

The health impact of (sexual) torture amongst Afghan, Iranian and Kurdish refugees: A literature review

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Key points of interest

- Despite the high prevalence of torture in Iran, Afghanistan and the geo-cultural region of Kurdistan, there is a lack of health-related research on this population. This is particularly true for Afghans.
- There is no health research on sexual torture focused on Afghan, Iranian and Kurdish survivors.
- Culture, gender and sexuality mediate the embodied experience of trauma. Therefore, they need to be more than a mere 'footnote' in trauma research.

Abstract

Background: Amongst Muslim majority countries, torture is reported most in Afghanistan and Iran. In addition, despite the significant impact of sexual violence on individuals and public health, the issue has been poorly researched amongst victims of torture. *Objectives:* The original intention of this paper was to review the health impact of sexual torture amongst Iranian and Afghan refugees in high-income countries; however,

a comprehensive search of relevant databases did not produce any results. The aim of this review was then altered to examine those health-related studies that explored the impact of torture in this population. Special attention was given to the discussion of gender and sexual violence in those studies.

Methodology: Web of Science, PILOTS, Medline, PsycINFO, Scopus, Popline and the online catalogue at DIGNITY were searched for health studies that examined the health impact or predictors of adverse health outcomes in Afghan, Iranian and Kurdish refugee survivors of torture.

Outcome: Seven papers were identified and examined in this review. The results were limited by the diverse methodologies, by the use of psychiatric tools that had not been validated in this population, and by small sample sizes. Since there is a high prevalence of sexual torture in Iranian and Kurdish refugees, the issue merits greater attention in this population. Studies are most limited amongst the Afghan population. Moreover, there is a great need for further culture-and-gender-specific health research in torture survivors from Muslim backgrounds.

Keywords: Sexual torture, health, Muslims, refugees

Introduction

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Refugees (UNHCR)¹ estimates that 15% of the 25.4 million refugees worldwide try to settle in developed countries. Many of them have experienced various types of trauma, trauma, torture being amongst them.

Torture can result in a plethora of physical problems, including shame, guilt, social withdrawal, substance abuse as well as a variety of mental health problems (Isakson & Jurkovic, 2013). A large systematic review and meta-analysis undertaken by Steel et al. (2009) that included 81,866 refugees from 40 countries found that torture was associated with 23.6% cases of post-traumatic stress disorders (PTSD) and 14% of depression.

While reports on the prevalence of torture in asylum seekers vary widely, estimates range from 30% to 84% (Duffy et al., 2016, Kalt et al., 2013). Similarly, sexual torture is reported by 63% - 80% of female and 25% - 56% of male torture survivors in high-income countries (Busch et al., 2015; Lunde & Ortmann, 1990). The 1984 UN Convention against Torture regards sexual torture as any sexual offence conducted by or at the direction of official authorities that results in mental and physical suffering.^{2,3} It is reasonable to assume that the actual rates of sexual torture are higher than estimated since it is well known that sexual violence is either never explicitly admitted to or is disclosed late (Leatherman, 2011, Peel, 2004; Oosterhoff, 2004; Patel & Mahtani, 2004).

This silence surrounding sexual torture is worth our attention. There is little doubt that the physical and psychological methods and the impact of all forms of torture are impossible to decouple. Yet, there seems to be something unique about sexual torture that leads to a level of stigmatisation and silence far beyond other forms of torture (Canning, 2015; Sansani, 2004). One explanation that has been offered is that no other type of violence targets the individual's identity and sense of a coherent self in the same way that sexual violence does (Agger, 1989). The 'self' we are referring to, however, is a cultured and gendered entity in a socio-political context.

There is indeed some evidence for this context-dependent impact of torture. Cross-cultural research acknowledges a link between the response to a traumatic event and socio-cultural factors (Jobson 2009; Summerfield, 1999). After all, people's values, attitudes and behaviours and the way they perceive the social world determine their experience (Berry et al., 1992). For instance, it is suggested that the subjective perception of the severity of torture and the sense of loss of control correspond with mental health outcomes in survivors (Basoglu & Parker, 1995). Further, Leaman's and Gee's (2012) analysis of 131 African torture survivors in the U.S. illustrates that 'positive religious coping' is a protective factor from adverse mental health outcomes in relation to physical torture. This, however, does not hold true for sexual torture. In contrast, another recent U.S. study by Song and colleagues (2015) reveals that being of Muslim faith is one of the characteristics associated with adverse mental health outcomes in tortured refugees. Culture, religious/political affiliations, and sociodemographic variables impact individual and societal responses to sexual

¹ 2017 in Review - Trends at a Glance: <http://www.unhcr.org/5b27be547.pdf>

² Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. United Nations General Assembly: <http://www.un.org/documents/ga/res/39/a39r046.htm>

³ Many scholars have contested the UN definition of torture. See for example V. Canning (2015).

assault (Burt, 1980; Suarez & Gadalla, 2010). It is however clear that both gender and sexual torture have received far too little attention in academia.

Gender is not only an identity marker but also a “social structure” that places people, relationships and human activities in hierarchical categories in a manner symbolically associated with masculinity and femininity (Mazurana & Proctor, 2013, p. 2). Seen in this light, it becomes evident that men and women, having been exposed to different cultural messages, will appraise and interpret sexual violence, which is an attack on their sense of “private” and “social” self, differently (Sansani, 2004, p. 352). It also seems likely that the multiplicity of traumatic experiences—polyvictimisation—influences the prevalence of PTSD in tortured refugees (Young & Chan, 2015, p. 26). Unsurprisingly, polytraumatisation is more prevalent among female refugees (Kastrup & Arcel, 2004; Kira & Tummala-Narra, 2015). Having interviewed 160 women at a centre for treatment of torture survivors, Kira et al. (2010) argue that while gender discrimination is not directly associated with PTSD, being female increases the risk of PTSD through a direct increase of cumulative traumatogenic dynamics, stressors that predispose an individual to respond differently to new traumas. Tellingly, an evaluation of the literature related to health and refugees suggests a higher rate of mental health disorders in female refugees compared to male refugees (Hollander et al., 2011); however, the relationship between gender and psychopathology after trauma remains inconsistent and contradictory. In 2008, a review of predictors of PTSD in survivors of war and torture by Johnson and Thompson found female gender to be a risk factor. It is important to note that this finding was not replicated in the systematic review of Bogic et al. (2015), which investigated the long-term

mental health effects of war trauma. Still, their research uncovered a higher prevalence of anxiety in women.

Taking all the above into consideration and bearing in mind the significant number of torture survivors from Muslim-majority countries such as Afghanistan and Iran,⁴ it is striking that health-related research on sexual torture in this population is largely absent from the main corpus of academic literature. A recent systematic review of health impacts of war-related sexual violence (not sexual torture specifically) from 1981 to 2014 identified just 18 papers from five sub-Saharan countries and two papers on Croatia (Ba & Bhopal, 2017). It is important to recognise that this time period coincides with the Iranian revolution, the Iran-Iraq war, the conflict in Afghanistan as well as the ongoing Israel-Palestine conflict, a dispute where sexual assault has been reported on Palestinian men by Israeli authorities (Weishut, 2015). Similarly, publications by the organisations Justice for Iran⁵ and the Iran Human Rights Documentation Center⁶ detail hundreds of testimonies indicating a high prevalence of rape of women in the prisons of the Islamic Republic of Iran. Even so, research often treats sexual torture in Muslim countries as a mere ‘footnote’ or frames it within a human rights and international relations perspective rather than a dynamic founded in health care.

⁴ Where does torture happen? www.freedomfrom-torture.org/page/where_does_torture_happen

⁵ Justice for Iran: <http://justice4iran.org/category/publication/>. See especially: “Raped out of Paradise: Women in Prisons of the Islamic Republic of Iran” (June 2013)

⁶ Reports by Iran Human Rights Documentation Center: <http://www.iranhrdc.org/english/publications/reports/index.1.html>

Purpose of the review

In order to address this gap in the research and respond to evidence that supports a link between the impact of trauma and a victim's socio-cultural background, this review initially intended to investigate the reported health effects of sexual torture amongst Afghans and Iranians; Kurdish survivors were also included since Iran has a substantial Kurdish population. While some Kurdish refugees may have originated from Iraq, Syria or Turkey, those countries were omitted to limit the socio-cultural diversity of the participants. However, a search through the main health databases produced no health-related results on sexual torture. It was therefore decided to broaden the topic to examine health-related literature covering torture in general in Afghan, Iranian or Kurdish asylum seekers/refugees. Special attention was paid to discussions of sexual violence or gender in the studies. This review therefore focuses on papers that study Afghan, Iranian or Kurdish torture survivors and:

- 1) report on the health impacts of torture in general;
- 2) or discuss the predictors of the adverse health outcomes.

Methods

Selection criteria

Studies were eligible for inclusion in this review if they: (1) reported on Afghan, Iranian or Kurdish refugees in high-income countries; (2) presented data on refugees from these groups who were torture survivors; and (3) explored the physical/mental health impact of such torture.

Case reports, editorials, opinions and discussions investigating the effectiveness of particular interventions and studies measuring the sensitivity of a psychological tool were excluded. Studies that examined

refugees as a general population, rather than specifying their ethnic/national background, or focused on a diverse range of traumas, such as soldiers from conflict zones, were also excluded.

Search strategy

Web of Science, PILOTS, Medline, PsycINFO and Scopus were searched using subject headings (e.g. mental disorders, refugees, emigrants, sex offence, rape, torture) and keywords (e.g. PTSD, migrants, displaced persons, sexual violence). Papers from Popline were also added by searching for refugees and torture. Additionally, the online catalogue at DIGNITY⁷—Danish Institute Against Torture Documentation Centre and Library—was examined separately for items indexed with the term 'sexual torture'. Due to language barriers, only papers in English, Persian and Dari were included. No Kurdish papers were found. The search considered refugees to any countries and there was no date limit applied.

Data extraction and analysis

After removing duplicates, 114 studies were identified in the main databases and 235 more in the library of DIGNITY. Their titles and abstracts were examined against the inclusion criteria. When a review of the abstract of a paper did not clarify its relevance, the study was retrieved and reviewed in full text. Ultimately, a total of seven papers met the review criteria and their information on study design, participants, setting, measurement tools and outcomes were extracted and summarised (see Table 1).

⁷ DIGNITY is a Danish Human Rights Institute specialising in clinical and research work on torture at an international level.

Most studies included participants from more than one country; therefore, studies were only included where the nationalities of participants were explicit and a substantial number of them (set at one-third as expecting a higher number was unrealistic and a lower figure was considered insignificant) were Afghans, Iranians or Kurds.

As outlined in Figure 1 (see Appendix 1), following the initial screening, 97 studies from the main databases were excluded on the basis of their abstracts. After examining the full texts of the remaining 17 papers, six were retained for inclusion in this review. Of the 11 papers that were removed, two did not report on torture survivors, five included a heterogeneous group with insufficient participation by the cohort of interest, two were single case reports, and two investigated interventions.

All 235 papers from DIGNITY were examined individually, and after discarding those studies with a human rights rather than a health or medical framework, only one paper was retained. This resulted in a total of seven papers that are included in the review.

Findings

Table 1 summarises the main findings of this review.

Description of selected studies

Of the seven papers included, four were conducted in Scandinavian countries, predominantly in Denmark (three), while the other two locations were Germany (one) and the United Kingdom (two). Four study designs were cross-sectional, one longitudinal and two were case-file reviews. Three studies recruited only Iranian refugees, and one study exclusively focused on Kurdish torture survivors (both from Freedom from Torture (FFT) in the UK); the remaining studies

had an ethnically mixed group. Sample sizes ranged from 17 to 139.

Health outcomes and measurement

The papers measured physical and mental health outcomes, predictors of mental health, and the functional impairment that can occur as a result of torture. A diverse methodology was used (see Table 1). The symptoms of PTSD were defined through the Diagnostic and Statistical Manual of Mental Disorders (DSM).

The two studies conducted at FFT (Bradley & Tawfiq, 2006; FFT, 2013) reviewed records of comprehensive interviews conducted by doctors trained to recognise symptoms of torture in accordance with the Istanbul Protocol.⁸ Within this context, depression, anxiety and PTSD were defined according to the DSM criteria. In the five other studies, various psychometric tools were used to supplement interviews; apart from the two studies undertaken by Morville et al. (2014, 2015), different instruments were used in the studies. The following well-known questionnaires were utilised to measure trauma, anxiety and depression: self-reported questionnaires such as the HTQ (Harvard Trauma Questionnaire),⁹ Hopkin Symptom Checklist-25 (HSCL-25),¹⁰ the Hamilton Rating Scale for Depression (HAMD)¹¹

⁸ Istanbul Protocol is an official UN manual for examination and documentation of torture. See <http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf>

⁹ See Harvard Programme in Refugee Trauma for full questionnaire: <http://hprt-cambridge.org/screening/harvard-trauma-questionnaire/>

¹⁰ Ibid. <http://hprt-cambridge.org/screening/hopkins-symptom-checklist/>

¹¹ Ibid. <http://hprt-cambridge.org/screening/hopkins-symptom-checklist/>

Table 1: *Summary of main findings*

Author	Title of publication	Study site	Measurements	Study design and sampling	Health outcome	Predictors of health outcome
Priebe & Esmaili 1997	Long-Term Mental Seque- lae of Torture in Iran-Who Seeks Treatment?	Germany	Interviews Symptoms self-rated on the full 65-item version of the von Zerssen Complaints Observer ratings of psychopathology (Hamilton Rating Scale for Depression (HAMD) and the Hamilton Rating Scale for Anxiety (HAMA) PTSD-symptoms as defined in DSM-III	Cross-sectional Purposive sampling N=34 Iranian torture survivors	PTSD: 53%	Poor language skills and PTSD symptoms of arousal and intrusion associated with therapy-seeking behavior
Ghaz- inour et al. (2003)	Personality Related to Coping and Social Support Among Iranian Refugees in Sweden.	Sweden	Beck Depression Inventory (BDI) Temperament and Character Inventory (TCI) The Coping Resources Inventory Schedule of Social Interaction Symptom-Checklist- 90 (SCL-90-R) Global Severity Index (GSI) Pos. Symptom Total (PST) Pos. Symptom Distress Index (PSDI)	Cross-sectional Convenience sampling. N=100 Iranian refugees (Soldiers 45% Prisoners and Tortured victims 25% + civilians in war)		Good social support, being self-directed and not harm-avoidant and being female associated with less psychopathological disorders
Bradley & Tawfiq (2006)	The Physical and Psychological Effects of Torture in Kurds Seeking Asylum in the United Kingdom	UK FFT	Records, interviews and examination with interpreter	Retrospective Case file review 97 Kurdish torture survivors	PTSD: 14% Anxiety: 7% Major depression: 7% Chronic pain: 22% Sexual assault: 30% of women	No association between chronic pain and psychological problems No association between sexual assault and psychological problems Association between reporting sexual torture and female gender No association between gender and psychopathology

Author	Title of publication	Study site	Measurements	Study design and sampling	Health outcome	Predictors of health outcome
Carlson et al. (2006)	Mental Health and Health-Related Quality of Life A 10-Year Follow-Up of Tortured Refugees	Denmark Reha-bilitation and Re-search Centre for Tor-ture Vic-tims	Interviews Harvard Trauma Questionnaire (HTQ) HSCL-25 Hopkin Symptom check-list-25 (HSCL-25)	Longitudi-nal study All new pa-tients from 1991-1994. Follow-up conducted in 2002-2003 N= 139 (126 men and 13 women) 33.7% Iranians 29.5% Ira-qis, 18.7% Lebanese. 63.8% Muslims	PTSD: 56.1% Depression: 69.1%	Time factor: After 10 years Health-related quality of life and mental health symptoms im-proved Physical pain: the main predictor of mental health symptoms at baseline but not long-term Long-term, the main factors associated with emotional distress and poor quality of life were poor social support and unemployment Higher education levels were linked with increased anxiety
FFT Country report (2013)	We will make you regret every-thing: Torture in Iran since the 2009 election. Freedom from Torture Country Reporting	UK FFT	Detailed forensic evidence obtained for medico-legal reports	System-atic Case Review A total of 50 clients (40 men and 10 women) who had been de-tained and tortured from 2009 onwards and had given consent for research.	Sexual tor-ture in 60% of the clients (n=6 women, n= 24 men) Chronic pain: 48% PTSD: 90% (n=45) Depression: 54% (n=27) Suicidal ideation: 54% (n=27) Self-harm: 20% (n=10) Attempted suicide: 12% (n=6)	Gender not associated with prevalence of sexual torture

Author	Title of publication	Study site	Measurements	Study design and sampling	Health outcome	Predictors of health outcome
Morville et al. (2014)	Activity of Daily Living Performance amongst Danish Asylum Seekers: A cross-sectional study	Denmark Asylum centres	Observation-based test assessment of motor & process skills Interviews using WHO wellbeing index Major Depression inventory (MDI) pain detect questionnaire (PDQ) for neuropathic pain Self-rated Health (SRH) Activities of daily living measured (ADL) and AMPS= Assessment of Motor and Process Skills (AMPS) Telephone interpreters used	Cross-sectional study All new asylum seekers from Feb to June 2011 recruited. Identified through Danish Red Cross N= 43 (36 male, 7 female) Iran (42%), Afghanistan (39%) and Syria 77% tortured Participants	Severe depression: 37% Moderate depression: 16% Mild depression: 12% Impaired Physical and mental health Activities of daily Living (ADL) compared to general population 35% reduction in ADL process skills 27% reduction in ADL motor skills	Statistically significant correlation between ADL competency and pain as well as psychological distress, but no difference between tortured and non-tortured asylum seekers
Morville et al. (2015)	A Longitudinal Study of Changes in Asylum Seekers Ability Regarding Activities of Daily Living During Their Stay in the Asylum Center	Denmark Asylum centres	Interview, questionnaire as Morville (2014)	Cross-sectional study Participants from previous research (Merville, 2014) N=17 (3 women and 14 men) Iranian: n=8 Afghanistan: n=6 Syrians: n=3 Asylum seekers, mainly torture survivors (n=14)	Pain: 72% in tortured and non-tortured refugees	Decrease in ADL-ability (see above) and an increase in pain and mental health problems after 10 months

and Anxiety (HAMA),¹² Beck Depression Inventory (BDI),¹³ and the Major Depression Inventory (MDI).¹⁴

Morville et al. (2014, 2015) also collected data on the impairment of Activities of Daily Living (ADL) such as household chores, management of money, and social relations. ADL-ability was measured using Assessment of Motor and Process Skills (AMPS). This is a tool which has been standardised cross-culturally on more than 150,000 individuals. It evaluates problems in terms of motor functions (moving self and objects) and processes (organising and adapting actions).

Only Carlsson et al. (2006) reported on translating and back-translating the questionnaires into the respondents' native languages. They also operated WHO Quality of Life-BREF (WHOQOL-Bref), a cross-culturally applicable tool for the assessment of quality of life that comprises psychological, physical, social and environmental factors.¹⁵ Questionnaires used by Ghazinour et al. (2003) were all self-reported and in Swedish because of the linguistic skills of the Iranian participants.

To synthesise data stemming from diverse outcome measures and different categories, the discussion of results is divided into two sections that are based on the main topics covered in the papers. In the first part, the focus will be the health outcomes of torture

victims, and in the second section, the predictors of mental health will be explored.

Health impacts of torture

Six papers provided prevalence rates of PTSD, but only four discussed other health impacts of torture, such as chronic pain, impairment of ADL, depression, anxiety, and suicidal ideation and attempts (see Table 1).

The evidence for the pervasiveness of psychopathology in survivors of torture was considerable; however, the prevalence rates varied widely: PTSD (14% - 90%), anxiety (7%) and depression (7% - 69.1%). The highest PTSD rates came from a Country Report for the UN Special Rapporteur on the status of human rights in Iran (FFT, 2013). This report was informed by a systematic case review of 50 forensic medico-legal reports (40 male and 10 female). Most clients were urban, well-educated and skilled professionals. 54% (n=27) of them had suicidal ideations. Attempted suicide was reported in 12% (n=6) and self-harm in 20% (n=10). The prevalence of sexual torture for Kurdish and Iranian clients at FFT was, respectively, 30% - 60% for women and 1% - 60% for men (Bradley & Tawfiq, 2006, FFT, 2013).

Morville et al's (2014, 2015) papers indicated a reduction of 35% in ADL process skills and 27% in ADL motor capabilities in traumatised asylum seekers compared to the general population. In addition, 72% of their participants suffered from pain (n=31) with headache being the most prevalent site. Neuropathic pain was present in 9% (n=4). In comparison, the prevalence of chronic pain in FFT clients was significantly lower at 48% for Iranian victims (FFT, 2013) and 22% for Kurdish participants (Bradley & Tawfiq 2006). 12% were disabled due to their physical injuries.

¹² See <http://www.assessmentpsychology.com/HAMA.pdf>

¹³ See <http://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/beck-depression.aspx>

¹⁴ See <https://psychology-tools.com/major-depression-inventory/>

¹⁵ See WHOQOL-Bref at http://www.who.int/mental_health/media/en/76.pdf

Predictors of adverse mental health outcomes

All seven papers in this review commented on predictors of mental health problems, but the central focus remained on pre-migratory factors such as education, personality characteristics and coping mechanisms as well as post-migratory determinants like time since resettlement, social support, employment and language skills.

Personality characteristics and socio-economic factors

Ghazinour et al. (2003) found that low scores on the Beck Depression Inventory were associated with harm-avoidance, self-directedness (sense of individuality) and cooperativeness (being part of a whole) as well as good social support. The latter was highlighted as the most significant correlate to mental health by Carlsson et al. (2006). Their results suggested that the main long-term factors associated with emotional distress and poor quality of life were poor social support ($p < 0.01$) and unemployment ($p < 0.001$). Also noteworthy is that higher education levels were linked with increased anxiety ($p < 0.05$).

Physical pain

Bradley & Tawfiq (2006) asserted that there was no association between the experience of chronic pain and psychological symptoms. Yet, this was disputed by Carlsson et al. (2006) who investigated survivors who had undergone an initial assessment at a Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen from 1991-1994 and then were reassessed ten years later. At follow-up, the study had 139 participants, equaling 63% of the originally recruited individuals. They maintained that chronic pain was a predictor of mental health problems in the proximity

of trauma. However, this predictor was not determinative ten years into resettlement. Morville et al. (2014) also claimed a statistically significant correlation between ADL competency and pain, though the tortured clients did not differ from non-tortured groups in terms of both pain and psychopathology.

Time

Time has been described as a variable that may influence the mental health of refugees. Morville et al. (2014, 2015) showed a decline in ADL-ability as well as an increase in pain and depression over time. In contrast, Carlsson et al. (2006) found that health-related quality of life improved for participants after living in their adopted country for a substantial period of time ($p < 0.01$). Moreover, after controlling for gender and age, mental health symptoms were significantly less at follow-up ($p < 0.001$). This mirrors the body of current literature proposing that the proximity of time to exposure to torture is directly linked to depression and PTSD (Steel et al., 2009). Morville et al's (2015) contrary findings can be ascribed to the small sample size as well as the timing of the follow-up which was only ten months after arrival, a period of time that can be argued to still be in the early days of migration.

Gender

Gender as a predictor was addressed in two papers. In Ghazinour et al's (2003) study, women exposed to trauma were less likely than men to display psychopathological disorders ($p < 0.01$). Yet, Bradley & Tawfiq (2006) did not find any correlation between gender and mental health; although women who had been sexually assaulted reported psychological disorders more often, this was not statistically significant.

Help-seeking behavior

Lastly, language skills, besides higher levels of PTSD symptoms of arousal and intrusion, emerged as likely predictors of therapy-seeking behaviors in Iranian torture survivors (Priebe & Esmaili, 1997).

Discussion

Typically, methodologically robust investigations reveal a lower prevalence of psychopathology in tortured refugees than weaker studies. Smaller samples, self-reported questionnaires and point prevalence, rather than period prevalence, produce higher rates of symptoms (Kalt et al., 2013; Johnson & Thompson, 2008). Further issues are the inter-study heterogeneity in connection with the outcome measures that lack cross-cultural validity. Most studies also suffer from the fact that they were cross-sectional, which carries the major limitation that causal determinants of health cannot be established. There were two thorough record reviews conducted at FFT (Bradley & Tawfiq, 2006, FFT, 2013). Large variations were still observed. For example, sexual torture had occurred in 60% of Iranian men and 60% of Iranian women as opposed to 30% of Kurdish women and 1% of Kurdish men. The prevalence rates for health outcomes varied too—PTSD in 14%-90% and chronic pain in 22%-48% of participants—with higher rates reported by Iranian survivors.

It is also remarkable how little research exists on Afghan survivors of torture. In this paper, they were only represented in Morville et al's studies (2014, 2015). Azam Dadfar (1994), who had worked as a psychiatrist in a refugee camp for Afghans in Pakistan from 1987 to 1990, has documented a prevalence of 51% for anxiety disorders, PTSD and depression. He also noted substance abuse, mistrust and rage in men and higher

vulnerability to psychological and physical suffering in women.

With respect to predictors of mental health, better mental health outcomes were positively associated with social support, language skills, employment and amount of time living in the host country as well certain personality characteristics. An association between physical pain and poor mental health was suspected in the short-term but not the long-term.

Regarding the role that gender and sexual violence play in mental health outcomes, Bradley & Tawfiq's (2006) findings are consistent with Steel et al's (2009) meta-analysis that did not reveal any statistically significant association between gender and PTSD or depression in traumatised refugees. However, only a small percentage (15%) of their participants were women. In contrast, a recent retrospective study undertaken in the U.S. examined the correlation between demographics and type of torture in 235 individuals, and it found that PTSD, anxiety and depression were significantly correlated with rape (Hooberman et al., 2007). Similarly, an association between suicidal ideation and being female or having a history of sexual torture has been illustrated (FFT, 2013; Lerner et al., 2016).

Limitations of the review

The current study was unable to analyse the grey literature and papers in Turkish and a formal quality assessment of the papers included in the review was not undertaken. Drawing conclusions from the cited studies are also limited because of the small sample size that was biased towards Scandinavian countries. It should also be noted that three out of the seven studies also comprised nationalities other than Iranians, Afghans and Kurds. The same applies to the types of trauma studied as three studies involved

stressors other than torture. Clearly, such broad metrics will limit the conclusions that can be drawn for victims of torture.

Conclusion

This literature review set out to examine the health impacts of sexual torture amongst Afghan, Iranian and Kurdish refugees in high-income countries; however, due to the absence of data specifically addressing this form of torture, the review shifted focus to torture in general while still paying close attention to gender and sexual violence as predictors of adverse health outcomes.

Based on the studies in this review, there is a high prevalence of psychological morbidity amongst Afghan, Iranian and Kurdish tortured refugees. Therefore, the most obvious contribution of this paper is the systematic demonstration that there is a dearth of robust research on this population, particularly Afghans. Moreover, despite its reported pervasiveness, sexual torture was not adequately investigated in the reviewed studies. This lack of scholarly attention is consistent with the widespread silence surrounding sexual torture in society. This silence on sexual torture needs to be broken and the urgency is best summarised in a report on sexual torture published by the human rights organisation Justice for Iran,¹⁶ where the authors point out that: “the public silence in this matter has meant that the victims of sexual torture had to find individual strategies to re-build their lives” (p. 31).

Torture does not occur in a vacuum. Neither is the torture survivor a hollow

object subjected to a trauma. Similarly, the ‘self’ is not singular but a fusion of unique positioning and diverse embodied experiences in time and place (Crenshaw, 1991). If health research and clinical practice are to address the needs of the service users, then a more nuanced and critical understanding of the ‘cause’ and response to suffering is required for. Jefferson (2017) remarks that the fight against torture is usually framed in a medicolegal, human rights, developmental or trauma narrative. This review aims to expand the lens to incorporate epistemologies from postmodern feminist discourse with its distinct conception of gender identity politics and power dynamics. Our theoretical frameworks are crucial because where we locate a problem will impact our priorities, adopted strategies, and resource allocation (Bracken, 2001, pp. 741-2). Therefore, the path towards developing culturally and gender-sensitive health research starts with the simple but powerful step of paying deliberate attention to gender, sexuality and culture in the design, data collection and analysis of research. This is feasible with quantitative and qualitative methodologies alike.

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¹⁶ Crime and Impunity - Sexual Torture of Women in Islamic Republic Prisons (2013). Justice for Iran (pp.31). Retrieved 20 October 2018 from <http://www.wluml.org/resource/crime-and-impunity-sexual-torture-women-islamic-republic-prisons>

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Appendix 1

Figure 1: Flow Chart of Study Selection

