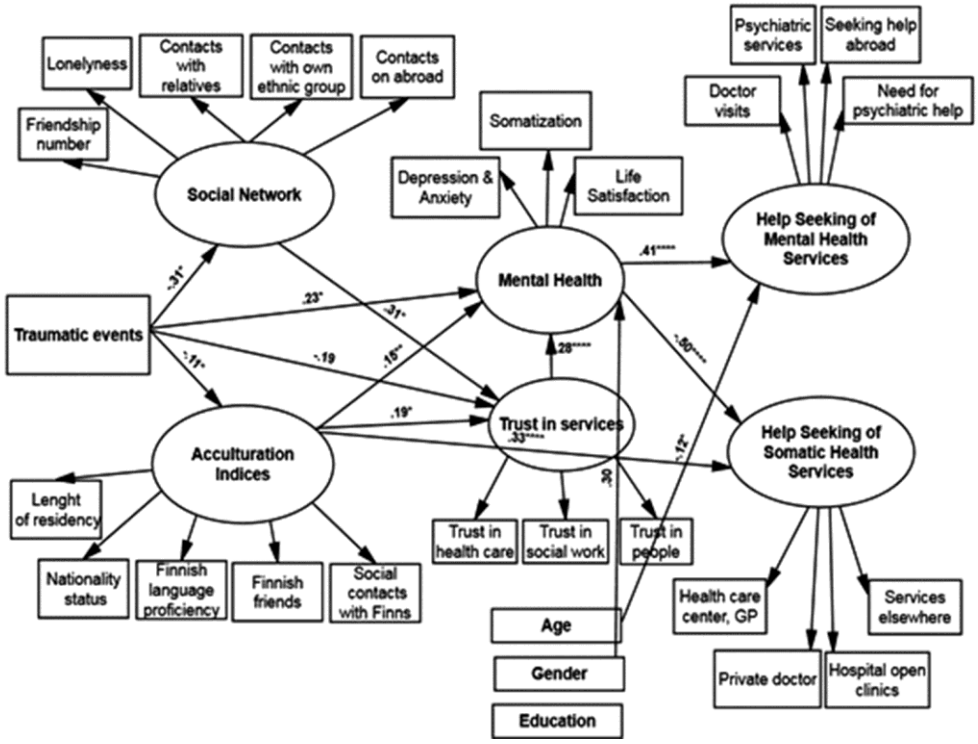

Figure 3. Results of the Help-Seeking Model of Psychosocial Factors in the Kurdish Immigrant Group (Structural Equation Model).

Acculturation played a significant role in use of mental and somatic health services only in one, the Kurdish immigrant group (Figure 3), while social networks played a role in Kurds and Russians (Research question 8). High exposure to traumatic events, a small social network and low acculturation were all associated with mistrust in health services that in turn was further associated with help-seeking through increased mental health symptoms. Of background variables, age and gender were associated with help-seeking: younger Kurdish immigrants were seeking more of mental health services (β = -.12, CR = -2.34, p < .03), and women suffered more mental health problems (β = .30, CR = 3.23, p < .001).

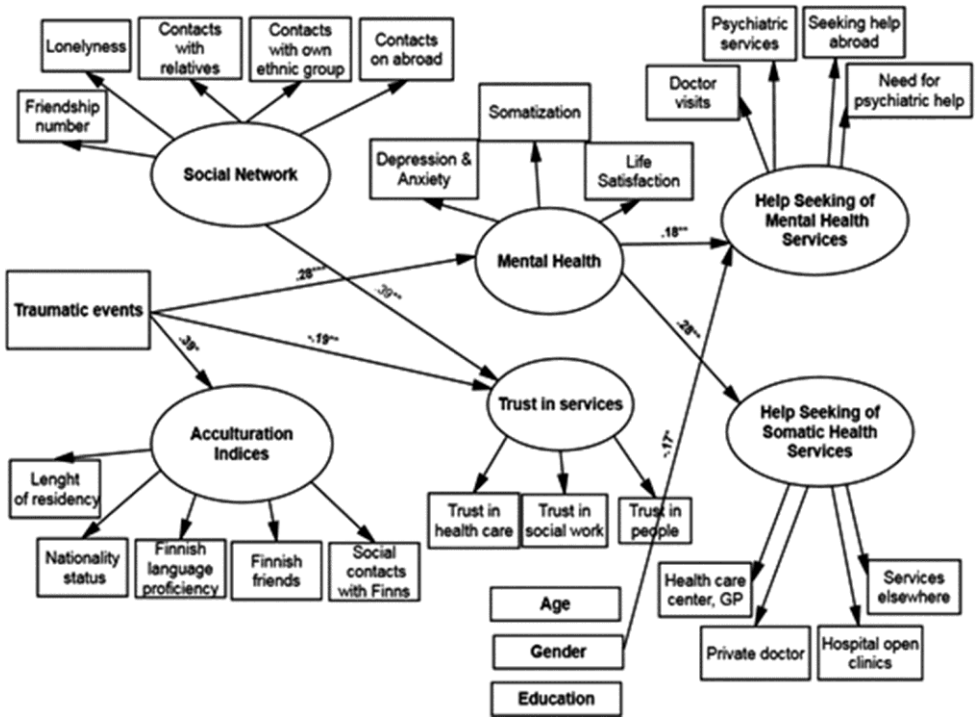

Figure 4. Results of the Help-Seeking Model of Psychosocial Factors in the Somali Immigrant Group (Structural Equation Model).

Among Somali immigrants (Figure 4), the SEM model explained 29% of help-seeking for somatic healthcare services, and 6% of help-seeking for mental health services. The model showed insufficient fit indices ($\chi 2$ (331) = 782.17, $p < .0001$; $\chi 2/df = 2.36$; CFI = .89, TLI = .89, except RMSEA = .062 (90% CI .057–.068)). Thus, interpretations of this result should be made with caution. The reported experience of traumatic events was in the model indirectly associated with help seeking from mental and from somatic healthcare. In the group of Somali immigrants, the use of mental health services by men was more frequent than by women.

9 DISCUSSION

The dissertation study ties together significant findings regarding cultural differences in the manifestation of trauma sequelae (study I), culturally sensitive psychotherapeutic dream work (study II), and cultural influences in help-seeking for mental health problems after traumatic events (study III).

The results of the first study strengthen the argument that cultural factors have an impact on the presentation of mental health symptoms (study I). Posttraumatic stress symptoms were especially high among South Eastern Europeans who had been exposed to torture and other violence during the war in Former Yugoslavia, compared to Middle Eastern, Central African, and Southern Asian torture survivors. The results of this cross-cultural study emphasize cultural differences and showed that PTSD symptoms of trauma-related intrusion and avoidance featured more strongly as a sequel to traumatic events in individuals originating from a culture with more individualistic features in comparison to the participants in the other subgroups, who originated from societies with a more collective and interpersonal layout. However, one shortcoming of this research is the fact that the division in cultural subgroups was based on geographical factors and the differences in individualism – collectivism were assumed and not measured via a questionnaire. This made the division artificial to some degree. However, differences in social orientation between the cultural subgroups used in the present study are based on earlier research (Nisbett, 2004). While Southern Eastern European culture does not present as a strongly individualistic one in comparison to other cultures in Europe, in comparison to the other cultural groups in the present data this group showed stronger individualistic features. Southern Eastern participants came from cultures favoring personal opinions (Catina, 2006) and taking care only of one's immediate family and oneself vs a collective view of taking care and respecting one's extended family. The Southern Asian group, which reported the lowest level of PTSD symptoms, consisted of individuals from strongly collective societies. A lower level of PTSD in Asian study participants has also been reported in earlier research (Keller et al., 2006). Concerning collective cultures, it has been found that emotional experiences can influence a change in beliefs about the self (Mesquita, 2001), which indicates a more fluid and flexible self-concept (Jayawickreme, Jayawickreme, & Foa,

2013). Flexibility in ones' self-concept means that contradictory beliefs are more easily tolerated. This flexibility may act as a shield against a breakdown of the self and can impede the development of PTSD (Dalgleish, 2004).

Concerning the significantly higher level of PTSD in South Eastern European torture survivors, the level of traumatic experiences (low: 1-5 events, vs high: 6-11 events) was also highest in this group with over 54% reporting a high level in relation to the other groups (41.9%–53.8%). The difference was however not statistically significant. In earlier research studies excluding a comparison with trauma victims from other cultural origin the especially high PTSD levels among refugees from diverse areas of Ex-Yugoslavia have also been emphasized (Alexander et al., 2007; Momartin et al., 2004; Turner et al., 2003). All individuals participating in study I had a history of torture and ill-treatment, and had suffered war and refugee-related losses and violence. Because of the similar distribution of traumatic events through the participants in all cultural subgroups, the higher level of PTSD symptoms cannot be explained by the number of diverse traumatic events.

Another explanation for the higher PTSD-symptom level in South Eastern European origin participants could be the felt acceptance in the host country. A study examining the mental health of war refugees from the same area, long-settled in three European countries, found a significant association between mental health and felt acceptance (Bogic et al., 2012). While Finnish culture is situated from a cultural viewpoint closer to South European culture than Middle Eastern, Central African, or Southern Asian cultures (Fearon, 2003), this does not necessarily mean that inter-cultural encounters and communication appears easier for the subject involved. Acceptancy issues may influence mental health even in a more significant way particularly in the Europe-based group of participants. The loss of loss of work and professional identity due to language and integration problems could be of negative influence and make acceptance-issues stronger. However, felt acceptance was not measured in the present study and future research may strengthen or weaken this notion.

Physiological disability was not associated with somatic complaints in any of the groups, which emphasizes the impact of torture and other traumatic events on somatic experiencing. Similar results have also been found succeeding psychological torture in Palestinian ex-prisoners (Punamäki et al., 2010). Concerning the lower level of somatic complaints in Central African torture survivors in comparison to South Eastern Europeans and non-significantly in comparison to the other two groups, this result can be influenced by what participants understood under type of somatic complaints asked. It is possible that they – in reporting somatic complaints

– may not have included culturally rooted expressions for somatic sensations as body heat or "crawling" beneath the scalp (Rasmussen et al., 2007b). Middle Eastern and Southern Asian individuals reported similar quantities of somatic complaints. Middle Eastern torture survivors originate from a culture where complaints are described in a physical way (Kizilhan, 2017), using the body and bodily sensations as a metaphor for psychological suffering and emotional experience. Participants of the other subgroup, with a Southern Asian cultural background, have been reported to either lack verbal concepts to communicate emotional distress (Minhas & Nizami, 2006) or the expression of emotional pain through somatization is more culturally accepted and less stigmatizing (Kohrt & Hruschka, 2013). Research shows that somatic complaints seem to be represented across many refugee groups and it seems that somatic problems are more easily taken up by the immigrant patient in healthcare facilities. A trend in the use of healthcare services exclusively for somatic problems in some ethnocultural migrant groups, even when psychological distress is clearly displayed has been detected by healthcare professionals (Kirmayer & Young, 1998; van Ommeren et al., 2002).

Women suffered higher levels of depressive and traumatic symptoms, which lies in accordance with earlier research presented in a review on civilian survivors of war and torture trauma by Johnson and Thompson (2008). The women of the sample reported also more histories including sexual trauma, which is strongly associated with the development of PTSD (Zlotnick et al., 2006). However, disclosing having endured sexual violence is because of differences in gender roles difficult for men, and may have influenced the information given in this research study. Regarding research question number three, no significant differences in the experience of somatic symptoms emerged between gender. Women experienced somatic symptoms on a similar level as men. The result may derive from the fact that for all cultural groups included in the study, the expression of psychological pain was more culturally accepted. Further, all participants in study I regardless of gender had experienced torture and exposure to different types of other traumatic events on an equal level.

In study II, culturally sensible dream work in individual psychotherapy with torture survivors did significantly support the therapy process. Working through the dream content brought memories of the trauma events and emotions connected to them into consciousness and into the dialogue between the client and his therapist. Narration and reflection on the dream material helped work through trauma memories and significantly and positively influenced the rehabilitation process. In both psychotherapies, the cultural sensibility of the psychotherapist towards the

client's own cultural viewpoints were in a crucial role. Through a respectful and nonhierarchical stance and a validation of the clients' own views stemming from their cultural realm the exploration of the dream material connected to the trauma was made possible. Further, other culturally rooted ways of experiencing were verbalized and reflected upon in relation to the trauma history of the client.

A culturally sensitive stance in psychotherapy with tortured refugee clients regarding the results of the present study (study II) of major importance and, in comparison to manualized psychotherapies it makes a collaboration between the culturally diverse client and psychotherapy stronger, through respectfully integrating the clients' own viewpoints stemming from his or her home culture. As it is often the case, there is a strong desire to avoid traumatic memories and they are not easily shared with others, even in a psychotherapeutic process. Working through traumatic memories reduces however the risk against future and chronic posttraumatic sequelae (Foa et al., 2009).

Working with dreams especially with clients from cultures who traditionally appoint a warning or punishing meaning to the content in question, or come from a culture where dreams are not allowed to be shared, needs particular attention from the psychotherapist. Through a respectful initiation to the theme, containing an interest in the client's cultural view and an explanation of the usefulness in discussing dream material, a refugee client may open up to discussing the fear inducing dreams in the therapy. An important contribution of using dream work with traumatized refugees is the opportunity therein to strengthen the client's own resources, validating the importance of own perceptions and embedded cultural meanings detected in dream material by the client. Important themes connected to the traumatic event, which the client may not have been able to touch, as guilt, shame, loss, and mourning, can emerge via the dream material and can thus be discussed and reflected upon. Shame for example is a frequent emotion in the aftermath of trauma. It is therefore vital to find methods to address shame and the often-used maladaptive shame-regulation strategies in PTSD treatment. Via dream work this was made possible.

One major advantage of working with dreams as proposed in this study is the fact that this procedure is applicable to diverse psychotherapeutic approaches. While in many healthcare facilities for tortured refugees a lengthy psychotherapy of more than 30 sessions may not be possible to offer, a shorter psychotherapy directly targeting dream work and nightmare content could be the method of choice. Another possibility to work with dreams could be a group therapy setting. Therapy groups have a row of advantages. They are economical and they emphasize peer

support. In refugee rehabilitation facilities therapy groups seem to achieve incoherent results because of the complex and difficult issue of revealing traumatic histories of torture to others (Wöller, 2016; Drozdek & Bolwerk, 2011). Working with the content of dreams in a group setting adjusts the focus (at least at the beginning of the group) away from the real personal histories and towards the subjective pain suffered by every participant. Sharing these emotions with others is helpful.

Study III modeled the roles of trauma, social network, acculturation, trust and mental distress in health help-seeking in three cultural immigrant groups of Somali, Russian, and Kurdish origin settled in Finland. The model achieved to explain help-seeking of both mental and somatic healthcare services. The percentages of explained variances however varied between groups. In Russian and Kurdish immigrants, the model explained a greater share of seeking mental healthcare services, while among Somalis, it explained better seeking help from somatic healthcare services. Considering the results of the group of Somali origin, they may be less familiar with the role professional mental healthcare in Finland plays, and how doctors or psychologists and psychotherapists could help alleviate problems as murug (sadness) or gini or waali (craziness) (Carroll, 2004).

Across Russian, Somali, and Kurdish cultural groups both similarities and profound variations in psychosocial factors contributing to help-seeking behaviour were found. Especially the roles of social network and acculturation varied in their influence on help-seeking behaviour. In the Russian participants trauma-related distrust in services may be influenced by the country's Soviet history during which mental health institutions were used as places of detention (Jenkins et al., 2007). Apart from pharmacological medicines self-medication with natural plants, folk medicine, alternative medicine and occultism seem to be favored as treatment throughout diverse circles of Russian society (Krasheninnikova, 2017). For Russians, a wide and active social network was associated with more trust in services offered by Finnish professionals and better mental health. In Kurds a bigger social network was similarly connected to a stronger trust in healthcare services and good mental health. Also for Somali participants the own social network seemed to play the main role in influencing trust in Finnish services, but did not associate with help-seeking from professional Finnish healthcare. The results point to clear variations between cultures in the conceptualization and the quality of support of one's social network. Mental healthcare services today should put an emphasis on embracing the specifics in help-seeking paths of cultural minority patients who carry highly complex problems with them. The role of trust and social bonds in help-seeking paths also

adds useful information for the planning and delivering services to these populations.

Considering factors related to gender, the study showed a higher level of mental health symptoms in the women of the Russian and of the Kurdish ethnic group. Underlying this result can derive from distinct causes in each group. The women in the Kurdish group came from a geographical area deeply influenced by military attacks, turmoil, violence and persecution, which may have emphasized mental health symptoms in Kurdish women, at least in part. Most Russian women came in comparison from a more peaceful area. Further, it is possible that Russian women had less mental health issues through a better assimilation, for example through better language skills, which has a supportive role in relation to mental health.

In the Somali subgroup men used more mental health services than women. This outcome can be influenced by the appointed gender roles inherent in Somali culture: a strong partriarchal tradition seems to hinder women to actively participate in decision-making. These differences in social roles appointed to men and women are grounded in history and maintained by the larger ethnic group (Triandis, 1989) of Somali immigrants. Culturally grounded beliefs may deter Somali immigrants from accessing mental healthcare services (Ellis et al., 2010). Recent research has shown that Somali men and women seem to differ in their attributions of mental health problems: women attribute them more to socio-religious factors (as interpersonal relations and relationships with God or spirits), while men attribute mental health problems more to somatic and psychological factors, or intra-individual causes (Kuittinen et al., 2017). The conceptualizations of mental illness in the Western cultural sphere and in Somalia differ remarkably from each other and spirits are considered as a distinct but not the only cause of mental illness by Somalis while in the Western sphere this belief is not accepted. Religion, for example Qu'ran readings (all Somalis were of Muslim religion in the present study, in line with earlier research), is therefore a traditional and still used source for healing (Tiilikainen, 2000; Mölsä et al., 2010). In Kurds, women experienced more mental health symptoms than men. The reported worse mental health condition of Kurdish women compared to Kurdish men can stem from the societal situation and interpersonal relations of Kurdish immigrant women (Assari et al., 2015). Comparing the women of Somali and Kurdish background, it seems that in both cultures the women seem to concentrate their care and energy traditionally more on other members of the family than themselves. Women conform to the roles assigned to them. It has been found that providing care to family members can influence the mental and physical health

of women negatively because of a higher amount of stress this caring activates (Schulz & Beach, 1999).

9.1 Limitations

In Study I, the levels of the cultural groups in the PTSD subscales intrusion, avoidance and hyperarousal measured by the IES used in the study, were not a target in analysis. Because of contradictory results in earlier research of cultural groups originating outside Europe, the US or Canada, differences in PTSD subscales were not examined (Rasmussen et al., 2007b; see also Vinson & Chang, 2012). Further, the size of the data was with N=78 subjects was relatively small and made have to be taken into account in an attempt to generalize the results of the present study (study I). Further, with a bigger data set an examination of the subscales would have been possible and certainly interesting. In a recent study with refugees from Papua New Guinea (Tay et al., 2015), which is a traditionally collective culture (Triandis et al., 1986), both trauma-related intrusion and avoidance were on a high level in trauma survivors, while the third subdomain of the PTSD-construct, hyperarousal presented to a lesser extent. It would have been interesting to examine a dose-response relationship regarding the quantity and length of torture experiences (Kaysen et al., 2010). In the data however, only the number of diverse traumatic events had been collected, and no exact information on the length of imprisonment.

Considering the division of the cultural groups in more collective and more individual ones', no questionnaire was used to measure the degree of individualism – collectivism. One could argue that the degree of individuality in the South European cultural group is less pronounced than in Northern European cultures as for example Finland, or even Middle European cultures. However, the individuality in this group is still to some degree higher than in Central African, South Asian and Middle Eastern cultural groups. Further, the use of the individualism-collectivism construct in explaining cultural differences was used because of the high attention received in cultural psychology studies. In the study, individuals from diverse countries where integrated in cultural subgroups which can raise some criticism. However, even nationality or ethnicity can in the light of research not be proposed as a clear cultural divide (Lopez & Guarnaccia, 2000). The results of this research comprise at least a significant suggestive quality with regard to cultural variation in the manifestation of trauma sequalae.

In the dissertation study it was a further goal to depict especially the situation of women refugees and torture survivors in comparison to men. Information on women is more scarce than on men in trauma rehabilitation treatment because of the discrepant numbers in trauma treatment centers. In study I, this discrepancy featured clearly and prevented data accumulation of approximately the same number of men and women. A similar distribution of men and women in each of the subgroups would have made the results statistically more powerful.

In study II and III, the level of posttraumatic symptoms was measured by the Impact of Event-Scale (IES). It should be mentioned at this point however, that it is problematic to use these kind of questionnaire measures in a cross-cultural context, because the symptoms described may not be universally evident and translations are difficult (Yeomans & Forman, 2009). The Impact of Event-Scale has been validated for use in various cultural groups and has demonstrated solid diagnostic accuracy and is used widely in research with different cultural groups (John & Russell, 2007; Morina et al., 2010). Regarding validation matters when using questionnaires with participants from different cultural regions, this problem concerns - at some level at least - also other instruments used in the present study. Also concerning the impact of the type of trauma, torture has been emphasized in studies I and II as the cause of trauma in the participants of the research. All participants had indeed survived clear histories of torture trauma. However, all participants with torture trauma had experienced also other very stressful events, some before the torture trauma, many during the flight from the home country and further stressful events were reported or suspected to have happened during the time of settling in Finland. Therefore, this research cannot claim to examine purely effects of torture trauma. A study examining purely consequences of torture is however almost impossible to do, because torture occurs mostly in combination with political persecution, repression or war, and, life as a refugee heightens the risk for the occurrence of other possibly traumatizing events.

In study III, the results need to be considered in the light of several methodological issues. The use of a cross-sectional design for SEM modeling, which did not render possible to conceptualize help-seeking as a process model, was a limitation. The applied model of traumatic events and psychosocial factors associating with help-seeking behaviour should be understood as a process. Therefore, a prospective study with at least two timely different measuring points, for example from arrival to a certain date of later residence, would have been more ideal and revealing to examine the hypotheses of the present study (study III).

The self-report approach used in the study may have caused bias concerning mental health symptoms and history of traumatic events. Clinical psychiatric interviews in addition would have given a possibility to measure the accurately and objectively. Retrospective re-telling of traumatic events related to war, disaster and violence, especially sexual violence, gives in to distortions and inexactness, due to current mood and memory lapses. Especially the help-seeking model for the Somali cultural group needs to be interpreted with caution. First, their use of mental health services was very low, and thus, the variation in the outcome variable was narrow. Second, the model fit of their help-seeking behaviour was not as good as in the other two groups, consisting of Russian and Kurdish immigrants.

Religion, which in some cultures influences and is part of mental health treatment, was in the present study only in a very marginal role. This was related at least in part to limitations in the data. The role of religious affiliation and the importance of religion in the study participant's life and health could have provided interesting additional information regarding opinions about mental health treatment and help-seeking. In the third substudy (study III) stigma was not measured and therefore, an inclusion in the model was not made possible. Earlier research however emphasizes the influence of stigma on help-seeking for mental health problems in Somali and Kurdish cultures (Bolton et al., 2014). Further research could provide ways how to overcome this obstacle.

Clear obstacles appear in research with refugee torture victims. A fear of causing re-traumatization through extensive interviewing of the survivors about their trauma history and the possibility of experiencing the situation in a similar manner than interrogations during captivity has led to a certain resistance of developing research in this field (e.g., Carlsson et al., 2014). However, the clients participating in study I and study II were all very interested and eager to participate in research examining the depth and nature of their mental health problems and the development of treatment methods.

9.2 Implications for clinical practice

The results of the dissertation study highlight the significance of cultural meaning making of the illness experience of a client from another culture and differences between cultures. Further, this research also emphasizes the value of using culturally sensitive methods in psychotherapy. Through an open mind and interest in cultural specifics, and a non-judgemental attitude of the health professional a mutual

contextualization of the client's problems can be achieved and both his individual and culturally grounded needs can be better understood. Working methods in use by the therapist can be modified and adapted to fit the specific demands of the situation and the individual client. Through emphasizing a collaborative stance with the client, a culturally sensitive framework for working through trauma can be created. In this vein, the client can hopefully adapt and build strength to maneuver through the many stressors of daily life and social relations, and possibly, the relishing of positive events in one's life. Further, considering torture trauma, the high and complex sequelae also documented in this dissertation study, deserve more attention. As traumatic sequelae influence also the next generation and the acculturation process (Danieli, 2016), specialized and research-based rehabilitation and psychotherapy should be made more available.

Psychological treatments for mental health problems and trauma sequelae are developed continuously and are available for all citizens in Finland. Treatment options are however strongly linked to the psychiatric diagnosis which is based purely on the symptom lists presented in diagnostic manuals. These options do not consider sociocultural variations in individuals as factors of significance in influencing interest in, choosing and starting a psychological treatment. Further, only a small group of psychotherapists are comfortable or have experience with using an interpreter in psychotherapy with a refugee client. Immigrants who have a trauma history and experience mental health problems seem to have more difficulties than native citizens in getting into treatment, while a subjective need for mental health services is clearly discernible (Castaneda et al., 2012).

In specialized clinics and organizations helping traumatized refugees in mental health issues in Finland at present, the focus lies mainly on the assessment of psychological symptoms (Lehti et al., 2016). Considering treatment options, multimodal therapy constitutes the general policy. Referrals of clients with a refugee background can be made also to psychotherapists in private practice. In many cases, psychotherapy is because lacking language proficiency conducted with the help of a professional interpreter. Specialized interventions for psychological trauma are less in the focus and access to those seems still to be behind a barrier to refugee clients. Especially therapies with refugee torture survivors are prone to end prematurely. It is of utmost importance for healthcare professionals to recognize this problem when making treatment decisions and it would be helpful to make it possible to restart therapy after a while if the client does make contact again. This problem is one that may feature also in clients with another kind of trauma-history. Integrative psychotherapeutic and psycho-dynamic approaches deserve to be recognized as

working and highly recommendable in the rehabilitation of torture survivors and traumatized refugees (Varvin, 2016).

Not only traumatized refugees profit of developing healthcare in a culturally sensitive direction. The Finnish population today contains a growing number of immigrants, who come for other reasons to Finland than refugees: those are issues related mostly to work or private life. Also, this group of immigrants needs healthcare services which accept a client's view of his health problems and treatment options, culturally influenced views are listened to and at least discussed, while they may clash with the viewpoints of a Finnish raised and schooled health professional. A lack of understanding, interest, acknowledgement of explanatory models can lead to distrust, a negatively experienced contact between client and professional, and result in non-compliance and conflicting actions of the patient regarding the doctor's orders.

In the present study, the situation of women torture survivors and refugees in Finland was a further focus. The similar high level of symptoms (study I, study II) and gender differences in help-seeking (study III) should be taken in account of by treatment policy planners and caregivers working in treatment facilities with multicultural clients. The finding in study I of the similar amount of torture undergone by women in comparison to men, should make health professionals aware of the fact that women still are a minority in treatment for posttraumatic stress sequelae. It would be important to take action in the future in making help available especially for women, who are often the caretakers of their families and – in many cases – out of cultural reasons do not seek help for their mental health problems in a similar way as men seem to do. Regarding help-seeking by women from Kurdish or Somali cultures, the development of alternative mental health services should be given more thought. As for example mistrust in health services and low acculturation was higher in Kurds with high trauma exposure, support networks or peer support with an indirect focus on mental health rehabilitation could act in a prophylactic or preventive function considering mental health problems, or, in situations of active mental disorder, help alleviate symptoms in this distinct group. Hopefully this research can contribute to the development of culturally sensitive healthcare services through the findings presented and conclusions drawn above.

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11 ORIGINAL PUBLICATIONS

Due to restrictions in the permission to publish copyrighted content, two of the three research articles included in this dissertation study (studies II and III) are not published in digital form in this dissertation.

Carla C. Schubert & Raija-Leena Punamäki (2011) Mental health among torture survivors: cultural background, refugee status and gender, Nordic Journal of Psychiatry, 65:3, 175-182, This is the authors accepted manuscript of an article published as the version of record in Nordic Journal of Psychiatry © 21 Sep 2010 - https://www.tandfonline.com/10.3109/08039488.2010.514943

Mental health among torture survivors: cultural background, refugee status and gender

CARLA C. SCHUBERT , RAIJA-LEENA PUNAMÄKI

Background: The experience of torture places the survivors at a heightened risk for somatic and mental health problems. Aims: This study examined the role of culture, refugee status and gender in the mental and somatic health among help-seekers in a centre for torture survivors in Finland. Method: The 78 participants (29 women and 49 men) were interviewed and assessed with the Impact of Event Scale-Revised (IES-R) and the Hopkins Symptom Checklist-25 (HSCL-25) scales and their somatic complaints were registered. Groups with Middle Eastern, Central African, Southern Asian and South Eastern European cultural backgrounds were compared. Results: Group differences were found in post-traumatic stress disorder (PTSD) and depressive symptoms and somatic complaints. As hypothesized, Southern European torture survivors showed a higher level of PTSD than cultural groups from more traditional collective societies in Middle East, Asia and Africa, and more depressive symptoms than survivors from a Southern Asian background. Against the hypothesis, South Eastern European subjects reported also more somatic complaints than Central African survivors. Women suffered more from PTSD and depressive symptoms than men in all cultural groups. Asylum-seeking status was marginally associated with anxiety symptoms only in the South Eastern European group. Conclusion: Health services should consider the infl uence of culture in the expression of psychological and somatic symptoms and avoid a simplistic distinction between somatic and psychological expressions of pain. • Anxiety , Cultural factors , Depression , PTSD , Somatic complaints , Torture survivors. Carla C. Schubert , M.A. , Department of Psychology , University of Tampere , Tampere , FIN-33014 , Finland , E-mail: carla.schubert@uta.fi ; Accepted 9 August 2010.

Despite an absolute ban on torture and ill-treatment declared in the International Bill of Rights and in the UN Conventions, torture is worldwide practised in over 100 countries (1, 2). Approximately 20% of asylum seekers in Europe have been subjected to various forms of torture, the number of torture survivors thus being around 400,000 in EU countries (3). These survivors have been exposed to systematic infl iction of severe mental or physical pain, aiming at deliberately breaking down their personal integrity, which places them at a heightened risk for mental health problems (4). Yet, a relatively small number of survivors is seeking and receiving medical, psychological and social help: the number is estimated to be 16,000 in EU countries (3). Our research focuses on the mental health sequelae among survivors who seek help in a Centre for Torture Survivors in Finland.

Research confirms high levels of post-traumatic stress disorder (PTSD), depression, anxiety, pain and multiple somatic complaints among torture survivors from Asian (5 – 7), Middle Eastern (8, 9), Central African (10) and European (11 – 13) countries. For instance, in help-seeking torture survivors in Sweden, a PTSD prevalence of 62 – 92% was found (14), and of Nepalese help-seeking survivors, 80% suffered of

clinical depression and anxiety (7). The level of psychiatric disorders is substantially lower but significant in community samples including survivors (4). Mental health problems and somatic complaints are common among torture victims who have resettled as asylum seekers and refugees (15, 16), and who may experience additional stress of acculturation and racism (17). Evidence shows that torture survivors suffer from mental health problems many years after their exposure (18, 19).

Given that torture survivors come from a wide variety of countries, knowledge about their cultural background is of crucial value in understanding their mental health and psychosocial strengths and problems. Culture shapes the subjective and collective meaning of trauma and expression of pain. As a collective programming of the mind its inherited values, beliefs, norms and rituals guide individual responses, including psychiatric symptoms (20, 21). Research on survivors ' mental health has mainly concentrated on single national or ethnic groups, e.g. Somali (22, 23), Bhutanese (24), Tamil (16), Kurdish (8), Kosovo Albanians (12), Punjabi Sikhs (25), Iraqi (26), and Southeast Asian or Indochinese refugees (27). Cross-cultural comparisons of survivors are scarce, focusing often on help seeking refugee populations (14).

There is some consensus that psychiatric disorders such as depression are expressed as somatic symptoms outside the Western world in traditional collective societies, characterized by advocating social harmony, traditions and emotional dependency on community. Especially Asian collectivist societies incorporate a world view that does not dichotomize between body and mind, a view that further supports an almost exclusive reporting of somatic symptoms (28–30). Cross-cultural studies among torture survivors partly confirm the hypotheses of cultural specificity in expressing predominantly somatic complaints instead of psychiatric and psychological symptoms such as PTSD. Moisander & Edston (14) found the highest level of somatic symptoms in Asian torture survivors in their six-nation comparison study. Similarly, especially high levels of somatization were found among tortured Bhutanese refugees (31). Keller and colleagues (32) found that tortured refugees from Asian countries showed lower levels of PTSD symptoms than survivors from Africa, Europe and South-America. Also in Afghan society, somatic symptoms seem to be a common way of expressing distress (33).

Yet, there are studies that have not confirmed culture-specific differences in expressing PTSD, but report equally high PTSD levels among torture survivors from both collective traditional (31) and individually orientated Western countries (34). Torture survivors from Former Yugoslavia are typically found to report both somatic and psychological symptoms on an almost equal level (12). The findings of somatic versus psychiatric symptoms in African cultures are also conflicting. As hypothesized, Burundian trauma survivors exhibited low levels of PTSD symptoms, but high levels in somatization symptoms (10). Conversely, Moisander & Edston (14) found that torture survivors with African background scored lowest in somatic symptoms compared with survivors from other cultures. In line with the still limited cross-cultural research, we may expect especially Asian tortured refugees to report more somatic symptoms, while Western survivors are hypothesized to exhibit more psychological distress.

A long-lasting asylum process increases the risk for psychiatric symptoms (36–38). Ryan and colleagues (37) reported that psychological distress symptoms decreased in a follow-up of 12 and 24 months only among emigrants in Ireland, who had obtained a secure legal residence. The authors associated the change with general improvements of life situation, including work permits and better healthcare. Keller et al. (32) found that torture survivors who had been granted asylum had signifi cantly fewer PTSD symptoms than those with pending applications. No studies to date have analysed whether the insecurity related to the asylum process would create distinct mental health responses in survivors from different cultures. Women are generally found to be more vulnerable to trauma and show higher levels of mental health problems than men, especially depression, anxiety and PTSD symptoms (39, 40). Available scarce evidence confirms also that tortured women are at greater risk of affective and anxiety disorders than tortured men (31). Concerning somatic symptoms, some findings show women to be also more vulnerable to them (41), while

others suggest that men respond to trauma in more behavioural than intrapsychic ways including health problems (40).

Aims of the study

Our aims are, first, to examine how cultural background is associated with mental health and somatic complaints among torture survivors seeking treatment in Finland. We hypothesize that survivors from traditional collective societies from Middle East and Central Africa, but especially from Southern Asia, would present with significantly more somatic symptoms than survivors from South Eastern European background, whereas the survivors with the European, individually oriented background would show more PTSD, depressive and anxiety symptoms. Secondly, we analyze the role of refugee status and gender in associating with mental health and somatic symptoms. We hypothesize that asylum seekers show a higher level of PTSD, depressive and anxiety symptoms and somatic complaints than survivors who have been granted a permanent refugee status. Furthermore, women as torture survivors would show higher levels of PTSD, depressiveness and anxiety than men, who in turn may show somatic complaints.

Methods

Participants and procedure

The participants were patients at the Helsinki Deaconess Institute ’s Centre for Torture Survivors in Finland. A sequential sampling was obtained of survivors who had appointments with the staff in the Centre, resulting in 78 who gave a written consent to take part in the study. Of 81 approached three refused. Of the participants 62.8% (n=49) were men and 37.2% (n=29) women. Their mean age was 37.60+/- 9.50 years and mean length of stay in Finland 2.68 +/- 2.57 years. The participants represented 14 countries from Middle East (e.g. Iraq and Lebanon), Central Africa (e.g. Congo and Rwanda), Southern Asia (Afghanistan and Sri Lanka) and Europe (e.g. Kosovo, Bosnia-Herzegovina). The cultural background variable is based on this broad category of national and ethnic information. The study protocol was approved by the ethics committee of the Helsinki Deaconess Institute, and all participants gave written consent after being informed about the rights and commitments related to the study. During the entrance interview, mental health professionals, namely psychologists, a psychiatric nurse and a psychotherapist of the centre administered the battery including PTSD, depressive, anxiety and somatic symptoms, and demographic and trauma-related information. They fi lled out the questionnaires together with the client and with help from professional interpreters if necessary. Culturally appropriate translations of the questionnaires were available in seven languages, and professional interpreters were employed for the assessment of other language groups. The interpreters were trained individually in order to gain a better understanding of the questionnaires and proceedings.

Measures

PTSD symptoms were assessed by the Impact of Event Scale-Revised (IES-R), a self-report measure consisting of 22 items. They cover intrusive, avoidance and arousal sentiments, as well as experiences related to traumatic events. The participants evaluated on a Likert scale (1 not at all to 5 very often) the occurrence of each symptom during the previous week. A total score was obtained by adding up all the

symptom items, with a higher score indicating more severe problems. The internal consistency was relatively low (Cronbach ' s alpha 0.65). For clinical cut-offs, 35 for the sum of the two subscales intrusion and avoidance was used according to Weiss & Marmar (42).

Depressive and anxiety symptoms were measured by the Hopkins symptom checklist-25 (HSCL-25), a selfreport inventory including 15 depressive symptoms and 10 anxiety symptoms. The participants evaluated their mood and behaviour during the previous week using a Likert scale (0 not at all to 4 extremely often). Mean sum scores for depressive and anxiety symptoms were calculated (Cronbach 's alpha 0.86 for depressive and Cronbach ' s alpha 0.71 for anxiety symptoms). The established clinically significant cut-off score of 1.75 was utilized (43).

Somatic complaints were indicated from the patient chart information reported by the client in the entrance interview, which was conducted by the same clinical professionals mentioned at the beginning of the method section. The clients were asked to describe actual somatic problems that after medical assessment had stayed unexplained, using the question: "have you experienced somatic problems or pains lately that a medical doctor could not find an explanation for? " and common prompting about symptom severity, occurrence and medication was used when needed. The sum of somatic complaints counts the number of somatic problems mentioned, ranging here between 5 and 24 (mean 12.24; mode 12; 14.3% reported). Examples include complaints that are typical for torture victims such as pains in joints, neck and back, headaches, heart palpitation, dizziness and nausea, as well as exhaustion and breathing difficulties.

The participants also reported if they suffered from a severe physical injury (yes, no, chronic invalidity). Exposure to trauma: Experiences of different types of trauma were assessed by asking the times of imprisonments and detentions and by 11 traumatic events derived from the Harvard Trauma Questionnaire (44). They cover witnessing atrocities to others, attack or injury, rape, sexual molestation, life-threatening accident, natural disaster, combat, witnessing serious injury or killing, life threats and terrorizing, and other stressful events. A sum variable was constructed to indicate the occurrence of trauma events, ranging from 0 to 10. The number of exposures to each trauma was not inquired.

Results

Descriptive results. Demographic characteristics of the sample according to cultural background are presented in Table 1. Pearson ' s chi-squares tests revealed group differences in gender, civic status, work situation, legal refugee status and family unification. In the Middle Eastern and Southern Asian groups there were more men than women, whereas in Central African group there were equal gender distributions and two-thirds of the South Eastern European consisted of women. Of the South Eastern European survivors almost all were married, while the share was hardly a half among Central Africans. Only 13 of the participants were employed, part-time or less, and the percentage was highest (38.5%) in the Southern Asian group. Among the participants from Southern Asia, however, only one (7.7%) had gained a refugee status and they lived more often than others without their families in Finland. In the other cultural groups, about a third had a refugee status. The subgroups differed further in their age, F (3,74) 3.59, P< 0.02 η^2 =0.13, the Central African group being younger than others. Religious affiliations naturally differed in groups, although Islam was the dominant congregation in all groups except the Central African. Table 1 shows no group differences in education, exposure to trauma or physiological disability. The educational level was generally low with almost half of the participants having a school history of 5 – 10 years. In all groups, about a half reported more than five traumatic events. More than a third (38.5%) reported having a physiological injury or disability. Two persons had a chronic invalidity, and they are included in the disability class.

Table 2 presents the percentages of different types of trauma, and reveals some gender-specific exposures. Women were more often the victims of sexual trauma, whereas men had been more often in combat situations and had served long prison sentences. The percentages of participants who scored above the clinical cut-offs 88.3% for PTSD, 78.2% for anxiety and 78.2 for depression. Culture and mental and somatic health One-way analyses of covariance (ANCOVAs) were applied to examine whether the cultural background was associated with PTSD, depressive and anxiety symptoms and somatic complaints. Gender, age, legal status and work situation were used as covariances, because groups differed in them.

The ANCOVA analyses revealed that gender was a significant covariance for PTSD, and gender and work situation for depressive symptoms. In the subsequent ANOVA analyses, these interaction effect terms were included and the non-significant covariances were dropped. The results in Table 3 show significant cultural differences in PTSD and depressive symptoms and somatic complaints. The Hochberg post-hoc tests reveal, as hypothesized, that in the South Eastern European group, the levels of PTSD symptoms were higher than in other cultural groups, but depressive symptoms were higher only in comparison with the Southern Asian group. Against to our hypothesis, South Eastern European survivors reported more somatic complaints than survivors from Central Africa. The Middle Eastern and Southern Asia groups were in the middle in their level of somatic complaints. No group differences were found in the level of anxiety symptoms. We further examined whether physiological disability was associated with somatic complaints, and ANOVA showed a non-significant association (F (1,63) 2.13, P=ns, $\eta^2 = 0.03$.

The cultural group X gender interaction effects on PTSD and cultural group gender and work situation – interaction effects on depressiveness were non-significant, indicating that male and female torture victims and unemployed and employed were similarly vulnerable in all cultural groups. Generally, however, as hypothesized, women scored higher than men in PTSD symptoms (mean=71.00+/- 9.51 vs. 66.24 +/- 11.20; t (76) 2.00, P<0.05), and depressive symptoms (mean=2.24+/- 0.53 vs. 1.98 +/-0.45; t (76) 2.24, P<0.03). No gender differences were found in anxiety or somatic complaints. Refugee status and mental and somatic health A 3(Cultural background) X 2(Legal status) ANOVAs were run on PTSD, depressive and anxiety symptoms and somatic complaints in order to study the role of asylum process in mental health. Because the Southern Asian group had only one person with refugee status, the group is not included in the analysis. Results showed non-significant main effects of the legal status on symptoms and complaints, thus defeating the hypothesis of stable refugee status associating with low symptom and complaint levels. There was a marginally significant interaction effect on anxiety symptoms (F (2,64) 2.84, P< 0.06, $\eta^2 =0.09$, indicating that in the South Eastern European group the asylum seekers scored higher in anxiety symptoms than refugees, whereas the legal status was not associated with anxiety in Middle Eastern and Central African groups (Fig. 1).

Discussion

The results of this study contribute to the argument that cultural factors have an impact on the manifestation of mental health symptoms. As hypothesized, psychiatric distress in the form of PTSD and depressive symptoms was especially high among South Eastern European torture survivors, who had been exposed to atrocities during the war in Former Yugoslavia. The results accentuate PTSD symptoms as illustrators of the painful process of trauma-related intrusion and avoidance in individualistic Western cultures, but fail to do that in cultures enhancing more collective and interpersonal forms of processing traumatic memories. Similarly, other researchers have documented especially high PTSD levels among refugees from Bosnia (11, 15) and Kosovo (12), although these studies did not compare trauma victims from other cultures. There were no differences in number of traumatic events experienced by the studied cultural groups, and greater exposure can therefore not explain the occurrence of PTSD. All participants

had experiences of torture, abuse and ill-treatment combined with various war and refugee related losses and violence. The clinical levels of PTSD and psychiatric distress were very high (78 – 88%), corresponding with other research among help-seeking torture survivors (7, 14).

Against our hypothesis, the South Eastern European survivors had also more somatic complaints than survivors from more traditional societies; however, the difference was significant only between the European and the Central African group. Similarly, earlier studies have shown that patients from former Yugoslavia present an especially high number of somatization problems to their physicians (34). According to Coughlan & Owens-Manley (45), Bosnian refugees express psychological distress often somatically because mental health problems are socially not accepted among refugees from former Yugoslavia. Weine has emphasized the stigma against mental health sufferers to be especially strong for Bosnian refugees (46). Lopez Cardoso and colleagues interpreted the high level of somatization among Kosovar Albanians as a culturally determined way of expressing depression (47). The high level of somatic symptoms can also relate to the fact that mental health services in the Kosovo and Bosnia were still very limited before the war and there was no tradition of community-based psychiatric services (48). The results concur with arguments that parallel expression of negative feelings in both psychiatric and somatic forms is universal (49, 50), which is in line with early cross-cultural research showing trauma victims to experience physical symptoms besides psychological ones disregarding their cultural origin (51 – 53).

A majority of the research among torture survivors has assessed non-specific somatic complaints or somatic symptoms (5, 31). Their contents were highly similar to those that our torture survivors reported in the entrance interview covering musculoskeletal, gastrointestinal, cardiovascular and respiratory system symptoms, dislocated pains and weakness. Fewer studies among torture victims have used the ICD classification of somatoform disorders including e.g. somatization and body dysmorphic disorder, pain disorder or hypochondriasis. An ICD-based study found a substantially higher level of somatoform disorder among asylum seekers than among members of the native population in the Netherlands (38).

Contrary to our expectations, asylum seekers did not generally experience higher levels of PTSD, anxiety, depression or somatic complaints than refugees with legal residency status. Our marginal results suggest that torture survivors from South Eastern Europe were more anxious if they were still asylum seekers. Culture provides coping tools and philosophies for dealing with insecurity and life-danger. The asylum seeking process typically evokes fears of failure and memories of neglect, and apparently cultures provide unique working models to deal with the anxiety. Keller et al. (32) found in their study that legal status was significantly associated with PTSD but not with depression or anxiety, which may reveal more about the dynamics of an insecure life situation in which intrusive memories are activated and avoidance acts to suppress them.

Our sample is highly homogeneous as all subjects were torture survivors and had similar exposures to other traumas, too. However, the cultural groups differed in demographic factors, e.g. survivors from Central Africa were younger than others, and Southern Asians had succeeded best in finding work, but had less often got a legal refugee status. Interestingly enough, factors like age, working situation and refugee status were not significant in controlling the culture – mental health link.

Our research serves critics for methodological and conceptual defi ciencies. Our sample is relatively small and would greatly benefi t from a control group of nonhelp-seeking torture survivors. We could not replicate the earlier studies (14, 31) in assessing the mental health, somatic symptoms and torture experiences of survivors from specific ethnic or national groups. Furthermore, the procedure that the participants filled out the instruments of psychiatric symptoms together with professionals from the clinical staff and interpreters may not be ideal, as professional interpreting may have influenced the documenting. Ours was a kind of choice between clinical diagnostic interview and self-reporting questionnaire study. The

choice of instruments is not free of problems. Although instruments like the Hopkins Short Symptom checklist and the IES-R have been frequently used in non-Western contexts (54), culturally relevant assessments would still be more ideal.

A conceptual point of critique is the forming of cultural groups where persons from relatively wide geographical territories were put together. The South-Asian subsample is especially highly heterogeneous including Afghanistan and Sri Lanka. We cannot claim that the participants of the South-Asian group are very close to each other in their cultural inheritance. However, the cultures of these countries are strongly collectivistic societies living in a mainly rural setting. The mean level of education is similarly low and somatic complaints are more common and better accepted than psychological problems (55, 56). Furthermore, in earlier studies " nonclassic " traumatic reactions of a similar kind have been reported in both Sri Lankan (55) and Afghan (56) persons. Similar criticism can be addressed to us for calling Bosnian and Kosovarian culture South Eastern European as that general term may include other countries on the Balkan Peninsula and Central Europe.

Better knowledge of cultural factors in the expression of trauma-related pain is particularly important for developing culturally sensitive mental health treatments (57). Our results suggest that clinicians working with multicultural patients should avoid a simplistic distinction between somatic and psychological expressions of responses of their clients. In particular, Western healthcare professionals working in non-psychiatric primary healthcare units should be attentive when confronted with patients from foreign cultural background presenting with somatic symptoms. A general openness to the unique ways that torture survivors from different cultures cope with current stressors such as the asylum process and other insecurities is suggested as a fruitful approach in healthcare.

Acknowledgements — This study received financial support from the Oskar Öflund Foundation.

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

Table 1. Percentages and frequencies of demographic factors according to the cultural backgound

	Middle Eastern		Central African		Southern Asian		European		
	%	*n*	*%*	*n*	*%*	*n*	*%*	*n*	$\chi 2$
Gender									12.31**
Man	60.6	25	43.5	10	76.9	10	36.4	4	
Woman	19.4	6	56.5	13	23.1	3	53.6	7	
Civic Status									19.14*
Married	58.1	18	47.8	11	69.2	9	81.8	9	
Single	38.7	12	39.1	9	23.1	3	0	0	
Widow	3.2	1	13.0	3	0	0	0	0	
Divorced	0	0	0	0	7.7	1	18.2	2	
Education									21.45
No formal schooling	0	0	4.3	1	0	0	0	0	
Primary school	22.6	7	39.1	9	7.7	1	18.2	2	
Secondary school	41.9	13	34.8	8	53.8	7	54.5	6	
Vocational school	25.8	8	8.7	2	0	0	27.3	3	

Higher education	9.7	3	13.0	3	38.5	5	0	0	
Work situation									7.86*
Working part time	19.4	6	8.7	2	38.5	5	0	0	
Unemployed	80.6	25	91.3	21	61.5	8	100	11	
Religion									
Christianity	6.5	2	91.3	21	0	0	0	0	88.03****
Islam	58.1	18	4.3	1	76.9	10	100	11	
Buddism	0	0	0	0	23.1	3	0	0	
No religion	35.5	11	4.3	1	0	0	0	0	

Table 1 continues

	Middle Eastern		Central African		Southern Asian		European		
	%	*n*	*%*	*n*	*%*	*n*	*%*	*n*	$\chi 2$
Legal status									12.31**
Asylum seeker	64.5	20	69.6	16	92.3	12	72.7	8	
Refugee	35.5	11	30.4	7	7.7	1	27.3	7	
Family members in Finland									11.24**
No	42.3	11	62.5	10	0	0	10.0	1	
Yes	57.7	15	37.5	6	100	6	90.0	9	
Trauma exposure									0.82
Low (0-5 events)	58.14	18	52.2	12	46.2	6	45.5	5	
High (6-11 events)	41.9	13	48.8	11	53.8	7	54.5	6	

Note: [a] The number ranges between N=58-78 due to missing information

* p < .05, ** p < .01, **** p < .0001

Table 2. Percentages and frequencies of exposure to trauma according to gender

	All		Women		Men	
Exposure to trauma	n	%	n	%	n	%
Combat	27	34.6	3	10.3	24	49.0
Life threatening accident	20	25.6	10	34.5	10	20.4
Natural disaster	14	17.9	3	10.3	11	22.4
Witnessing injury/ killing	54	69.2	20	69.0	34	69.4
Rape	17	21.8	14	48.3	3	6.1
Sexual molestations	36	46.2	20	69.0	16	32.7
Attack or injury	58	74.4	17	58.6	41	83.7
Life threats & terrorizing	77	98.7	28	96.6	49	100

Other stressful events	75	96.2	27	93.1	48	98.0
Witness atrocities to other	55	70.5	24	82.8	31	63.3
Long imprisonment (> 12mo)	19	24.4	3	10.3	16	32.7

Note: Women, n=29 and Men n=49

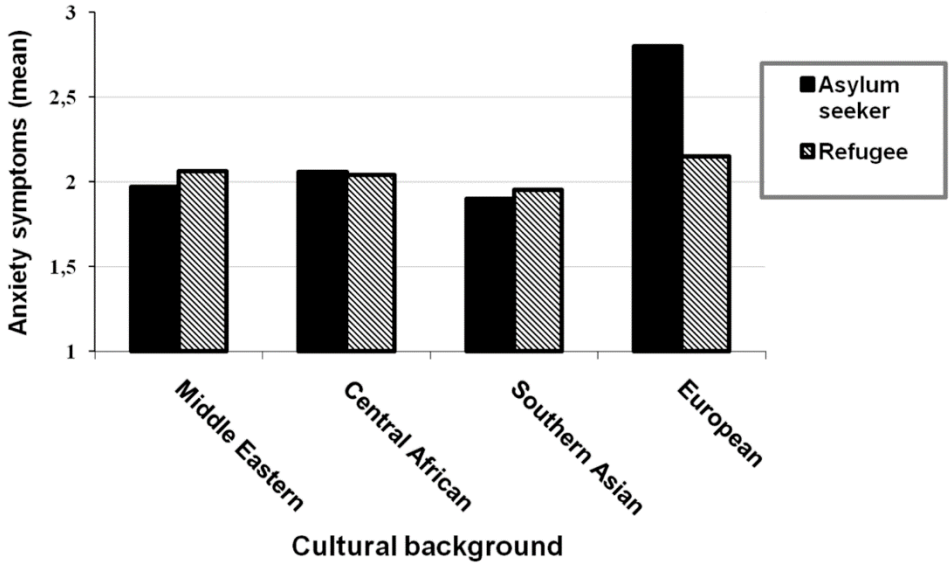
Table 3. Means and standard deviations and ANOVA statistics of mental health and somatic symptoms according to the cultural background of torture survivors

	PTSD		Depressiveness		Anxiety		Perceived somatic health	
Cultural background	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Middle Eastern	67.58[a]	2.28	2.08 [ab]	.09	2.04 [a]	.07	13.20 [ab]	.66
Central African	65.95 [a]	2.11	2.02 [ab]	.10	2.07 [a]	.09	10.89 [a]	.82
	63.60 [a]	3.30	1.86[a]	.13	1.95 [a]	.11	13.14 [ab]	1.35
Southern Asian								
European	77.54 [b]	3.14	2.40[b]	.15	2.33 [a]	.12	16.50 [b]	1.27
ANCOVA statistics	F(3,74)=4.31, p<.008 η^2=.16 [*)]		F(3,74)=2.62, p<.05 η^2=.11 [**)]		F(3,73)=1.86, p=ns.; η^2=07		F(3,67)=5.01, p<.005; η^2=.22	

Note: The values with different letters differ from each other at >.01 Hochberg post-hoc tests due to different group sizes

[*)] The model includes 2 (gender) X 4(Cultural groups) interaction effect [**)] The model includes 2 (gender) X 4(Cultural groups) and 2(Work status) X 4(Cultural groups) interaction effects

Figure 1. *The cultural background X refugee status –interaction effect on anxiety symptoms*



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