



Survivors of Torture: A Hidden Population

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Introduction

Working with migrants and refugees clearly demonstrates that extreme life experiences clustered around war and different forms of persecution are frequently found in many of the groups encountered. Torture, an act forbidden by numerous international declarations and conventions, such as the United Nations Convention against Torture,^{1,2} remains a frequent and destructive form of persecution despite ratification of the Convention by a large number of countries. It has been documented that even children are submitted to torture in many countries.³ Although common, torture cannot be seen as a simple phenomenon, and the sequelae represent a complex challenge for treatment.

Definitions of Torture and Ethics Guidelines for Physicians

Conceptions of torture vary among cultures, legal systems, and organizations. Nevertheless, the essential elements of torture include the following: it is purposeful and systematic; it occurs in captivity, usually face-to-face; and it intends to destroy the victim's personality through the infliction of psychological or physical suffering.

The UN Convention Against Torture defines in Article 1: 'For the purposes of this Convention, torture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed,

or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.'¹ The World Medical Association (WMA) in its declaration of Tokyo offers a similar definition: 'For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason. The declaration of Tokyo as well as a later WMA declaration underline the duty of physicians not to participate in any such act, but to take an active stance in the fight against torture.'⁴

The importance of an active and responsible role of physicians against torture – prohibited without any exceptions – has been underlined in a recent WMA document.⁵ The same document, referring also to regional documents such as the American Convention on Human Rights in paragraph 19, specifically recommends that 'National Medical Associations support the adoption in their country of ethical rules and legislative provisions:

19.1 aimed at affirming the ethical obligation of physicians to report or denounce acts of torture or cruel, inhuman or degrading treatment of which they are aware;

19.2 establishing, to that effect, an ethical and legislative exception to professional confidentiality that allows the physician to report abuses, where possible with the subject's consent, but in certain circumstances where the victim is unable to express him/herself freely, without explicit consent.

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19.3 cautioning physicians to avoid putting individuals in danger by reporting on a named basis a victim who is deprived of freedom, subjected to constraint or threat or in a compromised psychological situation.

20. Disseminate to physicians the Istanbul Protocol.

21. Promote their training on the identification of different modes of torture and their sequelae.

22. Place at their disposal all useful information on reporting procedures, particularly to the national authorities, nongovernmental organisations and the International Criminal Court.⁵

These ethics guidelines support the increasing criticism about attempts of some governments, and physicians in those countries, to justify exceptions. The guidelines also refer to the Istanbul Protocol as the recommended UN standard for documentation of torture: 'In some cases, two ethical obligations are in conflict. International codes and ethical principles require the reporting of information concerning torture or maltreatment to a responsible body. In some jurisdictions, this is also a legal requirement. In some cases, however, patients may refuse to give consent to being examined for such purposes or to having the information gained from examination disclosed to others. They may be fearful of the risks of reprisals for themselves or their families. In such situations, health professionals have dual responsibilities: to the patient and to society at large, which has an interest in ensuring that justice is done and perpetrators of abuse are brought to justice. The fundamental principle of avoiding harm must feature prominently in consideration of such dilemmas. Health professionals should seek solutions that promote justice without breaking the individual's right to confidentiality. Advice should be sought from reliable agencies; in some cases this may be the national medical association or non-governmental agencies. Alternatively, with supportive encouragement, some reluctant patients may agree to disclosure within agreed parameters (Istanbul Protocol, paragraph 68).⁶

While the political discussion might at times lead to a blurring of standards,⁷ clear definitions of torture are a key precondition to prevention and legal guidelines, and partly overlapping concepts such as that of organized violence^{7,8} can be applied in situations such as the development of treatment programs.

Freedom from torture in this context should be seen as a major factor in healthcare and at the same time as a contribution to a civil society.

It might be noted that trends in perpetrator research – an issue of importance for, among other

reasons, prevention – indicate that, especially in mass violence or systematic torture, many torturers are literally the neighbor next door. They may have been mistreated, tortured themselves, or exposed to psychological manipulation, convincing them of the need to torture to protect society or as a moral obligation.⁹

Aims of Torture

Reasons for the use of torture vary. There may be individual motives such as greed, personal cruelty, or monetary gain. In cases of more systematic torture, political aims take precedence, including creating terror, stigmatizing, and damaging the assertiveness of opponents or nonconsenting minorities. Sometimes the victims are mistaken for someone else. Situations where torture occurs are not restricted to premises where one is deprived of liberty, such as prisons, police stations, and prison camps, but also to the public sphere, the streets, or even the homes of victims. Especially in these latter situations, friends or family members might witness torture and suffer psychological stress or traumatization without having been directly tortured themselves. Being forced to witness the torture of family members was a common method of indirect torture in the war-torn countries of Central America during the 1980s.

Prevalence of Torture

Every year, Amnesty International lists countries that practice torture and usually the list exceeds 120 countries. Table 50.1 displays selected studies documenting the prevalence of torture survivors among community samples of refugees. Estimates vary due to methodological issues and differences in the use of torture in those countries. In the 1990s, there were approximately 14 million refugees living in Western Europe and North America, of whom 5% to 35% (700 000 to 4.9 million) were believed to have been tortured.¹⁰ If this 5–35% figure is applied to more recent calculations of 23 million refugees, then up to 8 million tortured refugees exist worldwide. At the primary care practice level, a study of three urban medical clinics in Los Angeles, California, found that 7% of all foreign-born Latino patients had experienced political torture.¹¹ None of the patients recalled their primary care provider ever inquiring about their exposure to political violence or torture. It seems safe to say, therefore, that primary care

Table 50.1 Empirical studies including torture prevalence estimates in selected population samples

Primary author	Setting and sampling method	Sample size	Country of origin/study	Torture prevalence
Thonneau et al., 1990 ¹³	Western refugee setting: all applicants for refugee status in Quebec, Canada, referred to obligatory medical examination	1994	Composite/Canada	18%
Montgomery & Foldspang, 1994 ¹⁴	Western refugee setting: consecutive sampling of asylum seekers arriving in refugee reception center	74	Middle East/Denmark	28%
Kjersem, 1996 ¹⁵	Western refugee setting: all asylum-seekers arriving in Denmark 1.1.86–30.6.88	9579	Composite/Denmark	10.1%
Shresta et al., 1998 ¹⁶	Near-area refugee setting: identification of all physically tortured refugees in UNHCR camps in Southern Nepal	85078	Bhutan/Nepal	3%
Hondius et al., 2000 ¹⁷	Western refugee setting: refugees recruited to treatment center by flyers	156, dominated by non-help-seeking refugees	Turkey, Iran/Holland	76%
de Jong et al., 2001 ¹⁸	National sample: random selection from community populations in four countries	653 610 1200 585	Algeria Cambodia Ethiopia Gaza	8% 9% 26% 15%
Modvig, 2001 ¹⁹	National sample: random population sample	1033 household representatives	East Timor	30%
Iacopino et al., 2001 ¹⁵	Near-area refugee setting: random sample of households in Macedonian and Albanian refugee camps for Kosovars	1180 household representatives	Kosovo/Macedonia and Albania	4%
Tang & Fox, 2001 ¹⁶	Near-area refugee setting: Random sample of Senegalese refugees in two camps in Gambia (n = 242)	80	Senegal/Gambia	16%
Ekblad et al., 2002 ³⁸	Western refugee setting: random selection from airline lists of pre- accepted refugees arriving in Sweden (n = 2930)	402 sampled, 218 participated 98 participated in phase 2 follow-up	Kosovo/Sweden	51%
Lie, 2002 ³⁹	Western refugee setting: all settled refugees in 20 municipalities of Norway, May 1994–December 1995	791 invited, 462 contributed data	Composite/Norway	6% (14% witnessed torture)
Jaranson et al., 2004 ³⁷	Western refugee setting: representative community sample	1134	Ethiopia & Somalia/US	44%

Updated from Modvig J, Jaranson J. A global perspective of torture, political violence and health. In: Wilson JP, Drozdek B, editors. Broken spirits: the treatment of traumatized asylum seekers, refugees, war and torture victims. New York: Brunner-Routledge Press; 2004:42–43.

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Figure 50.1 A victim of 'falanga.' (We are grateful for Dr. Maria Piniou-Kalli of MRCT in Athens for supplying this photograph.)

physicians may be treating persons who survived political torture without knowing this and consequently may not fully meet their patients' needs. Studies in primary care populations from a mixture of countries find similar estimates of prevalence in primary care.¹²

Methods of Torture

While beatings are the most common form of torture, more specific techniques can be observed in many countries. Examples are shown in Table 50.2 but a listing of torture methods can never be complete because torturers are constantly inventing and varying methods.

Regional variation occurs in the specific forms of torture – often characterized by special names – such as 'telefono' (beatings to both ears with subsequent injuries to the outer and inner ear) and 'falanga' (beatings to the soles of the feet, leading to swelling, extreme and often chronic pain) (Fig. 50.1). Mutilating injuries consisting of, for example, amputation of limbs or other body parts are common in some regions, such as Rwanda or Iraq, and are, as is usually the case with torture, intended to punish or to create impairment and stigma.

In the realm of psychological torture methods, regional variations occur with cultural and social differences in what is considered shameful, unhealthy, or dangerous, or as a function of cultural and religious taboos. For instance, one of the authors (DE) interviewed and examined Tibetan nuns tortured by Chinese authorities. They reported that their torture included discarding their supplies used during menstruation in manners inconsistent with

their Tibetan Buddhist beliefs about discarding such bodily fluids. This led to imbalances in their spirit that were believed to cause their chronic symptoms similar to fatigue and depression. Hindu authorities in India cut the hair of Sikh men, another example of psychological torture that is regionally specific.

Though the physical aspects of torture might be more obvious, psychological techniques and psychological aspects of physical torture are nearly always present and strongly interact with the physical symptoms. Because psychological torture is so easy to hide and deny, it is often used instead of physical torture. As evidenced by recent debates in the United States and Europe, there is little agreement on what constitutes psychological torture, making it easier for it to be denied and called other things. Still, torture survivors have often told us that it was the psychological methods, such as mock execution or being forced to witness the torture of a friend, that caused them the most lasting harm.

Overall Health Effects

Torture may have both immediate and long-lasting physical and psychological consequences. As clinicians in countries receiving refugees, we rarely encounter the most immediate phases, and those coming for treatment may have undergone torture years prior to accessing care. The survivor may have been fleeing, lack money to pay for treatment, suffer stigma, or experience a refusal for treatment by the healthcare system. Injuries encountered, therefore, might be complicated by lack of timely treatment.

For many survivors, a visit to the primary healthcare clinic may be their only contact with healthcare services.²⁰ Help-seeking²¹ and the pattern of reporting of symptoms might be determined by interrelated factors such as gender, culture, and trauma-related factors such as shame or avoidance.^{21,22} Impairment can be caused by combinations of both physical and psychological factors.

Physical health effects

Certain types of torture may give rise to specific symptoms and signs and will usually be related to the severity of the applied method. 'Telefono' torture, for example, has been linked to tinnitus.²³ Violent shaking, a common torture technique in some countries, might lead to cerebral edema and subdural and retinal hemorrhage.²⁴ Some techniques may 'only' cause scars, but the more specific forms, such

Table 50.2 Overview of torture methods

Physical methods	Psychological methods
<p>Blunt trauma Unsystematic (beatings all over) Systematic (e.g. under the soles of the feet, i.e. 'falanga,' on both ears, i.e. 'telefono')</p> <p>Penetrating trauma Stinging (e.g. under nails) Cuttings (mutilation) Amputations Shots</p> <p>Crushing trauma Mutilation of, e.g. extremities by trampling</p> <p>Positional torture Fixation/restriction of movement by use of ropes, chains, straps Fixation in forced unphysiological positions, e.g. in small boxes, rooms or cages (the tortoise) Suspension with arms tied behind the back (Palestinian hanging), on a stick in the hollows of the knees, locked with tied wrists (the parrot stick), in feet or hair</p> <p>Shaking Shaking of the head for a long time</p> <p>Asphyxiation Near-drowning, e.g. in polluted water (submarino) Near-suffocation, e.g. by use of ropes or plastic bags (dry submarino)</p> <p>Chemical and physical torture Chemical tissue damage (e.g. skin, mucous membranes, underlying tissue) by use of acids, bases, inhalation of chilli, kerosene, etc. Physical tissue damage by use of electricity, cold, heat, or fire (burns)</p> <p>Pharmacological and microbiological torture Forced intake of toxic doses of, e.g. neuroleptics Inoculation of pathogenic bacteria or viruses (e.g. HIV) Deprivation of access to necessary medicine (e.g. insulin)</p> <p>Sexual Torture Rape, possibly forced between two victims Instrumentation of genitals</p> <p>Animal torture Enticing animals (dogs, rats, insects etc) to assault or attack a fixated victim</p>	<p>Humiliation Verbal humiliations, e.g. sexual humiliations and mocking Forced humiliating actions (e.g. breaking taboos, renouncing ideological, political or religious foundation) Depersonalization/dehumanization (e.g. being called by number instead of name, blindfolded for weeks or months) Interrogation in the nude</p> <p>Threats Against the victim (e.g. death threats, threats of rape, torture) Against the victim's family</p> <p>Mock executions</p> <p>Deprivation Of light and sound Of food and drink Of access to toilet facilities Of sleep Of company Of access to medicine and medical assistance</p> <p>Experiencing the torture of others</p>

From: Modvig J, Jaranson J. A global perspective of torture, political violence and health. In: John P. Wilson and Boris Drozdek, editors. Broken spirits: the treatment of traumatized asylum seekers, refugees, war and torture victims. New York: Brunner-Routledge Press, 2004:38–39.

as 'falanga' and hanging by a limb, may lead to lasting impairment and chronic pain.

Among the most frequently encountered complaints are chronic pains in the head and back. The chronic pain and tension may be accompanied by fibrositis and myofascial pain.²⁵⁻²⁸ In those who have been exposed to 'falanga',²⁵ we observe damage to connective tissue and damaged heels, thereby rendering walking painful and difficult, even years after the torture. Genital torture can be followed not only by psychological sequelae and sexual dysfunction, but also by chronic pain syndromes.²⁹ Especially in the identification of factors leading to chronic pain, an interdisciplinary and transcultural approach must be followed, as the expression of distress, emotions such as shame, and physical changes in tissue and neuroanatomical structures must be taken into consideration. For example, rhabdomyolysis after beatings has been observed to be linked to life-threatening renal failure.³⁰⁻³²

To document specific physical sequelae, detailed or digital imagery of superficial injuries and skin lesions can be augmented by specific radioimaging and other diagnostic techniques. Magnetic resonance imaging has been proven effective in many forms of injuries such as 'falanga' and blunt brain injuries.³³ Bone scintigraphy has been demonstrated to be effective in the documentation of injuries not detected by regular X-rays.^{34,35}

Psychiatric and psychosocial health effects

The psychological consequences following torture are frequently the most important sequelae as they are long-lasting and disabling. However, many torture survivors initially present with physical complaints and describe in detail various physical symptoms, while it is later that the psychological problems may be revealed.²⁰ Thus, Salvadoran refugees who suffered from war-related traumas may express their emotional distress with somatic complaints, though without connecting these complaints to their traumatic experiences. Still, persons who survive torture may suffer from functional disability simply due to their psychiatric symptoms, independent of both physical effects of the torture and of medical health status. Commonly, survivors exhibit a collection of psychological symptoms that do not fit a single psychiatric disorder or do not fulfill DSM-IV criteria³⁶ for a disorder, such as somatic symptoms with no obvious cause, depressed mood, insomnia, nightmares,

anxiety, difficulty concentrating, and avoidance of trauma reminders.

Torture destroys trust so that survivors may not trust others in their community or social networks, thus greatly reducing their resources for social support, employment, friendship, and adjustment to a new society. They may feel estranged from members of their own culture. This may be due to feelings of shame or to fear – often based on fact – that there are members of rival political groups in the country of exile who could threaten their family's safety back in their home country. Progressing through the asylum application process may be adversely affected if the survivor is afraid of government officials and persons in uniforms or if their post-traumatic stress disorder symptoms are provoked when encountering these reminders. These unique consequences of torture are often manifested in ways that are misinterpreted by non-health service providers. For example, our clients have encountered lawyers who do not fully appreciate how trauma impairs memory, social workers who may not understand why a torture survivor refuses to use an interpreter provided by the consulate of the survivor's country, and job placement services that erroneously ascribe a survivor's reluctance to wear a security guard uniform to an unwillingness to work.

Post-traumatic stress disorder

Diagnostic issues for refugees and immigrants are discussed elsewhere (see Ch. 49). However, there are aspects of diagnosis that need special emphasis when assessing torture survivors.

Post-traumatic stress disorder (PTSD) has been shown to be the most important but not the only diagnostic category in survivors of torture (for example, see references 16, 18, 20-22, 24, 26, 27). Estimates of PTSD prevalence among samples of torture survivors vary greatly due to differences between populations (see Table 49.1). The differences include the forms of torture and trauma exposure, the time that has passed since torture, the frequency and severity of exposure, and several other factors occurring before and after torture.^{17,18,22,37} Refugee status and exile must be seen as especially important factors, contributing to mental health symptoms^{17,37-39} and may influence mental health through their effects on social support or continued danger because of the risk of forced return. Symptoms might fluctuate, depending on coping strategies, social support, and stressors. News reports from the home country, war pictures, court situations, or asylum

procedures can trigger intrusive phases, while distraction through activity and work can lead to avoidant phases.

The development of PTSD might also be related to other protective and risk factors in survivors of torture. Basoglu et al. showed an increase in diagnoses of PTSD among tortured nonrefugees compared to matched controls (18% versus 4%, $p = 0.04$).^{40,41} In a nonrefugee group of Turkish political activists and nonactivists, Paker et al. found significant differences between those who had been tortured and those who had not been tortured in current PTSD (20% versus 4% in activists, 30% versus 0% in nonactivists) and current major depression (8% versus 0% for activists, and 23% versus 0% for nonactivists).⁴² Despite significant differences in mental health outcomes in the tortured and nontortured groups of Basoglu's and Paker's studies, the most striking finding was that the severity level of psychopathology was lower than expected, especially in the context of very severe and prolonged torture experiences. One explanation for this finding is that higher levels of political activism are associated with less severe levels of psychological symptoms. A matched-control study of tortured Tibetan nuns compared to nontortured Tibetan nuns found a differential effect of torture on forms of distress, with statistically nonsignificant differences in the rates of depression.⁴³ Protective factors such as strong belief systems (monastic Buddhism) and life in an environment that supported and nurtured their beliefs and culture (a monastery in Dharamsala, India) may have mitigated the occurrence of psychiatric symptoms. Dedication to Buddhist religion was recently shown to be a protective factor for both anxiety and depression in a study of tortured and nontortured Bhutanese refugees.¹⁶

Post-traumatic stress disorder does not adequately encompass the entire symptomatology of torture survivors.⁴⁴⁻⁴⁶ The category of 'complex' PTSD or DESNOS (disorder of extreme stress not otherwise specified) has been proposed to cover the complexity of torture and similar forms of extreme trauma.^{47,48} In spite of this extension of concepts, many important sequelae observed can best be described on a descriptive level. PTSD – especially after sexual violence – is often accompanied by 'associated symptoms' including shame and guilt feelings.⁴⁸ The last are of major importance as they appear to be responsible for much of the chronicity observed and interfere with social functioning lead to treatment avoidance, low treatment compliance, and other forms of self-punishing behavior. Such symptoms are also at least partly included in the complex PTSD

list of symptoms. In addition, dissociative symptoms that are frequent in trauma and torture survivors are also not completely covered by the DSM-IV PTSD concept and might require attention. Complex changes in behavior and personality, partly overlapping with some of the symptoms mentioned before, are covered by the new WHO ICD-10 category of 'Enduring personality change after catastrophic experiences' (F 62.0).⁴⁹

Comorbidity, especially with depression (MDD), with possible suicidality, is high and should not be neglected by a singular focus on PTSD.^{45,50} Brain trauma can create symptoms similar to PTSD and depression, especially impaired concentration, irritability, and a feeling of lack of energy, and must be diagnosed to avoid inadequate treatment.^{51,52}

Substance abuse, especially of alcohol or benzodiazepines, can be common in some populations, frequently as an effort of 'self-treatment' of symptoms of PTSD or depression. Suicidal ideation might be high, especially if there is no perspective of a future life.

Assessment of Torture Survivors

It is important to begin the assessment of torture with a caveat. To focus attention on torture above and beyond the other stressors and traumas commonly experienced by refugees may not always be to the patient's advantage. Torture may be just one of many traumatic stresses experienced by patients who have frequently endured years of persecution, war, exile, death of loved ones, immigration to a foreign culture with the attendant insecurities and threats to health and well-being, not to mention loss of property, position, and existential place in the world. In this context of years of stress and trauma, torture can be just one factor contributing to their current health status (Box 50.1).

General considerations discussed below should be kept in mind when offering treatment. Standard physical treatment approaches might be very effective if they include psychological help and assistance with legal and social needs. First, primary care clinicians must suspect that a patient was tortured. Given the high prevalence in refugee samples from both the community and primary care settings, one's suspicion should be raised often when evaluating refugees. Patients are unlikely to offer this information so clinicians should inquire (see Ch. 48). Some survivors may assert that they have 'put their experiences behind' them and don't want to be reminded about the pain. They don't believe that

Box 50.1**Case study 1**

A Bosnian woman had been repeatedly raped and tortured by soldiers for the express purpose of genocide. Some weeks before, neighbors had advised her to flee, but she did not want to leave the village she loved. Shortly after the rape, she lost contact with her husband, who had been taken away by soldiers, imprisoned, and then 'disappeared.' She decided to abort a child she had conceived during rape, since she could not deal with this. She escaped to a neighboring country, found work, but felt 'strange' and 'unreal.' She could not speak about these events, especially about the rape, and, since she could not get any news about her husband, she could not start to mourn or remarry. She had frequently consulted physicians for chronic lower back pain, but physical therapy and analgesic medication provided only limited reduction of symptoms. A gastroscopy recommended for gastric pain and a suspected abuse of analgesics was first avoided, and then refused shortly before the examination, because the patient experienced extreme fear, trembling, and sweating. In a consultation with a female psychiatrist, previously undiagnosed symptoms of severe PTSD, shame, and guilt feelings were identified. The 'normality' of such a reaction was discussed as part of a focused intervention, treatment with a selective serotonin reuptake inhibitor was recommended, and she was referred to a psychotherapist. At a later stage, family therapy was added, since the older of the patient's two daughters reported increasing problems at school. After 2 years, the patient was free of pain, had secured a better job, and had started a new relationship with a Croatian neighbor.

torture is still influencing their physical and mental health. Clinicians should not compel patients to discuss details but, instead, allow them to disclose events as they become comfortable, possibly over months or years.

Countries with widespread persecution create a climate of general distrust among their citizens. This may even compromise the trust in physicians, who, in their home countries, refused to treat torture survivors for fear or ideological reasons. Physicians were even suspected of giving confidential information to agents of the state or to other persecutors. Physicians may have been directly involved in their torture or have been present during the torture (to help torturers determine when their pain infliction

is approaching death). As a first step, trust has to be restored. It is especially important to affirm the safety and confidentiality of the doctor-patient relationship in primary care practice. Increasingly, torturers use methods that leave no scars or grossly visible evidence that torture has occurred. Consequently, survivors may feel that clinicians will not believe them if they tell the horrible truth.

It is also important to consider who is present in the treatment setting. Shame, fear of overburdening family members, or fear of stigma in the case of sexual torture or psychological symptoms might require a setting with only 'safe' members of the family. This must be balanced with the need for reassurance and cultural patterns regulating visits to the physician. Both mental health problems and known sexual violation might in some cases even lead to a threat to the victim's life and endanger the social standing or marriage prospects of other family members. Persistent reporting of somatoform or dissociative symptoms that do not respond to direct treatment again might be an indicator of such undisclosed sexual trauma and require a very sensitive approach. Specific to severe trauma, apparently harmless situations such as an ECG, a gastroscopy, or a general examination can lead to reactivation of unprocessed memories of torture.

Torture survivors often need a wide variety of service providers, including healthcare workers, social workers, immigration lawyers, job placement specialists, and English as a Second Language (ESL) teachers. This is beyond the resources of most primary care clinics and often the survivors themselves to coordinate these services toward the common goal of achieving healing. Communication between these health services, legal services, and social services is often difficult. Therefore, referral to specialized torture treatment programs and centers might be advisable.

The case management services offered by torture treatment centers help create a more seamless delivery of services and ensure that clients receive referrals in a timely manner. Often these centers provide an integrated team of physicians, mental health specialists, social workers, and a network of immigration lawyers who provide multidisciplinary care for survivors. For instance, social workers may assist them with job training and obtaining citizenship, and lawyers may help solve legal problems. These centers are often eager to receive referrals from primary care clinicians and often provide training about torture survivors for the primary care staff. Our clinical experience is that a high proportion of survivors who are able to attend these centers

improve significantly in a year or two. This may reflect selection biases (persons who can attend these centers on a regular basis may be intrinsically different from those who can not), or the value of integrated and multidisciplinary services beyond medicine and psychology. Empirical evidence is lacking that specialized centers achieve improved treatment outcomes over standard care. Centers can be found in most major cities in the US, although access to these may be difficult for many survivors due to limited hours or transportation obstacles. Websites include the National Consortium of Torture Treatment Programs (NCTTP) <http://ncttp>, Doctors of the World <http://www.doctorsoftheworld.org/>, and Physicians for Human Rights <http://www.phrusa.org>. In other countries, IRCT and IRCT-affiliated centers can offer advice or treatment (<http://www.irct.org>). When referring, care should be taken to avoid a feeling of inadequacy or stigma in the patients. Benefits should be carefully explained.

Irritation, disbelief, avoidance, or aggression by the therapist or treating physician can indicate counter-transference feelings, which strongly influence the interaction with the patient. Calming down, discussion with colleagues, or supervision can help to maintain a therapeutic attitude and keep treatment effective. Especially if working with severely traumatized clients on the longer term, therapists or physicians risk vicarious traumatization or secondary traumatic stress (STS), the psychological, spiritual, and social effects of working with trauma victims and of exposure to the traumatic stories they tell. Burn-out prevention strategies, and possibly special training, are required. According to Charles Figley,⁵³ STS is the constellation of emotional and behavioral responses that can result from 'knowledge about a traumatizing event experience[d] by a significant other. It is the stress resulting from *helping or wanting to help* a traumatized or suffering person.' Also termed 'compassion fatigue' and 'co-victimization,' it is *secondary* trauma because the trauma is experienced vicariously, through a person being a witness or a recorder to another's story. The manifestations of STS can mirror the psychological symptoms experienced by the victim. For instance, STS may include feelings of depression, irritability, intrusive recollections ('I can't get it out of my head'), sleep disturbances, nightmares, emotional numbing, or intolerance of others' experiences, especially the stresses of daily life. It might be noted that culture shock can work both ways and create an additional element of stress in both the patient and the therapist.

Treatment of Mental Health Sequelae of Torture

Besides the special care necessary to form a positive general environment and interaction, disturbed sleep patterns, as part of PTSD, MDD, or more specific reactions to imprisonment, might be the first target symptoms. The fear of memories and nightmares related to the torture experience and exhaustion due to sleep deprivation can impair any self-healing and coping strategies. Trazadone and similar antidepressants can help to re-establish normal sleeping patterns and avoid dependency problems.⁵⁴ Other pharmacological treatment strategies are discussed in Chapter 49.

An integrated treatment package would necessarily include counseling and/or culturally adequate forms of psychotherapy, which even might be first-line interventions in many cases.

Support should be given to the survivor in finding a therapist experienced in trauma or torture treatment. Specific therapeutic strategies might consist of modifications of standard therapeutic modalities such as cognitive behavior therapy (CBT) and could be augmented by newly developed techniques such as eye movement desensitization and reprocessing (EMDR)⁵⁵ and testimony therapy,⁵⁶ the last a specific approach for the treatment of survivors of torture.

The stigmatization common in many cultures to mental health remains an important issue that requires careful handling and providing adequate information to the patient. Again, brain trauma must be considered in patients with a history of beatings or falling, especially if symptoms such as irritability and concentration difficulties persist in spite of otherwise adequate treatment and recovery.

Forensic Evaluations

Forensic issues, although not common in everyday practice, might be important in several situations. Particularly, two situations might still require a precise and complete reporting outside of general documentation and treatment needs: asylum procedures and documentation for courts.

Many survivors of torture seek asylum or other forms of protection in host countries. During asylum procedures, documenting sequelae can be a key factor in offering help. In many asylum cases, victims are denied or financially unable to access an independent expert, and documentation can be seen as

the next best alternative. The special trust developed with an independent expert can help with a forensic strategy that avoids retraumatization.

Compensation for physical and psychological injuries encountered might require forensic documentation as an important form of evidence and can provide support for the victim.

The international standard recommended in the forensic documentation is the Istanbul Protocol (IP) that can be downloaded from the UNHCR website.⁵ The IP gives detailed explanations about different sequelae, diagnostic and documentation strategies, and can also be a helpful tool in the general medical work with torture survivors.⁶

Lawyers and judges in this context frequently question statements by victims of torture, not understanding the importance of typical sequelae. Post-traumatic disorders and brain injury can interfere with a complete or uncontradictory reporting of the experiences encountered by the survivor through physical or psychological mechanisms. Negative findings might also reflect a discrepancy between memories and physical sequelae. Factors influencing incomplete recall, especially of physical violence, include shame or guilt feelings, the natural course of healing, and efforts to hide torture techniques. Opinions must be formulated with care to avoid discrediting survivor. Information about the general medical and psychological status of torture survivors might be helpful for lawyers and judges, who commonly model their approach to decision-making and fact finding on assumptions that do not apply to torture survivors.

Conclusion

Torture affects the physical, mental, and social well-being of survivors. Primary care clinicians, when sensitized to the unique needs of torture survivors, can help the survivor overcome physical, psychological, and psychosocial dysfunction and disability.

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