



LONG-TERM EFFECT OF PSYCHOLOGICAL TRAUMA ON MENTAL HEALTH OF AGED PEOPLE DISPLACED AFTER WORLD WAR II

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BACKGROUND

Displaced people are of excess risk of poor psychological outcome due to forced migration, traumatic events, and resettlement in unfamiliar environments (Fazel et al. 2005). Unfortunately, the wide majority of studies on traumatic events are conducted in the immediate aftermath of the event, so that its long-term impact on psychological functioning remains unknown (Hunt & Gakenyi, 2005). Studies on short-to-medium term effects, leaving the possibility that early reactions could reduce naturally over time as well as trauma that occurred decades ago could resurfaces in frail elderly suffering from cognitive dysfunctions or emotional problems (Averill, 2000; Krause et al., 2004). The purpose of this study is to get an insight in the effect of lifetime trauma on processes of healthy aging. Specifically, in this analysis we aimed to assess the long-term effect of war-related trauma on mental and physical health in elderly people forced to migrate after World War II, now resettled in Hamburg, Germany.

METHODS

Within a population-based cohort-study (LUCAS, Longitudinal Urban Cohort Aging Study), we identified a community sample of 414 people, displaced after World War II. We sampled a n=414 control group without displacement, matched by gender and age. Participants were asked to fill in a postal survey composed by validated questionnaires assessing exposure to traumatic events, psychiatric symptoms, disability and use of health services as well as social, economic, pre- and post migration factors. The postal survey was completed by 466 (53%) adults. Mean length of resettlement was 52.7 years (SD 13.2) and mean time since self-perceived most severe traumatic event 58.8 years (SD 18.3).

MEASURES

Traumatic events: Harvard Trauma Questionnaire
Psychological health: depression and anxiety (PHQ); severity of posttraumatic symptoms (IES-R)
Physical health: global self-rated health (EUROHIS-8); checklist of chronic health conditions and activity restrictions (CCHS Health Survey)
Health utilization: amount health service consultations
Internal consistencies: satisfactory between $\alpha \leq 0.70$ and $\alpha \leq 0.97$.

SAMPLE

n=44 spouses excluded due to eliminate concordance in response to assesment in domestic setting.
Proof of Matching: all sociodemographic parameter are not significantly different

DEMOGRAPHICS	DISPLACED n=208	CONTROL n=214	EXPOSURE TO TRAUMATIC EVENT (HTQ; response as experienced)	DISPLACED n=208	CONTROL n=214
age (range 68-98; M,SD)	74.54 (5.27)	75.94 (6.31)	lack of food or water	163 (78.4%)	123 (58.9%)
gender			forced separation from family members	130 (63.1%)	55 (26.6%)
male	70 (33.7%)	82 (38.3%)	lack of shelter	127 (62.0%)	53 (25.9%)
female	137 (65.9%)	132 (61.7%)	combat situation	126 (61.5%)	86 (41.5%)
marital status			ill health without access to medical care	112 (54.4%)	50 (24.2%)
never married	11 (5.3%)	15 (7.1%)	being close to death	90 (43.9%)	56 (27.1%)
married	120 (58.3%)	108 (51.2%)	imprisonment (*)	20 (9.7%)	16 (7.8%)
seperated	2 (1.0%)	3 (1.4%)	unnatural death of family and or friend (*)	40 (19.5%)	32 (15.6%)
divorced	19 (9.2%)	17 (8.1%)	forced isolation from others	29 (14.1%)	8 (3.9%)
widowed	54 (26.2%)	68 (32.2%)	serious injury (*)	26 (12.6%)	22 (10.8%)
living status			murder of family or friend	20 (9.7%)	6 (2.9%)
alone	78 (38%)	93 (43.5%)	murder of stranger or strangers	18 (8.8%)	1 (0.5%)
with partner	119 (58.9%)	113 (53.3%)	rape or sexual abuse	15 (7.3%)	5 (2.4%)
with family	8 (3.9%)	4 (1.9%)	lost or kidnapped	12 (5.9%)	-----
other	2 (0.9%)	2 (0.9%)	torture	8 (3.9%)	-----
netto income			brainwashing	-----	-----
up to 500	14 (7.2%)	15 (7.2%)			
500 to 1000	55 (28.4%)	38 (18.4%)			
1000 to 2000	100 (51.5%)	128 (61.8%)			
above 2000	25 (12.9%)	26 (12.6%)			

all differences are significant at $p < 0.001$; unless noted. * not significant

HYPOTHESES

1. People who experienced displacement will exhibit greater depressive mood, anxiety and posttraumatic stress.
2. People who experienced displacement will exhibit less subjective health and greater amount of chronic conditions and activity restrictions.
3. Following the life change model (vulnerability perspective, Breslau et al., 1999), the more displaced people are exposed to cumulative trauma the greater the risk for probable poor health outcome.

RESULTS

	COMPARISON OF PSYCHOLOGICAL HEALTH STATUS				COMPARISON OF PHYSIOLOGICAL HEALTH STATUS				
	DISPLACED n=208 M (SD)	CONTROL n=214 M (SD)	F-VALUE F	p-VALUE $p \leq .05$	DISPLACED n=208 M (SD)	CONTROL n=214 M (SD)	F-VALUE F	p-VALUE $p \leq .05$	
DEPRESSION	5.10 (3.71)	4.18 (3.52)	1.080	0.010	GLOBAL SELF-RATED HEALTH	2.39 (0.62)	2.26 (0.61)	3.958	0.028
PANIC	0.51 (1.30)	0.32 (1.10)	9.341	0.052	NO. OF CHRONIC CONDITIONS	2.85 (2.03)	2.47 (1.68)	6.390	0.036
POSTTRAUMATIC STRESS	37.24 (25.39)	25.28 (25.50)	.212	0.0001	ACTIVITY RESTRICTIONS	1.65 (0.18)	1.62 (0.18)	.161	0.100

Displaced people experienced higher rates of traumatic events during their life. Findings regarding poorer outcomes are inconsistent. Displaced people exhibit greater depressive and posttraumatic stress, but no panic symptoms. Further they rate their perceived physical health as subjective worse and report more chronic conditions, but don't reveal as restricted in daily activities. Additional, having poorer health outcomes does not lead in this sample to higher numbers of health-care consultations during the last year ($p=0.463$).

ASSOCIATION BETWEEN INDICED OF HEALTH STATUS AND TRAUMA EXPOSURE IN DISPLACED PEOPLE

TRAUMA EXPOSURE	DEPRESSION		POSTTRAUMATIC STRESS		SELF-RATED HEALTH		CHRONIC CONDITIONS	
	DEFINED CASES CUT-OFF >10	ODDS RATIO (95% CI)	DEFINED CASES CUT-OFF>33	ODDS RATIO (95%CI)	DEFINED CASES BY MEAN	ODDS RATIO (95%CI)	DEFINED CASES BY MEAN	ODDS RATIO (95%)
NO TRAUMA	1		1		1		2	
1-5 TRAUMA	8	11.6 (*)	41	1.2 (*)	32	2.2	49	0.9
≥ 6 TRAUMA	15	4.8 (*)	57	1.0	47	0.9	48	1.2

Logistic regression analysis; * $p < 0.05$ for comparison with no exposure to trauma

Certain interaction between trauma exposure were associated with a higher risk of symptom severity. Trauma exposure is significantly associated with adverse psychological but not physical functioning. The high odds ratio (11.6 and 4.8) for depression are noteworthy. Overall, increased risks conferred by exposure to 1 – 5 trauma, reduce in exposure categories >6.

DISCUSSION

These findings demonstrate that there are long-term psychological disadvantages in people who are forced to migrate, although the current findings are inconsistent. This might be a result of:

1. Use of trauma exposure calculated in amount. We will conduct content and component analysis for defining trauma dimensions.
2. High co-morbidity within the sample. Will be treated: (a) in OR use of group without any diagnosis as reference; (b) consider possible association with trauma dimension as it is possible that overlapping but distinguishable stresses may trigger distinctive but co-occurring symptom complexes.
3. Effect of age cohorts. Will be treated: (a) split today's age cohorts to account for different steps in decline and frailty; (b) consider time since trauma to account for exposure at different developmental points in the life course.

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