Trauma and Resiliency

A STUDY OF REFUGEES FROM IRAN RESSETLED IN SWEDEN

Mehdi Ghazinour
Umeå University Medical Dissertation

**Trauma and Resiliency:** a study of refugees from Iran resettled in Sweden
From the Division of Psychiatry and WHO collaborating Center,
Department of Clinical Science,
Umeå University, SE-901 85 Umeå, Sweden

*Front cover:* Picture provided by Lars-Åke Strömfelt.

Tryckeri Print & Media, Umeå University, 309015
Papper Omslag: Silverblade Matt 300g Inlage: Cream 90

Abstract
Several single factors have been identified as related to coping with trauma and as protective factors. Several studies emphasize the importance of personality, core beliefs, coping strategies and social support. However little attention has been paid to resiliency. The aim of the study was to identify some determinants of an individual’s resiliency after experienced traumatic life events, and to address the issue of its relationship to personality characteristics, psychopathology, coping resources and strategies, social support, sense of coherence and quality of life.

In the present study, a convenience sample of 100 Iranian refugees, 66 males and 34 females in the age range of 18-65 were investigated. All the subjects have experienced one or several traumatic life events as soldiers, political prisoners or have been victims of torture or have escaped from the country in a stressful way. At the time of the present investigation the mean time living in Sweden was for male subject’s 12.8 years and for female 11.8.

Nine instruments were administered during individual sessions, Temperament, Character Inventory (TCI), The EMBU (Swedish acronym for own memories concerning upbringing), The Symptom Checklist-90-Revised (SCL-90 – R), Beck Depression Inventory (BDI), Interview Schedule of Social Interaction (ISSI), Coping Resources Inventory (CRI), The Dysfunctional Attitude Scale (DAS), WHOQoL Group, 1995 (WHOQoL-100), The Sense of Coherence Scale (SoC).

Several significant associations were found between personality temperament and character, parental rearing and psychopathology. When experiences of parental rearing were investigated in relation to psychopathology, male subjects scored high on parental rejection and were also more depressed compared to females. Although the individuals in the sample suffered from depression or anxiety, there were individuals that had adapted themselves well with the new life in Sweden and its demands. Nineteen percent of subjects who had low harm avoidance and high self directedness received more social support, had better coping strategies, higher sense of coherence and finally a better quality of life.

This dissertation underscores the importance of multiple indicators when trying to understand resiliency. Personality traits, parental rearing, coping resources, social support and sense of coherence were the strongest predictors for resiliency. Having a systemic perspective helps to explain why some individuals are healthy and resilient despite traumatic life events, escaping from home country, applying for asylum, establishing a new home, learning new languages, to study and establish and develop new bonds.

Keywords: Temperament and character, Parental rearing, Coping, Social Support, Sense of coherence, Quality of life, Psychopathology, Resiliency.
This work is dedicated to:

Those refugees who participated in the study and made this project possible

My colleagues in the psychiatric clinic and mental nurses who meet refugees in their daily work
This work is dedicated to:

Those refugees who participated in the study
and made this project possible

My colleagues in the psychiatric clinic and mental nurses
who meet refugees in their daily work
Foreword:
I have been interested in human behavior as long as I remember. My clear and obvious memories goes back to the age of 7 or 8 years when I wondered why some people behave like this and that and took form seriously in the age of 11 and 12 years when Iran was in a dramatic social change by the revolution in 1979. People were in the streets and were angry, and I asked myself why. But step by step, I have switched my question from WHY to HOW. Very soon I understood that I will not find any answer to many “whys” in our life and it will be more appropriate to ask “how”. How come that people would like to get another regime? However, my reflection on people’s behavior had motivated me to read about that interesting topic and to discuss with adults in my context. This topic requested my increasing attention when I became arrested as political prisoner and became interrogated in a military base and than transferred to a prison in a political section at the age of 14 years. During the interrogation and later on in the prison I met many people who had survived torture and some persons who had experiences of war and escape from the front. Some of them were in bad physical condition but, surprisingly, were of good mental condition in spite of their traumatic life events. Others were heavily psychologically and physically disturbed. I witnessed everyday how people in the prison became weak or strong. My questions became more and more important to me: how does it come that some people keep their sense of humor and are still optimists planning for their life after freedom whereas others accepted their conditions and lost their sense of individuality.

I was in prison for one year. Thereafter I moved to Europe.
Twelve years later I was confronted with the same phenomena in my daily work in a psychiatric clinic working with outpatients from 23 different countries. I met persons who had been victims of torture or had escaped from a war country, or who had been raped during a stressful escape from their country. Some of the patients had somatic pains because of traumata but were still in a rather good psychological state. Some others were heavily disturbed and tried to commit suicide or suffered from severe depression. When I looked around me more precisely, I noticed that there are lots of refugees who were well established in every dimension of their life in their new country despite their previous traumatic life events.

As I said I have always been curious about human behavior. I decided to investigate the phenomena which I had witnessed in prison and, now observe everyday in clinical work. Additionally, my knowledge in the
field of trauma and my contact with many patients stimulated me to do something in memoriam of all of those nice people who do not exist any more. I learned from the patients that there is still a need to perform more research to be able to understand these phenomena. I just wanted to take some part of that burden.

I wondered: “How does it come that some of us are resilient and some of us more vulnerable when faced by trauma”.

So, there were three reasons for this study. (a) To contribute to a better understanding and hopefully create some new knowledge about coping with trauma and resiliency. (b) To better understand Iranian refugees life and psychological conditions in Sweden and (c) for my own process of recovery.

Mehdi Ghazinour
List of Original Paper

The present thesis is based on the following studies which will be referred to in the text by their Roman numbers.


**Abbreviations**

ANOVA: Analysis of Variance

MANOVA: Multivariate Analysis of Variance

UNHCR: United Nations High Commissioner for Refugees

WHO: World Health Organization

APA: American Psychiatric Association

DSM: Diagnostic and Statistical Manual of Mental Disorder (APA)
Contents

Introduction ........................................................................................................... 13
   Refugees Situation Worldwide ........................................................................ 13
   Refugees and mental health ............................................................................ 14

Socio- Cultural Background of the investigated Iranian refugees .................. 14
   The recent history and people of Iran .......................................................... 14

Review of the Literature .................................................................................... 15
   History of the trauma theories ...................................................................... 15
   Contemporary definition of trauma ................................................................. 17

Theoretical background ...................................................................................... 19
   Resilience-definition and perspective ............................................................ 19
   Personality, Cognition and resilience ............................................................. 20
   Cognitive Appraisal ....................................................................................... 25
   Affective reaction to distress ........................................................................ 25
   Parental Rearing ............................................................................................ 26
   Salutogenesis perspective ............................................................................. 27
   Coping with trauma and resilience .............................................................. 27
   Social support and resilience ....................................................................... 29
   Quality of life ................................................................................................. 29

The Aim of the study ........................................................................................ 30
   Study I ........................................................................................................... 31
   Study II .......................................................................................................... 31
   Study III ......................................................................................................... 31
   Study IV ......................................................................................................... 31
   Study V .......................................................................................................... 31
   Subjects ......................................................................................................... 31
   Key search terms ............................................................................................ 34

Methods .............................................................................................................. 34
   Material and instruments ............................................................................. 34
   Statistics ......................................................................................................... 38

Summary of the papers ...................................................................................... 39
   Paper I ........................................................................................................... 39
   Paper II ......................................................................................................... 40
   Paper III ....................................................................................................... 40
   Paper IV ....................................................................................................... 40
   Paper V ......................................................................................................... 41
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethical considerations</td>
<td>41</td>
</tr>
<tr>
<td>Main Conclusion</td>
<td>42</td>
</tr>
<tr>
<td>Limitations</td>
<td>42</td>
</tr>
<tr>
<td>Overview of specific findings</td>
<td>44</td>
</tr>
<tr>
<td>Major findings</td>
<td>45</td>
</tr>
<tr>
<td>General Discussion</td>
<td></td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>61</td>
</tr>
<tr>
<td>References</td>
<td>62</td>
</tr>
<tr>
<td>Appendix (Paper 1-5)</td>
<td>74</td>
</tr>
</tbody>
</table>
Introduction

Refugees’ Situation Worldwide

According to Amnesty International report 2002, there were estimated to be about 17 million refugees and asylum-seekers across the world at the beginning of 2001. The overwhelming majority of these - more than 70 per cent - live in the world’s poorest countries far from the attention of the world’s media. In the Middle East, the political instability has led to an increase in the number of asylum-seekers since Golf War in 1991. For example, Jordan provides protection and assistance to 900 urban refugees from Iran, Sudan and Somalia. Jordan is host to over one million Palestinian refugees as well. Iran has protected millions of Afghans from previous regime as well as US attacks. Pakistan is host to hundreds of thousands displaced people from Iran and Afghanistan today. Iran-Iraq war, Kurdish plights in Turkey-Iran- Iraq - Syria and Palestinians’ living conditions have always been important issues for United Nations and its administration UNHCR to deal with. This represents only a small part of the refugees’ situation worldwide. West European countries have had a tradition to take care of many refugees during the past 50 years. A review of asylum seekers in Europe is presented in table 1.

Table 1. Asylum seekers to some west European countries during 2000-2001 according to Inter Governmental Consultation, IGC

<table>
<thead>
<tr>
<th>Country</th>
<th>total Jan-Dec 2001</th>
<th>total Jan-Dec 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>24 527</td>
<td>42 677</td>
</tr>
<tr>
<td>Denmark</td>
<td>12 403</td>
<td>10 077</td>
</tr>
<tr>
<td>Finland</td>
<td>1650</td>
<td>3170</td>
</tr>
<tr>
<td>France</td>
<td>47260</td>
<td>38 747</td>
</tr>
<tr>
<td>Ireland</td>
<td>10325</td>
<td>10 920</td>
</tr>
<tr>
<td>Holland</td>
<td>32 579</td>
<td>43 895</td>
</tr>
<tr>
<td>Norway</td>
<td>14 782</td>
<td>10 842</td>
</tr>
<tr>
<td>Switzerland</td>
<td>20 633</td>
<td>17 659</td>
</tr>
<tr>
<td>Spain</td>
<td>9 219</td>
<td>7 235</td>
</tr>
<tr>
<td>England</td>
<td>86 186</td>
<td>98 866</td>
</tr>
<tr>
<td>Sweden</td>
<td>23 449</td>
<td>16 283</td>
</tr>
<tr>
<td>Germany</td>
<td>88 287</td>
<td>78 698</td>
</tr>
<tr>
<td>Austria</td>
<td>24 513</td>
<td>18 284</td>
</tr>
<tr>
<td>TOTAL</td>
<td>395 863</td>
<td>379 353</td>
</tr>
</tbody>
</table>
Many refugees arrived in Sweden (2001) from following countries: Iraq (6 206), former Yugoslavia (3 102), Bosnia-Hercegovina (2 775), Russia (840), Iran (780), El Salvador (618) and Afghanistan (593).

38 858 Iranian refugees applied for asylum in Sweden Between 1984 and 2001. They represent 10% of the total number of asylum seekers in Sweden (Migrationsverket, webb site).

Refugees and mental health

As a host country, Sweden like many other countries received thousands of refugees as survivors of torture, war, and organized violence. The survivors often additionally have experienced a dramatic escape. Furthermore, some of them became victims in the country of settlement due to long waiting time to get a permission to stay. However, to be “a refugee” implies to be exposed to a series of life events to cope with. Investigations about refugees’ mental health conditions showed that the psychological and psychiatric consequences of torture and war trauma are often affective disturbances, somatic complaints and/or social impairment (Holtz, 1998). Recent studies identified prevalent accompanying symptoms, such as depression, anxiety, and anger (Chemtob et al., 1997b; Kessler et al., 1995), which may be pervasive with negative impact on quality of life. Anger, for example, frequently causes major-social war-related, and legal problems (Chemtob et al., 1997b) interfering with the modification of the traumatic memory (Riggs et al., 1992).

Socio-cultural background of the investigated Iranian refugees

The recent history of the people in Iran

During the past decades Iran has gone through several political, economical and social psychological changes. At the time of the Islamic revolution in 1979, Iran was a constitutional monarchy under the Pahlavi dynasty (Hunter, 2000). After the revolution 1979, the revolutionary elites, operating under heavy impact of the shi’a legacy (concerning the legitimacy and authority of political relations,) created an ideological political system which has been controlled by a set of institutions dominated by religious leaders and pro-revolutionary elites (Arjomand, 1988). Despite that Iran is the most multi-cultural state in the region with its 60 millions population and more than 60 different ethnic communities, scattered in various parts of the country, the Islamic government tried to
ignore the multi-cultural aspect of the Iranian population. After 1981, the control of the Iranian political system shifted to pro-revolutionary elites who closely followed Khomeini’s ideas. At this period, with the support of radical religious factions, the leadership declared that their goal was not only to “free” the Iranian society, but the whole world as well. All resources were mobilized to conduct this “holy war” and to provide the world with ‘more happy future’ founded upon Islamic principals. These elites sought to mobilize mass support for their causes to establish a permanent Islamic regime in Iran (Aras, 2001).

This period was characterized by an attempt to stifle all divergent opinions, declaring all oppositions to be “anti-revolutionary” and “agents of imperialism”. Islam was seen as the only legitimate source of political thought and dominated the public sphere completely (Berzin, 2000). This strategy by the Islamic regime caused many Iranians to flee from home. Estimates of the number of Iranian refugees vary from 750,000 to 1.5 million, worldwide. Most of them preferred to settle in Western Europe or in the United States of America (Abrahamian, 1982).

Iranian-Iraqi war (1980-1988) and the political repression were two major reasons why Iranian people mostly young, escaped from country. From 1983 to 1993, a high number of Iranians applied for asylum in Sweden and nowadays, 60,000 Iranians are estimated to live in Sweden. From 1993 until 2003 the number of Iranian asylum seekers has decreased dramatically because of war ended between countries (Migrationsverket, webb site).

Review of the Literature

History of the trauma theories

Since the beginning of the 17th century, evidence of trauma exposure and subsequent consequences were more often documented. For example, in 1666, Samuel Pepys diary reported about individuals’ responses and coping with the Great Fire of London (Daly, 1983). However, Janet (1886, 1889/1973) and Freud (1953/1905, 1955/1920, 1959/1925, 1962/1896) were among those who introduced the term ‘trauma’ in a more comprehensive clinical perspective and research.

In 1895, Breuer and Freud discussed in “Studies about Hysteria” that mental disorders could sometimes be caused by psychological trauma. Most of other researchers during that time believed that psychiatric patients suffered primarily from biological defects. Janet (1886, 1889/1973) was
already working on an effective, systematic psychotherapy for trauma survivors, but his hypothesis was that patients were not able to integrate traumatic memories because their brains were degenerated. Freud’s idea was that hysterical patients repress their awareness of traumatic memories in order to defend against them. Psychic balance is kept by a compromise that partially expresses the repressed traumatic memory in terms of symptoms. Freud noticed that every female and male hysterical patient, he treated, had experiences of sexual abuse (Freud, 1896/1962). Since he suggested that children do not have sexual feelings, he believed that molestation prematurely and traumatically evoked their sexuality. Later, he left this “seduction theory” on the grounds that a) not all hysterical patients were seduced, and b) children do, indeed, have sexual feelings (Freud, 1905/1953). At this moment, Freud paid more attention to rather general questions about psychological development and less on traumata. Freud’s returned to the topic of traumata during World War I. In Beyond the Pleasure Principle (1920/1955), he tried to explain psychological trauma as a result of a break in a psychic stimulus barrier. Like Janet (Van der Hart et al., 1989), Freud assumed the survivors’ intrusive and avoidant symptoms (later core element of post traumatic stress disorder [PTSD]) as a biphasic attempt to cope with trauma. Freud postulated that survivors repeat these memories with the goal to control them. At this point, he revised his theory of trauma and included post traumatic dreams rooted in this repetition compulsion.

Abraham Kardiner (1941), one of Freud’s colleagues, published his findings about the treatment of many combat veterans in World War I. He referred to relationships between psychological and biological factors in what he named the “physioneurosis of combat survivors”.

However, the two world wars activated a large number of clinicians and theoreticians to reflect on psychodynamic models and to develop therapeutic interventions. The therapeutic interventions in the post-war years were almost all based on psychoanalytic theory. World War II even provided conditions to study the effects of massive psychic trauma on non-combatants. Studies on survivors of the Holocaust (Krystal, 1968), concentration camps and of Hiroshima (Lifton, 1967) indicated that overwhelming events could numb basic human recourses and abilities and result in a kind of “death in life.” Krystal (1988) developed an information-processing model of psychological trauma, which emphasized that overwhelming events make the psyche’s energy unable to use anxiety as a signal for the mobilization of defence. According to Krystal, the ego is defenceless without its normal signal processing. That means, when
the system is disrupted, anxiety and other affects fail to master psychic needs. Affects may become muted, overwhelmed, or dysfunctional. For example, alexithymia can be a result of that kind of disruption.

Melanie Klein (1975) speculated about the psyche’s efforts to balance love and hate in the context of the relationship between self and others. Heinz Kohut’s self psychology theory was also applied to the psychological problem of trauma survivors (Ulman and Brothers, 1988). A stable sense of self in the course of normal narcissistic development can be disrupted or even devastated by experiences that threaten the relevance of the self.

Winnicott’s (1965) study on holding environment, which enables children to manage fears of physical and psychological annihilation as they grow up, provides valuable pattern as to how adults succeed or fail to maintain psychic balance confronting traumatic life events. Object relations theory, which is trying to understand how intra-psychic processes and structures develop in the context of interpersonal experiences, contributed important insights into how trauma survivors’ relationships and social contracts cause psychopathology. Kudler (1991) has suggested that Winnicott’s holding environment is basically Freud’s stimulus barrier. Fairbairn (1943a) defined pathology of trauma as releasing repressed, internalised relationships with so-called bad objects. Psyche may act with anxiety because of a hated and feared object (such as a frustrating parent). Treatment emphasizes the regaining balance between acceptable levels of dependence and aggression.

Contemporary definition of trauma

Webster’s New Twentieth Century Dictionary defines trauma as “an injury or wound violently produced” and as “an emotional experience, or shock, which has a lasting psychic effect” (Simon and Schuster, 1983). Originally, the term ‘trauma’ comes from Greek language and means ‘wound’ (Abdulbaghi, 1999). Individuals’ reactions to traumata have been described for more than a century (Foa and Rothbaum, 1998) under different names, including “hysteria” (Putnam, 1881), “nervous shock” (Page, 1885), “traumatophobia” (Rado, 1942), and “war neurosis” (Grinker and Spiegel, 1943).

Although Kardiner’s study on psychological disturbances of traumatic life event was available for clinical application when World War II started, most of the psychiatric experiences in the field of trauma from World War I had been forgotten and a series of new studies were performed (Van der
Kolk et al., 1996). After World War II many investigations were performed on war veterans and people who had been put in concentrations camps (Archiblad and Tuddenham, 1965; Eitinger 1964). The most important finding of those studies was that extreme traumata caused severe biological, psychological, social and existential consequences. In addition, human capacity to cope with psychobiological stressors dramatically decreases later in life (Van der Kolk et al., 1996).

However, new concepts and a new terminology have been introduced in psychiatry concerning prevention and intervention of psychological consequences of traumatic experiences. The Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (APA) provides one “official” definition of all mental illnesses. When first published in 1952 PTSD was called “stress response syndrome” and was derived from “gross stress reaction”.

In the second edition (DSM-II), 1968, trauma-related disorders were called “situational disorders”. Finally, in 1980 all different name and terms as “rape trauma syndrome”, “battered woman syndrome”, “abused child syndrome”, “shell shock”, “Vietnam veterans syndromes”, “fright neurosis”, “combat/war neurosis”, “operational fatigue” and “compensation neurosis” were replaced by the concept of “post traumatic stress disorder” in DSM-III (APA, 1980). Post-Traumatic Stress Disorder (PTSD) was defined as a “syndrome”, i.e. a collection of symptoms, used and placed under a sub-category of “anxiety disorders”. The term describes the delayed and often chronic reaction experienced by people exposed to particular kinds of intensive negative emotional demands encountered in war zones, natural disasters and other catastrophic situations. Such heavy stress reactions often include:

- Startle responses, irritability, impairment in concentration and memory, disturbed sleep, distressing dreams, depression, guilt, phobias, psychic numbing, and multiple somatic complaints.

In the current edition, DSM-IV (1994), “Post-traumatic Stress Disorder” is placed under “stress response” grouping and still remains in the “anxiety disorder” category. The change from “syndrome” to “disorder” was done taking new investigations and new attitudes in psychiatric care into account (Van der Kolk et al., 1996). With few exceptions, until DSM-IV, most combat veterans were diagnosed with “shell shock”, which didn’t permit them to long-term treatment. Other combat veterans were sometimes merely diagnosed with having “bad nerves”.

The initial definition of PTSD described a psychological condition experienced by a person who had faced a traumatic event that was caused
by a catastrophic stressor outside the range of usual human experience (an event such as war, torture, rape, or natural disaster). This definition separated PTSD stressors from the “ordinary stressors” that were characterized in DSM-III as “Adjustment Disorders”, such as divorce, failure, rejection and financial problems (Keane et al., 1994).

Traumatic life events and their consequences are not unknown phenomena. Wars, tortures and natural disasters always happen during the development of the mankind. Evidence for post-traumatic reactions was detected in soldiers in combat and torture was used against war prisoners and political prisoners. In Europe, torture was extensively used by Christian church during the middle Ages (Jacobsson et al., 1993).

Theoretical background

Most of current studies and investigations in refugee health deal with psychiatric and psychosocial disturbances. Although it has been much research on children’s resiliency facing natural disasters and war, few studies on adult’s ability facing traumatic life events. No study has been done before on resiliency of Iranian refugees as far we know. Although resiliency is a relative new field in care area, it needs more investigation.

Resilience – definition and perspective

Research on resilience was in the beginning focused on children. Children’s individual variations in response to adversity were investigated to better understand protective forces which are differentiating children with healthy adaptation profiles from those who were less well adjusted. This approach was opposite to previous research in the understanding of maladaptive behaviour (Luthar et al. 2000). Rutter (1990) defined resilience as the positive end of the distribution of developmental outcomes among individuals at high risk. A definition of resilience that appears to incorporate the literature is as following: Resilience is a universal capacity which allows a person, group or community to prevent, minimize or overcome the damaging effects of adversity. Resilience may transform or make stronger the lives of those who are resilient. The resilient behaviour may be in response to adversity in the form of maintenance or normal development despite the adversity, or a promoter of growth beyond the present level of functioning. Further, resilience may be promoted not necessarily because of adversity, but, indeed, may be developed in anticipation of inevitable adversities (Grotberg 1997).
Resilience turns to a dynamic process including positive adaptation within the context of significant adversity. Two critical conditions are implied (Luthar et al. 2000): a) exposure to a significant threat or severe adversity; and b) gains by effort of a positive adaptation despite major assaults on the developmental process (Luthar and Zigler 1991; Rutter 1990).

Early investigations were focused on individual qualities of “resilient children” such as independence and high self-esteem (Luthar et al. 2000). During the last two decades the focus of research has changed from identifying obvious protective factors to understanding underlying protective processes. Rather than simply studying which child, family, and environmental factors are involved in resilience, researchers are increasingly striving to understand how such factors may contribute to positive outcomes (Luthar et al., 2000). Defining resilience is a continuing problem and there is a lack of consensus about the domain covered by the construct of resilience (Kaufman et al., 1994). The problem of defining resilience as a construct may not be for lack of agreement on many of the factors and characteristics of resilience; rather, the problem may be more related to the dynamic interaction of the resilience factors, and the sources of resilience factors; e.g., internal/external; resources/skills (Grotberg 1997).

However from this point of view personality, sense of coherence as a internal factors, parental rearing, social support and quality of life as as an external factors, and coping resources and strategies as a resources and internal factor, seem to be interesting phenomenon to study because these factors maybe act as mediators to the individual’s basic response to stress and psychiatric/psychological health or disturbances.

**Personality, cognition and resilience**

Individuals behave differently in similar situations and evaluate conditions differently based on their unique expectations, values, previous experiences and temperament (DeNeve and Copper 1998). Personality traits and well-being in relation to stressful life events have been the topics of many investigations. Usually, when reflecting about someone’s personality, we think about what makes one person different from another or perhaps even unique. This question refers to individual differences. In some theories, it represents the central topic. It is not easy to describe or to explain how individuals develop particular ways of interacting with the world. This is another issue of individual differences (Huffman et al., 1991). Since the 1960s, three different major approaches have dominated the investigations of individual differences:
type theories, trait theories and psychoanalytic theories (Mischel, 1984). The psychobiological model of personality by Cloninger (1986, 1987) and his research group is one of the personality trait theories. Cloninger's personality model is based on Allport's (1937) definition of personality which claimed that personality represents a dynamic organization within the individual based on psychophysical systems which in turn determines its unique adjustment to the environment (Allport, 1937). Cloninger's model is comprised of temperament and character. Individual differences are dependent on distinctions within temperament and character (Cloninger, 1998). Temperament traits are defined as basic emotional response patterns, such as fear, anger, and attachment. Temperament is supposed to be mainly genetically inherited and relatively stable during the life span (Goldsmith et al., 1987). The four temperament dimensions that Cloninger and colleagues identified refer to individual differences in four basic emotional responses. These are: Harm Avoidance (HA), Novelty Seeking (NS), Reward Dependence (RD) and Persistence (P). Character refers to individual differences in voluntary goals and values, which focus on insight learning and the representation of our world. The three character dimensions are: Cooperativeness (CO), Self-Directedness (SD) and Self-Transcendence (ST), (Cloninger, 1998).
Table 2. Temperament and Character dimensions of Cloninger’s personality theory (Cloninger, 1994).

<table>
<thead>
<tr>
<th>Personality Dimension</th>
<th>Temperament Descriptors</th>
<th>Character Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TEMPERAMENT</strong></td>
<td><strong>High Score</strong></td>
<td><strong>Low Score</strong></td>
</tr>
<tr>
<td>Harm</td>
<td>worrying &amp; pessimistic</td>
<td>relaxed &amp; optimistic</td>
</tr>
<tr>
<td>Avoidance</td>
<td>fearful &amp; doubtful</td>
<td>bold &amp; confident</td>
</tr>
<tr>
<td></td>
<td>shy;</td>
<td>outgoing</td>
</tr>
<tr>
<td></td>
<td>fatigable.</td>
<td>vigorous.</td>
</tr>
<tr>
<td>Novelty</td>
<td>exploratory &amp; curious</td>
<td>indifferent;</td>
</tr>
<tr>
<td>Seeking</td>
<td>impulsive;</td>
<td>reflective;</td>
</tr>
<tr>
<td></td>
<td>extravagant &amp; enthusiastic</td>
<td>frugal &amp; detached;</td>
</tr>
<tr>
<td></td>
<td>disorderly.</td>
<td>orderly &amp; regimented.</td>
</tr>
<tr>
<td>Reward</td>
<td>sentimental &amp; warm</td>
<td>practical &amp; cold</td>
</tr>
<tr>
<td>Dependence</td>
<td>dedicated &amp; attached;</td>
<td>withdrawn &amp; detached</td>
</tr>
<tr>
<td></td>
<td>dependent.</td>
<td>independent.</td>
</tr>
<tr>
<td>Persistence</td>
<td>industrious &amp; diligent;</td>
<td>inactive &amp; indolent;</td>
</tr>
<tr>
<td></td>
<td>hard-working;</td>
<td>gives up easily;</td>
</tr>
<tr>
<td></td>
<td>ambitious &amp; overachiever;</td>
<td>modest &amp; underachiever;</td>
</tr>
<tr>
<td></td>
<td>perseverant &amp; perfectionist.</td>
<td>quitting &amp; pragmatist.</td>
</tr>
<tr>
<td><strong>CHARACTER</strong></td>
<td><strong>High Score</strong></td>
<td><strong>Low Score</strong></td>
</tr>
<tr>
<td>Self</td>
<td>mature &amp; strong;</td>
<td>immature &amp; fragile;</td>
</tr>
<tr>
<td>Directedness</td>
<td>responsible &amp; reliable;</td>
<td>blaming &amp; unreliable;</td>
</tr>
<tr>
<td></td>
<td>purposeful;</td>
<td>purposeless;</td>
</tr>
<tr>
<td></td>
<td>resourceful &amp; effective;</td>
<td>inert &amp; ineffective;</td>
</tr>
<tr>
<td></td>
<td>self-accepted;</td>
<td>self-striving;</td>
</tr>
<tr>
<td></td>
<td>habits congruent with</td>
<td>habits incongruent with</td>
</tr>
<tr>
<td></td>
<td>long term goals.</td>
<td>long term goals.</td>
</tr>
<tr>
<td>Cooperativeness</td>
<td>socially tolerant</td>
<td>socially intolerant;</td>
</tr>
<tr>
<td></td>
<td>empathic;</td>
<td>critical;</td>
</tr>
<tr>
<td></td>
<td>helpful;</td>
<td>unhelpful;</td>
</tr>
<tr>
<td></td>
<td>compassionate &amp; constructive;</td>
<td>revengeful &amp; destructive</td>
</tr>
<tr>
<td></td>
<td>ethical &amp; principled</td>
<td>opportunistic.</td>
</tr>
<tr>
<td>Self</td>
<td>wise &amp; patient;</td>
<td>impatient;</td>
</tr>
<tr>
<td>Transcendence</td>
<td>creative &amp; self-forgetful;</td>
<td>unimaginative &amp; self-conscious;</td>
</tr>
<tr>
<td></td>
<td>united with universe;</td>
<td>pride &amp; lack of humility;</td>
</tr>
</tbody>
</table>
According to Cloninger and his colleagues (1993), personality is defined as the way that individuals learn from experience and adapt their feelings, thoughts, and actions. Specifically, personality can be defined as a dynamic organization within an individual of the psychobiological systems that modulate adaptation to a changing environment. This includes system regulation by means of cognitions, emotions and moods, personal impulse control, and social relations (Cloninger et al., 1993). “Learning” processes represent core phenomena in Cloninger’s theory. Learning is broadly defined as “the organization of behaviour as a result of individual experience” (Thorpe, 1956).

Based on the hypothesis that temperament, character traits and differences in learning abilities cause individual differences, Cloninger formulated his model of personality. Some of the major differences between temperament system of functioning and character system of functioning, brain substrate and inheritance are shown in table 3.

Table 3. Differences in learning between temperament and character

<table>
<thead>
<tr>
<th>Learning Variable</th>
<th>Temperament</th>
<th>Character</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Awareness</td>
<td>Automatic</td>
<td>Intentional</td>
</tr>
<tr>
<td>Form of Memory</td>
<td>Percept Procedures</td>
<td>Concept Propositions</td>
</tr>
<tr>
<td>Type of activity</td>
<td>Habits, Skills</td>
<td>Goals and Values</td>
</tr>
<tr>
<td>Type of Emotion</td>
<td>Reactive, (unconscious)</td>
<td>Evaluative (conscious)</td>
</tr>
<tr>
<td>Learning Principle</td>
<td>Associative Conditioning,</td>
<td>Conceptual Insight</td>
</tr>
<tr>
<td>Rate of Acquisition</td>
<td>Gradual (Quantitative)</td>
<td>Abrupt (Qualitative)</td>
</tr>
<tr>
<td>Key Brain System</td>
<td>Limbic System Striatum</td>
<td>Temporal Cortex Hippocampus</td>
</tr>
</tbody>
</table>

Although Cloninger focused on temperament and character, other researchers paid attention to cognition trying to understanding human behaviour in different situation. Cognitive approaches refer to the impact of mental processes on behaviour. Kelly’s (1955) personal construct theory and Bandura’s (1977) self-efficacy model are two major approaches of cognitive perspectives on personality. However, a tradition that had an effect on most researchers and clinicians was based on a “constructionistic model”.

Piaget (1952, 1960, 1964) was one of the scientists who created a constructionistic model in order to explain how cognitions are developed. He used the term “scheme” for mechanisms within an individual to stress
that humans have different aspects of his or her world at any given moment. Piaget believed that children develop schematic outlines or maps of what the world is like and maintain these outlines throughout life. Processes of adaptation play a central role in Piaget’s theory. This term describes mechanisms by which schemes are developed as a result of adjustment that occurs through the processes of assimilation and accommodation (Dworetzky, 1983). The individual’s way of collecting information and of perception is compatible with the person's current understanding of the world according to Piaget. This mechanism is called assimilation. Accommodation describes the process in which the person adjusts or changes his or her cognitive structures to internalised aspects of an experience not currently represented in them.

At the same time when Piaget developed his model of humans’ cognition, Bowlby (1958, 1969, 1973) investigated and developed an intraorganismic model of emotional responses known as attachment theory. Bowlby emphasised the interaction between parents and children as a necessary factor for fostering attachment. His investigation on infants and children resulted in the concept of “internal working models”. According to Bowlby, an internal working model refers to the child’s memories of the attachment relationship, memories based on which the child can understand what he or she can expect from caregivers in different situations. One of the theory’s central concepts is the term “secure base” used by Ainsworth (1973). This term describes the child’s predisposition to use the attachment figure as a secure base of actions to explore the environment.

The approaches of Piaget and of Bowlby became of central importance in psychiatric models, e. g., by Ellis (1962) and Beck (1967). Bandura (1977, 1978a, 1978b, 1982, 1986, 1997, 2001) identified an important element in human behavioural responses to life events, so-called “self-beliefs”. He (1986) discussed in more detail a view of human functioning and suggested that individuals are self-organizing, proactive, self-reflecting and self-regulating rather than reactive organisms shaped and shepherded by environmental forces or driven by concealed inner impulses. Based on this perspective, human behaviour is viewed as the result of a dynamic interplay of personal, behavioural and environmental influences. However, Bandura emphasises that cognition is of a central importance in individuals’ capability to construct reality, self-regulate, encode information and perform behaviours. Bandura’s core assumption regarding the role of self-efficacy beliefs in human functioning is that “people's level of motivation, affective states, and actions are based more on what they believe rather than on what is objectively true” (Bandura, 1997).
Cognitive Appraisal

A body of research and investigation has been performed to understand the relationships between cognitions and emotional responses to stimuli. The concept of cognitive appraisal is based on the assumption that emotions are always responses to our perceptions of the eliciting stimuli. For example, Myers (1992) has shown that human's happiness is obviously to be found not in material goods but rather in one's cognitive state of mind. The idea that emotional reactions are triggered by cognitive appraisal rather than environment, enables us to take into account that individuals (or even the same person at different times) can have very different emotional responses in the same situation towards a person or an object (Smith 1993).

The concept of cognitive appraisal led to the phenomenon of “dysfunctional beliefs” developed by Ellis (1962) and Beck (1976). They suggested that some beliefs are irrational or dysfunctional and can cause unnecessary emotional distress. Individuals who have irrational beliefs or dysfunctional thinking tend to overreact with strong negative emotions like anger and fear.

Affective reactions to distress

Nowadays researchers’ interest has turned towards affective responses to assault. Anxiety is one of the most common reactions to different traumatic life events. More precisely, several researchers (Calhoun et al., 1982; Klipatrick et al., 1981) documented general and diffuse anxiety as a usual response to trauma, which has been observed up to 16 years post assault (Foa and Rothbaum, 1998). Depression is another type of affective reaction that has been noted. Even though depression is a common reaction to traumatic life events, it appears to be less persistent than anxiety (Atkeson et al., 1982; Frank and Stewart, 1984). Linked to depression, suicidal thoughts and behaviour have been observed. For example in an investigation on sexual assault victims by Resick (1988), he found that 43% of the subjects showed suicidal thoughts and 17% had made an suicidal attempt. Even anger has been noted as an affective reaction to distress. In a study made by Riggs et al. (1992), 116 rape and other crime victims were compared to matched non-victimized control group (n=50), studying anger and anger-expression. The results showed that in general, victims were angrier than a non-victimised control group.
Parental Rearing

Since long time ago researchers have tried to understand how much of our personality is caused by the way our parents treat us when we are growing up. Many studies have focused on child rearing, children’s behaviour, their development and mental health (Baldwin, 1949; Kelly, 1955; Schaefer, 1960; Roger, 1961; Mahler, 1967; Bandura 1977). They were mainly interested in interactions between parents and children. Different approaches have been established over the time. For example, Baumrind (1980) divided parenting styles into three patterns: authoritarian, permissive and authoritative.

Recently Perris and co-workers (Perris, 1981, 1989, 1991,a,b; Perris and Perris, 1985; Perris 1982; Eisemann, 1985) developed a complex theoretical framework that took into account the interaction of cultural, biological, and psychosocial variables in the development of an individuals’ susceptibility to psychopathological manifestations, and the interplay of the vulnerable individual with his or her environment (Perris, 1994).

The model stresses “individual vulnerability” as the core of psychopathology. Perris and co-workers proposed that a continuous dialectical interaction occurs between factors belonging to different domains, which represent determinants of psychopathology and between the vulnerable individual and his or her environment. Because of this continuous interaction, vulnerability is not a static, unchangeable trait. Additionally, the model enables a conceptualisation of traumatic events in terms of an interaction with the individuals’ experiences.

Several investigations (Wethington and Kessler, 1989; Miller, Dilorio et al., 2002) have demonstrated that vulnerability factors will enhance the individual’s reactivity to stressful events, and that each individual is idiosyncratically vulnerable to particular events that might leave another person unaffected. Furthermore, the model suggests that life events, when considered in the context of vulnerability, can be understood in terms of those factors that are assumed to enhance an individual’s vulnerability, and might cause a mental breakdown, or those issues that might represent a buffer against the effect of further hardship and traumatic life event (Perris, 1994).

Based on assumptions of the vulnerability model a lack of emotional warmth and care, a lot of rejections, even overprotection during childhood by parents were found to represent crucial and important risk factors of developing psychopathology in adulthood (Perris et al, 1986; Mackinnon et al, 1993).
Salutogenesis perspective

While most researches have focused on pathogenetic aspects of illness and vulnerability models, there are only few researchers who focused on protective factors, which are involved in resilience processes following traumatic life events. One of the theoretical approaches to resilience is Antonovsky's model of salutogenesis with Sense of Coherence as the central concept.

In the early 70ies, Antonovsky (1972) developed the concept of “salutogenesis” in an attempt to explore the origins of health. After construction of the salutogenic model, Antonovsky (1979) designed in detail a concept and some measurable factors, which are assumed to promote or to preserve health in terms of: Sense of Coherence (SoC). He suggested that ‘Sense of Coherence’ works as a personal dispositional orientation towards oneself and the surrounding world, which enables the individual to find more adequate strategies to cope with internal or/and external stressful life events. Three important components of the Sense of Coherence which are based on structure, order and predictability were identified by exploratory interviews in an attempt to design an operational measure (Flannery and Flannery, 1990):

Comprehensibility, which represents the beliefs that one internal and external environments are structured, predictable, and explicable

Manageability, which represents the beliefs that one, has the necessary resources available to meet the demands of the environment and finally Meaningfulness, which represents the beliefs that these demands are challenging and worthy of personal investment and engagement, also this component provides a motivational power.

The theory of ‘Sense of Coherence’ has been used as background in a wide range of clinical and non-clinical research which strongly suggests that a high ‘Sense of Coherence’ is closely related to better health and well being (Dahlin et al, 1990). In psychiatric research and health care, ‘Sense of Coherence’ has been found to be an important variable for predicting suicide in patients (Petric and Brook, 1992). The strength of the salutogenesis model is represented by its emphasis on individuals “generalized resistance resources” (GRR). It means that every person has resistance resources to deal with stressful life events more or less successfully (Antonovsky, 1993a).

Coping with trauma and resilience

The mechanism of adaptation to changes and life demands has interested several researchers. Lazarus (1966), Bandura (1977) and Kobasas (1979)
developed important models of humans’ coping mechanisms in face of stressful life events.

Lazarus and Folkman (1984) defined coping as “the person’s constantly changing cognitive and behavioural efforts to manage specific internal or external demands that are facing individual in time of stressful life event”. The model consists of two parts: (a) primary appraisal and (b) secondary appraisal. The primary appraisal represents the decision whether the situation is potentially harmful or beneficial and the decision on what type of harm or benefit is at stake. The secondary appraisal includes the evaluation of options and available resources for coping with the situation. The theory outlines two major types of coping: problem-focused and emotion-focused. Problem-focused coping is aimed at altering the physical dynamics of particular situations and represents an external strategy that is most effective when environmental manipulation is possible. Emotion-focused coping is defined as an internal strategy including individuals’ attempts to alter his or her emotional appraisal of the particular encounter. The effectiveness of each strategy depends on the situation and available resources.

Coping resources are inherent resources which enable a person to handle stressors, to experience less intense symptoms, or to recover faster from exposure (Hammer and Marting, 1988) whereas coping strategies can be understood as internal or external actions that individuals do in reaction to a specific stressor occurring in a specific context (Pearlin and Schooler, 1978).

In the early 70s, Kabosa (1979a, 1979b) investigated employees’ reactions to stress when the working condition was breaking up. Over a period of eight years, she found that there were two different patterns responding to that stress. One group of people developed an increasing pathology. It was described suffering from medical and psychological problems and symptoms and showing help-seeking behaviour in terms of visits to physicians. In contrast, the individuals of the second group showed no changes in symptoms during this stressful period compared to the time before its onset. Surprisingly, they seemed healthier and more robust. They essentially rose to meet the challenge. Kabosa called these persons having a stress-hardy personality. Hardiness is supposed to regulate energy and the capacity to pace in order to sustain the effort needed to deal with stress and strain. According to Kobasa, additional components of hardiness are learned, i.e. cognitive, behavioural, and interpersonal skills that enhance the perception of stress as a challenge and an opportunity to grow.
Social Support and resilience

One of the most important environmental resources of individuals, who are confronted with stressful events, is the knowledge that they can rely on others for help and support in a time of crisis. Sarason (1990) postulated that knowing somebody who values and care for us represent the basic need in the social support in a network. Social support has been found to be a strong protective factor against stress in many investigations. E.g., House et al. (1988) investigated effects of loneliness and social isolation in the United States, Finland and Sweden. Kulik and Mahler (1989) studied social support as a recovery factor from stressful medical interventions. Social support was found providing relief from psychological distress in people confronted with various stressful life events (Holahan and Moos, 1990; Rodin and Salovey, 1989).

Recent theoretical analyses of social support suggest a number of ways in which it might enhance physical and psychological well-being (Cohen, 1988). Two classes of effects have been identified: a) direct effects on physical and psychological well being that occur even when people are not experiencing stress and b) buffering effects that protect people from the impact of stressors. In terms of direct effects, individuals who feel that they are part of a social system may experience a greater sense of identity and meaning in their lives, which in turn results in greater psychological well-being and enhanced immune system functioning (Cohen, 1988; Rodin and Salovey, 1989). Buffering the impact of negative events by providing aid that helps to eliminate or to reduce stressors causes an additional effect of social support. Social support also enables people to feel that they have the backing of others, and this can increase their feelings of control over stressor.

Quality of life

Quality of Life (QoL) represents an area of research that has attracted a great deal of interest over the past ten years, particularly in the areas of health and social services, but increasingly in medicine, education, and others (Aronson 1997) including a discussion whether quality of life is an objective or subjective concept or both.

The concept of QoL is multidimensional and a generally accepted definition is not yet available. QoL is either interpreted as “conditions of life” or as “experience of life”. The study of Quality of Life includes an examination of factors that contribute to the goodness and meaning of life as well as people’s happiness. It also explores the interrelationships among these factors.
The ultimate goal of QoL-studies and its subsequent applications is to enable people to live with a high quality of life, i.e., both meaningful and enjoying life (Ferrans and Powers 1992; Meeberg 1993). The Constitution of WHO defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The World Health Organization defines the QoL as the “individuals’ perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concern”. This emphasises that QoL comprise a personal meaning.

It is a broad-ranging concept affected in a complex way by the person’s physical health, psychological state, and level of independence, social relationships, personal beliefs, and relationship to salient features of the environment (WHO QoL group 1995). It implies that the measurement of health and effects of health care should include not only an indication of changes in the frequency and severity of diseases, but also an estimation of well-being. Therefore, the WHO initiated and developed QoL-measurements that can be used in a variety of cultural settings allowing comparisons of results from different populations and countries. The WHOQOL-BREF is an abbreviated 26-item version of the WHOQOL-100. Both versions are self-administered. These instruments serve many purposes including its application in medical practice, research, audit, and policy-making.

The structure of the WHOQoL-100 reflects the issues that scientific experts and lay people in each of the field centres felt were important to quality of life. The six assessed domains of QoL are:

1. Physical health
2. Psychological health
3. Level of independence
4. Social relationships
5. Environment

**The Aim of the study**

The objectives of this dissertation were to investigate determinants of coping, resiliency and psychopathology in a sample of Iranian refugees resettled in Sweden who have been victims of severe traumatization. A
refugee population presents an exclusive opportunity to study resilience. Escaping under stressful circumstances, migration and resettlement presents a set of adaptive challenges related to wide-ranging changes in existence, daily life and environment. This study has two foci, one general and one specific: - The general aim was to study psychopathological manifestations and to identify resiliency mechanisms which are related to stressful life events. Those topics that have been generally in focus in this study were the following: personality, parental rearing, coping resources, and sense of coherence, social support and quality of life. - The specific aim was to study the mental health of Iranian refugees as an ethnic minority in Sweden.

Table 4. The aim of the different studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study I</td>
<td>To investigate relationships between temperaments, character and perceived parental rearing related to psychopathology among Iranian refugees resettled in Sweden.</td>
</tr>
<tr>
<td>Study II</td>
<td>To investigate the interrelatedness between temperament and character according to Cloninger’s theory of personality, coping behavior and social support among refugees who were traumatized many years ago.</td>
</tr>
<tr>
<td>Study III</td>
<td>To investigate relationships between sense of coherence, coping and social support and quality of life among subjects who had been victims of various traumata.</td>
</tr>
<tr>
<td>Study IV</td>
<td>To investigate relationships between Sense of Coherence as a resistance resource and psychopathological disturbances among Iranian refugees resettled in Sweden.</td>
</tr>
<tr>
<td>Study V</td>
<td>Based on Cloninger’s personality model, to examine relations with internal and external factors such as social support, sense of coherence and coping resources in order to understand individual differences in developing psychopathology or well-being after traumata.</td>
</tr>
</tbody>
</table>

Subjects

In a cross-sectional study, a convenience, non-random sample of 100 Iranians, who had been exposed to various kinds of extreme traumatic life
events in Iran before their escape to Sweden, were selected by availability and investigated by means of a set of questionnaires in individual sessions from December 2000 to December 2001. At the time of investigation, all were resettled in Sweden as refugees. Almost all the participants live in Västerbotten County in the northern part of Sweden.

The inclusion criterion was that subjects should be of Iranian origin, age above 18 years old and having experienced some kind of traumatic life event. The participants were recruited through the University Hospital Psychiatric Clinic, the Iranian association in Umeå and volunteers who wanted to help to carry out the study. A few number of refugee denied participating for several private reasons. All subjects were informed about the topic, aim and voluntaries of the investigation. All subjects signed a written informed consent prior to the study. Nine questionnaires in Swedish language were administered during individual sessions. However, the first author is native Persian speaking, which enabled the study and which was important in the process of data collection. Since all participants had a sufficient command of the Swedish language, no interpreter was necessary except for some of the participant who needed some explanation and guiding through the questionnaires.

All measurements are in use in Sweden since several years and the Swedish versions had been developed in several steps according to established guidelines including forward-backward translations by native speakers, population testing, and revisions of items according to more colloquial language (Sartorius and Kuyken 1994). A standard set of written socio-demographic questions was used to assess information like gender, marital status, duration of stay in Sweden, level of education, type of trauma.
Table 5.
Details of the sample and the experienced traumata

<table>
<thead>
<tr>
<th></th>
<th>N = 66</th>
<th>N = 34</th>
<th>N = 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years</td>
<td>38.4 ± 7.33</td>
<td>35.7 ± 7.07</td>
<td>t = 1.77; p = .080</td>
</tr>
<tr>
<td>Years in Sweden</td>
<td>12.8 ± 4.63</td>
<td>11.8 ± 4.21</td>
<td>t = 1.03; p = .304</td>
</tr>
<tr>
<td><strong>Educational level in Sweden</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>University training</td>
<td>22</td>
<td>20</td>
<td>42</td>
</tr>
<tr>
<td>University student – currently</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Technical school</td>
<td>7</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Unskilled worker</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>No further Education in Sweden</td>
<td>23</td>
<td>8</td>
<td>31</td>
</tr>
<tr>
<td><strong>Marital status in Sweden</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>30</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Married</td>
<td>20</td>
<td>17</td>
<td>37</td>
</tr>
<tr>
<td>Divorced</td>
<td>16</td>
<td>7</td>
<td>23</td>
</tr>
<tr>
<td><strong>Type of Trauma</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soldiers in war (1980-1988)</td>
<td>42</td>
<td>3</td>
<td>45</td>
</tr>
<tr>
<td>Civilian war victims</td>
<td>14</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>Political imprison /victim of torture</td>
<td>15</td>
<td>11</td>
<td>26</td>
</tr>
<tr>
<td>Sexual rape</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Stress during escape from Iran</td>
<td>57</td>
<td>29</td>
<td>86</td>
</tr>
</tbody>
</table>
Methods

Material and instruments

*TCI. Temperament and Character Inventory.*

The TCI was used to assess personality characteristics according to Cloninger’s theory. It is a 238 items true/false self-administering questionnaire measuring four independent, largely genetically determined dimensions of temperament - Novelty Seeking as a tendency toward exhilaration in response to novel stimuli or cues; Harm Avoidance as a heritable bias in the inhibition or cessation of behaviour; Reward Dependence reflects the tendency to maintain or pursue ongoing behaviours, and Persistence as a tendency of perseverance in behaviour despite frustration and fatigue. Additionally, three character dimensions, which are supposed to be predominantly determined by socialization processes during the life-span.

Concerning literature, several relevant scientific journals and two major sources were searched, online database MEDLINE from 1970 and PsychInfo from 1975 until 2002. The key terms used in the initial searches are shown in the box.

**Key Search Terms**

- **Refugee:** Iranian asylum seeker, Iranian resettled, political violence, Iranian war trauma, refugee, refugee health.
- **Trauma:** torture, escaping and stress, Iranian political refugees, war, rape
- **PTSD:** psychiatric affective disorder, anxiety, war anxiety, PTSD, war disturbances.
- **Personality:** personality
- **Parental rearing:** parental style, upbringing, child development, parental rearing.
- **Coping:** Coping resources, coping strategies, coping and personality, coping and trauma, coping and stress
- **Social support:** social support
- **Sense of Coherence:** Antonovsky, sense of coherence
- **Quality of life:** Life satisfaction, WHO QoL, quality of life
- **Resiliency:** resiliency
are measured - Self-Directedness as the extent to which a person identifies the self as an autonomous individual; Cooperativeness reflects the extent to which a person identifies himself or herself as an integral part of the society as a whole; and Self-Transcendence reflects the intensity of identification with unity of all things (Cloninger et al., 1993). Its validity and reliability was reported as satisfactory in several investigations on the basis of various personality theories (Battaglia et al., 1996; Stallings et al., 1996) in different patient groups and by several neurobiological parameters (Brown et al., 1992; Bulik et al., 1995).

CRI. Coping Resources Inventory (Hammer and Martings, 1988)
The questionnaire was developed to provide a standardized measure of coping resources currently available to individuals for managing stress. It consists of 60 items related to five domains: cognitive - extent to which individuals proceed a positive sense of self-worth, a positive outlook to others, and optimism about life in general; social - extent to which individuals are in social networks that make them able to find support in times of stress; emotional - degree to which individuals are able to accept and express a range of affect; spiritual/philosophical - focused on actions of individuals which are guided by stable values derived from religious, familial, or cultural tradition or from personal philosophy; physical - degree to which individuals enact health-promoting behaviours believed to increase physical well-being. For each item, respondents use a 4-point scale to indicate how often they have engaged in the described behaviour or activity over the past six months. Cronbach Alpha scores have been reported to vary between .56 for physical coping resources among high school students and .87 for emotional coping resources for total scores about .90 among adults (Hammer and Martings, 1988).

ISSI. Interview Schedule of Social Interaction (Henderson and Byrne, 1982)
It measures general aspects of social support. In one section affectionate bonds are explored with the dimensions availability (AVAT) of attachment and its adequacy (ADAT). The ISSI also measures the availability (AVSI) and adequacy of other social ties (ADSI), a sense of social integration, reassurance of personal worth, the opportunity for nurturing others, a sense of reliable alliance and obtaining help and guidance. The reliability of the ISSI scores was examined in terms of internal consistency (Cronbach alphas between .94 for ADAT and .77 for AVSI) and split-half reliability (between .86 for ADSI and .82 for AVSI) (Unden and Orth-Gomer, 1989).
Henderson and Bryne (1982) examined the relationship of the ISSI scores with personality traits according to Eysenck. Extroversion was found positively correlated with AVSI, whereas all four scales were negatively related to trait neuroticism with the strongest relationship to ADAT and ADSI.

**BDI. Beck Depression Inventory**

The BDI is a 21 items self-report inventory designed to assess current severity of depression (Beck et al. 1961). Several investigations have demonstrated its psychometric properties in comparison with other self-ratings of depression (Kendall et al. 1987; Hautzinger, 1981). Cronbach alpha scores for the internal consistency generally ranged between 0.90 and 0.96 (Richter and Richter, 1995).

**SCL-90 - R. The Symptom Checklist-90-Revised**

The Symptom Checklist-90-Revised is a 90-items self-report inventory developed by Derogatis (1977, 1994) for the assessment of psychological problems and psychopathological symptoms. Each of the 90 items is rated on a 5-point scale of distress (between “0 = not at all” and “4 = extremely”). Subsequently, the answers are summarised into nine primary symptom dimensions: somatization, obsessive-compulsive symptoms, interpersonal sensitivity, anger-hostility, depression, anxiety, paranoid ideation, phobic anxiety and psychoticism (Schmitz et al., 2000). In addition, three global indices provide a measure of overall psychological distress: the Global Severity Index (GSI), the Positive Symptom Total (PST) and the Positive Symptom Distress Index (PSDI) (Schmitz et al., 2000). Cronbach Alpha of the GSI was reported to be 0.97. The sensitivity is reported to vary between 0.59 and 0.88 depending on the various sub-scores. Jacobson and Truax (1991) investigated its sensitivity to change and clinical significance.

**EMBU (Swedish acronym for own memories concerning upbringing)**

EMBU questionnaire is a self-report inventory, originally devised in Sweden (Perris et al., 1980). It comprises 81 items for the retrospective assessment of parental rearing behaviour. The questions have to be answered separately for the father and mother on a 4 point Likert-type scale (1 = no, never; 2 = yes, but seldom; 3 = yes, often; 4 = yes, most of the time) (Risther et al., 2000).
Dutch psychometric studies performed by Arrindell et al. (1994) yielded a four factor solution with rejection, emotional warmth, overprotection and favouring subject. These represent the standard variables in most of the investigations using the EMBU.

**DAS. The Dysfunctional Attitude Scale**

The Dysfunctional Attitude Scale is the most frequently used instrument for the assessment of dysfunctional attitudes according to Beck’s cognitive theory of depression. The 40 items have to be answered on a 7-point Likert-type scale. High internal consistency and test-retest reliability have been demonstrated. DAS-A structure based on three factors was derived by Hautzinger (1981): factor 1 (F1) “depressogenic information processing”, factor 2 (F2) “perfectionistic attitudes” and factor 3 (F3) “self-esteem depending on the approval of others”.

**WHOQoL-100 (WHOQoL Group, 1995), Quality of Life**

The Quality of Life questionnaire, which was developed by the WHO, consists of 100 items related to six domains (physical health, psychological health, level of independence, social relationships, environment, spirituality, and one general domain overall quality of life). Each item is measured from 1 to 5 according to four underlying Likert scales referring to intensity, capacity, frequency and evaluation. All scores are standardized as a 0 = worst quality of life to 100 = best quality of life scale. The internal consistency of the Danish version was reported to be .97 with a test-retest reliability of .70 (Noerholm and Bech (2001). They even performed an intensive validation study of the Danish version and found support for the satisfactory external and discriminant validity.

**SoC. Sense of Coherence Scale**

The Sense of Coherence Scale (Antonovsky, 1987) was used to measure the individual’s orientation to see life as comprehensible, manageable and meaningful. It comprises of 29 items that are rated on a 7-point Likert scale from 1 – very often to 7 – very seldom or never. Cronbach’s Alpha scores between .84 and .93 are reported by Antonovsky (1987). A weak sense of coherence was predictive of psychological distress and psychopathological manifestations in clinical and community samples (Sammallahti, 1996).
Statistics
Means and standard deviation were calculated for describing the variables under investigation. Pearson correlations between personality dimensions, psychopathological, quality of life and coping, social support, sense of coherence scores were calculated. One-way ANOVA concerning severity of depression and history as soldier in Iran and personality as well as parental rearing even psychopathology, coping and social support were calculated to see if there are any differences between variables. Multiple regression analysis with the SoC factors as independent variables and the psychopathological scores as dependent variables were calculated. MANO-VAs with SoC scale-categories and educational level as independent and all psychopathological variables as dependent variables were calculated.

Table 6.
Summaries of instruments and statistical analyses in the studies

<table>
<thead>
<tr>
<th>STUDY INSTRUMENT</th>
<th>STATISTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Study I</strong></td>
<td></td>
</tr>
<tr>
<td>TCI- Temperament and Character Inventory</td>
<td>Means and standard deviations</td>
</tr>
<tr>
<td>EMBU- Own memories of parental rearing</td>
<td>Linear corr.coef. (Pearson’s r)</td>
</tr>
<tr>
<td>BDI- Beck’s depression Inventory</td>
<td>One-way ANOVA</td>
</tr>
<tr>
<td>SCL-90-R- Symptom Check list, 90-Revised</td>
<td></td>
</tr>
<tr>
<td><strong>Study II</strong></td>
<td></td>
</tr>
<tr>
<td>TCI- Temperament and Character Inventory</td>
<td>Means and standard deviations</td>
</tr>
<tr>
<td>CRI- Coping resource Inventory</td>
<td>Linear corr.coef. (Pearson’s r)</td>
</tr>
<tr>
<td>ISSI- Interview Schedule of Social Interaction</td>
<td>One-way ANOVA</td>
</tr>
<tr>
<td>BDI- Beck’s depression Inventory</td>
<td>Bonferroni correction</td>
</tr>
<tr>
<td>SCL-90-R- Symptom Check list, 90-Revised</td>
<td></td>
</tr>
<tr>
<td><strong>Study III</strong></td>
<td></td>
</tr>
<tr>
<td>WHOQoL-100- Quality of Life questionnaire</td>
<td>Means and standard deviations</td>
</tr>
<tr>
<td>SoC- Sense of Coherence</td>
<td>Linear corr.coef. (Pearson’s r)</td>
</tr>
<tr>
<td>CRI- Coping resource Inventory</td>
<td>One-way ANOVA</td>
</tr>
<tr>
<td>ISSI- Interview Schedule of Social Interaction</td>
<td></td>
</tr>
<tr>
<td>BDI- Beck’s depression Inventory</td>
<td></td>
</tr>
<tr>
<td>SCL-90-R- Symptom Check list, 90-Revised</td>
<td></td>
</tr>
</tbody>
</table>
Summary of the papers

**Paper I:** Do Parental Rearing and Personality Characteristics have a Buffering Effect against Psychopathological manifestations among Iranian Refugees in Sweden?

Our hypothesis was that temperament, character and parental rearing exert buffering effect against PTSD with the particular impact of specific factors. – One hundred refugees participated in the project. They were assessed by means of the SCL-90-R, the BDI, the EMBU, and the TCI. Despite the experience of an extreme trauma some of the refugees did not suffer from severe depression or other psychosomatic complaints. A high level of Self-Directedness appeared as having a possible buffering effect against PTSD after several severe traumata. Furthermore, we found specific effects of other personality characteristics and of parental rearing in determining the relationships between the experience of several traumatic events and later psychopathological manifestations among the refugees. The educational level and the length of living in Sweden represented important socio-cultural factors in decreasing psychological disturbances.
Paper II: Personality and Coping among Iranian refugees

The aim was to investigate the interrelatedness between temperament and character according to Cloninger’s biosocial theory of personality, coping behaviour and social support among traumatized individuals.

Personality, psychopathological disturbances, coping resources, and social support were assessed in 100 Iranian refugees resettled in Sweden, who had been exposed to various extreme traumatic life events in Iran before their escape.

Individuals, traumatized by war experiences as a soldier, with low BDI scores showed the lowest scores in Harm Avoidance and the highest in Self-Directedness and Cooperativeness. Concerning the coping resources and social support scores, these subjects scored slightly higher and the traumatized refugees with high BDI scores scored slightly lower.

Resilient refugees are characterized by low harm avoidance; high self-directedness and high cooperativeness which might enable the resilient refugees to develop effective coping strategies, to find sufficient social support, and to become resistant against severe traumata.

Paper III: Quality of life among Iranian refugees resettled in Sweden

Relationships between quality of life, psychopathological manifestations and coping related variables were examined among 100 Iranian refugees resettled in Sweden, i.e., individuals who have experienced several severe traumata.

Individuals, traumatised by combat experiences as a soldier during the war, with low depressivety showed on average the significantly highest overall quality of life, the best physical health, the highest scores according to the sense of coherence most pronounced for “Meaningfulness” and the best availability of social integration. Quality of life, coping resources, and social support were found closely related to psychopathological manifestations. Motivational orientations and coping competencies enable some traumatized individuals to resist several traumata and to live in a good quality of life without psychopathological disturbances.


Based on Antonovsky’s model of salutogenesis a high Sense of Coherence is supposed to be related to better health and well-being. The general aim of the present study was to investigate relationships between Sense of
Coherence as a resistance resource and psychopathological disturbances among 100 traumatised Iranian refugees resettled in Sweden.

Questionnaires assessing Sense of Coherence, depression, general psychopathology and dysfunctional attitudes (SoC, BDI, SCL-90-R, and DAS) were administered during individual sessions.

The scores of the Sense of Coherence domains were able to explain relatively high amounts of variance of all psychopathological scores. Manageability was of highest impact mainly for the prediction of DAS scores. The factor comprehensibility emerged as less important in the regression.

The results suggest that Sense of Coherence does not have a specific buffering resilience effect. However, “Meaningfulness” seems to be more important concerning severity of depression, whereas “Manageability” has a stronger impact on dysfunctional attitudes. A higher level of education emerged as a possible resilience factor.

Paper V: Dimensions of Personality and Resilience in Iranian Refugees

The aim of the study was to take a look at relations with internal factors as personality, coping resources and sense of coherence and external factors such as social support, in refugees with the focus on resilience. One hundred traumatized refugees were investigated several years after resettlement in Sweden. The correlations between Harm avoidance (HA) and Self-Directedness (SD) were found significant with the psychopathological variables severity of depression (BDI), Global Symptom Index (SCL-90), Dysfunctional Attitude scale (DAS) and the overall level of quality of life (QoL). High HA occurred as a strong predictor of psychopathology, particularly when combined with low coping resources. The results point to that the personality dimensions Harm Avoidance and Self-Directedness can be interpreted as indicators of the level of psychiatric disturbance. Dividing Self-Directedness in three different category (low, average and high) show significant results concerning all variables (CRI, ISSI, SOC, QoL, BDI, SCL-90,DAS) except for Adequacy of Attachment (social support variable).

Ethical considerations

The participants have been victims of different kinds of traumatic life events. Research into such intimate and disturbing aspects of a person's
life is intrusive, even when the participants show a great enthusiasm for investigation. In the trauma literature, however, ethical issues have not featured strongly in the past ten years. The International Society of Traumatic Stress Studies has not issued any particular guidelines for research into the effects from traumatic events, (Raftery 1997).

Raftery (1997) even notice that of the past seven years of Journal of Traumatic Stress and recent books such as the International Handbook on traumatic Stress Syndromes revealed no specific reference or edition devoted to ethical aspects of trauma research. In other areas of human research there is more interest and one is more likely to find reference to ethical guidelines in a text on qualitative research (Glesne and Peshkin, 1992). This is why I decided with high respect for the participant; to try to meet them rather as an active individual than see them as a subject for my investigation. When investigating traumatic life events in refugees, there is always a risk of reactualisation of former traumatic experiences. “Safety” is one of many factors which have been identified as an important relationship mechanism in meeting with traumatized people (Herman, 1992). The design of the study paid a great attention to this factor. Several conditions were distinguished which increase the secure base in the relationships between the interviewer and the subjects. The aim of investigation was explained in the native language. Explaining in a native language was important as a sign of respect and making the atmosphere warm in the process of the assessment. A letter of information was an additional tool to develop an informed consent. Surprisingly, most of the participant expressed their satisfaction with the topic and showed an intensive collaboration when they understood the aim of the study. The Ethical Review Committee of the Medical Faculty of Umeå University approved the study protocol. All participants were given both verbal and written information.

Main Conclusion

Limitations

The interpretation of the findings is limited by the small sample size, a lack of assessment of the time since the occurrence of traumata, by the cross-sectional design and by the long period since the traumatic events took place.

Another source of error might be caused by the recruitment method. Surprisingly, most of the Iranians who were asked to participate were highly interested in the topic of study except some few refugees who ex-
pressed their support for the investigation but chooses to stay out of the study. However, the number of instrument was in some way problematic for some individuals. Unfortunately, prior to our project we couldn’t find any comparable study in adult Iranian refugees in Sweden. It would be of interest to investigate the development of living conditions during the processes of confrontation with the new culture after resettlement. However, the limited number of the participants does not substantially reduce the importance of the findings, even though some results did not reach a satisfactory level of significance. It is important to remember that the focus in this investigation is on relationship between some variables in the sample.
## Overview of specific findings

<table>
<thead>
<tr>
<th>Study I</th>
<th>Personality Parental rearing and Psychopathology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male refugees were more depressed than females. Parental rejection showed the closest relation with psychopathology. According to parental rearing, male refugees perceived less emotional warmth and more rejection compared with females. Women scored higher in temperament dimension Reward dependence and character dimension Self-Directedness.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study II</th>
<th>Personality + Coping + Social support and Psychopathology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Females had more coping resources specifically in terms of social and emotional coping resources. Males scored significantly higher on depression, also less ability to coping resources. 19 subjects with army experience scored low in Harm avoidance and high in Self-Directedness and Cooperativeness. These individuals have better coping resources and better social support and less psychopathology.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study III</th>
<th>Coping resources + Social support and Quality of life + Sense of Coherence Related to Psychopathology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male refugees reported a lower level of overall quality of life mainly based on a lower level of independence and lower satisfaction with the domains of social relations, environment, and spirituality. Females showed higher comprehensibility, manageability, and meaningfulness. Coping resources, Social support, quality of life and sense of coherence were higher in 19 subjects with army experiences.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study IV</th>
<th>Sense of coherence and Psychopathology</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Those with army traumata and less educational level reported more psychopathology compared with those who had no experience of army and higher education. High level of Sense of Coherence is associated with less somatization and less cognitive distortions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study V</th>
<th>Personality and Social support + Coping resources + Sense of coherence and Psychopathology Related to Quality of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There is strong association between personality dimensions, temperament and character (Reward Dependence, Harm Avoidance and Self-Directedness) and quality of life. Harm Avoidance, Self-Directedness and Cooperativeness explained severity of depression and intensity of anxiety. There is strong relationship between Self-Directedness and Adequacy of Attachment as a social support variable. Subjects with high Harm Avoidance and low Self-Directedness show more psychopathological disturbances in terms of poor coping resources, social support, sense of coherence and quality of life, compared with those with low HA and high SD. Dividing character dimension of Cloninger’s personality theory to three different category (Below SD = 23 subjects, Average SD = 56 Subject and Above SD = 21 subjects), results indicate that 21 subjects of the refugees with high SD have high score in almost measured variables compared with those how have low and average SD.</td>
</tr>
</tbody>
</table>


Major findings

In Study I, we tried to understand if there are any personality factors in terms of temperament and character dimensions and dimensions of parental rearing which modulate individual’s coping resources and strategies. We found close relationships between personality and parental rearing which probably determine the course of well-being or psychopathology. e.g., we found gender differences in depression score: male Iranian refugees were more severely depressed than the females. But interestingly we could not find significant gender-differences in any of the SCL-90 scales.

When dividing the sample in four groups – a) BDI-score below mean + not in the army; b) BDI-score below mean + army; c) BDI-score above mean + not in the army; d) BDI-score above mean + army, significant differences could be found between the groups in all of the SCL-90 scores, the EMBU-factors and the personality dimensions except for Novelty seeking and Self-Transcendence (table 7/8).

The scores of Harm Avoidance, Reward Dependence, Persistence, Cooperativeness, Self-Directedness as well as parental rejection and emotional warmth were most pronounced among 25 depressed subjects who had been volunteers in the army in Iran (group d) compared to the other participants (paper I, table 7). Parental overprotection scores were highest among 18 subjects who were depressed and had not been in the army (group c).

From a constructivistic perspective, we might be able to explain this phenomenon by the concept of “internal working model” that was introduced by Bowlby (1958-1973). He emphasised that sensitive responses by caregivers to the infant creates the basis for a secure infant-caregivers relationship, and thus enables the child to develop positive internal working models of himself or herself and others (Bretherton et al 1989). These models will become parts of the personality structure and provide a sense of stability in stressful situation (Bretherton 1985) and are reflected by the character dimensions Self-Directedness and Cooperativeness according to Cloninger’s theory. The internal working model has been described even by Beck (1976) in terms of (dysfunctional) schemes. He suggested that, in face of stress, a set of dysfunctional schemes may be activated and the person will become vulnerable to depression. However, Beck’s theory focused on the cognitive functions of humans and Bowlby’s on emotions and rearing. Looking to our data this finding is consistent with other studies which have shown that lack of emotional warmth often together with overprotection during childhood, are risk factors for
development of depression or anxiety (Mackinnon et al., 1993). In our study males have received less emotional warmth from fathers with mean score 37.75 ± 10.70 in comparison with females with mean score 45.06 ± 7.61. According to perceiving emotional warmth from mother male refugees has received less emotional warmth 46.26 ± 12.80 compared with females 53.33 ± 8.80.

In study I we tried to study the relationship between personality and parental rearing related to psychopathology (fig. 1).

Figure 1. Personality and parental rearing in relation to psychopathology

In our sample we found that males have been more frequently victims of several and repetitive traumatic events than females. The intensity of stress was higher for males than for females because the former were more often forced to be in the war fronts. Despite several traumatic experiences, there are nineteen traumatized refugees who did not develop psychopathological disturbances. These means that 19% of the individuals in our sample reported lower Harm Avoidance and higher Self-Directedness as well as less parental rejection and more parental emotional warmth than the depressed (see table 7 article 1).

This finding is consistent with previous studies. e. g., Cloninger (1986) found that individuals with low Harm avoidance experience very little
anxiety or fear about danger. In other words, these persons do not need to protect themselves from fear; instead they attack the fear (Beck, et al 1985). It is interesting to reflect over the subject’s cognitive appraisal. Protecting their selves from danger in army demands a high functioning of cognition related to coping resources and strategies. Furthermore, Cloninger found that persons with high Self-Directedness are responsible, disciplined and often have some aim to strive. Self-Directedness is also associated with hope (Cloninger, 1994).

The complex relationship between low Harm Avoidance and high Self-Directedness as well as with parental emotional warmth might enable some refugees not to develop psychopathological disturbances. This finding indicates strong relationship between personality dimensions and parental rearing regarding resiliency. However, it is an open question if temperament, character and parental rearing are the only important factors in the development of resilience? Of course, there are additional determinants.

In study two (II), we investigated the interrelatedness between temperament and character according to Cloninger’s biosocial theory of personality, coping behaviour and social support in former traumatized refugees. Two constructs were added compared with study (I) as figure 2 show.

**Figure 2.** Personality, coping behaviour and social support in relation to psychopathology

Our previous finding in study I indicate that personality traits and parental rearing practices are major determinants of well being despite
the increased complexity of the analysed model. Refugees traumatized by war experiences in the army with low BDI scores showed the lowest scores in Harm Avoidance and the highest scores in Self-Directedness and Cooperativeness. 19% of the subjects in the army with low scores in Harm Avoidance, with little anxiety or fear for danger and high scores on Self-Directedness, who are probably responsible, aim-full, disciplined in behaviour, and self-accepting, are on average characterised by the absence of depressive symptoms years after their traumatisation. Cooperativeness established as an additional character dimension that interacts with Self-Directedness.

Cooperative people are described as persons who are empathic, friendly and take distance from hostility and aggressive behaviour (Cloninger, 1986). These two character dimensions might increase the ability to cope with traumata in a more satisfactorily manner and persons with this character will probably therefore find more social support. Cloninger has never discussed the topic of resiliency, but maybe a combination of such personality temperament and character as we found in our study determine a primary mechanism of resiliency.

However in study II we tried to study personality dimension in relation to social support. Social support was defined by House and colleagues (1988) as an interpersonal transaction involving one or more of: 1) emotional concern (liking, love, empathy), 2) instrumental aid (goods or services), 3) information (about the environment), or 4) appraisal (information relevant to self-evaluation). Using the ISSI instrument that consists of one-section about affectionate bonds, comprise the dimensions availability of attachment (AVAT) and its adequacy (ADAT). The ISSI also measures the availability (AVSI) and adequacy of other social ties (ADSI), a sense of social integration, reassurance of personal worth, the opportunity for nurturing others, a sense of reliable alliance and obtaining help and guidance.

Our findings indicate that females suffer from less severe psychological disturbances in terms of lower BDI and GSI scores compared with males. There are some possible explanations for this finding. Female Iranian refugees were possibly less frequently exposed to more than one kind of trauma with lower severity and shorter duration than males. For example duration of participation in army between male and females is shown in table 7.
Table 7. Gender differences in duration of traumatization

<table>
<thead>
<tr>
<th>Time as Soldiers in Iran and Iraqi war (1980-1988)</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 24 months military service</td>
<td>35</td>
<td>3</td>
</tr>
<tr>
<td>24 months up to 36 months</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>36 up to 84 months</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

We observed that male subjects have been more frequently exposed to emotional rejection. Based on their higher Reward Dependence and Self-Directedness, females have possibly more social and emotional coping resources. Reward Dependence and Self-Directedness are associated with love and hope. The interaction between temperament and character makes these individuals less vulnerable and increase their abilities to cope with stress and trauma more adequately. The differences between genders might have a socio-psychological background. In an investigation of 330 children, 189 (57.2%) boys and 141 (42.7%) girls, Iranian psychiatrists have shown that boys had more psychological disturbances than girls especially concerning emotional disorders (Alishahie et al., 1996). This phenomenon might probably be explained by seeing Iran as a traditional society where the expectations on a boy up to adult man are higher than on the girls. This assumption was suggested by the Iranian anthropologist Price (2002).

However this finding raises reflections about resiliency from a gender perspective. Although only three women in our sample have been in the army, most of them have been victims of several severe traumata. The question which is open to discuss is, has females better resilience mechanisms than males?

The substantial correlation between the personality dimensions Harm Avoidance and the character dimension Self-Directedness and coping resources in terms of highly significant correlations was expected. This implies that individuals who tend to be carefree, courageous, optimistic, and confident as well as mature; self-sufficient, responsible, reliable, goal-oriented, constructive, and well-integrated have generally more coping resources. Individuals of this predisposition tend to reduce stress. They succeed to provide resilience factors in terms of high social support and good coping skills which protects against psychopathological manifestations (Smith, 1993). Persistence (ambition), Reward Dependence (love), and Cooperativeness (compassion) seem to be of significance regarding
social and emotional coping resources as well as the availability of social support in terms of attachment and social integration with smaller impact compared to Harm Avoidance and Self-Directedness. These findings point to the importance of personality characteristics concerning attachment and social integration and to the fact that resilient refugees are characterised by a high self-esteem.

According to Tajfel and Turner (1979), individuals try to belong to groups that will reflect positively on their self-esteem; since maintaining a positive level of self-esteem represents a basic motivation for human being. At the same time, to belong to a social group also requires the agreement with group norms. That is partly included in the phenomena of attachment and social integration. Resilient refugees might interpret their new situation in their chosen country as a challenge and try to adapt to the new groups, the new country with its societal, social, cultural and individual specifics. Social integration enables refugees to act in a manner that is predictable and appropriate to the social role which the individual plays at time.

In study three (III), we tried to explore how quality of life and sense of coherence is affected in relation to coping and social support. Adding two instruments WHOQoL-100 and SoC in the analysis, made it possible to measure individuals’ life quality and sense of coherence. Figure 3 shows our way of thinking:

**Figure 3.** Coping, Social support, Quality of life and sense of coherence in relation to psychopathology

<table>
<thead>
<tr>
<th>Coping Resou.</th>
<th>Social Interac./Social Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive</td>
<td>Availability of attachment</td>
</tr>
<tr>
<td>Social</td>
<td>Adequacy of attachment</td>
</tr>
<tr>
<td>Emotional</td>
<td>Availability of Social ties</td>
</tr>
<tr>
<td>Spiritual</td>
<td>Adequacy of Social ties</td>
</tr>
<tr>
<td>Physical</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality of Life</th>
<th>Sense of Coherence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health</td>
<td>Comprehensibility</td>
</tr>
<tr>
<td>Psychological health</td>
<td>Manageability</td>
</tr>
<tr>
<td>Level of independence</td>
<td>Meaningfulness</td>
</tr>
<tr>
<td>Social relationship</td>
<td></td>
</tr>
<tr>
<td>Environment</td>
<td></td>
</tr>
<tr>
<td>Spirituality</td>
<td></td>
</tr>
<tr>
<td>Overall quality of life</td>
<td></td>
</tr>
</tbody>
</table>

Psychopathology
BDI
SCL-90-R
The results indicate that male subjects were on average more severely depressed than females. Furthermore, males reported a significantly lower quality of life. This confirms previous studies concerning the association between depression and quality of life including the effect of depressive information processing within the interpretation of the individuals world, e.g. quality of life (Beck, 1967). Quality of life includes the physical and psychological factors, social relationship and functional well being as well as symptoms that impact on ones ability to gain satisfaction of his or her way of living. Being depressed has, of course, a negative impact on quality of life. Another possible explanation might depend on males’ construction of sense of coherence. A high score of SoC in females enables them to cope with adversity positively (Antonovsky 1993a).

Furthermore, the Iranian males were often living separately, whereas a higher number of females were living in a family.

However, sense of coherence, social support and coping with stress generally represent key factors in the maintenance of health. We found quality of life, coping resources, and social support closely related to psychopathological manifestations. Our results in paper III table 7 show that 19 individuals in army according to the severity of depression and the Global Symptom Index of the SCL-90 reported:

- Significantly higher level of quality of life
- Better physical conditions
- Highest scores concerning Sense of Coherence most pronounced for “Meaningfulness”
- Best availability of social integration

These findings can be explained in three ways: a) cognitive, b) affective and c) open behaviour. The interrelations between coping, social support, quality of life and meaningfulness are probably associated with the survivors’ thoughts or beliefs towards the world, environment and others (Ajzen, 1988). The coping resources were also more developed among those soldiers with low BDI-score. The high scores on “Meaningfulness” for the resistant refugees underline the importance of motivational orientations and attitudes within these coping processes and resilience. A refugee who has managed different kinds of traumatic life events and even tried to organize himself or herself in a country which is far from own cultural codes and signals has probably a higher and more flexible
attribution capacity. Attribution is the process of making judgments about the causes of events and behaviour (Smith, 1993). This means, in turn, that resilient refugees have good problem-solving skills. These skills are one of the most significant coping strategies when confronted with stress (Lazarus and Folkman, 1984).

Since we identified a group of nineteen individuals who were resistant to trauma, we became interested to study the phenomenon of ‘resilience’ more intensively.

Therefore, in study four (IV), we investigated relationships between Sense of Coherence and psychopathology (fig. 4).

Figure 4. Relationship between Sense of Coherence and Psychopathology

<table>
<thead>
<tr>
<th>Sense of Coherence</th>
<th>Psychopathology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensibility</td>
<td>BDI</td>
</tr>
<tr>
<td>Manageability</td>
<td>SCL-90-R</td>
</tr>
<tr>
<td>Meaningfulness</td>
<td>DAS (dysfunctional attitude scale):</td>
</tr>
<tr>
<td></td>
<td>Depressogenic information processing</td>
</tr>
<tr>
<td></td>
<td>Perfectionistic attitudes</td>
</tr>
<tr>
<td></td>
<td>Self-esteem depending on the approval of others</td>
</tr>
</tbody>
</table>

The results suggest surprisingly that Sense of Coherence does not have a specific buffering resilience effect. This finding can possibly be explained by differentiating between “Meaningfulness” and “Manageability” as two relatively independent components of Sense of Coherence. The first one seems to be more important concerning severity of depression, and the second component has a stronger impact on dysfunctional attitudes. The central issue of meaningfulness is: “Does my understanding of my life give me energy, direction and purpose?” If the individual fails to find meaning in daily life he or she might become isolated and passive. However, problems with meaningfulness reduce humans’ sense of direction and energy. The central issue of comprehensibility is: “How can I make my world less chaotic and unpredictable?”

A higher level of education emerged as a possible resilience factor. The results indicate a negative relationship between Sense of Coherence and psychopathological symptoms. A high level of Sense of Coherence is
associated with low degree of somatization and with only few cognitive distortions. However, generalized resistance resources might represent another variable, which could be of importance according to meaningfulness as a resilience factor. Antonovsky introduced a concept of generalized resistance resources and claimed differences between his model and those of others, e.g., Bandura’s “self-efficacy”, Kabosa’s “hardy personality” and Lazarus’ and Folkman’s “problem solving” models. Firstly, generalized resistance resources have a salutogenic orientation with focus on factors which moderate, reduce or eliminate stress factors. Secondly, every human being has individual unique generalized resistance resources to cope with daily life stress and to promote Sense of Coherence. Thirdly, the model is global and multicultural and not related to a specific mastery strategy.

In study five (V), we focused on the construction of dimensions of personality and “resilience” as figure 5 shows.

Figure 5. Personality dimension and “resilience”

The topic of resilience takes into account the role of personality as one internal factor. It seems that there is strong correlation between personality and resiliency. Cloninger personality dimension theory is probably the first which takes in to account the temperament aspect of resiliency. The results of our study demonstrate the importance of temperament and character as resilience factors. The close relationships between high Harm Avoidance and low Self-Directedness can be interpreted as indicators of the level of psychiatric disturbances. This is consistent with previous studies on the co-morbidity of psychiatric disturbances. Thus, resilience appears presumably to depend on certain innate personality
factors such as temperament and character. A number of individuals who have coped effectively were identified. Those highly self-directed individuals have higher SoC-scores compared to those average and low self-directed individuals. Our finding indicates that there are a number of individuals, who were characterised by maturity, strength, self-sufficiency, responsibility, reliability, and goal-oriented-ness, who are, in turn, resilient against psychological disturbances. Despite experiences of various types of stressful and traumatic events such as resettlement in a new country far away from their Middle Eastern culture, learning new language and completely different living conditions in addition to their previous personal trauma such as combat experiences or torture or stressful escape, there are individuals who cope with fear and stress as something meaningful. This implies that the individuals had to cope with stressors, which were highly complex, of varying intensity and duration and they are confronted with new challenges on everyday. However, more studies are required to improve our knowledge further about what helps some people to do well, about protective factors and resilience when faced with stress and traumatic events.

**General discussion**

Are inter-individual differences in personality related to differences in the way of coping with traumata? Is our psychological bond to our caregivers something that gives us resources to cope with traumata? Is our construction of ‘Sense of Coherence’ and social support something that allows us to achieve a good quality of life or, in a negative sense, to develop psychopathological disturbances? Many questions are still open or have to be revised in the light of new research.

The aim of this study was to investigate coping with trauma, resilience, and psychopathology.

Several theories contribute to the understanding of the human ways of survival. Some of these contributions tried to make major theoretically explanations, whilst others tried to investigate one aspect in relation to established theories. Freud (1896/1962) tried to explain how the affective world, both the inner (i.e. unconscious) and overt, (projection and transference), early emotional experiences, conflicts and fixations determine the way in which an individual understand the world. Often the unconscious part dominates the way of looking at the real world. Erikson (1963), in his eight stages of development, and Adler (1979), in his theory of inferiority and the drive for power from a different view, emphasized the role
of society and the social setting in the way individuals understand the world. The belief and meaning approach presented by Maslow and later developed into a psychological theory and psychotherapeutic approach by Frankl (1975) based on his extreme experiences of the Holocaust, was another angle of the interest of the topic.

Shifting from the psychoanalytic view of intrapsychic mechanisms to emphasising interpersonal mechanisms evolved a new paradigm in the framework of psychiatric care of traumatized people. This means that the origin of psychopathology caused by traumata was not found in the mother-infant relationship as Klein postulated, even not in the conflict between two ideal egos. The individual’s response to the environment should rather be focused. Bandura, Cloninger, Perris, Lazarus and many others offered contributions to the understanding of humans’ reactions when faced to traumatic life events. These researchers paid more attention to the interaction between individuals and their environment, and this implied several advantages. For example, this approach enables us to identify the origin of psychopathology not only in the child-parents relationship but rather in the organized violence in a certain country. ‘Organized violence’ is defined according to WHO (1986) “The interhuman infliction of significant, avoidable pain and suffering by an organized group according to a declared or implied strategy and/or system of ideas and attitudes. It comprises any violent action which is unacceptable by general human standards, and relates to the victim’s feeling”. ‘Organized violence’ is applied, e. g., when a government does everything inhuman to keep the opposition aside. Today many investigations confirm how people have been victims of political violence, e. g., by torture (Mollica and Caspi, 1991; Morris et al 1993). From this perspective, many parents became free from the feelings of guilt that psychoanalytic theory devised to them. Furthermore, it became more important to explore constructs like ‘trauma resistance’, ‘protective factors’, ‘hardy personality’ and ‘resilience’ and a salutogenetic perspective could be implemented in the psychiatric care.

Since many researchers investigated predictors of psychopathological manifestations or prevalence of psychiatric disorder after traumata (Foa and Rothbaum, 1998; Paunovic, 2001; Boden 2002; Søndergaard, 2002), we tried rather to study psychopathology as well as protective factors and resiliency.

My intention was to offer some contributions to the topic of resiliency. I preferred to investigate an Iranian population for several reasons. Firstly because adult Iranians represent a rather unknown population in
the scientific literature compared to other ethnical groups as refugees, and even my own background could be a resource in the course of the investigation. Secondly refugees from Iran are one of the largest ethnical groups in Sweden and many practitioners from different disciplines have every day contact with Iranian people. Although the sample is not representative, we are able to develop some assumptions.

One of the most important finding in this investigation was the nineteen individuals also 19% of the sample who we can possibly see as resilient. They have experienced trauma but at the time of investigation they have quite good psychological health. Looking to paper I table 8 we divided the sample into four groups according to their depression score. – a) BDI-score below mean + not in the army (38 subjects) = 3.76±4.00; b) BDI-score below mean + army (19 subjects) = 4.74±4.60; c) BDI-score above mean + not in the army (18 subjects) = 29.17±12.66; d) BDI-score above mean + army = (25 subjects) 35.72±10.79. However this maybe is one of the characteristic pictures of Iranian refugees in this sample, and can be interesting for practitioners. But the interesting question is why 19 of the subjects have no psychiatric disturbances despite their traumatic experiences. Those refugees can we possibly see as resilient with low score of Harm Avoidance and high score of Self-Directedness. We can assume that those two personality dimensions in a complex interaction with parental rearing are the basic stones of resiliency. Our findings show that those who received emotional warmth of both father and mother were healthier compared with those who received less. The personality dimension low HA and high SD is pronounced in 19 subjects in our sample. Cloninger describe the individuals with low HA as optimistic and confident and with high score of SD as a mature, strong, responsible, resourceful person with long term oriented goals. From this aspect one assumption can be that personality dimension and parental rearing command the course of resiliency from adversity. Those 19% of refugees who today have good quality of life also had a high level of coping resources and had received good social support. These individuals had better problem solving skills which in its turn had lead to achieve social adequacy and social attachment in their new home country.

Sense of coherence is another important mechanism. The results show that manageability and meaningfulness have been two important aspects in time of stressful life events. Looking at table 3 in study V we divided character dimension of Cloningers personality theory to three different category (Low SD = 23 subjects, Average SD = 56 Subject and High SD = 21 subjects) notice that 21 subjects of the refugees with high SD have
high score in almost measured variables compared with those how have low and average SD. Table 8 show the measured variables:

Table 8. Measured variables in relation to high Self-Directedness (SD) category

<table>
<thead>
<tr>
<th>Cognitive strategies</th>
<th>Social support</th>
<th>Quality of life</th>
<th>Sense of coheren.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive coping</td>
<td>Availability of attachment</td>
<td>Overall level of QoL</td>
<td>Comprehensibility</td>
</tr>
<tr>
<td>Social coping</td>
<td>Availability of social integration</td>
<td>Physical QoL</td>
<td>Manageability</td>
</tr>
<tr>
<td>Spiritual Coping</td>
<td>Adequacy of attachment</td>
<td>Social relationship</td>
<td>Meaningfulness</td>
</tr>
<tr>
<td>Physical Coping</td>
<td>Adequacy of social integration</td>
<td>Environment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Independence</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Spiritual QoL</td>
<td></td>
</tr>
</tbody>
</table>

For example looking to social coping those with high SD 21% have mean score 39.86±4.90 compared with those how showed a psychiatric disturbances because of average SD 56% , 35.91±7.09 and finally compared with those how had lowest SD 23% , 23.65±4.97. 21% of the subjects have even better social integration and overall level of quality of life with the highest level for physical health. Some possible explanation can be that refugees have received necessary help which they needed for recovery of trauma and in its turn have affected their standard of living and quality of life.

The result raises an interesting question. “Should an individual comprise all the studied factors for being resilient”? The answer is “No”. According to my opinion we should have a systemic perspective to the matter of resiliency. Regarding all variables (personality, parental rearing, cognitive function, coping recourses and strategies, social support, three component of sense of coherence and even quality of life) it seems that resiliency is not to understand as a linear pathway. Resiliency has
to be seen in a systemic network which comprise internal factor as personality trait and dynamic process. Several researchers suggested various relevant models. However, nobody investigated all of these variables in their inter-relational complexity yet. My assumption is that in the course of the individual's life span all the variables are relatively independent developed and they are in interaction at least in two directions. Figure 6 show those possible elements of resiliency:

**Figure 6.** suggested model over resiliency:
As we noticed, low Harm Avoidance and high Self Directedness are correlated with social integration in one way but, at the same time, the society’s possibility to provide refugees living conditions is additionally important. This assumption implies that when one mechanism, like social attachment is low, other components or other mechanism like the physical health might probably compensate the lack of social attachment. There is no linear structure or exclusive pathway that causes particular coping strategies and resources. Our findings support one main hypothesis: Resiliency is an ability which is determined by a number of systems that interact with each other and can enable individuals to come back from an adversity even stronger. My hypotheses reject the idea that coping with trauma depends on only one factor as “coping skills”, “beliefs”, “concepts” and “schemata”. There are not such exclusive “core beliefs” or particular “SoC” which have a buffering effect. I am aware that my dynamic position to resiliency is contrary to a “trait” personality perspective. My idea is that resiliency is a link between personality traits and other constructions as social support, quality of life or sense of coherence (fig.7).

**Figure 7.** Resiliency as a link between personality trait and dynamic process

My suggestion is in some way consistent with Luthar (2000) and colleagues. He and colleagues has suggested that resiliency turns to a dynamic process including positive adaptation within the context of significant adversity. However the phenomenon of “resilience” can rather be explained by several interactive mechanisms. Possibly, we can interpret this interaction in terms of “activity”. The term “resilience activity” has several advantages. Firstly, resilience activity refers to individual differences concerning their approach to stressful events. Secondly, the term is less linear and automatically supports a series of mechanisms than “strategy” which refers to some predictable factors like problem-solving and emotional coping. Thirdly, “resilience activity” refers to the whole individual in his or her social context. This three suggestions can actualize the question “if resiliency is a form of activity why in our study we identify only nineteen subjects who possibly are resilient and not fifty or all the subject, because every subject in the sample can more or less be
resilient?”. I guess the number of resilient subjects in our study depend on the criteria used to define high stress and high competence. I mean all the subject had experienced extreme and severe traumata and the choice of these criteria has its impact on the result related to resiliency. However the model above may have some advantages in a clinical practice, having a resiliency activity in mind is possibly helpful to identify which behaviour is more or less weak or strong concerning the particular individual at a specific point in time and in a specific situation. Acting from a systemic perspective on resiliency practitioners to not need to be merely restricted to the individual’s responses to stress. This enables him or her to keep cultural and social aspects in mind all the time. This hypothesis must be, of course, further investigated. My intention in this dissertation has been to reflect on human behaviour in some critical moment of life. I assume that resilience is a process which enable individual’s to recover from trauma. But “where ends the process of recovery”? “How long can an individual be resilient?” “Can we use the concept of resiliency in clinical work with the patient?” There are still several questions to investigate not only about the construct of “resilience activity” but rather about the definition of the resiliency.
Acknowledgements

I would like to express my sincere gratitude and thanks to all those who made this study possible and particularly to:

Professor Martin Eisemann, my supervisor, for his professional guidance and invaluable support. You helped me get started with the project and you introduced me in the world of instruments for evaluating psychological phenomena. Your numerous helpful comments on the manuscript have been a great help.

Professor Joerg Richter, my friend and tutor. You have been an invaluable source of knowledge and support over the years and have given me many insights into understanding my study and fruitful discussion in time of my frustration and even help in statistical part of the studies.

Professor Lars Jacobsson, for his support, constructive criticism and expert advice. You provided many valuable suggestions. I deeply appreciate your support for the finalization of the project.

Habib Emami from Teherans University for his support on research and helping me to understand the Iranian culture.

Nasrollah Ghazinoori for his skilful and prompt revision of the English.

I wish to thank Margaretha Lind and Doris Cedergren for their excellent administrative assistance.

Although I have received much valuable help for this thesis, needless to say, any errors and oversights are mine.

I wish to thank my wife Malin, who often stimulated me to finish my study. I will also thank my colleagues and friends Silvia and Lars-Åke Strömfelt, Anita Lassinanri Blom, Stefan Rosenqvist and Jan Bränström for their support and encouragements.

Of course my gratitude is especially extended to the many patients and traumatized refuges that I have seen who have taught me about the reason and the “logic” of resiliency, and have helped me understand that: Life goes on despite adversity”.

This thesis was supported financially by grants from the Faculty of Clinical Science department of Psychiatry, Umeå University, Sweden
Reference:


Arrindell, W. A. Perris, C. Eisemann, M. Van der Ende, J. Gaszner, P.
Iwawaki, S. et al. (1994). Parental rearing behaviour from a crosscultural
perspective: A summary of data obtained in 14 nations. In: Perris, C.
Chichester: Wiley & Sons; p. 145-171.

Aronson, K. J. (1997). Quality of life among persons with multiple sclerosis

Psych, 50, 96-102.


Research and Therapy, 1, 237-269.

Psychologist, 33, 334-358.

Psychologist, 37, 122-147.


Bandura, A. (1986). Social foundation of thought and action: A social cogni-

Freeman.


Battaglia BP, Przybeck TR, Bellodi L, Cloninger CR. (1996). Tempera-
ment dimension explain the comorbidity of psychiatric disorder. Compr
Psychiatry; 37(4) 292-298.


Beck AT, Ward CH, Mendelson M., Mock J, Erbaugh J. (1961). An inven-
tory for measuring depression. Arch Gen Psychiatry; 4: 53–63.

New York: Hober.


**Herman, L. J.** (1992). Trauma and Recovery, Glasgow.


**Inter-governmental Consultations on Asylum, Refugee and Migration**


Migrationsverket. www.migrationsverket.se


UNHCR. www.unhcr.ch/cgi-bin/texis/vtx/home


