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The Trauma Story:
A Qualitative and Quantitative Exploration of Iraqi Survivors' Experiences

by

Marwa Hossam Shoeb

B.S. (Brown University) 2002

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Requirements for the degree of
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Committee in charge:

Professor Harvey Weinstein, Chair
Professor Jodi Halpern
Professor Emily Ozer

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The thesis of Marwa Hossam Shoeb is approved:

Chair

Date

11/22/05

Date

11/21/05

Date

11/22/05

University of California, Berkeley

Spring 2006
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A Qualitative and Quantitative Exploration of Iraqi Survivors' Experiences

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Marwa Hossam Shoeb
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The Dead Know No Fear

I went out like a sleepwalker

Aroused by nightmares

I began searching for my homeland

In all continents

On earth and in heavens

Praying

Reciting every supplication

Carrying shrines on my shoulders

And a generation of orphaned martyrs

And a generation of veteran martyrs

And another awaiting the massacre

All the martyrs and the massacred

Are resurrected

Standing as tombstones above the graves

Fearless as death

The children of death

Are waking up

In their shrouds

With their heads shaven

Crying out:

Oh homeland of the innocent

Were you for us a graveyard?

Or a homeland?

Iraq under Saddam was a land of hopelessness, sadness, and fear. Our men were tortured, our women were raped, and our kids came to the world with birth defects as a result of Saddam gassing his own people. . . . Iraq under Saddam was a hell and a museum of crimes.

—Kurdish woman, Sulaymaniyyah

*What Was My Choice?*

One has learned to allow a tiny space in the head for contingency.

Yet, losses befall suddenly

– of the river and the date palms that used to balance

of the friends circling your glass like a crescent.

Then you in one moment peel yourself of whom you love

and alone, dim-sighted, grope your way home,

the light of the street lamps heavier than darkness

the burden of exile than in memory.

Tantalizing ourselves with hope

shielding ourselves against . . . but the question in the middle

of exiles suddenly attacks:

– What have you chosen?

No longer trusting ourselves

about to desert the self,

annihilated in God’s self,

or prefer to watch, like a trap,

the tripwires of another.

—Iraqi Poet in Exile, Fawzi Karim (2002)
CHAPTER 1

THE HARVARD TRAUMA QUESTIONNAIRE: ADAPTING A CROSS-CULTURAL INSTRUMENT FOR MEASURING TORTURE, TRAUMA, AND POSTTRAUMATIC STRESS DISORDER IN IRAQI REFUGEES

Mental health has emerged as a core public health concern in complex emergencies because of many historic milestones. For example, studies of war veterans have revealed the serious mental health effects of conflict. Psychological casualties exceeded physical ones by two to one in World War I, while in World War II, 33% of all medical casualties were attributable to psychiatric causes (Armfield, 1994). Ten years after the Vietnam War, 15% of U.S. veterans were still affected by posttraumatic stress disorder (PTSD; see Kulka, Schlenger, Fairbank, & Weiss, 1990). In current conflicts, over 90% of all fatalities are civilians, typically from the poorest sectors of non-Western societies (Kleber, Figley, & Gersons, 1995). An epidemiological survey conducted between 1997 and 1999 among survivors of mass violence from Gaza, Algeria, Ethiopia, and Cambodia reported PTSD rates as high as 37.4% (de Jong et al., 2001).

There is a growing recognition of the value of incorporating culturally specific idioms of distress into assessments of mental health when working in non-Western conflict and postconflict situations, where cosmologies are quite distinct from those found in Western nations (Bolton, 2001; Kleinman, 1995). Studies have shown that a strict reliance on the language and constructs of Western psychiatry risks inappropriately prioritizing syndromes, such as PTSD, which, however important, are eclipsed by the concerns of local populations for whom indigenous idioms of distress are more salient (Summerfield, 1999). Indeed, many fundamental issues, such as the impact of traditions on the trauma response, the identification of culture-specific symptoms, and the usefulness of Western psychiatric diagnoses, need to be taken into account.

The U.S.-led overthrow of Saddam Hussein in December 2003 created a window of opportunity to address the mental health needs of Iraqis affected by more than two decades of war and oppression. To date, however, research and intervention efforts have been guided primarily
by a biomedical conceptualization of mental health (Summerfield, 1999). There are no assessment measures that include indigenous Iraqi idioms of distress and no empirically based framework for understanding how Iraqis understand and articulate psychological well being and suffering. This study illustrates how ethnography informed the development of the Iraqi version of the Harvard Trauma Questionnaire (HTQ), a simple and reliable screening instrument that is well received by refugee patients and bicultural staff. The methodology described represents a useful approach to examining local cosmologies and developing culturally appropriate assessment tools in cross-cultural settings.

**Posttraumatic Stress Disorder**

*The Emergence of PTSD*

Throughout the 20th century, interest in the psychological impact of trauma has peaked during and after wartime. Psychiatrists had long recognized that exposure to horrific events could produce symptoms of stress in previously well-adjusted individuals. Syndromes such as shell shock and combat fatigue had been observed in soldiers following the American Civil War and the First and Second World Wars (Dean, 1997; Summerfield, 1999). These syndromes were characterized by intrusive thoughts and images, nightmares, social withdrawal, numbed feelings, hypervigilance, and frank paranoia (Ozer, Best, Lipsey, & Weiss, 2003). At the time, most doctors believed that these reactions dissipated soon after the stressor was removed, unless preexisting vulnerabilities or psychopathology was present (McNally, 2005). The conventional wisdom about traumatic stress reactions changed during the Vietnam War. Combatants showed stress reactions that were delayed, chronic, or both (McNally; Sommer & Williams, 1994). Since these responses could not be accommodated within the existing diagnostic framework, psychiatrists proposed the diagnosis of PTSD, which was officially recognized in the third edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* in 1980 (Marshall, Spitzer, & Liebowitz, 1999).
According to the DSM-IV (1994), PTSD is a syndrome comprising three clusters of signs and symptoms: (a) repeatedly reexperiencing the trauma (Criterion B: e.g., intrusive recollections of the event, nightmares); (b) avoidance of activities and stimuli associated with the trauma and emotional numbing (Criterion C: e.g., difficulty experiencing positive emotions); and (c) heightened arousal (Criterion D: e.g., irritability, exaggerated startle reflex). The disorder can be diagnosed only if a person has been exposed to an event that qualifies as a traumatic stressor (Criterion A). The symptoms must also persist for at least 1 month (Criterion E) and must cause distress or impairment (Criterion F).

Controversies in the Study of PTSD

Several contentious points have emerged during the evolution of the diagnosis of PTSD. Some concern fundamental issues in nosological development and others are specific to trauma research. In his book, Remembering Trauma, Richard McNally (2005) includes the following: (a) the broadening of the stressor criterion in DSM-IV (1994), (b) problems in the dose-response model of PTSD, (c) distortions in the recollection of trauma, and (d) the deliberate exaggeration of symptoms in Vietnam veterans seeking to obtain the PTSD diagnosis.

The broadening of the stressor criterion in DSM-IV. The diagnosis of PTSD, originally intended to apply only to the aftermath of events outside the range of ordinary human experience, such as torture, combat, and sexual assault at knifepoint, has become attached to much more everyday encounters such as muggings, difficult births, and road accidents. Further, the most recent reformulation of PTSD widens the definition of traumatic stressors to include the experience of hearing the news that something bad has happened to someone close. According to McNally, the changes introduced in DSM-IV (1994) have accelerated a “conceptual bracket creep” (McNally, 2003), in which an ever-widening field of adverse events is subsumed under Criterion A. With such diverse stressors deemed causally relevant to PTSD, the identification of common psychobiologic mechanisms underlying symptomatic expression will be difficult.
Problems in the dose-response model of PTSD. The dose-response model holds that PTSD symptoms worsen as the severity of the stressor increases. Many researchers interpret this model in terms of Pavlovian fear conditioning. However, numerous studies fail to support this paradigm of PTSD. Although cumulative trauma remains the most consistent predictor of PTSD across studies, much of the variance of symptom scores remains unexplained (Mollica, McInnes, Poole, & Tor, 1998). The situation thus may be more complex in that different thresholds of trauma exposure may be necessary to trigger individual subdomains of PTSD (intrusions, avoidance/dissociation, and arousal). Also, distinct categories of trauma may vary in their impact on PTSD symptoms, with torture being more potent than other traumas in that respect (Basoglu et al., 1994). In fact, the relationship between dose and response might be nonlinear. That is, if PTSD symptoms reach near maximum severity after a certain dosage of exposure, further exposure might not add much to existing levels of psychiatric impairment. Unfortunately, by recasting the PTSD dose-response model in nonlinear terms, any pattern between dose and symptoms would be consistent with it (except, of course, a linear one; see McNally, 2003). Finally, the animal conditioning model implies that traumatic stressors cause PTSD by producing toxic levels of fear in victims. However, stressors can also traumatize by inciting guilt and shame (McNally). Only human beings capable of cognitive self-representation can experience such complex self-referent emotions. Thus, Pavlovian animal-conditioning models that reduce trauma to its biological basis cannot capture this uniquely human aspect of trauma.

Distortions in the recollection of trauma. Most of what researchers know about intrusive recollections and nightmares, for example, is based on asking patients to think back and reflect on the frequency of intrusive thoughts and nightmares. Patients have rarely tracked the frequency of these symptoms in structured diaries. Asking patients to estimate how often they have suffered from intrusive thoughts, nightmares, and flashbacks during the past month—let alone, say, since the Vietnam War—amounts to relying heavily on fallible autobiographical memory. Indeed,
several studies show that although survivors retain traumatic memories very well, even recollections of the most horrific events are not immune to alteration of time (McNally, 2003).

*The deliberate exaggeration of symptoms in Vietnam veterans seeking to obtain the PTSD diagnosis.* Several cases of phony combat veterans have been exposed; these are men who claim to be suffering from combat-related PTSD, but who never saw combat. According to Summerfield (1999), PTSD offered them legitimimized victimhood, moral exculpation, and a disability pension through a doctor-attested sick role. The inadvertent inclusion of such participants puts into question the integrity of the PTSD database.

Finally, according to Mollica and his colleagues (1998), Western psychiatric diagnostic criteria are still grappling with the degree of overlap between symptoms associated with PTSD and symptoms associated with other diagnoses such as depression and anxiety. A number of studies have reported high rates of coexisting disorders in Vietnam veterans diagnosed with PTSD, such as drug and alcohol abuse, depression, and personality disorders. Currently, little is known about the relationship between PTSD and major depression (Mollica et al.).

*PTSD as a Social Construction*

In addition to these contentious issues in the study of PTSD, cross-cultural application raises other concerns. The origins of PTSD are rooted in the lives of U.S. veterans of the Vietnam War, both as soldiers and later as patients of the Veterans Administration Medical System (Ozer et al., 2003). Many of the early proponents of PTSD were part of the antiwar movement in the United States, arguing that men widely seen as having perpetrated atrocities were also victims traumatized by roles thrust on them by the U.S. military establishment (Scott, 1990). PTSD was as much a sociopolitical as a medical response to the problems of a particular group at a particular point in time, yet the mental health field rapidly accorded it the status of scientific truth, supposedly representing a universal and essentially context-independent entity (Summerfield, 1999). Although the features of PTSD are identified regularly in different settings worldwide, we cannot assume that they carry the same meaning in each setting. Suffering arises from, and is
resolved in, a social context shaped by the meanings applied to events (Kleinman, 1987). The distinctiveness of the experience of war or torture lies in these understandings and not in a biopsychomedical paradigm.

Further, Western diagnostic systems, primarily designed to classify diseases rather than people, are highly problematic when applied to diverse non-Western survivor populations. Many ethnomedical systems have taxonomies that range across the physical, moral, and supernatural realms and do not conceive of illness as situated in the body or mind alone (Kleinman, 1995). Thus, local categories of emotional distress may or may not overlap with DSM-IV (1994) psychiatric criteria.

Moreover, survivors are forced into an unhelpful emphasis on psychiatric symptoms to obtain social resources. Ironically, the survivors' trauma stories become the currency with which they enter exchanges for physical resources at their new places of refuge (Kleinman, 1995). Indeed, to receive even modest public assistance, a survivor may need to undergo a transformation from one who has lived through the greatly heterogeneous experiences of political terror, to stereotyped victim, to standardized sufferer of a textbook sickness.

In addition, the differential diagnosis of PTSD does not mention normal grief responses to trauma (Marshall et al., 1999). Grief can also involve an altered sense of the real with emotional symptoms (crying, guilt, anxiety, anger), cognitive signs (reminiscences, intrusions), and behavioral manifestations (disturbed sleep, social withdrawal, fatigue; see DSM-IV, 1994). Given that the time course of spontaneous recovery after traumatic experiences varies considerably, the requirement of 1 month of symptoms before the diagnosis of PTSD can be made does not distinguish adequately between normative and pathological posttraumatic responses (Marshall et al.). For example, in much of the world, fidelity to the dead lasts more than 2 months, and in many religions, the experience of human misery is taken to be a defining condition of people's existential plight (Kleinman, 1995). Ironically, in 1994, the DSM-IV introduced the diagnosis of acute stress disorder (ASD) to fill the diagnostic gap that existed in
the initial month following trauma (Marshall et al.). However, the ASD diagnosis may only further pathologize transient stress reactions.

These are not merely conceptual issues, but also ethical ones, given the danger of misunderstanding and indeed dehumanizing survivors via reductionist labeling. Health professionals have a duty to recognize typical distress symptoms, but also to attend to what individuals carrying the distress most need help with. The trauma field may be in danger of attending only to those cues that match prior assumptions about the preeminence and universality of psychological trauma and the validity of Western checklists in capturing this suffering. The trauma field has ignored the example set by work on establishing an empirical basis for tapping into the psychological or psychiatric impact of trauma in a culturally appropriate way. For example, the diagnosis of cultural bereavement was suggested by Eisenbruch (1992) as a more culturally sensitive description of the trauma response of Indochinese survivors. While including PTSD-like symptoms, cultural bereavement refrains from attaching a stigmatizing psychiatric diagnosis and places the symptom-picture of refugees within a normalized social context (Eisenbrusch).

The issues above challenge the framing of war suffering as a mental health concern, with PTSD being the final outcome of trauma. They also implicitly raise the question of how PTSD symptoms might best be measured. The following sections discuss the various assessment scales for PTSD, with a focus on their advantages and shortcomings.

The Assessment of Posttraumatic Stress Disorder

*Interviewing Trauma Survivors*

The process of developing a clinical instrument for the assessment of traumatic events and their related symptoms presents special problems that are inherent in evaluating, diagnosing, and treating trauma survivors. Clinicians are often faced with the changing nature of the trauma story, the gaps and lapses in the patient’s memory, the emotional upset shared by both the therapist and the patient as personal accounts of horrible life experiences unfold, and the complex
task of assigning a diagnosis to the diversity of symptoms reported by trauma survivors (Mollica, McDonald, Massagli, & Silove, 2004). In clinical settings that treat survivors from diverse cultural backgrounds, these issues are further complicated by the impact of cultural beliefs and values on the meaning attributed to negative life events and on the expression of emotional distress (Mollica et al.).

Research evidence from work with trauma survivors suggests that a triadic model—in which the clinician and the patient relate to a questionnaire—is most useful in providing a context for discussing painful issues (Cienfuegos & Monelli, 1983). The questionnaire lessens the difficulty of communicating and, at the same time, moves the trauma out of the private realm into the world of public fact (Cienfuegos & Monelli). Memory is also being enhanced by using neutral methods such as checklists that help “put words around” the trauma events and symptoms, while signaling to the patients that the clinician is well aware of the type of the experiences they might have endured (Mollica et al., 2004). Unlike traditional open-ended history taking, this structured technique is brief and can also test the accuracy of the trauma survivor’s memory over time. Further, the collected clinical impression has been that the trauma survivors appreciate the recognition by the therapist of the trauma they survived and have strong desires to talk about their experiences under favorable conditions where confidentiality, informed consent, and respect for survivors is obvious (Mollica et al.).

Those interested in assessing PTSD can select from a wide range of sophisticated measures, including structured clinical interviews and standardized scales. The following two sections provide an overview of psychometric theory and instruments for assessing PTSD.

Introduction to Psychometric Theory

Psychological tests are evaluated with respect to two important characteristics: reliability and validity. Reliability refers to the consistency or replicability of test scores. Test developers often report the consistency of scores over time (test–retest reliability), over different interviewers or raters (interrater reliability), or over different items on the same test (internal consistency; see
Sommer & Williams, 1994). In addition to being reliable, a good test is valid. Validity refers to the meaningfulness or accuracy of inferences made on the basis of those scores. A test for PTSD can be said to be valid if it has items that assess the key aspects of the disorder (content validity), if it predicts something such as a clinical diagnosis or response to treatment (criterion-related validity), or if it correlates with other measures of PTSD but not with measures of other disorders (construct validity; see Sommer & Williams).

Psychological tests are often assessed on the basis of their diagnostic utility, a type of criterion-related validity pertaining to a test’s ability to predict diagnostic status. Three steps are involved in determining the diagnostic utility of a test (Briere, 1997). First, a diagnostic criterion or gold standard must be selected; the gold standard is typically a diagnosis determined on the basis of a clinical interview but may also be a composite criterion based on several sources of evidence. Second, both the gold standard and the test are administered to a group of examinees. Third, various cutoff scores on the test are investigated for their utility or their ability to correctly predict the outcome of the gold standard. Cutoff scores divide the group of examinees into two, such that those above the cutoff are predicted to have the diagnosis and those below the cutoff are predicted not to have the diagnosis (Briere). The optimal cutoff score for differential diagnosis is the test score that leads to the greatest number of correct predictions.

Some PTSD measures have excellent diagnostic utility but none can predict the gold standard perfectly (Wilson & Keane, 2004). There are two kinds of errors in prediction: false positive and false negatives. False positives occur when an examinee scores above the cutoff on the test but does not have the diagnosis according to the gold standard. False negatives occur when an examinee scores below the cutoff on the test but does have the diagnosis. Diagnostic utility is often described in terms of sensitivity and specificity, which are two measures of test performance that take into account errors in prediction (Briere, 1997). Sensitivity is the true positive rate, or the probability that those with the diagnosis will score above the cutoff on the test. Specificity is the true negative rate, or the probability that those without the diagnosis will
score below the cutoff on the test. Sensitivity will be low if the test yields many false negatives, and specificity will be low if the test yields many false positives. It is important to note that sensitivity and specificity depend not only on the quality of the screening interview and its administration, but also on the characteristics of the population of interest (Loong, 2003). Where prevalence of mental health disorders are low, such as in primary health care and community samples, mental health screening instruments have lower sensitivity and higher specificity due to the relative abundance of clear-cut negative cases. Conversely, in mental health care settings where prevalence of disorders and symptoms are greater, higher sensitivity and lower specificity are expected due to the relative abundance of clear-cut positive values.

**Trauma Interviews and Measures**

*Clinical interviews.* In clinical research on PTSD, it has become standard practice to use structured interviews for diagnostic decision making because they allow investigators to specify precisely how diagnoses were made and whether the diagnoses are reliable and valid. The Structured Clinical Interview (SCID) and the Diagnostic Interview Schedule (DIS) are two of the most widely used structured interviews. The SCID assesses Axis I and Axis II disorders in the *DSM-IV* (1994); it consists of separate modules for each diagnostic category (Keane, Weathers, & Kaloupek). The PTSD module of the SCID consists of probe questions for each of the 17 PTSD symptoms in *DSM-IV*, plus questions on survivor guilt. Several studies suggest that the PTSD module of the SCID is a measure with respectable reliability and validity. Yet, this instrument is limited because it yields only dichotomous information about each symptom and, as a result, disorder severity and changes in symptom level cannot be easily detected (Keane et al.).

The DIS is a highly structured interview, providing a comprehensive examination of the Axis and Axis II diagnostic categories (Keane et al., 1992). Several studies noted that in clinical settings the PTSD-DIS functioned well, correlating highly with other known PTSD measures. However, data on its utilization in the field, where the base rate of PTSD was low, showed its poor performance (Keane et al.). Interestingly, studies conducted in African countries (Rwanda,
South Africa, and Nairobi) showed that the PTSD-DIS functioned well in the field after adjustments for cultural fit (Bolton, 2001; Carey, Stein, Zungu-Dirwayi, & Seedat, 2003; North et al., 2005).

*Standardized scales.* With hundreds of scales available, this section will be limited to reviewing the most commonly used questionnaires in recent research for studying adult civilian trauma in clinical or community populations. The scales differ in terms of (a) length and format, (b) development background, and (c) psychometric properties. General guidelines are provided for considering which scales may be the most useful in different settings. These guidelines reflect varying strategies for assessing PTSD criterion A1 (trauma events) and A2 (trauma symptoms).

In terms of trauma events, the most basic issue to consider in comparing the measures is how well they satisfy criterion A1 (Wilson & Keane, 2004). Although all the scales include a range of traumatic events, they vary in the definitional boundaries of the relevant population of events. Decisions regarding how narrowly or broadly to define the relevant domain of events depend on the assessor's intent. A second important issue to consider is whether the range of traumatic events being assessed is sufficient (Wilson & Keane). Clearly, scales with more items have a greater likelihood of identifying traumatic events. However, they take longer to administer, and some include items that would not qualify as traumatic. A third issue that requires additional consideration is the use of catchall events that compromise specificity (Wilson & Keane). The reasoning behind the inclusion of these items is clear; it would be too difficult for researchers to enumerate every traumatic event that might conceivably occur. Such items also give respondents the chance to report experiences that were important to them, which can be informative as well as helpful in building rapport. However, these issues may be tapping into personal crises and failures that are not truly in the domain of traumatic events. Finally, the wording of the trauma events is important, such as that items must include behavioral descriptions of events (e.g., the phrase *forced sexual activity* is preferred over *rape*; see Wilson & Keane).
In summary, any list of life events, traumatic or otherwise, is a sample representing a larger population of life events. Dohrenwend, Yaher, Egri, and Mendelsohn (1978) must be credited with directing researchers' attention to the fact that decisions made in constructing the list will ultimately determine the kinds of inferences and generalizations that can be made. He raised two basic and related questions: How do we define the events to be sampled and what is the population of events from which the sample is to be drawn? Life event-scale developers have seldom described explicitly the population of events that the items on their scales purportedly represent (Mollica et al., 2004). Some consensus among researchers is implicit in these measures. If we exclude the contribution of open-ended or catchall items, no trauma scale is so broad as to include all events demanding readjustment (e.g., moving to a new place) or even all undesirable life events (e.g., losing a job). Yet, consensus still has not emerged with regard to just where to draw the line between traumatic events and other undesirable events (Mollica et al.). This is a critical issue for content validity, which like construct validity, is often established more on conceptual than empirical grounds (Mollica et al.).

With regard to measuring trauma symptoms, the scales also use different approaches. The most common strategy is to create measures that map directly onto the 17 criterion symptoms included in DSM-IV (1994), such as the PTSD Checklist (PCL) and the Posttraumatic Stress Diagnostic Scale (Wilson & Keane, 2004). The second method has been to develop scales that assess symptoms of posttraumatic stress continuously and in a manner less rigidly tied to DSM guidelines, such as the Penn Inventory and the Trauma Symptom Checklist-40. The third line has been to derive PTSD subscales from larger symptom inventories that are commonly used in clinical practice and research, such as the Minnesota Multiphasic Personality Inventory (MMPI) and the Symptom Checklist-90 (SCL-90). A fourth way has been to develop measures that are tailored to assess culturally relevant outcomes, such as the HTQ and the Revised Civilian Mississippi Scale (see Table 1; Wilson & Keane).
As a final note, one needs to acknowledge that the extent to which a PTSD measure must be anchored to a specific traumatic experience is among the points of most controversy in trauma assessment (Wilson & Keane, 2004). When symptoms are not tied to a specific stressor, it is difficult to establish for certain that the respondent met criterion A1 or even that the various symptoms pertain to an event at all. However, epidemiological research has shown quite clearly that it is not uncommon for people to experience multiple events, and victims may not be cognizant of the reason they feel a certain way. The best way to manage this dilemma is to acknowledge the issue and to be clear about the reasons for deciding on one measurement approach or the other.

Table 1. Summary Descriptions of 10 Standardized Self-Report Measures of PTSD

<table>
<thead>
<tr>
<th>Scale</th>
<th>Number of items</th>
<th>Evidence of stability</th>
<th>Evidence of consistency</th>
<th>Evidence of validity</th>
<th>Reporting period</th>
<th>Anchored to identified event</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td>17</td>
<td>( r = .83 )</td>
<td>.92</td>
<td>Strong</td>
<td>Past month</td>
<td>Yes</td>
</tr>
<tr>
<td>PCL</td>
<td>17</td>
<td>( r = .96 )</td>
<td>.97</td>
<td>Strong</td>
<td>Past month</td>
<td>Varies</td>
</tr>
<tr>
<td>Purdue PTSD-R</td>
<td>17</td>
<td>( r = .71 )</td>
<td>.91</td>
<td>Moderate</td>
<td>Past month</td>
<td>Yes</td>
</tr>
<tr>
<td>PTSD-Interview</td>
<td>20</td>
<td>( r = .95 )</td>
<td>.92</td>
<td>Strong</td>
<td>Lifetime</td>
<td>Yes</td>
</tr>
<tr>
<td>PTSS</td>
<td>10-12</td>
<td>na</td>
<td>.85-.90</td>
<td>Moderate</td>
<td>Past week</td>
<td>No</td>
</tr>
<tr>
<td>Penn Inventory</td>
<td>26</td>
<td>( r = .96 )</td>
<td>.94</td>
<td>Moderate-strong</td>
<td>Past week</td>
<td>No</td>
</tr>
<tr>
<td>MMPI-PTSD</td>
<td>46</td>
<td>( r = .94 )</td>
<td>.95</td>
<td>Moderate-strong</td>
<td>Not explicit</td>
<td>No</td>
</tr>
<tr>
<td>SCL-Supplemented PTSD</td>
<td>43</td>
<td>na</td>
<td>na</td>
<td>Moderate</td>
<td>Past 2 weeks</td>
<td>No</td>
</tr>
<tr>
<td>Revised Civilian</td>
<td>30</td>
<td>( r = .84 )</td>
<td>.86-.92</td>
<td>Moderate-strong</td>
<td>Varies</td>
<td>Partially</td>
</tr>
<tr>
<td>Mississippi</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HTQ</td>
<td>16 + 14</td>
<td>( r = .92 )</td>
<td>.96</td>
<td>Moderate-strong</td>
<td>na</td>
<td>Partially</td>
</tr>
</tbody>
</table>

Note. na, data not available. Data are adapted from Assessing Psychological Trauma and PTSD, by J. P. Wilson and T. M. Keane, 2004, New York: Guilford Press.

Advantages of Standardized Scales over Clinical Interviews

Although both the clinical interviews and the standardized scales can be used in research, screening, and clinical settings, the advantages of the latter have become apparent over time. First, the scales are simple and brief, as opposed to the lengthy and complicated clinical interviews that must be administered by a mental health professional. Second, the scales ask
about several traumatic experiences, while the clinical interviews have detailed and repetitive questions around a single event. For survivors of mass violence, who have all experienced polytrauma and come from various backgrounds, the clinical interviews could be overwhelming (Mollica et al., 2004). Last, the scales' continuous quantitative measures provide a full range of symptoms within a population as opposed to the typical symptom/no-symptom judgment of clinical interviews.

In summary, by using standardized instruments, clinicians can (a) specify the current severity of a disorder for a given individual; (b) track changes in severity over time and predict course, prognosis, and response to treatment; and (c) communicate assessment results efficiently. Although there are now numerous reliable and valid measures of PTSD, future progress in this field would be served best by efforts to refine and cross-validate the existing scales. As measurement becomes more standardized, a database can be built that elucidates the presence and nature of PTSD across different populations and events.

Cross-Cultural Adaptation of Instruments

In the following section, I discuss the cross-cultural adaptation and validation of standardized scales in general and specifically as they apply to the HTQ. The HTQ illustrates an ambitious attempt to balance cross-cultural standardization with cultural specificity in developing assessment tools.

The two traditional methods of observation in cross-cultural research are the emic and etic approaches (Flaherty et al., 1998). The emic approach uses culturally defined variables and therefore requires an insider's view of the culture. The etic approach applies the concepts of a behavior and techniques for measuring that conduct in one culture to a different one. This method yields little insight into the differences between cultures with respect to the meaning of actions. It has been suggested that culturally specific signs and symptoms of a ubiquitous disorder, such as depression, will be overlooked if one uses diagnostic criteria from Western culture in a non-Western setting (Kleinman, 1977).
Flaherty and colleagues (1998) proposed a stepwise validation for cross-cultural equivalence including five major dimensions (see Table 2). These dimensions are as follows.

1. **Content Equivalence**: The content of each item of the instrument is relevant to the phenomena of each culture being studied.

To achieve such equivalency, a team of content experts (e.g., social scientists, anthropologists, psychiatrists) from the target and source cultures rates each item as relevant, irrelevant, or questionably relevant. Items rated by a single team member as irrelevant or by two or more members as questionably relevant should be eliminated; items receiving one rating of questionable relevance should be reconsidered for inclusion.

2. **Semantic Equivalence**: The meaning of each item is the same in each culture after translation into the language (written or oral) of each culture.

The key to establishing such equivalency is the back-translation technique described by Brislin (1977). First, a single bilingual person or a small team of individuals working on all items together translates the instrument from Language A to Language B. Second, the instrument is back-translated from Language B to Language A by another bilingual person or team. Third, a panel of bilingual experts examines these two versions and rates each item as “exactly the same meaning in both versions,” “almost the same meaning in both versions,” or “different meaning in each version.” There are other effective approaches that can be adopted for the cultural adaptation of an instrument (VanOmmeren et al., 1999).

3. **Technical Equivalence**: The method of assessment is comparable in each culture with respect to the data it yields.

Certain cultures may be both uncomfortable and unfamiliar with the data collection methods that seem natural in Western culture, such as a pencil-and-paper test (Flaherty et al., 1999). In some cultures, private interviews, particularly of women, by male interviewers are generally not done (Hammad, Kysia, Rabah, Hassoun, & Connelly, 1999).
4. Criterion Equivalence: The interpretation of the measurement of the variable remains the same when compared with the norm for each culture.

For example, if an independent criterion is established for a variable such as depression, then the instrument should be able to distinguish depressed from nondepressed groups based on the independent criterion. Obviously, the value of criterion validity for an instrument is only good to the extent that the independent criterion actually measures the phenomenon or variable in question (Flaherty et al. 1998). In cross-cultural research, criterion equivalence refers to the instrument’s capacity to assess the variable in both cultures studied and to the fact that the interpretation of the results from the instruments is the same in both cultures (Flaherty et al.).

5. Conceptual Equivalence: The instrument is measuring the same theoretical construct in each culture.

An example of assessing conceptual equivalence is the measurement of stressful life events across cultures. If stressful life events are observed to have a positive correlation with psychophysiological symptoms in both cultures studied and if a cross-culturally valid way of measuring psychophysiological symptoms exists, then the finding of significant correlations between the two variables (life events and symptoms) would provide support for the conceptual equivalence of the life events instrument (Flaherty et al., 1998).

Table 2. Understanding Equivalencies

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
<th>Lacking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incomprehensible</td>
<td>Its original sense is not evident</td>
<td>Semantic equivalence</td>
</tr>
<tr>
<td>Unacceptable</td>
<td>It is offensive</td>
<td>Technical equivalence</td>
</tr>
<tr>
<td>Irrelevant</td>
<td>It queries phenomena unrelated to underlying construct</td>
<td>Content equivalence</td>
</tr>
<tr>
<td>Vague</td>
<td>Either the folk or scientific criterion does not exist</td>
<td>Criterion equivalence</td>
</tr>
<tr>
<td>Meaningless</td>
<td>It is not used by the society or practitioners</td>
<td>Conceptual equivalence</td>
</tr>
</tbody>
</table>

It is important to note that each of the five equivalence dimensions is mutually exclusive of the others; an instrument can be cross-culturally equivalent on one or more of these dimensions and not on others. The goal is to design a scale with cross-cultural equivalence in all five dimensions. Such rigor, however, is the exception rather than the rule in cross-cultural research (Mollica et al., 2004).

A number of studies have been published providing detailed description of the complex process of cross-cultural equivalence (VanOmmeren et al., 1999; Beck, Bernal, & Froman, 2003; Bravo, Canino, & Rubio-Stipec, and Woodbury-Farina, 1991). In the following sections, I discuss such a process through the adaptation of the HTQ to the Iraqi context.

**The Harvard Trauma Questionnaire**

*Development Background for the HTQ*

In the mid-1980s, Mollica and his colleagues at the Harvard Program in Refugee Trauma recognized a void in the development of standardized measures in the field of cross-cultural psychiatry. The group generated the HTQ, which is a cross-cultural instrument designed for the assessment of trauma and torture related to mass violence and their sequelae. The scale was developed in the Indochinese Psychiatry Clinic (IPC) in Brighton, Massachusetts, over a 4-year period. Its purpose was twofold: to obtain information about the actual trauma events, including torture, experienced by Indochinese refugee patients and to assess DSM symptoms and presumably culture-specific symptoms associated with PTSD (Mollica et al., 2004). A bicultural team of clinicians with extensive experience in treating Indochinese refugee patients generated the items for the HTQ. In accordance with Flaherty’s outlined criteria for cross-cultural validation, the items of the HTQ were translated from English into Khmer, Laotian, and Vietnamese by three bilingual Indochinese mental health clinicians, two of whom were psychiatrists and the other an experienced translator. The final versions were then back-translated blind into English by bilingual workers. A team of Western professionals and bicultural mental
health workers familiar with Indochinese patients reviewed both versions. The resulting version was piloted in IPC for 1 year. Since that time, the HTQ has demonstrated efficacy in the identification of PTSD symptoms and psychological distress in culturally diverse environments (Mollica et al.).

*The HTQ Sections*

Consistent with the current concept of PTSD, both trauma events and associated symptoms are included in the same questionnaire (Mollica et al., 2004). The HTQ is composed of five parts: (a) trauma events, (b) personal description, (c) brain injury, (d) posttraumatic symptoms, and (e) scoring of the instrument.

*Trauma events (Part I).* The earliest version of the HTQ contained a list of 17 trauma events derived from the core war-related experiences of Indochinese populations. This list emerged from clinical information derived by IPC staff and interviews undertaken with key community informants, individually and in focus groups (Mollica et al., 2004). Respondents endorsed individual events according to four options (E = experienced, W = witnessed, H = heard about, or N = no). In the current version of the HTQ, response options have been simplified to “yes” or “no,” overcoming potential ambiguity in documenting whether an event (such as murder) was “witnessed” or “experienced.” However, the witnessing option was retained where relevant. For example, being present (witnessing) when someone else was tortured or raped is regarded as a trauma event in its own right.

The list of trauma events in the original version of the HTQ was included in a questionnaire given to 1,000 Cambodians living in Site 2, a refugee camp on the Thai-Cambodian border (Mollica et al., 2004). The responses were subjected to factor analysis. The following six dimensions emerged: (a) head injury, (b) bodily injury, (c) forced confinement and coercion, (d) witnessing violence to others, (e) warlike situations, and (f) material deprivation. The application of the HTQ in other community studies resulted in the addition of two other
dimensions of trauma: “forced to harm others” and “disappearance, death, or injury of loved ones” (see Table 3).

The HTQ contains one item explicitly inquiring into experiences of torture. The torture item is operationalized according to the following definition: “While in captivity you received deliberate and systematic infliction of physical or mental suffering” (Mollica et al., 2004). A list of specific torture events has been included, which adds critical details about the types and numbers of events experienced (see Table 4). It is important to note that the HTQ trauma items are drawn from a population of events that closely satisfies DSM-IV (1994) criterion A1 for PTSD.

Table 3. Categories and Examples of Trauma Events in the HTQ

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Material deprivation</td>
<td>Lack of shelter</td>
</tr>
<tr>
<td></td>
<td>Lack of food or water</td>
</tr>
<tr>
<td>War-like conditions</td>
<td>Exposure to sniper fire</td>
</tr>
<tr>
<td></td>
<td>Used as a human shield</td>
</tr>
<tr>
<td>Bodily injury</td>
<td>Beating to the body</td>
</tr>
<tr>
<td></td>
<td>Knifing or axing</td>
</tr>
<tr>
<td>Forced confinement and coercion</td>
<td>Forced labor</td>
</tr>
<tr>
<td></td>
<td>Forced to find and bury bodies</td>
</tr>
<tr>
<td>Forced to harm others</td>
<td>Forced to physically harm family member or friend</td>
</tr>
<tr>
<td></td>
<td>Forced to destroy someone else’s property</td>
</tr>
<tr>
<td>Disappearance, death, or injury of loved ones</td>
<td>Disappearance or kidnapping of spouse</td>
</tr>
<tr>
<td></td>
<td>Murder, or death due to violence, of son or daughter</td>
</tr>
<tr>
<td>Witnessing violence to others</td>
<td>Witness torture</td>
</tr>
<tr>
<td></td>
<td>Witness rape or sexual abuse</td>
</tr>
<tr>
<td>Head injury</td>
<td>Beatings to the head</td>
</tr>
<tr>
<td></td>
<td>Suffocation or strangulation</td>
</tr>
</tbody>
</table>

Table 4. Examples of Torture Events

<table>
<thead>
<tr>
<th>Threatened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being chained or tied to others</td>
</tr>
<tr>
<td>Placed in sack, box, or very small space</td>
</tr>
<tr>
<td>Strangled, choked, suffocated</td>
</tr>
<tr>
<td>Subjected to a mock execution</td>
</tr>
</tbody>
</table>


*Personal description (Part II).* This section includes two open-ended questions asking respondents for subjective descriptions of the most traumatic events they experienced in both their countries of origin and resettlement. These questions provide an inroad into the respondents' own understanding of the relative effects of their experience.

*Brain injury (Part III).* This section inquires about direct injury to the head as well as experiences that may lead to brain damage, such as suffocation, near drowning, and starvation. Evidence indicates that head trauma is frequent among populations who have experienced extensive violence (Goldfeld, Mollica, Pesavento, & Faraone, 1988). Brain injury is often associated with psychiatric symptoms (Kwentus, Hart, Peck, & Korstein, 1985), neuropsychological deficits (Goldfeld et al., 1988), and impaired social functioning (Edna, 1987). Recording this information is important since some of the psychological symptoms reported by torture and trauma survivors may be secondary to specific and gross physical central nervous system dysfunction rather than to the psychological impact of trauma alone (Kolb, 1987).

Among Cambodian refugees in Site 2, head trauma, which was prevalent in torture survivors, was associated with severity of depressive and PTSD symptoms (Mollica et al., 2004). Therefore, the current version of the Cambodian HTQ inquires into additional types of head trauma such as other warfare-related head injuries caused by shrapnel and bullet wounds. The role of starvation and severe weight loss in producing cognitive deficits has also been
documented in a number of studies of prisoners of war (Sutker, Allain, Johnson, & Butters, 1992); it has been expanded in the revised Cambodian HTQ.

*Posttraumatic symptoms (Part IV).* It is widely recognized that measures of PTSD, depression, and anxiety, although documenting core responses to trauma, are not comprehensive in their coverage of the multiple adaptive stresses that characterize the human response to disasters (Silove, 1999; Steel & Silove, 2001). Therefore, in the Original and Revised Cambodian HTQs, *DSM-IV* (1994) PTSD symptoms are followed by a number of items describing other reactions to violence and displacement. Although they are statistically correlated with symptoms of PTSD (Mollica et al., 1998), the additional items aim to gauge personal perceptions of psychosocial functioning in response to the complex stresses of persecution, violence, and displacement. For people who have been uprooted, preoccupations with current and future roles, social relationships, and economic functioning are foremost and may be as pressing, or even more so, as concerns about the psychological impact of past traumas (Silove).

Beginning with the Original Cambodian HTQ, a set of 14 refugee-specific responses was added to the 16 *DSM-IV* (1994) PTSD items. This list of 14, which includes two items that describe the symptoms of dissociations, was believed to reflect the feelings and symptoms described to IPC clinicians by refugees (see Table 5).

In the Revised Cambodian HTQ, the 14 refugee-specific items were expanded to 24 items in six underlying domains of social functioning: (a) skills and talents, (b) physical impairments, (c) intellectual functioning, (d) emotional functioning, (e) social relationships, and (f) spiritual/existential concerns (Mollica et al., 2004). The two dissociation symptoms were maintained. None of the items in the scale are tied to a specific stressor (see Table 6).

The construct validity of the HTQ relies on the construct validity of PTSD as a disease entity that is separate and distinguishable from other psychiatric disorders. Although considerable information has been accumulating regarding the validity of PTSD (Keane, Wolf, & Taylor, 1987), it has not been established in non-Western cultures. Whereas it appears that PTSD
symptoms do exist across cultures, it is not known which symptoms are core to the trauma response and which symptoms are specific to the culture.

Table 5. Refugee-Specific and DSM-IV PTSD Items

<table>
<thead>
<tr>
<th>Type</th>
<th>Item</th>
<th>Type</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reexperiencing items</td>
<td>1. Recurrent thoughts/memories</td>
<td>Refugee items</td>
<td>17. Others don’t understand</td>
</tr>
<tr>
<td></td>
<td>2. Feeling event happening again</td>
<td></td>
<td>18. Difficulty doing daily tasks</td>
</tr>
<tr>
<td></td>
<td>16. Sudden emotional physical</td>
<td></td>
<td>20. Guilty to have survived</td>
</tr>
<tr>
<td></td>
<td>reaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. Hard to concentrate</td>
<td></td>
<td>22. Ashamed of terrible events</td>
</tr>
<tr>
<td></td>
<td>8. Trouble sleeping</td>
<td></td>
<td>23. Thinking why me?</td>
</tr>
<tr>
<td></td>
<td>10. Outbursts of anger</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance items</td>
<td>4. Withdrawn from people</td>
<td></td>
<td>25. You are only one who suffered</td>
</tr>
<tr>
<td></td>
<td>5. Can’t feel emotions</td>
<td></td>
<td>26. Feel other are hostile</td>
</tr>
<tr>
<td></td>
<td>12. Can’t remember parts of events</td>
<td></td>
<td>27. No one to rely on</td>
</tr>
<tr>
<td></td>
<td>13. Less interest in daily routine</td>
<td>Refugee items</td>
<td>28. Betrayed by trusted one</td>
</tr>
<tr>
<td></td>
<td>including dissociation terms</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>14. Don’t have a future</td>
<td></td>
<td>29. Can’t remember what you did</td>
</tr>
<tr>
<td></td>
<td>15. Avoid hurtful thoughts</td>
<td></td>
<td>30. Split into two people</td>
</tr>
</tbody>
</table>

Table 6. Expansion of Refugee-Specific Symptoms

<table>
<thead>
<tr>
<th>Category</th>
<th>Item example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills and talents</td>
<td>Feeling that you have less skills that you had before</td>
</tr>
<tr>
<td>Physical impairments</td>
<td>Feeling exhausted</td>
</tr>
<tr>
<td>Intellectual functioning</td>
<td>Difficulty paying attention</td>
</tr>
<tr>
<td>Emotional functioning</td>
<td>Blaming yourself for things that have happened</td>
</tr>
<tr>
<td>Social relationships</td>
<td>Feeling that you have no one to rely upon</td>
</tr>
<tr>
<td>Spiritual/existential concerns</td>
<td>Spending time thinking why these events happened to you</td>
</tr>
</tbody>
</table>


**Scoring (Part IV).** Parts I, II, and III of the HTQ were not primarily designed to derive numerical scores, although summation of trauma events or examination of the underlying factorial structure of trauma dimensions may be useful in research studies (Mollica et al., 2004). A comparison of the responses to Parts I and II may be especially interesting, since it adds personalized information about the salience of a particular trauma in each respondent. However, this assessment may not be sufficient. For survivors of violence, who have all experienced polytrauma, the importance of the remaining events is not clear through the current yes/no response options. Moreover, additional research is needed to demonstrate the validity of the items in Part I (Mollica et al.). The symptom section is scored as follows:

1. For the responses to each item, assign the following numbers:
   - 1 = "Not at all;" 2 = "A little;" 3 = "Quite a bit;" and 4 = "Extremely"

2. Add up Items 1–40 and divide by 40 to get the total score:
   \[
   \text{Total Score} = \frac{\text{Item 1} + \text{Item 2} + \ldots \text{Item 40}}{40}
   \]

3. Add up Items 1–16 and divide by 16 to get the *DSM-IV* PTSD score:
   \[
   \text{DSM-IV PTSD Score} = \frac{\text{Item 1} + \text{Item 2} + \ldots \text{Item 16}}{16}
   \]
An interview with a PTSD score and/or a total score of >2.5 is generally considered checklist positive for PTSD in an Indochinese population (Mollica et al., 2004). The total score only provides a rough guideline to the clinician in assessing the respondent’s overall capacity to meet the challenges of everyday life. As yet, the clinical importance of refugee-specific symptoms still needs to be determined; the scale has not been compared with other life-events measures. Further, we need clarification as to whether the culture-specific items reflect an objective measure of disability or whether they are proxy symptoms of distress primarily reflecting subjective feelings (Mollica et al.). Nevertheless, scores on individual items may provide the clinician with specific insights into the possible factors underlying a patient’s functional incapacity.

Validation of the HTQ

Mollica and colleagues examined the reliability and validity of the Cambodian, Lao, and Vietnamese versions of the HTQ in a clinical sample of 91 Indochinese refugees (Mollica, Caspi-Yavin, Bollini, Truong, Tor, & Lavelle, 1992). Reliability was very high: the symptom portion of the instrument yielded an alpha of 0.96 and a test–retest correlation of 0.92 within a week interval between tests. To assess criterion validity, research participants were divided into groups on the basis of independent diagnoses. The PTSD group showed significantly higher symptom scores than the non-PTSD group. A cutoff point of 75 (mean item value of 2.5) was found to maximize classification accuracy. Sensitivity was 0.78, specificity was 0.65, and the overall hit rate was 0.75.

These initial results provided the tools used in a large-scale study involving a random sample of nearly 1,000 Cambodian refugees living in camps along the Thai–Cambodian border (Mollica et al., 1998). Approximately one-third of the sample had PTSD scores in the clinical range (2.5+). Rates of PTSD varied from 14% among refugees reporting four or fewer trauma events to 81% among refugees reporting 25 or more trauma events. The relative odds ratio was 38.9 in the most traumatized group.
Adaptation of the HTQ to Non-Indochinese Cultures

The HTQ must be modified and adapted to the characteristics of each cultural group. The actual traumatic events as well as the meanings attributed to them vary according to the specific historical, political, and social context in which the trauma occurred. Thus, for each new refugee population, a different HTQ should be developed (Mollica et al., 1998). First, a new list of trauma events has to be created that would cover most of the traumatic events experienced by this group. For that purpose, the specific political and sociocultural history of trauma must be studied through means of historical analysis, oral histories, reports from key informants, and focus groups. Second, the DSM-IV (1994) items must be translated, back-translated, and tested for semantic equivalence. New refugee-specific symptoms of trauma can be identified by means of ethnographic studies, clinical experiences, key informants, traditional healers, and primary care settings. Each newly adapted screening instrument must have its cutoff value determined by comparing the scores on the instruments to a clinical diagnosis.

In 2005, there are six versions of this questionnaire (Mollica et al., 2004). The Vietnamese, Cambodian, and Laotian versions of the HTQ were written for use with Southeast Asian refugees. The Japanese version was written for survivors of the 1995 Kobe earthquake. The Croatian version was written for soldiers who survived the wars in the Balkans, while the Bosnian version was written for civilian survivors of the conflict. To adapt the HTQ to the Iraqi context, we must first understand the effects of trauma on Middle Eastern populations in general and on Iraqis in particular.

Trauma Studies in the Middle East

As in all modern wars, the victims of the latest Middle Eastern conflicts are mainly civilians. A small number of studies have been undertaken with adult war-affected populations in Palestine/Israel, Lebanon, and Iraq (many more studies have been conducted on children that will not be reviewed in this paper). Several common findings are of note. First, religious faith, a sense of commitment to a political cause, and psychological preparation for torture all appeared to
provide some protection against adverse psychological consequences (Elbedour, Baker, Shalhoub-Kevorkian, Irwin, & Belmaker, 1999; Gorst-Unsworth & Goldenberg, 1998; Karam et al., 1998). Second, in the posttraumatic context, loss of social networks and separation from family members were important factors that seemed to perpetuate psychiatric symptoms, particularly depression and PTSD (Gorst-Unsworth & Goldenberg; Karam et al., 1998; Laban, Gernaat, Komproe, Schreuders, & De Jong, 2004). Third, social factors in exile, such as language proficiency, social and economic adversity, fear of repatriation, and situation in the home country, appeared to be influential in preventing recovery from PTSD and other forms of psychosocial distress (Laban et al., 2004; Sondergaard, Ekblad, & Theorell, 2001). Last, the majority of participants described distinct somatization reactions (Elbedour et al.; Gorst-Unsworth & Goldenberg; Karam et al.; Laban et al.; Sondergaard, Ekblad, & Theorell).

Interestingly, given the severity of the reported traumas, the rates of PTSD in the study participants were neither high nor universal (Elbedour et al., 1999; Gorst-Unsworth & Goldenberg, 1998; Karam et al., 1998; Laban et al., 2004; Sondergaard et al., 2001). I will argue that this observation reflects the region’s cultural background. In the reviewed studies, almost all subjects are Muslims for whom faith is a form of refuge and therapy. A second significant feature of religiosity is related to attitudes toward death and martyrdom. Given that death to an individual is divinely ordained, one need not bear the guilt of the loss. Moreover, Muslims believe that God will avenge an injustice that befalls the faithful. Hence, the matter is left to God and the trauma is accepted as divine will. Further, interviews conducted with the victims and survivors revealed that they did not feel alone in the crisis and that the calamities that befall them were not only personal but also communal. This form of family and social support is prominent among Middle Eastern populations. Although the samples of these studies are relatively small and focused, precluding all epidemiological conclusions on the national level, they highlight certain cultural factors that may have provided partial protection against PTSD in these communities.
Background on Human Rights Violations and Political Violence in Iraq, 1979–2005

While violence and repression have been a widespread feature of Iraq’s modern history, the ascendance of Saddam Hussein to the presidency in 1979 inaugurated a period in which human rights violations steadily grew to unprecedented levels, exacerbated in part by Iraq’s unprovoked wars against Iran (1980–1988) and Kuwait (1990–1991); see Figure 1.

![Map of Iraq](image)

Figure 1. Map of Iraq (Maps of Iraqi Special Weapons Facilities, n.d.).

Political power rested exclusively in a harshly repressive one-party apparatus dominated by Saddam Hussein and members of his extended family. According to the constitution, the Arab Ba’ath Socialist Party governed the country through the Revolutionary Command Council (RCC), which exercised both executive and legislative authority (Tripp, 2000). President Saddam Hussein, who was also prime minister, chairman of the RCC, and secretary general of the regional command of the Ba’ath Party, therefore wielded absolute decisive power. Under the RCC and Ba’ath party structure, Saddam maintained total effective control of the security forces and the military. The regime’s security apparatus included militias attached to the president, the Ba’ath Party, and the Interior Ministry. These military and paramilitary forces often played an internal security role and were central to maintaining this “Republic of Fear,” a term developed by noted Iraqi scholar Kanan Makiya (1998).
The regime organized a network of informers from whose surveillance few Iraqis could escape; freedoms of speech, the press, assembly, association, religion, and movement were severely restricted (Inati, 2003). Persons suspected or accused, with or without evidence, of any of the large number of criminal offenses against the internal security of the state were arrested, imprisoned, and tortured (Inati). Iraqi soldiers who deserted or refused compulsory military service faced especially harsh penalties of mutilation and amputation (Amnesty International, 2001). Many detainees were sentenced to death after summary trials (Amnesty International). Further, relatives of persons imprisoned for political reasons also suffered confiscation of property and the deprivation of their means of subsistence (Human Rights Watch, 1993b).

Throughout the 1980s, the Iraqi government also forced the removal of ethnic and religious groups. The regime pursued a policy of “Arabization” in Kurdish regions, in which Kurdish property was confiscated and sold at reduced prices to Arabs (Tripp, 2000). In southern Iraq, hundreds of thousands of Shi’a were expelled from the country on the grounds that they were allegedly of Iranian origin (Amnesty International, 2001). The regime’s rule was further characterized by savage campaigns of violence against these groups. Mass graves related to five major atrocities, which fall under the international legal definition of genocide, have been identified (Human Rights Watch, 2003). In the 1983 attack against Kurds of the Barzani clan, whose leader is Mas’oud Barzani, the regime rounded up 8,000 Kurds and executed them in remote sites (Human Rights Watch, 1993a). In the 1988 Anfal campaign, as many as 182,000 persons disappeared. Most of the men were separated from their families and were executed in the desert. The remains of some of their wives and children have also been found in the same sites. Chemical attacks against Kurdish villages from 1986 to 1988, including the Halabja attack, killed 5,000 people immediately and caused long-term medical problems, related deaths, and birth defects among the children of thousands more (Human Rights Watch, 1993a). The 1991 massacre after the Shi’a uprising at the end of the Gulf War killed tens of thousands of Shi’a in the south (Human Rights Watch, 1992). Shi’a religious leaders, places of religious instruction,
and cemeteries were destroyed. The 1991 massacre of Kurds targeted civilians and soldiers who fought for autonomy in the north after the Gulf War (Tripp). These crimes have acquired a measure of notoriety and salience. However, thousands of other citizens, including hundreds of thousands of Marsh Arabs who were subjected to a policy calculated to specifically destroy their way of life, may also lie in as-yet undiscovered mass graves (Tripp).

In December 2003, Saddam Hussein was arrested and detained as part of a U.S.-led invasion of Iraq. His overthrow created a window of opportunity to create a peaceful and democratic sovereign state. However, the country remains plagued by human rights abuses and violence, albeit of a different nature. A 53-page report, written by Major General Antonio Taguba, found that between October and December 2003 there were numerous instances of "sadistic, blatant, and wanton criminal abuses" at Abu Ghraib prison (Taguba, 2004). American forces, Taguba reported, perpetrated this systematic and illegal abuse of detainees. Researchers have also estimated that as many as 100,000 Iraqis—many of them women and children—have died since the start of military operations (Roberts, Lafta, Garfield, Khudhairi, & Burnham, 2004). The deaths are a result of both air strikes by the U.S.-led coalition and ongoing violence. Events in Falluja, the fighting with the Mahdi militia of Moqtada Sadr in Baghdad and the south, continuing guerrilla attacks on coalition forces and their allies, more suicide bombings, and a spate of kidnappings and beheadings of foreigners have cast a very gloomy picture of the situation in the country (Cole, n.d.; Danner, n.d.; Stachlin, 2004).

As Iraqis are suspended between the death of the old system and the uncertainty of the new, they are most likely to experience the emotional consequences of living under Saddam's tyranny and through several wars that must include the ongoing trauma of the current insurgency in the country. Accordingly, understanding how survivors articulate psychological well being and suffering is crucial for adapting the HTQ.
Methodology

Field Site

The study was conducted in metropolitan Detroit, Michigan, where approximately 200,000 people of Arab descent live in and around the city; it is home to the oldest, largest, and most visible population of Arabs in North America (Baker et al., 2004). Seventy-five percent of residents were born outside the United States. Virtually all nationalities and ethnicities from the Middle East are represented: Lebanon/Syria (37%), Iraq (35%), Palestine/Jordan (12%), and Yemen (9%). This population is deeply religious, with 58% Christian and 42% Muslim. Most Christians are dispersed throughout Detroit’s suburbs, while two-thirds of all Muslims live in the ethnic enclave community of Dearborn, Michigan, often dubbed “Arab Detroit.” Compared to Arabs nationwide, the Arabs of Dearborn are more likely to be young Muslim immigrants, with large families and low incomes. For example, one fourth of the population reports family incomes less than $20,000 per year. Fifteen percent said they personally have had a bad experience after September 11, 2001, because of their ethnicity. These experiences included verbal insults, workplace discrimination, special targeting by law enforcement, vandalism, and physical assault (Baker et al.).

Since the 1991 Gulf War, metro Detroit has absorbed over 3,000 Iraqis a year (Abraham & Shryock, 2000). They have arrived directly from Iraq or via a third country, such as Iran, Turkey, Jordan, Syria, Lebanon, and the United Arab Emirates. Although the Iraqis seeking refuge in the United States come from a cross-section of Iraqi society, most are Southern Shi’a Muslims who fled under conditions of political duress. Thus, their lives have been disrupted in significant ways. These men and their wives tend to be poorly educated; struggling with the English language; working in low-wage, informal sector jobs without health insurance; and residing in crowded apartments. They live with feelings of remorse and reactions to trauma, not only about the conditions under which they fled their countries, but also about their country’s political turmoil and their own experience as a refugee. Many of these Iraqis suffer from chronic
illnesses that may be a result of the deplorable conditions in Rafha, the Saudi Arabian refugee camp where the majority lived for months or years. The Turkmen and Kurdish refugees, who were mainly based in Northern Iraq, fled to refugee camps in Turkey.

The Iraqi community in metro Detroit does not represent a cohesive unit. In addition to the divisions resulting from class, education, economic status, political convictions, and ideological beliefs, Iraqis are divided along lines of ethnicity. Three subcommunities live in the area: the Arabs, the Kurds, and the Chaldeans. Each has its own community center, voluntary associations, and clubs. Upon arrival in metro Detroit, refugees find themselves automatically drawn towards their own ethnic group and voluntary associations.

Sample

Interviewees recruited from the Arab Community Center for Economic and Social Services (ACCESS) constituted a convenience sample. Since its creation 30 years ago, ACCESS has grown to become the nation's largest and most comprehensive provider of Arab American human services, with nearly 108,000 yearly contacts in 70 different programs as diverse as employment and environmental projects, arts and culture, health programs, and youth and social services activities.

The following inclusion criteria were used in this study: (a) Iraqi-born, (b) Arabic speaker, (c) adult (age 21 and above), and (d) a refugee in the United States after the 1991 Gulf War. Thirty men and 30 women from various socioeconomic backgrounds, representing the ethnic and religious diversity of Iraq, participated in the study (see Table 7).
Table 7. Sociodemographic Characteristics

<table>
<thead>
<tr>
<th>Variable</th>
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<tr>
<td><strong>Total</strong></td>
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</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>30</td>
</tr>
<tr>
<td>Women</td>
<td>30</td>
</tr>
<tr>
<td>Age, y</td>
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</tr>
<tr>
<td>18-34</td>
<td>17</td>
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<tr>
<td>35-54</td>
<td>30</td>
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<tr>
<td>55-64</td>
<td>7</td>
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<tr>
<td>≥ 65</td>
<td>6</td>
</tr>
<tr>
<td>Ethnicity</td>
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<tr>
<td>Kurdish</td>
<td>6</td>
</tr>
<tr>
<td>Turkman</td>
<td>6</td>
</tr>
<tr>
<td>Chaldean</td>
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</tr>
<tr>
<td>Religion</td>
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<td>Sunni Muslim</td>
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</tr>
<tr>
<td>Christian</td>
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</tr>
<tr>
<td>Place of birth in Iraq</td>
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<td>Arbil</td>
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</tr>
<tr>
<td>Baghdad</td>
<td>10</td>
</tr>
<tr>
<td>Basra</td>
<td>9</td>
</tr>
<tr>
<td>Diwania</td>
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<td>Kerbala</td>
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<tr>
<td>Sulaymaniyyah</td>
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<td>Imprisonment in Iraq (months)</td>
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<td>35</td>
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<td>No</td>
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<td>Year of flight from Iraq</td>
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<tr>
<td>1996-2001</td>
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<tr>
<td>2002-2003</td>
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Table 7 (continued)

<table>
<thead>
<tr>
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<tr>
<td>Time in refugee camp(^{\text{a}}) (months)</td>
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<td>0-12</td>
<td>17</td>
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<tr>
<td>13-24</td>
<td>10</td>
</tr>
<tr>
<td>25-36</td>
<td>5</td>
</tr>
<tr>
<td>&gt;36</td>
<td>3</td>
</tr>
<tr>
<td>Year of arrival in Michigan</td>
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</tr>
<tr>
<td>1990-1995</td>
<td>31</td>
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<tr>
<td>1996-2001</td>
<td>21</td>
</tr>
<tr>
<td>2002-2003</td>
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<tr>
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</tr>
<tr>
<td>Good</td>
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</tr>
<tr>
<td>Poor</td>
<td>30</td>
</tr>
<tr>
<td>Employment status(^{\text{b}})</td>
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</tr>
<tr>
<td>Working</td>
<td>24</td>
</tr>
<tr>
<td>Not working</td>
<td>36</td>
</tr>
</tbody>
</table>

\(^{\text{a}}\) Only 8 women were imprisoned. \(^{\text{b}}\) Thirty-five out of the 60 subjects interviewed lived in refugee camps. Thirty out of the 36 subjects not working are women.

Although the majority of the participants were Shi'a Arabs, all Iraqi Muslims interviewed shared many values, customs, and norms of behavior. Further, in spite of differences in religious beliefs and rituals, there were no clear cultural boundaries between Iraqi Christians and Muslims. The difference in religious beliefs and rituals between Muslims and Christians will not be discussed in this paper. Further, since the majority of the sample was Muslim, the paper focuses mainly on the role of Islam in exile. Finally, at the level of the refugee experience, all Iraqis suffer from the well-documented problems relating to flight, displacement, and uprooting.

*Ethnographic Interviews*

Health professionals can refine their understanding of psychological disturbance in refugees if they recognize both the personal and cultural dimensions to the physical, mental, and moral losses survivors are trying to absorb (Kleinman, Das, & Lock, 1997). This anthropological view shows suffering as both an intersubjective process and a collective experience shaped by background, place, and time. These two kinds of suffering are best elaborated through life stories. Given its situational constructed nature, a life story is a strategy for self-representation, an attempt to make sense of the world, and a projection for the future (Geertz, 2000).
Drawing on the above anthropological framework, I conducted 60 interviews on individual life stories in Arabic. The decision to conduct the meetings in Arabic rather than Kurdish or Turkman—the other two Iraqi dialects—was based on the fact that Arabic is the primary language in Iraq and is understood by the majority of citizens.

In the interviews, I encouraged participants to provide a chronological account of their experience of life in Iraq, the decision to escape, the circumstances of their flight, the escape journey and transition in refugee camps, conditions surrounding their acceptance for resettlement by the United States, their early experiences in America, and the nature of their current social participation within the Iraqi community and the wider host community. As they described each stage of their life, respondents were asked also to express their emotional reactions to what was happening in their lives at that time. This included their feelings about living in and then leaving Iraq, their hopes and expectations of eventual return, and their degree of satisfaction with life in the United States.

To reconstruct their narratives, Iraqis needed not only the words with which to tell their stories but also an audience willing to hear their words as they intended them. Research shows the importance of open-ended interviews, emotional attunement, and genuine curiosity (Langewitz, Denz, Keller, Kiss, Ruttimmann, & Wossmer, 2002; Suchman, Markakis, Beckman, & Frankel, 1997). These characteristics comprise the kind of empathy that is crucial to such interviews. Thus, my task was to become an empathic listener by conveying to the interviewees that they were not alone and that they were being understood. To be empathic, listeners must see the world from the other’s perspective, be strong enough to hear without injury, and be ready to experience some of the terror, grief, and rage experienced by the interviewees (Halpern & Weinstein, 2004; Kleinman et al., 1997; Langer, 1991; Shay, 1994).

At the choice of the participants, the interviews were held in their homes, in ACCESS, in recreation centers, or in mosques. The conversations lasted approximately 1 hour and were conducted over a 3-week period in July 2004. I audio-recorded all meetings. Informed consent
forms, which fully described the research, put informants at ease once they realized that the discussions were private and confidential (see Appendix A). Further, since this community harbors deep mistrust of authorities, I offered every assurance to ensure the ultimate anonymity of the interviews. Strong support given by community leaders enhanced the project's success.

I transcribed the interviews in Arabic. The Arabic transcripts constituted material for qualitative analysis using a grounded theory methodology (Miles, 1984; Rubin, 2005). This involved a coding procedure with three levels. The first level, the text-based category, coded words and phrases used regularly and repeatedly throughout the text. The second level, the sensitizing concept, coded culturally specific ideas and understandings implicit in the text-based categories. The third and highest level, the theoretical construct, reflected my organization of the sensitizing concepts into a theoretical framework. Each level subsumed the level below it. That is, each sensitizing concept is a cluster of text-based categories, and each theoretical construct is a cluster of sensitizing concepts (see Appendix B). An Iraqi doctor and I coded the transcripts. As an additional check on our interpretation of the text, I presented our findings to 10 of the 60 men and women who participated in the study. The discussion occurred approximately 7 months after data collection. The subjects confirmed the accuracy of the report.

Findings

Scale Adaptation

Part I (Trauma Events), Part IV (Culture-Specific Trauma Symptoms), and the Torture List of the Harvard Trauma Questionnaire were adapted to the Iraqi context based on historical, socioeconomic, and human rights analyses, ethnographic study, and key informant interviews with both American and Iraqi cultural experts (historians, anthropologists, and psychiatrists) based in Iraq and the United States (see Appendices C and D). Part II (Brain Injury), Part III (Personal Description), and DSM-IV (1994) PTSD symptoms (Items 1–16 in Part IV) remained unchanged from the original version.
Trauma Events (Part I) and Torture List

The trauma and torture sections were divided into two periods: from July 1979 to April 2003 and from May 2003 to November 2005; these periods represent Saddam Hussein’s rule and events since the U.S.-led invasion of Iraq, respectively. To keep the scale as neutral as possible, and in turn to avoid offending the many political, ethnic, and religious groups in Iraq, only dates were listed.

Iraqi and American content experts rated each trauma and torture item as relevant, irrelevant, or questionably relevant. Items rated by a single member as irrelevant or by two or more members as questionably relevant were eliminated; items receiving one rating of questionable relevance were reconsidered for inclusion. For example, the item “brainwashing,” was excluded from the trauma list. According to content experts, a Muslim who has real faith and conviction in his or her heart will not be vulnerable to manipulations, threats, or distress. A Muslim’s resistance signifies a moral choice; it serves as a continuing self-assessment of his or her commitment to goodness and justice over evil and tyranny. Thus, the concept of brainwashing does not reflect trauma in Iraqi culture. Indeed, this event was not mentioned by any of the interviewed subjects. Another reconsidered item was the torture event “sodomized.” The content experts believed that such an item would be very offensive, citing seven references made in the Qu’ran to the story of Lot and the people of Lot (Sodomites). The act of sodomization is equivalent to an action of Kufr, which is the most blasphemous act that can be committed by a Muslim. The root word of Kufr is kafara, which means to conceal something or contest it. Thus, it refers to someone who covers up and challenges the Divine Truth after it has been revealed to him or her. However, since the Taguba Report (Taguba, 2004) reported sodomization as one of the human rights abuses in Abu Ghraib, the item was reworded as “Forcibly arranged in various humiliating or sexually explicit positions” (Torture list, Item 30). Although this translation is not the best paraphrase for the term sodomized—a more accurate rendition would have been “Forcibly penetrated by a foreign object”—the content experts felt strongly that any other
substitution in Arabic would have been both culturally and religiously alienating for the targeted population. Either they would have not answered the question or they might have been so insulted that the questionnaire would have not been completed. Thus, we could not ascertain whether or not sodomy had been committed. These examples highlight the importance of ascertaining the broader social and cultural contexts of Islam in this community.

The accepted trauma and torture items reflect the history of political violence and human rights abuses in Iraq. The following items are of special note because of their cultural significance:

- “Prohibited from ablution and prayer” (Torture list, Item 16): Islamic injunctions based on the Qu’ran and conduct of the Prophet Mohammad are outlined for an array of practices, including prayer. Prayer, which is the second most important pillar in Islam, is required of Muslims five times a day and is preceded by a ritual ablation.

- “Witnessed the arrest, torture, or execution of religious leaders or important members of tribe” (Trauma list, Item 13): The individual identity in Arab society tends to be much less important than the one defined by the family, clan, or religion. Thus, a person’s loyalty and duty to his or her kin and religious leaders are central.

- “Forced to undress in front of people” (Torture list, Item 29): Stipulations exist within Islamic law that dictate a specific amount of covering that is permissible in front of family members and strangers. Short or revealing clothes for both genders, but especially for women, are considered contrary to proper modest behavior.

Trauma Symptoms (Part IV)

The following discussion of Iraqi mental health beliefs and practices and local idioms of distress is based on data from the Dearborn interviews and key informant discussions with four psychiatrists in Baghdad.

Background of stigmatization. According to the interviewed psychiatrists, the general concept of mental disorder in Iraq is influenced more by superstition and pagan beliefs than by
teachings of Islam. The similarity between the interpretations relating to causation and treatment among different ethnic and religious groups seems to indicate archaic ideals held in common. However, the physicians pointed out that this description applies mainly to the less educated, rural segment of the population. The more urban the population, the more its concepts of illness approximate those of the West. Nevertheless, all four doctors concurred that some of these pagan beliefs, such as the evil eye, are still rife in the main cities.

Under the formal regime, the psychiatrists emphasized that mental illness was considered an abnormality that could not happen to people who were faithful Muslims. They noted the tendency of Iraqi patients with mental disorders to present somatic complaints in place of psychological ones. Because mental illness is very highly stigmatized among Iraqis—its presence in a family can lead to labeling that family's offspring unfit for marriage—the physicians reported that popular labels for mental illness cover only indisputably psychotic behavior and mental retardation. One such label is majnoon, which is originally derived from the word jinn (supernatural spirit). Minor psychiatric problems—depression and anxiety—most commonly are labeled as medical illnesses. According to the doctors, this labeling provides the Iraqi patient with a medical sickness, which releases him or her from responsibilities and sanctions, while affording care. Further, since there is virtually no psychotherapy available in Iraq and since indigenous healers and nonpsychiatric Western-style doctors handle the vast majority of minor mental disorders, the physicians indicated that most psychiatric care is given under the guise of putative medical care.

Despite the severity of the trauma most Iraqis lived through, the four psychiatrists stressed their clients' resiliency. They attribute this quality to Iraq's Arab and mainly Muslim society where family ties, honor, and religion provide a network of healing:

You go into one trauma and then you move on to another before the wounds of the previous one are healed. . . . We are not talking about one disaster. . . . There are at least
109/11s that happened to this country.... We have learned to adapt to major
catastrophes. (Psychiatrist, Baghdad)

*Local idioms of distress.* Based on the Dearborn interviews, the most commonly
mentioned indicators of distress were identified. The items included both indigenous and Western
constructs. The local terms are as follow:

- **Dayeg** (Symptom list, Item 41): Symptoms include ruminations, poor concentration,
lack of initiative, boredom, sleep problems, tiredness, and various somatic complaints
(headache, backache, muscle aches, heart palpitations, breathlessness, dizziness,
chocking sensation, lump in throat, butterflies in stomach, numbness, or poor
appetite). The feeling of being *Dayeg* can be associated with problems of daily living,
difficulties of uprootedness, feelings of insecurity due to disrupted relationships and
uncertainty about one’s future, or interpersonal conflict.

- **Qalbak maqboud** (Symptom list, Item 42): In a variety of expressions, many still
having English correlates, the heart (*g alb*) is treated as the subject of emotional
experience and a symbol of the true essence of the person. This phrase labels a
condition associated with a sensation of the heart being squeezed. This complaint is
often connected with feelings of sadness, dysphoria, or anxiety, stemming from
problems of daily living, insecurity about the future, uprootedness, family illness,
death, or sorcery. While somatization is prominent in Arabic culture, the discussion
of symptoms in terms of the heart does not seem to be an undifferentiated somatic
discourse for Iraqis, but a subtle talk on affect rooted in traditional understandings
and metaphors of the body.

- **Asabi** (Symptom list, Item 43): The term is derived from the word *asab*, or nerves,
which describes a condition of irritability, nervousness, lack of patience, and anger
outbursts in interpersonal relationships. Someone *Asabi* also usually wants to be left
alone.
• *Nafsaq Deeyega* and *Makhnouk* (Symptom list, Item 44): The terms respectively mean a feeling of constriction in the chest and a choking sensation. The chest is felt to be too tightly filled with unpleasant feelings to accommodate the inspiration of air. The person feels unable to take a deep breath, so that he or she may feel short of breath and sigh repeatedly. These terms can be used to describe tension associated with daily hardships (poverty, political repression, etc.); difficulties of uprootedness; feelings of insecurity due to disrupted relationships; and uncertainty about one’s worth, position, and future; or interpersonal conflict. Some also use these terms to describe experiences of panic.

• *Nafeetak ta`abana* (Symptom list, Item 45): The word *Nafeetak* is derived from the word psyche *El-Nafs*, which is a broad reference to human existence, meaning at different times body, behavior, affect, or conduct. The term means that a person’s soul is tired; it covers a wide range of undifferentiated anxiety and depression symptoms.

Other symptom items of note are as follows:

• “Spending time thinking why God is making you go through such events” (Item 28) and “Feeling that you have no one to rely upon but God” (Item 33): Muslims feel that God keeps a very close watch over them; He will punish them for sinful acts and reward them for good ones. Consequently, Muslims are apt to interpret any ill fortune that befalls them as God’s punishment.

*Translation*

Semantic equivalence of the HTQ was established in accordance with generally accepted guidelines for cross-cultural instrument development (Flaherty et al., 1998). Two Iraqis, a psychiatrist based in Baghdad and an experienced medical translator, translated the items of the HTQ from English into Arabic. Both individuals were experienced with Western and Iraqi mental health concepts and familiar with Iraqi patients. While maintaining accuracy in language, the
translations were kept simple and clear to be easily understood by people of all educational backgrounds. This version was then back-translated blind into English by a different Iraqi psychiatrist, with similar qualifications as the first one, who was also based in Baghdad. A third bilingual and bicultural Iraqi psychiatrist in the United States resolved problems in the translations. This psychiatrist rated each item as “exactly the same meaning in both versions,” “almost the same meaning in both versions,” and “different meaning in each version.” Finally, I reviewed the scale while referring to the transcribed Dearborn interviews. The transcripts contained the original language used by local people to describe their distress. Where the translators had originally used more formal language than is used by local people to express the same concept, the local term was substituted. For example, the word sack in Torture item 6, “Placed in a sack, box, or small place,” has several possible renditions in Arabic. The translators chose kees, whereas the men and women interviewed employed gounja, the word ultimately used in the scale.

Pretesting

The resulting version of the HTQ was pretested in Dearborn, Michigan, in January 2005. A group of four Iraqi men and four Iraqi women from various socioeconomic backgrounds, ethnicities, and religions were individually asked to listen to the instrument’s items one at a time and then paraphrase them. None of the interviewees suggested that any modifications were necessary to Parts I, II, and III and the torture list. In Part IV, Checklist symptom 40 for dissociation, “Feeling as if you are split in two people and one is watching what the other is doing,” surfaced as a weak item in this pretest. Five out of the eight participants thought that the question was referring to episodes of schizophrenia, while the rest asked for explanations. The concept is truly very difficult to translate into Arabic; further piloting is needed to determine the best way to phrase this symptom. Mollica and colleagues (1992) reported that among Indochinese refugees the same dissociation symptom had the lowest endorsement rate, was not as highly correlated with total symptoms as the other items, and did not achieve a statistically significant
level of differentiation between PTSD and non-PTSD groups. Mollica et al. speculate that either
dissociative symptoms are not associated with PTSD in Indochinese refugees or the concept is
difficult to translate into Indochinese cultural terms.

All interviewees indicated they would feel most comfortable discussing sexual trauma
with same-sex health professionals. The women also reported the importance of keeping
knowledge of rape a secret, especially from their husbands and parents. Community awareness of
the rape trauma will negatively stigmatize the victims and their extended family, causing all
family members to suffer from severe ostracism. With the understanding that clients may be
unable to accurately report culturally sensitive experiences of trauma, I decided that it was still
beneficial to present the question because it may cue the survivor that the therapist is aware of
these kinds of experiences and that others have reported them as well. With regard to the torture
list, half of the respondents did not have a concept of torture that included the variety of events
they experienced. Thus, specific questions should be asked by mental health professionals that
may more readily invite responses about psychological torture, such as being humiliated.

Discussion

The present study describes a set of methods for adaptation of the Harvard Trauma
Questionnaire to the Iraqi context. The scale was developed from an ethnographic study on
trauma in Iraqi refugees in the United States. This body of qualitative work allowed the
investigator to use Iraqis' own experiences, words, and meanings as the foundation for the items
on the instrument.

This study reflects the mutual challenges of the biological and cultural PTSD paradigms.
PTSD is neither a simple reflection in personal experience of psychophysiological processes nor a
culturally constituted phenomenon free of organic constraints. PTSD is of great interest to
anthropologists and psychiatrists alike because it offers a prime opportunity for exploration of the
interaction of culture and biology. In emphasizing the value of culturally specific assessment
measures such as the HTQ, I do not mean to suggest that such measures should replace etic or
conventional Western measures of psychopathology in work with non-Western war-affected populations. The concern is that researchers and clinicians have relied almost exclusively on such instruments, paying minimal attention to local expressions of well-being and distress among the communities in which they are working. These scales may have limitations that miss the varied dimensions of experience that result from traumatic exposure. However, increasingly, a number of researchers are recognizing the limits of imposing Western concepts of phenomena on other cultures. Bolton (2001) used three ethnographic qualitative methods to investigate Rwandans’ perceptions of problems following the 1994 genocidal conflict and the local validity of Western concepts, and to adapt existing measures, such as the HSCL-25, for local use. The three ethnographic methods were (a) free listing, which provided a list of local terms for mental symptoms and disorders, (b) key informant interviews that supplied more detailed information about these disorders, and (c) pile sorts, which confirmed the relationship among symptoms and disorders that emerged from the other two methods. Manson and Shore (as cited in Kleinman, 1977) developed conceptually equivalent versions of the American Indian Depression Schedule for different Indian groups with different languages and customs. Miller and his colleagues (in press) used a mixed method to examine Afghans’ local distress idioms and develop a culturally appropriate assessment measure. Finally, several Middle Eastern studies have translated and validated psychiatric screening scales, such as the Hospital Anxiety and Depression Scale and the 30- and 12-item General Health Questionnaires (Okasha & Mai, 2001). These studies further reflect the growing awareness of the limitations inherent in any single methodological approach to studying PTSD.

**Study Limitations**

Due to the security situation in Iraq, the study was conducted in the Iraqi refugee community in the United States. Although participants were very familiar with the kinds of traumas reported by their family members in Iraq since the fall of the regime, they did not experience this new wave of suffering firsthand. Further, the subjects who traveled to Iraq after
Saddam’s capture did so in the early months when the violence had not reached its current peak. It will be important to take note of the category of “other events” reported by participants when the HTQ is piloted in Iraq.

Although most Iraqis speak Arabic, it might be important to field test a version of the HTQ in Sorani or Kurmanji, the dialects spoken by the majority of Kurds, the second largest ethnic group in Iraq. Such a version will be essential for practitioners and researchers working in primarily Kurdish regions of the country.

Further investigation is also needed to establish the full range of symptom variation between Western and Iraqi constructs for trauma-related illness. Many questions remain unresolved. For example, are the culture-specific items used in the HTQ associated only with the Iraqi experience or are they generic to Middle Eastern refugee trauma or refugee trauma in general? How many additional, yet still undetermined, culture-specific symptoms exist for Iraqi patients? Are the symptoms associated with PTSD criteria core features of a trauma-induced illness in Iraqi culture? A cross-national investigation of PTSD using standardized instruments such as the HTQ can answer these questions.

Finally, grouping and classification of mental disorders in psychiatry has been notably understudied and little attention has been paid to a guiding theory (Parshall & Priest, 1993). This is exemplified by the DSM-IV (1994), which avoids any explication of its theoretical basis, yet appears to assume the validity of a biomedical model (Follette & Houts, 1996). According to this model, mental disorders are fundamentally biological in origin, and, given the common physiology of humans worldwide, psychopathology will be essentially homogeneous, with only superficial variation in presentation across peoples. The prima facie acceptance of the biomedical approach to the understanding of psychopathology is problematic, given that mental disorders have been shown to vary across cultures (Thakker & Ward, 1998). While the DSM-IV (1994) has attempted to extend its scope by acknowledging cultural factors, it is impeded by its reliance on notions of biology and ubiquity, which are at this time highly speculative (Thakker & Ward).
Conclusion

I propose assessing the psychometric properties of the HTQ in psychiatry clinics in Iraq. Mental health professionals will estimate internal consistency and construct validity, as well as establish cutoff scores through diagnostic interviews using DSM-IV (1994) PTSD criteria. All HTQ versions are given a cutoff value of 2.5 based on validation studies in Indochinese patients.

The HTQ is not intended to be used as a self-report; health care workers, under the supervision of a psychiatrist or psychologist, should administer the questionnaire. However, there is a serious dearth of mental health professionals in Iraq. According to key informants, there are only 90 psychiatrists and no psychologists, counselors, or other mental health providers in the country. Further, Iraq still uses an outdated system of institutions to treat the mentally ill: there are only two psychiatric hospitals in the entire country, located in the capital city of Baghdad, that serve the entire population of 24 million. Thus, key informants believe that a community-based system of mental health care that is integrated into the primary health care clinics in Iraq may be a better strategy. Indeed, with little training, primary care physicians can use the HTQ to obtain the patient’s trauma history and identify related physical and mental health sequelae, while providing culturally sensitive assistance in a nonstigmatizing environment.

In the face of complex emergencies, where social, cultural, and economic relations are disrupted, it is crucial to take an ethnographic approach to the study of health across societies. Ethnographic methods, which have a long history in anthropology, describe well-being, illness, and suffering in relation to the sociocultural contexts in which they occur. This framework requires that researchers attempt to understand the cultural variables that mediate and impinge on the local experience and expression of these notions, such as language, traditional practices, and faith. However, while this sort of methodological approach may seem sensible, it is not commonly used (Kleinman, 1992). This is perhaps because ethnography requires more time and probably more money than do traditional epidemiological or psychiatric research methods.
Whatever the reason, there is clearly a need for more context-centered studies that have the depth and complexity to deal with the richness of sociocultural data and to discover both cross-cultural similarity and diversity. The adaptation of the HTQ to the Iraqi context was shaped by the intricacies of Arabic culture and traditions. These influences infuse meaning into the scale's trauma events and symptoms, bringing Western and Arabic physicians closer to the subjective experiences of their Iraqi patients.

In the next chapter, I illustrate how a living sense of religion permeates the life stories of Iraqi refugees and informs their core notions of identity, home, and future. Further, I will argue that health professionals who strictly rely on Western trauma paradigms and questionnaires will entirely miss the role faith plays in restoring self-definition to survivors, especially Muslims who do not inhabit the secular space and time assumed by the PTSD model.
CHAPTER 2

LIVING IN RELIGIOUS TIME AND SPACE: IRAQI REFUGEES IN DEARBORN, MICHIGAN

Rape, torture, and extrajudicial executions of family members are just some of the traumas experienced by survivors of mass violence in their countries of origin, only to be followed by harrowing escapes, years of arduous existence in refugee camps, and perhaps exile. Edward Said (2000), a Palestinian literary critic, describes exile as the “unhealable rift forced between a human being and a native place, between the self and its true home.” As such, exile precipitates a “condition of terminal loss” caused by a “discontinuous state of being” (Said).

To capture the polytrauma of refugees who have resettled in the West, clinicians have shifted from the traditional open-ended psychiatric interview to shorter standardized symptom checklists for PTSD, reportedly the most prevalent diagnosis among survivors of mass violence (Wilson & Keane, 2004). These measures can specify the current acuteness of a disorder, track response to treatment, and communicate assessment results efficiently. However, by transforming the local distress idioms of survivors into the universal professional language of health complaint, the scales situate trauma in individual bodies rather than social happenings, emphasizing pathology rather than such meaningful events as cultural, especially religious, dislocations. Indeed, despite the fact that religion sustains many refugees in their process of uprooting, forced migration, and integration into the host country, spiritual precepts are conspicuously absent in questionnaires, and, in turn, from relief work (Gozdziak, 2002). Psychological treatment models rarely incorporate any spiritual dimension.

This absence is especially striking when meeting the needs of recent refugees from the Middle East. The movement of people from this part of the world has been associated throughout history with interrelated issues of politics, land, and war. The geopolitical and economic aspects of these displacements are well analyzed in the literature of the region (Black & Robinson, 1993; Castles, 1993; Shami, 1996). However, studies dealing with the lived experiences of Middle
Eastern refugees who resettle in the West are few. Some of these reports include Aswad’s (1980; Aswad & Bilgé, 1996) ethnic case studies of Arabic-speaking communities in the United States, Ansari’s (as cited in Parrillo, 1991) research on continuity and change in the Iranian diasporas in the United States, and Shadid’s (1991) study of the difficult integration of Muslim minorities in the Netherlands.

With the concentrated media coverage following the 2003 U.S.-led invasion of Iraq, the Iraqi refugee community in Dearborn, Michigan, became visible. However, there has been little in-depth examination of this community despite the fact that it is the largest of its kind in North America. In this paper, I present a qualitative study of 60 Iraqi refugees resettled in Dearborn, Michigan, and illustrate how religion permeates their lives, including their core notions of identity, home, and future. I argue that a strict reliance by health professionals on Western trauma paradigms and questionnaires will overlook the role faith plays in restoring self-definition to Muslim survivors.

**Context and Background**

According to Weil (2001), “To be rooted is perhaps the most important and least recognized need of the human soul.” Over the past three decades, anthropologists increasingly have become engaged in ethnographic studies of forced displacement (Colson, 2003). Much of their work has attempted to describe the broader psychosocial and religious matters facing various refugee groups in their countries of resettlement. A theme that emerges frequently in such studies is the myth of return.

The myth of return is an expression of exiles’ yearning to be anchored. This construct has two main functions. First, it reinforces the kinship boundaries of the community and its links with the homeland (Al-Rasheed, 1994; Dahya, 1973). Second, it enables the migrant to manage the pain of failing to integrate into the host society (Al-Rasheed; Dahya). The myth is therefore a practical solution to the dilemma of falling between the cracks of two worlds, including two sets of norms. This is especially necessary when the customs of the two worlds are in conflict.
when a person cannot place his or her trust either in the present or the future, an essentialized but lost culture is summoned to compensate for the absence.

However, it is a mistake to assume that the experience of becoming a refugee is necessarily felt as losing one’s culture. While some refugees will devote their exile to recreating the home they have left behind, others will commit themselves to constructing a niche in their new country of asylum (Zetter, 1999). The latter accept the need for transition and place greater emphasis on the integration of past values in their present and future lives by investing, for example, in their children’s education. They hope for a return but do not believe in its eventuality (Zetter).

Although the above explanations are useful in conveying the different ways in which refugees react to their displacement, they fail to explain why the myth of return varies between individuals. Al-Rasheed (1994), inspired by Kunz’s (1981) classification of refugees according to the nature of their identification with their country of origin, argues that the development of the myth of return is dependent on the refugees’ relationship with their homeland prior to flight and on their degree of marginality in regard to the society they have left behind. Al-Rasheed illustrates her point by considering two refugee groups: Iraqi Arabs and Iraqi Assyrians. The first belongs to the mainstream population of the country, whereas the second is a Christian minority in Iraq. She demonstrates that Iraqi Arab refugees, even after numerous years in exile, consider Iraq as their homeland and have every intention of returning once the desired political changes take place. In contrast, the Iraqi Assyrian refugees have severed all contacts with Iraq since their flight. Although many would like to visit Iraq, they see their exile as permanent. The same dichotomy can be found in Graham and Khosravi’s (1997) description of refugees settled in Sweden, more particularly the Armenians and Baha’Is from Iran on one hand and the Iranian political refugees on the other.

Thus, exile can serve to bring together refugees’ disjointed identities through their opposition to the host society’s culture. The reaffirmation of refugees’ identity allows them to
hold fast to their past through an act of remembering and nostalgia, thereby giving constancy to their current life in exile. However, exile also has the reverse effect of preventing refugees from developing new roots, since to fully integrate in the host country entails in their eyes letting go of the past. Consequently, the refugee finds himself “caught between two worlds” (DeSantis, 2001): the world of survival, which requires an orientation to the present, and the world of return, which results in an ambiguous orientation to almost any place of residence other than the homeland.

One of the ways refugees address the dilemma of being caught between two worlds is by turning to religion. Indeed, faith can serve as a source of emotional support, a form of social expression and political mobilization, and a vehicle for community building and group identity (De Voe, 2002; Gozdziak & Shandy, 2002; Welaratna, 1993). Further, the role of religion in coping with trauma becomes particularly significant in the debate between Western models of trauma and indigenous approaches to human suffering, which include spiritual beliefs and practices (Gozdziak, 2002). Studies have found that frequent religious involvement and greater intensity of religious experience may be associated with better health due to religion’s promotion of social support, a sense of belonging, and convivial fellowship (Levin, 1994). Researchers have tended to neglect the diversity of spiritual beliefs that sustain many refugees in the processes of displacement, migration, and integration into the host society (Gozdziak & Shandy).

Religion plays an especially important role in the life of Muslim refugees, who understand their faith as a way of life embracing both the external and the internal world of its believers. McMichael (2002), drawing on research with Somali refugee women living in Australia, describes the ways in which Islam provides an enduring home that is carried throughout displacement and resettlement (McMichael). Gozdziak (2002) also illustrates how Islam offers a sustaining thread in the lives of Kosovar Albanians and helps them to overcome the threat of discontinuity that arises with displacement.

In this study, I show the importance of Islamic faith for Iraqi refugees. I argue that responses to their trauma should be explained not only in terms of a universalistic human
psychology, but also through a particular Islamic lens and cultural heritage. This background serves as a source of general, yet distinctive, conceptions of the world, the self, and the relations between them and gives a meaningful form to a wide range of experiences—in tellectual, emotional, and moral—for both individuals and groups (Geertz, 2000).

Methodology

Please refer to Chapter 1 for a complete description of the field site, sociodemographic characteristics of the sample population, and ethnographic interviews.

Findings

The Struggle to Define Identity

A male Muslim definition of refugee. For exiles, membership and participation in their homeland is impossible. Consequently, they must redefine their social self within a new context. For Iraqi refugees in Dearborn, resettlement provided a medium through which the memory of the shared experience of uprooting was reworked to create new forms of identity based on a higher order justification.

Recognition of the enforced, and ascribed, position of refugee was neither sought after nor desired by the men I spoke to: "Saddam exported our guns, not our culture. . . . The world viewed us as terrorists then as victims. We are neither." Instead, many described themselves as Muhajirin ("those who leave their homes in the cause of Allah"; singular, Muhajir), conferring a noble aura to the Iraqi plight. According to Shahrani (as cited in Daniel and Knudsen, 1995), who noted the same self-definition among Afghani refugees in Pakistan, the Prophet Mohammad's hijrah—"the migration from the Domain of Disbelief to the Domain of Faith"—only to return to establish the Faith—serves as a potent paradigm shared by Muslims. Indeed, Iraqis link their struggle to take back their homeland—from Saddam and from the Americans—with the suffering of the Prophet Mohammad: "The Prophet said that he who escapes with his faith from one land to another, even if it is only the distance of an inch, will be worthy of paradise."
Thus, the identity of *Muhajir* serves as a centripetal anchor for Iraqi men, who otherwise may perceive themselves as failures living on government support in the United States. This religious notion of self empowers them by stabilizing their preexiled identity. For the *Muhajir* leaves only to return to triumph over the enemy who has temporarily displaced him from his rightful home.

*Women's quest for former selves.* While men were striving for new and solid identities as religious warriors, the experience of women was quite different. Given that many women became refugees as a result of the political decisions of their husbands, exile in their case precipitated a state of liminality, a concept invoked in anthropology by Van Gennep (as cited in Al-Rasheed):

“I don’t feel settled. Nobody prepared me for this life. When I got married, I expected my husband to look after me and support me. That is what I have been told since I was a little girl.”

“We live for our families and through our families. Exile (al-ghorbah) is a daily struggle. I feel like I’m dying every day in America.”

Al-Rasheed (1993) reported similar findings among Iraqi exiled women in London. She found that forced migration led to the breakdown of cultural expectations by threatening the notion that marriage is associated with settling down and establishing a family. And, since Iraqi women defined themselves wholly in terms of the roles they played in Iraq and for which they were evaluated and valued, they suffered more acutely from the collapse of their social world. According to Brison (2002), our notions of self are created through the process of symbolic interaction. This fashioned self remains dynamic throughout our lives, adapting as we encounter new people and situations. However, in certain extreme cases, this construct is so fundamentally challenged that individuals find themselves in an identity crisis (Brison). Indeed, even after 10 years in the United States, the restructuring of these women’s assumptive worlds had not taken place. They continue to hold on to their former selves because these selves are more predictable and less damaged.
Rejection of Arab identity and creation of a unified Iraqi identity in exile. The above analysis illustrates how Iraqis negotiate on the basis of past, now lost, positions rather than present standings to secure a positive feeling of self. For Iraqi Arabs, both men and women, this identity management has also meant a rejection of their Arabic character and the strengthening of their Iraqi one. In spite of a shared cultural heritage, Iraqi Arabs feel a keen sense of betrayal and mistrust vis-à-vis other Arab countries that did not come to their rescue during Saddam Hussein’s reign of terror:

“I fear that there will come a day when Iraqis will reject their Arabness. There are responsibilities that come with being Arab. But, our so-called brothers—the Egyptians, the Syrians, the Palestinians, and the Saudis—have completely abandoned us. I, for one, am ashamed of being an Arab. I just prefer to say I am Iraqi.”

“When the question is asked, ‘Who are you?’ Iraqis may reply in terms of tribal, regional, or ethnic, ties. In America, they also stress their Muslim identity.”

Thus, with uprooting, trust was violated on several fronts and yet affirmed on the national and religious levels. On the national front, Iraqis feel that their pain is communal; it is their duty to bear it. As they transmit the Iraqi language and customs to their children, they also plan to pass on the Iraqi pain as part of their national identity. On the religious stage, the sentiment of Arabness is replaced by the sentiment of Islam.

A shift toward the internal world. Iraqi men and women in Dearborn practice a more fervent form of Islam, reflecting the Islamic revivals in the Middle East (Shami, 1996). For example, hijab or head covering is very common; it represents pride and protection from the immoral standards of the surrounding community. For many Muslims in the West, Islam is a means of being “global and transnational but not on Western terms” (Shami,). Thus, Islam is interpreted and reinterpreted according to the specific pressures Iraqis have encountered in America:
“In Iraq, life is much simpler. What my husband and I teach at home is reinforced by the culture. But, in America, we have too much responsibility to keep the family together. America has this way of brainwashing you.”

“Religion is what pulls us together now. It is not that we carry fundamentalism with us to America. It is our experiences in this country that makes us hold on tightly to our Islamic identity.”

Thus, even if the association of home with homeland is cast into doubt during preflight events, the irony of exile is that the geographical distance from one’s country of origin often brings refugees emotionally closer to it, sometimes even closer than before their escape (Habib, 1996). And, to the extent that refugees are marginalized, they are likely to continue to hold onto their difference and in so doing further accentuate the host population’s perception of them as a threat to social cohesion (Barnes, 2001).

The Struggle to Define Home

Living between a good and a bad America. Two competing images of America loomed large in the psyche of the Iraqi refugee community in Dearborn. Iraqi Arabs in general espoused the “Bad America” view, while Chaldeans, Turkmen, and Kurds—minority groups in Iraq—adopted the “Good America” stance. The difference between these disparate perceptions of the United States is where Iraqis imagine their home.

“My son was born here. . . . Even though he never lived in Iraq, he is scared to set foot in the country. . . . Why? Because he sees the traces of Iraq’s torture chambers on his dad’s body and feels his pain. . . . Saddam’s atrocities have even touched my child born thousands of miles away. . . . America is the only country that opened its arms to us. Here, I can practice my religion without fear of persecution. No one is above the law. There is no glorification of the leader.”

“We don’t belong in America. Americans don’t want us here. I refuse to spend my life as a foreigner in a strange land. A person is only truly respected in his own country.”
The Kurds, Chaldeans, and Turkmen, who concentrate primarily on the United States’ internal affairs, are captivated by the country’s religious freedom, cultural pluralism, and democratic processes. For these Iraqis, the opportunity to practice their faith in America, when compared to the brutality and autocracy of their own governments, remains the most thrilling aspect of life in the West. Further, these minorities regard their migration as more or less a permanent solution to a historically alienated existence in their homeland (Tripp, 2000). Many of the Chaldeans interviewed have virtually no relatives left in Iraq; in Dearborn, they rely on an extended kinship network that links them with the already established Chaldean immigrants who came to Michigan in the 1950s. Individuals in these ethnic groups would like to be able to visit Iraq, but very few entertain the myth of return even after the overthrow of Saddam Hussein’s regime.

In contrast, Iraqi Arabs, who focus primarily on America’s foreign policy, view the United States as dominating the Muslim world and seeking to globalize its immoral culture. They find the incredible hardships caused by the U.S.-sponsored United Nations sanctions on Iraq and the 2003 U.S.-led invasion of their country as evidence of America’s intentions to steal their resources and eliminate Islam. They stress that they left their country because of various political pressures rather than economic necessity. They did not come here to establish roots; the majority described their migration as temporary even in those cases where people have already spent 10 years in the United States. For many of them, America is a holding tank until they can take back their lives in Iraq.

According to Khan (as cited in Bukhari, Nyank, Ahmad, & Esposito, 2004), these latter individuals are faced with a perplexing existential dilemma. They are not part of the Western or Islamic cultural mainstream; they live on the margins of both civilizations. If they perceive themselves as Western, then they suffer from cultural alienation, and if they conceive of themselves as part of the Muslim world, then they feel exiled. Hence, as long as Iraqis in the
United States solely hold on to their Islamic identity, they will experience this double alienation from the West and from the Islamic nation.

*Home as social cohesion.* Interestingly, all groups (Arabs, Kurds, Turkmen, and Chaldeans) referred to America as *Balad* (country) rather than *Watan* (Homeland), which is the term reserved for Iraq. This notion of a homeland was in their minds closely linked to trust and social cohesion.

“I have been in this ‘balad’ for a long time, so I feel an obligation to America. But, my ‘watan’ is Iraq. Iraq is very deep in my mind and in my heart.”

“My girl is 14 years old. . . . It’s time for her to get married. . . . I found her a suitable husband who was 24. . . . The social workers at ACCESS told me that the police would put me in jail if I went ahead with this marriage. . . . I would be charged with the rape of my daughter?! I don’t understand. . . . Isn’t this better than all these young American girls who are pregnant with no man?”

In the United States, Iraqis feel that they needed to negotiate not only in a strange culture but also even among themselves in a loose social environment wherein information about others is much harder to come by than in Iraq. According to them, in Iraq, one always knew someone who was familiar with the other party and could both supply information and exercise a kind of moral check. This especially applied to negotiating core identity ritual events, such as marriages.

Further, Iraqi Muslims talked of life in Iraq as being defined by the framework of Islam. Many emphasized that Islam and Iraqi culture are inseparable—daily existence is infused by Islamic morality and practice and that reference to religion always featured as a unifying part of their collective identity. No differentiation is made between faith and culture; customs are not relegated to local Arabic identity, and, therefore, are not freely shed.

*Home* is also a “nodal point of social relations” (Rapport & Dawson, 1998). For example, Iraqi writers and artists claim that their work requires a process of interaction with a responsive audience. Traditional audiences, locally known as *lovers* (*usahaan’q*), engage in constant exchange.
with the performers, from whom they receive emotions and with whom they share their pleasure (Inati, 2003). Many Iraqi writers and artists stated that they could not draw on such an audience in the United States. All of this clearly supports the framework of home as a space of identification (Rapport & Dawson).

*Home in religious space.* The above examples show that refugees are not necessarily free to construct home according to their own will. While home may be a negotiated sociocultural construct, it cannot be separated completely from physical spaces (Rapport & Dawson, 1998):

"With every prayer, I ask Allah to prolong my life until I visit the shrines in AnNajaf. I like to be surrounded by the holiness of this place. I feel blessed in Iraq. You can't recreate this sanctity here."

AnNajaf is renowned as the site of the tomb of Imam Ali, who the Shi’a consider to be their founder. Nearby is the Wadi-us-Salam (Valley of Peace), claimed to be the largest cemetery in the Muslim world, containing the mausoleums of several other prophets. Many Iraqis aspire to be buried there and to be raised from the dead with Imam Ali on Judgment Day. Over the centuries, numerous schools, libraries, and convents were built around the shrine to make the city the center of Shi’a learning and theology. Thus, although Iraqis have inscribed Islam on new physical spaces in the United States, they do not feel that their faith has as central a role in their contemporary lives. Islam, as all religions, therefore does have geography, which is often the repository of religious actions, narrations, and feelings. And, as the above quote illustrates, certain locations have their place in the construction of the imaginative domain of Dar ul-Islam (The House of Islam) (Shami, 1996).

The complex sense of home is conspicuous in these examples. No one country can be said to offer everything Iraqi refugees desire, in the sense of a home that meets all of a person’s identities. There is the original homeland, which for some people no longer represents home, but has instead become the place of nostalgia; there is home in the sense of a place that fulfills a person’s practical needs; and there is a home whose culture and religion best expresses identity.
Sense of security and threat: The aftermath of 9/11. During the interviews, Iraqis talked about their feelings of insecurity and exclusion following the events of 9/11:

“I didn’t leave my home for weeks. I was scared. Arabic stores were vandalized, women’s hijab was pulled from their heads; men were spat on, the FBI searched our homes. I don’t feel as safe in Dearborn since these events.”

Many Iraqis are now concerned with the immediate task of living in an environment that at once offers freedom as well as hostility. They are saddened by the irrational and incendiary media discourse on Muslims, which frequently makes terrorism synonymous with Islam. In the face of an onslaught against their faith, Iraqis feel that they cannot defend or assert themselves in any sustained way in the public space. Hence, they see their lives as precarious in the United States and many are considering resettlement in an Arabic Islamic country, such as Syria or Jordan.

The Role of Faith in Defining One’s Future

Islam gives meaning to suffering. Refugees described the public and private cultic rituals of religious worship as ways to ease anxiety, defeat loneliness, and establish a sense of being loved. Many also voiced an explicit awareness that war and displacement have led them to place increased importance on their Muslim faith. Thus, Islam offers a causal framework as a way of comprehending exile, where its adversities are the will of Allah:

“My suffering on this earth is a test that I must endure. I know that what has passed me by was not going to befall me and that what has befallen me was not going to pass me by. All I can do is go back to Allah and state my case and say ‘Allah, help me.’ The Prophet said to worship Allah as if you are seeing Him. For though I don’t see him, he sees me. Being in the presence of Allah all the time brings me great comfort. If I feel homesick or sad, I recite verses from the Qu’ran, I face towards Mecca and pray, and I fast.”
Allah is the empathic Other, who will always listen; no one’s suffering is meaningless in His eyes. To stress this point, Iraqis also cited the following two Arabic sayings: “Complaining to anyone but Allah is humiliation” and “Get to know Allah in prosperity and He will know you in adversity.” Hence, Iraqis communicated with God by praying five times a day. The prayers gave them not only a chance to express their feelings, hopes, and needs, but also helped them alleviate stress and structure their lives. In this context, faith offered both individual and group strength in times of hardship through belief in a powerful Being.

A future in the hereafter. Further, to the extent that resettled refugees view themselves within a religious framework, an additional resolution to the issue of belonging is emerging, where the meaning of one’s life transcends both the country of origin and the country of resettlement:

“The Qu’ran says that those who leave their homes in the cause of Allah, after suffering oppression, will be greatly rewarded in the Hereafter. Victory comes with patience, relief with affliction, and ease with hardship. I’ve put my trust in Allah.”

Muslims place much emphasis on the overriding power of God to determine all things. Not surprisingly, one of the earliest intellectual disputes was over the issue of how human responsibility and free will can be reconciled with the absolute sovereignty of God in Islam; and Islam is still frequently described as fatalistic in the West. To counter that point, many Iraqis cited the following Qu’ranic verse, where God says: “Allah will not change the situation of a people until they change themselves.” Hence, the essence of suffering lies within the Muslim him or herself. In the same way, the exit from such a state depends on the Muslim’s willingness to change him or herself in accordance with the teachings of Islam. Although some Iraqis used religious explanations and coping strategies to the exclusion of others, many more emphasized that Allah does indeed create all possibilities, but humans have the responsibility to choose their actions out of the many options before them.
This brings to the fore a central limitation of Western psychiatric tools for assessing PTSD in grasping the experience of Iraqi refugees. The sense of agency of these refugees was truly enhanced by believing in a hereafter. For example, the majority of Iraqis had no sense of a foreshortened future—a common symptom experienced by survivors of long-lasting trauma—since they believed that God’s kingdom is true home, where health and healing are promised to the faithful. The presence of this alternative world and future lifted their hopes and relieved their suffering:

“You only go to Heaven if you live according to the teachings of the Prophet. That means striving for piety, filling your heart with love, extending kindness to others, forgiving wrongdoings, accepting your lot in life, and thanking Allah for all that He has given you. I focus on these teachings in my everyday life. They give me purpose, peace, and security. My home in the Hereafter will be built with my faith and good deeds.”

Thus, a symptom of PTSD as described in the biomedical model has little meaning in a culture in which the spiritual dimension offers a future of peace and security.

Discussion and Conclusion

The crisis that precipitates refugee status is at once personal and social and therefore is a predicament that pursues refugees into their life in the country of asylum. Therefore, to understand these refugees in terms of posttraumatic symptoms alone is to fail to grasp their daily rhythms and, in particular, the way that Iraqi refugees address the problem of meaning by living in religious time and space. Thus, in confronting the suffering of survivors of mass violence, I argue that our primary responsibility is not to classify their diseases. It is rather to engage intensively with the social and moral nature of their injuries. And, since the essential injuries brought about by atrocity are moral and social, so the central treatments should be moral and social. These treatments are those that restore self-definition to the survivor. Recovery is not a discrete process: it happens in people’s lives and psychologies. It is grounded in the resumption of the sociocultural, spiritual, and economic activities that make the world intelligible.
Western biomedicine is still grappling with a body–mind dualism that resists consensus. Consequently, the idea that one's religious background might influence one's health and outlook has remained "part of the folklore of discussion on the fringes of the research community" (Levin, 1994). Meitzen and his colleagues who studied clinicians' knowledge of religious issues and their willingness to utilize such information in clinical practice found a low level of religious awareness on the part of mental health professionals (Meitzen, Seime, & Ward, 1998). They concluded, "This level of religious knowledge would not, in many instances, suffice to comprehend the beliefs and presuppositions about life in the world which shape the inner dynamics of an authentically religious patient" (Meitzen et al.). Sinclair (1993), a psychiatrist, further asserts that at its deepest level, PTSD is a spiritual diagnosis and that spiritual components need to be part of its treatment protocol. Finally, over the past decade, hundreds of published empirical studies have reported findings bearing on a possible salutary relationship between religion and health (Levin).

In this study, religious coping was shown to be motivated by a search for meaning, intimacy, and self. In addition, religious coping was adaptively problem focused, particularly when individuals viewed God as an empathic Other. However, as with any class of coping behavior, Pargament and Park (1995) propose that religious coping can involve maladaptive processes, such as using religious explanations to the exclusion of others (attributing illness solely to sin), using only religious coping strategies (relying on prayer alone to resolve illness), and using religion to justify maladaptive behavior (physical abuse in the name of scriptural discipline). Thus, clinicians should attend to their clients' potentially harmful religious coping behaviors while respecting religious orientation and seeking ways to support its beneficial effects.

Further, I argue that a better understanding of the tensions that render the constructs of identity, home, and time problematic for refugees would result in more culturally sensitive trauma instruments. However, since ethnographers interpret a field of interpersonal experience as they narrate the felt flow of the internal world, their interpretation is a creation as much as an
observation (Kleinman et al., 1997). For ethnography to resist the transformation of human lives into stereotypes, it must not be experience-distant (Kleinman et al.). For example, current PTSD scales only seek yes/no answers to “sense of foreshortened future” questions, which as I elaborated above could greatly illuminate a refugee’s sense of agency if pursued further to include religious time. Thus, measures developed in community refugee populations using empirical approaches combining qualitative and quantitative methods may create scales that are more valid in representing the experiences of refugees than methods where data are only obtained from the outside via expert and consensus approaches (de Jong et al., 2001; Flaherty et al., 1998; Hollifield et al., 2002). Only then can what is lost in biomedical renditions—the dialectical tensions found in a man or woman’s world of experience—be recovered in the refugee’s own words.

Additionally, in the context of rehabilitation in Western countries, specific cultural practices, such as religion in this population, are often deemed irrelevant by caseworkers who seek to neutralize differences to provide each person with an equal start (Daniel & Knudsen, 1995). However, these cultural practices are the foundation on which a meaningful self-definition for survivors may be restored. My experience with Iraqi refugees in Dearborn has reinforced my view that it is vital for providers to understand and utilize the religious context of their clients’ suffering in planning psychosocial interventions.

Researchers must consider the contextual nature of suffering, which necessarily involves issues of meaning, value, and many profoundly rooted conceptions that contribute to the way in which individuals see themselves and their world. Future research must place greater emphasis on these variables by ascribing more weight to alternative understandings and developing more culture-sensitive research methods. This study illustrates the importance of faith in understanding the constructs of identity, home, and future for Iraqi refugees in Michigan. Their commitment to Islam was not only life-long, but also life-wide. For these refugees, the allusions to liminality and
homelessness widespread in the descriptions of the dislocation that results from uprooting and exile are replaced by an alternative home that transcends time and space.
REFERENCES


Levin, J. S. (1994). Religion and health: Is there an association, is it valid, and is it causal? Social Science and Medicine, 38, 1475–1482.


APPENDIX A

ENGLISH CONSENT FORM

Dear Research Participant,

My name is Marwa Shoeb. I am a graduate student in the UC Berkeley-UC San Francisco Joint Medical Program, a five-year course of study leading to both an M.S. and an M.D.

I would like to ask for your help in conducting my Master’s research project. I am developing a clinical questionnaire to measure trauma events and symptoms specific to the Iraqi refugee experience. This questionnaire will hopefully help Arabic clinicians in the U.S. and Iraq provide Iraqi torture survivors with better medical care. In order to develop a questionnaire that is sensitive to Iraqi culture, and which takes into account the Iraqi historical, political, and social context, I would like you to describe, in your own words, your knowledge, attitude, and reactions to various categories of trauma events and symptoms.

If you choose to participate, you will be interviewed individually. The interview will allow you to share your thoughts on various issues. I will ask questions about your a) knowledge of trauma events and symptoms; b) understanding of the relationship between emotional suffering and social functioning; c) willingness to describe hurtful events and their sequelae; and d) ways of reporting such experiences. I want to stress that you will not be asked to share your own experiences or symptoms. However, the topics to be discussed may possibly raise sensitive and personal issues. The interviews will last for approximately 1 and ½ hours; light refreshments will be served.

There is no direct benefit to you from this study. However, we hope that this research will ultimately help clinicians provide Iraqi trauma survivors, in similar situations to yours, with better medical care.

The main risks for you in this study are 1) loss of privacy and 2) perhaps emotional discomfort. In order to ensure a safe and comfortable atmosphere, I ask that you keep what is said within the meeting confidential. Although interview questions will not directly elicit any personal experiences, discussions may remind you of past trauma. You may find it difficult discussing the issues addressed in the interviews. If you become too upset, you may choose not to answer the question or leave the meeting at any point. Should you continue feeling distressed, you will be referred to the Center’s appropriate services. Please remember that your participation in this research is entirely voluntary. Whether or not you continue to participate, all your answers will be kept strictly confidential. Further, your decision will have no bearing on your relationship with the ACCESS Center, ACCESS staff, or outside health providers.

Interviews will be tape recorded and then transcribed. I will use a code number to identify your comments; your name or any other potentially distinguishing information will never appear in connection with your remarks. Tapes and transcripts will further be kept locked in a file. In such studies, participants are often quoted in final reports. If I were to use any of your comments in a publication, I will take great care to ensure your anonymity.

After this study is completed, I may save my notes for use in prospective research. If you sign the Audio Release Form, I may also keep the audiotapes. However, the same strict confidentiality guarantees outlined in this letter will apply to any future storage and use of materials.
If you have any questions about your rights or treatment as a participant in this research project, please contact the University of California at Berkeley's Committee for Protection of Human Subjects at (510) 642-7461, email: subjects@uclink.berkeley.edu.

If you have any questions about the research, please feel free to call me, Marwa Shoeb, at (510) 684-8735 (e-mail: mshoeb@socrates.berkeley.edu). You may also contact my advisor, Professor Harvey Weinstein, at (510) 642-0965 (e-mail: harveyw@globetrotter.berkeley.edu). Please sign both copies of this letter and keep one copy for your future reference. Thank you very much for your time and your willingness to share your experiences and thoughts.

* * *

The study described above has been explained to me. I understand the study’s purpose and agree to participate in this interview.

________________________________________________________________________
Signature (Participant)       Date

________________________________________________________________________
Signature (Person obtaining consent)       Date
عزيزي المشارك في البحث:

اسمي مروة شعبث، وأنا طالبة أدرس بكلية الطب في جامعة كاليفورنيا سان فرانسيسكو، وأقوم حالياً بعمل استبيان طبي الغرض منه قياس حالات وأعراض الأذى النفسي والجسدي التي عاني منها الشعب العراقي تحت نظام صدام حسين وفي ظل الاحتلال الأمريكي.

لكل دولة ثقافة خاصة تتشكل وفقاً لتاريخها وسياستها ومجتمعها. هذه العوامل تؤثر على المفاهيم والمواقف والاحتياجات المحلية. في كثير من الظروف، بما فيها الصحة النفسية والجسدية. وبناه على ذلك، فإن معرفة المفاهيم العراقية عن حالات وأعراض الأذى النفسي والجسدي يعتبر جزءاً لا يتجزأ من عملية مساعدة العراقيين الذين لحق بهم ضرر نفسي أو جسدي للحصول على صحة عقلية جيدة. ولكي أتمكن من عمل "استبيان طبي" يأخذ في الاعتبار حالات وأعراض الأذى النفسي والجسدي العراقية، أود أن تشرح لي بأسلوبك الخاص أفكارك ومشاعرك إزاء هذه المفاهيم.

على الرغم من أنه ليست لك أي مصلحة مباشرة في هذه الدراسة، فإننا نأمل أن يساعد هذا البحث الأطباء في الولايات المتحدة الأمريكية والعراق في تقديم خدمة طبية أفضل للعراقيين الذين لحق بهم ضرر نفسي أو جسدي.

وإذا ما قررت أن تشارك في هذا الاستبيان، فسوف تستغرق المقابلة حوالي الساعة والنصف، وسيتم خلالها تقديم بعض المشروعات الخفيفة.

ولضمان بنية آمنة، فإنني أطلب منك إبقاء كل النقاش الذي يجري داخل الإجتماع سرياً. كما أرجو أن تنذكر دائماً أن مشاركتك في هذه الدراسة هي عمل طوعي بالكامل، فإذا لم ترغب في الإجابة على أي سؤال فكل كامل الحرية في ذلك. وفي حالة استمرارك أو عدم استمرارك في المشاركة، فإن كل الأجوبة التي قمت بالإجابة بها ستحافظ في سرية تامة. كما أود الإشارة إلى أن قرارك بالمشاركة في هذه الدراسة لن يكون له أي تأثير في علاقتك بالمركز، أو موظفي المركز، أو مقدمي الرعاية الصحية الخارجيين.

سيتم تسجيل هذه المقابلة صوتياً لغرض البحث فقط. إسمك أو أي معلومات قد تشير إلى شخصك لن تظهر أبداً في أي مطبوعة.

وفي حالة وجود أي استفسار أو سؤال فيما يتعلق بحقوقك كمشارك في مشروع البحث هذا، أمل الإتصال بجامعة "حماية حقوق المشاركين في البحث" بجامعة كاليفورنيا بيركلي على
الهاتف رقم: 642-610-510، أو بارسل بريد الكتروني على العنوان التالي:

subjects@uclink.berkeley.edu

أما إذا كانت لديك أي أسئلة أو استفسارات عن البحث، فأرجو عدم التردد في الإتصال بي (مرژه شعبیه) على الهاتف رقم 8735-684-610، أو بارسل بريد الكتروني على العنوان المنسق@socrates.berkeley.edu

التالي:

أرجو التكرم بتوقيع نسختي هذا الخطاب بالإلتزام بنسخة معك للرجوع لها مستقبلاً.

شكرًا جزيل الشكر على وقتكم ورغبتيك في مشاركة تجاربك وأفكارك.

بهذا أؤكد أن الدراسة الموضحة بعالية قد تم شرحها لي، وأفهم الغرض منها، كما أوافق على المشاركة في هذه المقابلة.

توقيع المشارك: ____________________
التاريخ: ____________________

توقيع طالب المواجهة: ____________________
التاريخ: ____________________

*****
APPENDIX B

CHAPTER II CODEBOOK
“Living in Religious Time and Space: Iraqi Refugees in Dearborn, Michigan” Study
General Instructions:
- When coding, use the most specific category or subcategory code (a.k.a., theme) applicable.
- Unless otherwise noted in the category’s definition, the codes should be applied to complete sentences (i.e., the unit of analysis is the sentence). The periods contained in the text demarcate the beginning and ending of sentences.

Theme 1

- **Label**: HOME
- **Definitions**: the person describes his/her relationship and attachment to his/her country of origin (Iraq), and country of resettlement (United States). He/she may also mention his/her belief in a “home” in the hereafter.
- **Indicators**: this code is a label applied to individual refugee narratives, not discrete sentences.
- **Exclusion**: experiences in other countries are not coded.

Theme 1a

- **Label**: GOOD AMERICA
- **Definitions**: the person is deeply enamored by the United States’ religious freedom, democratic processes, and cultural and political pluralism. He/she regards his migration to the United States as permanent.
- **Indicators**: mentioning any of the above.

Theme 1b

- **Label**: BAD AMERICA
- **Definitions**: the person sees the United States as a colonial power seeking to dominate the Middle East. He/she may list 1) the United States’ globalization of its immoral values, 2) the United States’ uniring support of Israel, 3) the United States-led invasion of Iraq, and/or 4) Abu Ghraib abuses as evidence of America’s intention to humiliate and eliminate Muslims. The person stresses that he/she didn’t come to the United States to establish roots.
- **Indicators**: mentioning any of the above.

Theme 1c

- **Label**: WATAN AND BALAD
- **Definitions**: the person refers to Iraq as *watan* (homeland) and the United States as *balad* (country).
- **Indicators**: mentioning the word *balad* and/or *watan*.

Theme 1d

- **Label**: BLESSED HOME
- **Definitions**: The person wants to build a home in Iraq, so he/she could be surrounded by the holiness of the place.
- **Indicators**: coded when person says, “With every prayer, I ask Allah to prolong my life until I visit the shrines in An Najaf,” or “I like to be surrounded by the
holiness of this place,” or “I feel blessed in Iraq. You can’t recreate this sanctity here.”

Theme 1c

> **Label:** HOME IN THE HEREAFTER
> **Definitions:** the person talks of an alternative home that transcends Iraq and the United States; this home is in the Hereafter. The person feels that the presence of this alternative world lifts his/her spirits and relieves his/her suffering.
> **Indicators:** coded when person writes, “My true home is in the Hereafter,” “I will be rewarded in the Hereafter,” “My home in the Hereafter will be built with my faith and good deeds.”

Theme 2

> **Label:** IDENTITY
> **Definitions:** the person describes his/her self-ascribed identity and the values, people, and/or environments that inform his/her self-definition.
> **Indicators:** these codes are labels applied to individual refugee narratives not discrete sentences.

Theme 2a

> **Label:** MUHAJIR
> **Definitions:** the person, who is a man, rejects the label refugee and describes himself as a **muhajir,** (a.k.a., someone who leaves his home in the cause of Allah).
> **Indicators:** mentioning the word “muhajir.”

Theme 2b

> **Label:** REJECTING ARABNESS
> **Definitions:** the person may feel a keen sense of betrayal and mistrust vis-à-vis other Arabs, who didn’t come to Iraqis’ rescue during Saddam’s reign of terror. As a result, the person may reject his/her Arabic identity and highlight his Iraqi one.
> **Indicators:** coded when person says, “I prefer to say I am Iraqi” or “I am ashamed of calling myself an Arab.”

Theme 2c

> **Label:** SOCIAL RELATIONS
> **Definitions:** The person is a writer or artist, who feels uninspired in the United States to produce work because of his/her lack of interaction with a responsive audience.
> **Indicators:** Coded when person says, “I don’t have my readers here,” “I need my people, my landscape to paint.”

Theme 2d

> **Label:** WOMEN IN EXILE
 Definitions: The person, who is a woman, feels that exile lead to the collapse of her social world and to the breakdown of cultural norms.

 Indicators: Coded when person says, “I feel like I’m dying everyday in America,” “Nobody prepared me for this life,” and “When I got married, I expected my husband to look after me and support me.”

 Theme 2e

 Label: CULTURAL PRESERVATION
 Definitions: the person feels that his/her main problem in the United States is one of cultural preservation. He or she may 1) worry about the disparities in morals between life inside and outside of the home; 2) practice a more fervent form of Islam; and/or 3) feel the need to be on guard not only among Americans but also among Iraqis because of Dearborn’s “loose social structure.”
 Indicators: mentioning any of the above.

 Theme 3

 Label: ISLAM
 Definitions: the person describes the role of Islam in his/her everyday life.
 Indicators: this code is a label applied to individual refugee narratives not discrete sentences.
 Exclusion: statements about the role of other religions.

 Theme 3a

 Label: GOD-WILLED DESTINY
 Definitions: the person feels that Islam’s public and private rituals offer him/her a causal framework for comprehending exile, where its adversities are the will of Allah.
 Indicators: Coded when person says, “I see my suffering on this earth as a test,” “The Qu’ran says that Muslims are rewarded in the Hereafter for their earthly plights,” or “I’ve put my trust in God.”

 Theme 3b

 Label: ISLAM AND IRAQI CULTURE
 Definitions: the person talks of life in Iraq as being defined by the frameworks of Islam. He/she may also feel that his/her faith is threatened and/or doesn’t have as central of a role in his/her daily life in the United States.
 Indicators: coded when person writes, “Islam and Iraqi culture are inseparable,” “Western society is incompatible with Islam,” “After 9/11, I didn’t leave my home for weeks.”
APPENDIX C

CULTURAL EXPERTS

Anthropologists:
- Stephanie Pandolfo, Professor of Social and Cultural Anthropology, University of California, Berkeley
- Martha Inhorn, Associate Professor of Medical Anthropology, University of Michigan

Historians:
- Juan Cole, Professor of History, University of Michigan
- Eric Davis, Professor of Political Science, Rutgers University

Human Rights Experts:
- Harvey Weinstein, Senior Research Fellow, Berkeley’s Human Rights Center

Psychiatrists:
- Yousif Hanna, consultant, Iraqi Ministry of Health/Department of Mental Health
- Richard Mollica, Director, Harvard Program in Refugee Trauma
- Abu Monaf Al-Jadiry, consultant, Iraqi Ministry of Health/Department of Mental Health
- Raoof Muheed, consultant, Iraqi Ministry of Health/Department of Mental Health
- Hussein Tuma, consultant, SAMHSA

Religious Leaders:
- Mohammad Al-Aloom, Shi’a imam, Dearborn, MI
استبيان هارفارد للإصابات و أعراض الشدة

HARVARD TRAUMA QUESTIONNAIRE

النسخة العراقية

Iraqi Version

________________________________________
الإسم/Name

________________________________________
الجنس/Sex

________________________________________
تاريخ الولادة/Date of Birth

________________________________________
الحالة الزوجية/Marital Status

________________________________________
التاريخ/Date
إرشادات:
نود أن ننصحك بمعالجتك السابقة والأعراض التي تشكو منها حالياً. كما أن هذه المعلومات تساعدنا على تزويدك بعناية أفضل. قد تجد بعض هذه الأسئلة مزعجة أو محرجة. فعقد تلك مطلب الحرية في عدم الإجابة. واطمئن أن هذا لن يؤثر في برنامج علاجك. كما أن إجابتك على هذه الأسئلة سوف تحقق في سرية تامة.

Instructions:
We would like to ask you about your past history and present symptoms. This information will be used to help us provide you with better medical care. However, you may find some questions upsetting. If so, please feel free not to answer. This will certainly not affect your treatment. Your responses will be kept confidential.

الجزء الأول: الحوادث المؤلمة

**PART 1: TRAUMA EVENTS**

نرجو أن تذكر إن كنت قد تعرضت لأي من الحوادث التالية (ضع علامة (✓) في العمود المناسب تحت تعمى أو لا).

Please indicate whether you have experienced any of the following events (check "YES" or "NO" for each column).

|-----------------------------------------------|-----|----|

<table>
<thead>
<tr>
<th></th>
<th>نعم</th>
<th>لا</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>2/2</td>
<td>Present while someone searched for people or things in your home</td>
<td></td>
</tr>
<tr>
<td>3/3</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>1/4</td>
<td>Property looted, confiscated, or destroyed</td>
<td></td>
</tr>
<tr>
<td>5/5</td>
<td>Forced to leave your hometown and settle in a different part of the country with minimal services</td>
<td></td>
</tr>
</tbody>
</table>

Oppressed because of ethnicity, religion, or sect
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7/6</td>
<td>Imprisoned</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7/7</td>
<td>هل عانيت من عدم إمكانية الحصول على الرعاية الطبية أو الدواء خلال مرضاك</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8/8</td>
<td>Suffered ill health without access to medical care or medicine</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9/9</td>
<td>Suffered from lack of food or clean water</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9/9</td>
<td>هل اضطررت على الهرب من وطنك</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10/10</td>
<td>Expelled from country based on ancestral origin, religion, or sect</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11/11</td>
<td>هل لم يكن لديك مكان آمن</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/12</td>
<td>Lacked shelter</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/12</td>
<td>Witnessed the desecration or destruction of religious shrines or places of religious instruction</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13/13</td>
<td>Witnessed the arrest, torture, or execution of religious leaders or important members of tribe</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13/13</td>
<td>هل شاهدت اعتقال أو تعذيب أو إعدام شخصيات مهمة من عشيرتك، دينك أو طائفتك</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14/14</td>
<td>Witnessed mass execution of civilians</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15/15</td>
<td>Witnessed shelling, burning, or razing of residential areas or marshlands</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16/16</td>
<td>Witnessed chemical attacks on residential areas or marshlands</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17/17</td>
<td>Exposed to combat situation (explosions, artillery fire, shelling) or landmine</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17/17</td>
<td>هل تعرضت لميدان الحرب (انفجارات، قصف مدفعي، نار الأسلحة) أو الألغام</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18/18</td>
<td>Serious physical injury from combat situation or landmine</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19/19</td>
<td>Used as a human shield</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19/19</td>
<td>هل استخدمتك كدروع بشرى</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20/20</td>
<td>Serious physical injury of family member or friend from combat situation or landmine</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21/21</td>
<td>Witnessed rotting corpses</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Description</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Witnessed murder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Forced to inform someone placing them at risk of injury or death</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Witnessed sexual abuse or rape</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Forced to physically harm someone (beating, killing, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Murder or violent death of family member (child, spouse, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Forced to pay for burial used to kill family member (child, spouse, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Disappearance of a family member (child, spouse, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Family member (child, spouse, etc.) kidnapped or taken as a hostage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Friend kidnapped or taken as a hostage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Someone informed on you placing you and your family at risk of injury or death</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Rent and performing funeral rites</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The table continues with similar entries for each row.
<table>
<thead>
<tr>
<th>رقم</th>
<th>السؤال</th>
<th>1979/7 من</th>
<th>1979/7 إلى 2003/4 من</th>
<th>2003/4 إلى الوقت الحاضر</th>
</tr>
</thead>
<tbody>
<tr>
<td>39/39</td>
<td>هل تعرضت للأذى الجسدي (الضرب، الطعن،)...؟</td>
<td>نعم</td>
<td>لا</td>
<td>لا</td>
</tr>
<tr>
<td>40/40</td>
<td>مضايفتك أو أخذت كرهينة</td>
<td>نعم</td>
<td>لا</td>
<td>لا</td>
</tr>
<tr>
<td>41/41</td>
<td>هل تعرضت للإساءة الجنسية أورغصنت</td>
<td>نعم</td>
<td>لا</td>
<td>لا</td>
</tr>
<tr>
<td>42/42</td>
<td>تم تطبيقك (معنى أنك وجدت في الأسر تعرضت إلى المعاناة النفسية أو الجسدية بشكل متساو ومنتظم)</td>
<td>نعم</td>
<td>لا</td>
<td>لا</td>
</tr>
<tr>
<td>43/43</td>
<td>نرجو أن تحدد أي موقف أخرى مخيفة أو شعرت عندها بأن حياتك معرضة للخطر (Please specify any other situation that was very frightening or in which you felt your life was in danger:)</td>
<td>نعم</td>
<td>لا</td>
<td>لا</td>
</tr>
</tbody>
</table>
PART II: PERSONAL DESCRIPTION

Please indicate what you consider to be the most hurtful or terrifying events you have experienced. Please specify where and when these events occurred.

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Under your current living situation (i.e. refugee camp, country of resettlement, returned from exile, etc.) what is the worst event that has happened to you, if different from above. Please specify where and when these events occurred.

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________
### PART III: HEAD INJURY

If you answer "YES" to the following trauma events, please indicate if you lost consciousness and for how long.

<table>
<thead>
<tr>
<th>Event</th>
<th>Loss of Consciousness?</th>
<th>Experience?</th>
<th>Duration (Hours)</th>
<th>Duration (Minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beatings to the head</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suffocation or strangulation</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>On the brink of drowning</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury to the head from nearby explosion</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injuries to other parts of the body (e.g., shrapnel, bullet wound)</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starvation</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes to item 6, what was your normal weight: __________________ Starvation weight: __________________

If yes to item 6, were you near death due to starvation? Yes: _______ No: _______
PART IV: TRAUMA SYMPTOMS

The following are symptoms that people sometimes have after experiencing hurtful or terrifying events in their lives. Please read each one carefully and decide how much the symptoms bothered you in the past week.

<table>
<thead>
<tr>
<th>(1/1) لا أبداً</th>
<th>(2/2) قليلاً</th>
<th>(3/3) إلى حد كبير</th>
<th>(4/4) بشدة</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>A little</td>
<td>Quite a bit</td>
<td>Extremely</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1/1</th>
<th>هل تعاودك الذكريات والأفكار لأكثر الحوادث ألمًا أو قرعاً؟</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/2</td>
<td>هل تشعر وكأنك تعيش الحادثة مرة أخرى</td>
</tr>
<tr>
<td>3/3</td>
<td>هل تأتيك كوابيس (أحلام مخيفة) متكررة</td>
</tr>
<tr>
<td>4/4</td>
<td>هل تشعر بالانفصال أو الانزواء عن الناس</td>
</tr>
<tr>
<td>5/5</td>
<td>هل تجد نفسك غير قادر على الإحساس بالعواطف</td>
</tr>
<tr>
<td>6/6</td>
<td>هل تجد نفسك سريع الجنون أو الاستثارة</td>
</tr>
<tr>
<td>7/7</td>
<td>هل تجد صعوبة في تركيز أفكارك</td>
</tr>
<tr>
<td>8/8</td>
<td>هل تجد صعوبة في النوم</td>
</tr>
<tr>
<td>9/9</td>
<td>هل تجد نفسك متوجهاً أو على حذر</td>
</tr>
<tr>
<td>10/10</td>
<td>هل تجد نفسك سريع الافعال أو تنتبه سورات من القضب</td>
</tr>
<tr>
<td>11/11</td>
<td>هل تتجنب الأعمال التي تذكرك بالحادثة المؤلمة</td>
</tr>
<tr>
<td>12/12</td>
<td>هل تجد نفسك غير قادر على تذكر بعض الحوادث التي سببت لك الألم</td>
</tr>
<tr>
<td>13/13</td>
<td>هل تجد نفسك أقل اهتماماً بالأعمال اليومية</td>
</tr>
</tbody>
</table>

Less interest in daily activities
<table>
<thead>
<tr>
<th>Date</th>
<th>Arabic</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/14</td>
<td>هل يشعر وكأنه لا مستقبل لل</td>
<td>Feeling as if you don't have a future</td>
</tr>
<tr>
<td>11/15</td>
<td>هل تتجنب الأفكار أو المشاعر المرتبطة بالحوادث المؤلمة</td>
<td>Avoiding thoughts or feelings associated with the hurtful events</td>
</tr>
<tr>
<td>11/16</td>
<td>هل تشعر برد فعل جسمي أو عاطفي عند ذكرك بالحوادث المؤلمة</td>
<td>Sudden emotional or physical reaction when reminded of the most hurtful events</td>
</tr>
<tr>
<td>11/17</td>
<td>هل يشعر يضعف الذاكرة</td>
<td>Poor memory</td>
</tr>
<tr>
<td>11/18</td>
<td>هل يشعر بالأوهام أو التعب الشديد</td>
<td>Feeling exhausted</td>
</tr>
<tr>
<td>11/19</td>
<td>هل تعاني من تهمل أو مشاكل جسمية</td>
<td>Troubled by bodily pain or physical problems</td>
</tr>
<tr>
<td>11/20</td>
<td>هل يشعر أن مهاراته الآن هي أقل مما كانت سابقا</td>
<td>Feeling that you have less skills than you did before</td>
</tr>
<tr>
<td>11/21</td>
<td>هل تجد صعوبة في الانتباه</td>
<td>Difficulty paying attention</td>
</tr>
<tr>
<td>11/22</td>
<td>هل تجد نفسك غير قادر على اتخاذ أي قرار في حياتك اليومية</td>
<td>Feeling unable to make daily plans</td>
</tr>
<tr>
<td>11/23</td>
<td>هل تجد صعوبة في مواجهة المواقف الجديدة</td>
<td>Having difficulty dealing with new situations</td>
</tr>
<tr>
<td>11/24</td>
<td>هل يشعر أن الشخص الوحيد الذي عانى من هذه الحوادث</td>
<td>Feeling that you are the only one who suffered these events</td>
</tr>
<tr>
<td>11/25</td>
<td>هل يشعر أن الآخرين غير قادرين على فهم ما جربته</td>
<td>Feeling that others don't understand what happened to you</td>
</tr>
<tr>
<td>11/26</td>
<td>هل يشعر بالذنب لأنك نجوت وما زلت على قيد الحياة</td>
<td>Feeling guilty for having survived</td>
</tr>
<tr>
<td>11/27</td>
<td>هل تلوم نفسك لما حدث</td>
<td>Blaming yourself for things that have happened</td>
</tr>
<tr>
<td>11/28</td>
<td>هل تستسلم تماماً قرر الله أن تواجه مثل هذه الحوادث</td>
<td>Spending time thinking why God is making you go through such events</td>
</tr>
<tr>
<td>11/29</td>
<td>هل يشعر بالحاجة إلى الانتقام</td>
<td>Feeling a need for revenge</td>
</tr>
<tr>
<td>11/30</td>
<td>هل يشعر أن الآخرين عدلون تجاهه</td>
<td>Feeling others are hostile to you</td>
</tr>
<tr>
<td>11/31</td>
<td>هل يشعر أن الشخص الذي وثقته قد خالفه</td>
<td>Feeling that someone you trusted betrayed you</td>
</tr>
<tr>
<td>Item</td>
<td>Arabic</td>
<td>English</td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
<td>---------</td>
</tr>
<tr>
<td>32/32</td>
<td>هل تشعر بعدم الثقة بالآخرين</td>
<td>Feeling no trust in others</td>
</tr>
<tr>
<td>33/33</td>
<td>هل تشعر أن ليس هناك من أحد يعتمد عليه إلا الله</td>
<td>Feeling that you have no one to rely upon but God</td>
</tr>
<tr>
<td>34/34</td>
<td>هل فقدت الأمل</td>
<td>Hopelessness</td>
</tr>
<tr>
<td>35/35</td>
<td>هل تشعر أنك عاجز عن مساعدة الآخرين</td>
<td>Feeling powerless to help others</td>
</tr>
<tr>
<td>36/36</td>
<td>هل تشعر بالعار بسبب الحوادث المؤلمة التي تعرضت لها</td>
<td>Feeling ashamed of the hurtful or traumatic events that have happened to you</td>
</tr>
<tr>
<td>37/37</td>
<td>هل تشعر بالذ�مة بسبب ما جرى لك</td>
<td>Feeling humiliated by your experience</td>
</tr>
<tr>
<td>38/38</td>
<td>هل تشعر أنك تُجد السوء على نفسك أو عائلتك</td>
<td>Feeling that you are a jinx to yourself and your family</td>
</tr>
<tr>
<td>39/39</td>
<td>هل اكتشفت بنفسك أو أخبرك أحد أنك قمت بما لا تستطيع أن تذكره</td>
<td>Finding out or being told by other people that you have done something that you can’t remember</td>
</tr>
<tr>
<td>40/40</td>
<td>هل تشعر أنك انقسمت إلى شخصين، وأن أحدهما يراقب ما يحدث الآخر</td>
<td>Feeling as though you are split into two people and one of you is watching what the other is doing</td>
</tr>
<tr>
<td>41/41</td>
<td>هل أنت ضابج</td>
<td>Dayeg (ruminations, poor concentration, lack of initiative, boredom, sleep problems, tiredness, and somatic complaints)</td>
</tr>
<tr>
<td>42/42</td>
<td>هل قلبك مقبوض</td>
<td>Qalbak maqbool (sensation of the heart being squeezed)</td>
</tr>
<tr>
<td>43/43</td>
<td>هل أنت عصبي</td>
<td>Asabi (irritability, nervousness, lack of patience, and anger outbursts)</td>
</tr>
<tr>
<td>44/44</td>
<td>هل تشعر بضغوط النفس وكأنك على وشك الاختناق</td>
<td>Nafak deeyeg and makhnouk (feeling of tightness in the chest and a choking sensation)</td>
</tr>
<tr>
<td>45/45</td>
<td>هل نفسك تعبئة</td>
<td>Nafseetak ta'bana (tired soul)</td>
</tr>
</tbody>
</table>

For further explications of items 41-45, please refer to the manual
Please indicate whether you have experienced any of the following events that many people consider torture (check "YES" or "NO" for each column).

<table>
<thead>
<tr>
<th>Event Description</th>
<th>من ١٩٧٩/٧</th>
<th>إلى ٢٠٠٣/٤</th>
<th>الحاضر ٥/٢٠٠٣-present</th>
</tr>
</thead>
<tbody>
<tr>
<td>١/١ Forced to write false confessions</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>٢/٢ Humiliated and threatened</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>٣/٣ Blindfolded</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>٤/٤ Forced to stand for long periods of time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>٥/٥ Chained or tied</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>٦/٦ Placed in a sack, box, or very small place</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>٧/٧ Placed in an isolation cell with no clothes, toilet, or ventilation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>٨/٨ Deprived of sleep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>٩/٩ Exposed to continuous and piercing noise</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>١٠/١٠ Exposed to strong heat, sun, or light</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>١١/١١ Exposed to rain or cold</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>١٢/١٢ Deprived of food and water for long periods of time</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Description</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>-----</td>
<td>------------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>13/13</td>
<td>Exposed to dirty conditions leading to ill health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14/14</td>
<td>Prevented from urinating or defecating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15/15</td>
<td>Deprived of medical care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16/16</td>
<td>Prohibited from ablution and prayer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17/17</td>
<td>Forced labor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18/18</td>
<td>Suspended from a rod by hands and feet for long periods of time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19/19</td>
<td>Stretched on a rack for long periods of time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20/20</td>
<td>Head, torso, back, genitalia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21/21</td>
<td>Beaten on soles of feet with rods or whips (Falanga)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22/22</td>
<td>Head submerged in water with near drowning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23/23</td>
<td>Burned by cigarettes, electrically heated rods, hot oil, fire, or corrosive</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>acid &quot;insab&quot; (please specify targeted areas: hands, torso, back, genitalia, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24/24</td>
<td>Electrocuted (please specify targeted areas: hands, torso, back, genitalia, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25/25</td>
<td>Fingernails, toenails, or teeth forcefully extracted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26/26</td>
<td>Forehead branded with an (x)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27/27</td>
<td>Body parts mutilated (ears, nose, tongue, hands, breasts, limbs, genitalia, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18/28</td>
<td><strong>19/29</strong></td>
<td><strong>20/30</strong></td>
<td><strong>21/31</strong></td>
</tr>
<tr>
<td>-------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>هل تعرضت إلى موقف الإعدام و تبين فيما بعد أنه كان تمثيل</td>
<td>هل أُجبرت على التعري أمام الآخرين</td>
<td>ظهور أوضاع متغيرة بما فيها الأوضاع الجنسية</td>
<td>في حالة الإجابة على (31) بنعم، هل تم تصويرك ظاهرياً؟</td>
</tr>
<tr>
<td>Subjected to mock executions</td>
<td>Forced to undress in front of people</td>
<td>Forcibly arranged in various humiliating of sexually explicit positions</td>
<td>If YES to (31), were you photographed?</td>
</tr>
</tbody>
</table>
 تسجيل درجات الجزء الرابع - أعراض الشدّة

Scoring Part IV-Trauma Symptoms

أ. اجمع عدد الأسئلة التي أجبت عليها

ب. انسحب القيم التالية لكل سؤال أجبت عليه

لا أبداً 1 = "Not at all"
قليلًا 2 = "A little"
إلى حد كبير 3 = "Quite a bit"
بشدّة 4 = "Extremely"

ت. اجمع الدرجات كلها ثم قسمها على عدد الأسئلة التي أجبت عليها

C. Add up item scores and divide by the total number of the answered items

DSM-IV PTSD SCORE = ITEMS 1-16

TOTAL SCORE = ITEMS 1-45

القيمة العامة = ينحدر 1-45

الأفراد الذين حصلوا على درجة أكثر من 16 يعتبرون لديهم أعراض PTSD.
الرجاء مراجعة الدليل للمزيد من المعلومات.

Individuals with scores on DSM-IV and/or total > 2.5 are considered symptomatic for PTSD.
See manual for additional information.

تطوير وترجمة برنامج هارفارد للاجئين الذين تعرضوا للذى ومرقة شعب

Developed by: Harvard Program in Refugee Trauma, Iraqi Mental Health Professionals, and Marwa Shoeb

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