Articles

Torture and War Trauma Survivors in Primary Care Practice

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Close to 1 million refugees from around the world have entered the United States, fleeing repression, war, terrorism, and disease. It has been estimated that among these are thousands who have experienced torture. Many refugees and immigrants will appear in the offices of health care professionals with symptoms that may be related either directly or indirectly to torture. Both physical and psychological torture may result in long-term sequelae. Physical effects may be found in every organ system, but psychological effects are most commonly manifest in the symptoms of the post-traumatic stress disorder. For physicians to recognize how torture can affect health status, it is important to understand that history taking may be difficult and that little information may emerge that would explain the origins of scars, fractures, or disabilities. Recognizing the clues to a torture history allows physicians to assist patients in describing the trauma. In addition, knowing the subacute and chronic signs and symptoms of torture enables physicians to diagnose and treat often obscure symptoms with a much clearer understanding of the sources of the difficulty. Paying special attention to the interview process will support torture survivors in detailing often horrific events.

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As newspaper accounts and photographs of torture, mass graves, rape, flight, and fear force us to recognize the plight of much of humanity, it is apparent that a substantial number of the world's refugees will appear in the United States and, ultimately, in the offices and examining rooms of health care professionals. It is critical to ask, What are the health effects of the physical and emotional trauma experienced by these men, women, and children? In addition, how can the sensitivity of primary care physicians in history-taking situations be enhanced so as to both elicit information about the trauma and offer support to those who have been so brutalized? For these patients, medical examinations may be fraught with anxiety for unique reasons. Physicians may have been involved in their torture, and examination tools and procedures may precipitate memories of the torture implements or methods. An authoritarian interaction between physician and patient as well as language difficulties may cause acute emotional reactions or profound withdrawal. Consequently, information required for diagnosis, treatment, and preventive interventions may be missed. Our rapidly changing world requires that we become aware of the context in which our multicultural population has arrived in the United States. In this article, we address how the risk factors of refugee status and torture or trauma influence health status.

Displaced Peoples

It has been estimated that there are 50 million refugees in the world, of whom 23 million have been forced to flee their countries of origin.[1,2] Men and women, elderly persons, children, and adolescents must confront the loss of home, family, culture, language, and all that represented stability and security. Malnourished and sometimes diseased, they may have lived in chaotic camps, further exposing them to violence and intimidation. Some of the following factors that lead up to the decision to flee have been described: political repression, detention, torture, terrorism, disappearances of family and friends, loss, and exile.[3(pp7–10)] From 5% to 35% of the world's refugees have been estimated to have experienced torture,[4(p85)] which, given the above figures, suggests that the population at risk lies between 1.1 and 8 million. To these must be added the substantial number of internally displaced people who have been the recipients of torture. Many others, although not directly tortured, have been exposed indirectly as family or friends of those who have been abused.

Torture

Torture in this context does not refer to domestic or street violence. Rather, it is a process of brutal human degradation that occurs in a setting of political repres-

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sion or state-sponsored terrorism. The World Medical Association, in its Declaration of Tokyo (1975), defines it as follows:

> Torture is . . . 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 United Nations Convention Against Torture (1984) notes that torture may take the form of physical or mental abuse, it is intentional, and it has a larger goal. "[S]uch pain or suffering is inflicted by or at the acquiescence of or with the consent of a public official or other person acting in an official capacity." Examples of this come readily to mind: Chile, Argentina, El Salvador, Guatemala, South Africa, and others.[5] An epidemiology of torture is difficult to develop because it is carried out in secret and suppressed from public knowledge. Without the work of such organizations as Amnesty International, Physicians for Human Rights, or Human Rights Watch, little would be known. In an analysis of 1992 Amnesty International data from sources as diverse as ex-prisoners, family members, and lawyers,[6] it was determined that "systematic torture and/or ill treatment" is carried out in 93 countries of the world.[7]

Sergio Pesutic, a Chilean physician, has described torture as "the dehumanized use of power."[8] Torture is thus an instrument of oppression, it is state-sponsored, and it is a display of overwhelming power on a personal level.

Why do states torture, and how does it affect its victims? The following five purposes have been suggested for torture[9]: information gathering, the incrimination of others, the indoctrination of the government's political belief system, intimidation, and isolation (from colleagues or similarly minded antigovernment comrades). Torture usually occurs in a context where social and psychological factors have coalesced to allow the dehumanization and negative labeling of targeted groups and where obedience to orders or authorization by the government becomes the reason to act, usually under the guise of patriotism.[10] Aside from the many physical sequelae of torture, the process is designed to render its victims nonhuman. Torture destroys the self and the very foundations of stability; the person undergoing torture can believe in nothing; questions of morality become irrelevant; decisions may become impossible choices; and survival may mean either forced betrayal or lifelong guilt. In a classic paper on brainwashing, three components were noted to be required for breaking down someone's resistance: debility, dependency, and dread.[11] Even with the utmost of human resiliency, long-term effects of these experiences are likely.

Why Is This Important to American Physicians?

Up to now, the United States has welcomed most of the world's legal immigrants and refugees. California has received more of this population than any other state. From 1985 to 1992, 810,750 refugees and asylees were granted US permanent resident status, and more than 7 million legal immigrants arrived during the 1980s.[12(pp80,81,89)] In 1990 it was estimated that about 600,000 refugees lived in California (almost a third of the nation's total).[13] As well, it was estimated that 1 of 50 Californians was a refugee. A substantial number of refugees are found throughout the western states.

TABLE 1.—*Historical Risk Factors for Torture*

Refugee or political asylee status
Immigrant from country with totalitarian history
Member of minority group in country of origin
Member of minority political party in country of origin
Civil war in country of origin
Residence in refugee camp
Military government in country of origin
Prisoner of war
Flash-point country—that is, Bosnia, Somalia, Rwanda
Multiple family members deceased due to trauma
History of arrest or detention
Leadership in an antigovernment organization or relative of same

The major population groups have come from Southeast Asia, Latin America, and eastern Europe. A large number of these refugees have experienced torture in such diverse places as Cambodia, Vietnam, the Philippines, Argentina, Uruguay, Chile, El Salvador, Guatemala, India, the former Yugoslavia, countries of the former USSR, Ethiopia, Eritrea, Zaire, Somalia, Kenya, South Africa, and many of the Middle Eastern states. Along with the multitude of skills and hope that they bring, they carry a legacy of guilt and terror. A simple Pap smear may awaken a memory of sexual trauma at the hands of militia; a bright light in the eye can bring forth a memory of interrogation; a question about scars may elicit profound fear of being reported to government authorities.

To provide comprehensive care, physicians must become aware of the possibility of torture in a refugee's or immigrant's history and develop the ability to recognize physical signs that indicate that torture has occurred. From our clinical experience with more than 300 refugee survivors of torture and from the relevant literature,[14] we propose a set of risk factors the presence of which in a history are suggestive of the possibility that a patient may have been tortured (Table 1).

Methods of Torture

Torture may include both physical and psychological methods, although they cannot always be separated. For example, hooding impedes normal breathing but also produces disorientation and fear. Tables 2 and 3 illustrate

common torture methods described by several authors.[3(pp8–9),15–17] Although there is much similarity of methods around the world, especially in a regional context, there is also variation. Survivors may be unable to describe exactly what happened to them because they may have been blindfolded, lost consciousness, sustained head injury, or have difficulty recalling or revealing the especially traumatic components of their experience.

The list given in Table 2 is not exclusive, and other forms of torture, such as stretching on a rack, are still used. Sexual torture is common[18] and, not surprisingly, often underreported by men and women. The use of implements and animals to humiliate and destroy the will often produce intense shame and a need for concealment.

Torturers often attempt to conceal their acts. To avoid physical evidence of beating, torture is often performed with a wide, blunt object, and victims are sometimes covered with a rug—or shoes, in the case of falanga (beating the soles of the feet)—to distribute the force of individual blows. Stretching, crushing injuries, and asphyxiation are also forms of torture that produce maximal pain with minimal evidence. For the same reason, wet towels may be used with electric shocks.

Psychological torture is part and parcel of physical abuse as well. Specific psychological methods have been honed through the years that are specially designed to promote "debility, dependency, and dread" so as to break people down. Included in these are sensory deprivation (isolation, hooding, constant noise, darkness), the restriction of physiologic needs (food, water, sleep, toilet), and social isolation. Added to these are humiliation in word and deed, overcrowding, filth, sexual abuse, threats, the use of drugs to distort reality or compromise breathing, and the use of psychological interrogation techniques that reinforce helplessness, such as abusing victims regardless of their responses to the interrogation.

TABLE 2.—*Some Common Methods of Physical Torture**

Method	*Examples†*
Beatings	Hitting, clubbing, kicking—whole body or specific parts (head, genitalia)—with fists, clubs, rifles; *telefono, falanga, planton,* stabbings, and razor cuts
Electric shock	Cattle prod, multiple electrodes, electrically charged bedspring (to breasts, genitals, anus)
Burning	Cigarettes, cigars, other hot implements, wet and dry *submarino,* forced inhalation of chemicals
Asphyxiation	Wet and dry submarino, forced inhalation of chemicals
Stretching	Suspension by limbs, forced abduction of the legs
Genital torture	Blunt or penetrating trauma, electrical, vaginal or anal rape, animal rape
Other trauma	Fingernail and toenail removal, removal of teeth or dental fractures, prolonged exposure to heat or cold

*From van der Veer,[3] Rasmussen,[15] Randall and Lutz.[16]

†*Telefono* is simultaneous beating of the ears; *falanga* is beating of the soles of the feet; *planton* is forced standing; wet *submarino* refers to the submersion of the head in contaminated water or other liquid or semiliquid waste, such as feces; dry *submarino* involves asphyxiation by a plastic bag or chemical inhalation.

TABLE 3.—*Some Common Forms of Psychological Torture**

Threats—pain, torture, execution
Isolation and uncertainty about release
Sensory deprivation
Mock executions
Forced witnessing of beatings, rapes, or executions of friends or family
Sleep deprivation
Interrogation for hours
Excessive noise

*From van der Veer[3] and Stover and Nightingale.[5]

Physical and Psychological Consequences of Torture

Given the number and variety of torture methods, widespread signs and symptoms are possible (Tables 4 and 5). Because most of the patients who present in the United States will no longer be in the acute post-torture state, we will describe some of the major subacute and chronic effects of torture.

Specific signs and symptoms may include scarring; hearing loss, with tears in the pars tensa; rib or other fractures; pulmonary tuberculosis; rectal bleeding; knee or vertebral problems; dysesthesia; plexopathy, especially brachial plexopathy; radiculopathies; hematuria and dysuria; and sexually transmitted diseases. Combining relevant facts in the history with more specific questions about torture will illuminate many of the physical findings and presenting symptoms. It should be kept in mind, however, that the degree of correlation between long-term signs and symptoms and specific torture methods is variable, and often the effects of torture may not be distinguishable from other diagnostic possibilities.

The most dramatic psychological consequence of torture and other extraordinary stressful events is the onset of the post-traumatic stress disorder. Recently revised by the American Psychiatric Association,[19] the case definition includes key components as shown in Table 6.

The full definition of the syndrome of PTSD can be found in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.[19] Symptoms may antedate the trauma; patients may experience symptoms from several diagnostic categories. The manifestations of the post-traumatic stress syndrome may vary according to the culture and language of the person who has experienced the traumatic event. A recent study suggests that the severity and type of presenting symptoms may reflect how the torture was perceived by the survivor, the nature of the stressors after the torture, and finally, the degree of social support received by the survivor.[20]

Because most of those who have experienced torture have appeared in western countries after long histories of trauma, including uprooting, civil disturbance, and flight,

TABLE 4.—*Key Physical Consequences of Torture*

All organ systems may be affected
Psychosomatic and neurologic symptoms are most typical in chronic state
Musculoskeletal system symptoms are common in acute and chronic states
Falanga may result in subcutaneous fibrosis and a compartment syndrome of the feet
Electricity and various methods of burning—cigarettes, chemical—may leave characteristic skin changes
Whipping may leave a characteristic pattern of scars
Body suspension and stretching of limbs may result in characteristic musculoskeletal and nerve injuries—such as brachial plexopathies
Beatings to the head with loss of consciousness may contribute to organic brain dysfunction
Genital trauma is often associated with subsequent sexual dysfunction

TABLE 5.—*Key Psychological Consequences of Torture*

Post-traumatic stress disorder
Generalized anxiety disorder
Major depression
Psychosis or brief psychotic reactions
Chronic organic brain syndromes due to head trauma or asphyxiation; primarily attentional and cognitive difficulties
Substance and alcohol abuse
Sexual dysfunction

with superimposed acculturative stress, it is difficult to ascertain whether there is a "torture syndrome" separate from the effects of refugee trauma. In addition, as social epidemiologists have increasingly elucidated, the effects of a traumatic experience are a culmination of biologic predisposition, environmental stress, coping factors, and other mediating variables, such as a person's social support, that may serve as protective influences.[21-23] Consequently, we do not have a comprehensive picture of which torture survivors will have long-term problems develop and which will show a resilience that allows for normal lives. We do know that there is a generally complete picture of the health effects of refugee trauma,[24] and the separate effects of torture over and above other influences of political repression on Turkish activists, for instance, have recently been demonstrated.[25] Other researchers have examined the effects of culture on the post-traumatic stress disorder, a critical question when survivors arrive in America from many different backgrounds.[26-30] Given the complexity of these influences, it is important to emphasize that torture exists, and that over and above refugee trauma, it leaves physical and emotional scars that can be measured or observed. Symptom presentation is influenced by culture, and whether any given person experiences long-term problems is a result of complex interactions of history, biology, the nature of the stressor, and the support received.

Illustrative Case

"Susana" grew up in a large middle-class family of eight children. Two of her siblings were politically active, and when she was 14, one of her brothers was "disappeared." Over the next few years, several members of her extended family were arrested, tortured, and executed.

As a teenager, she was arrested without charge and brought to the office of the local militia. Interrogated and tortured daily, she was accused of aiding a rebel group. Beatings with fists, kicks, and whips occurred whether or not she gave any response. On most occasions, she was beaten bloody; often she was left unconscious. The torturers used a variety of techniques: she was suspended upside-down from a bar by her hands and ankles as her feet were beaten (*falanga*) and then forced to walk on sharp stones. Both ears were struck simultaneously with open fists (*telefono*), causing intense head pain. She experienced mock executions and forced confessions at gunpoint.

After a period of solitary confinement, she was placed in a small communal cell with 50 women. The women slept on a concrete floor with no heat, no toilet, no ventilation, and little light or food. Women were taken out and raped; some never returned. The women were humiliated in many ways. Susana was sexually abused and became suicidal. She remained in the cell for five months, during which time 20 of the women were killed.

After release, she eventually left her country, fearful of being rearrested. Her once-close family is now scattered all over the world. Soon after she arrived in California, a cousin concerned about Susana's depression, insomnia, and fearfulness referred her to our clinic. At first she was interested only in medical treatment of the chronic musculoskeletal pain in her knees and feet and of abdominal pain that was continuous. As her medical treatment proceeded, she began to talk about the experiences that had left her with these symptoms. As memories resurfaced, a suggestion was made that psychotherapy might be of help. Although ambivalent, she met with a Survivors International clinician and began the long process of healing.

Torture Survivors and Health Care Professionals

Given the nature of torture and the legacy of trauma, it is not surprising that torture survivors or victims of brutal wars bring to the medical visit vulnerabilities that influence the physician-patient interaction. At a minimum, there may exist a basic mistrust that makes the act of receiving care difficult. In addition, one study has reported that some 20% of torture survivors indicate the

TABLE 6.—*Post-Traumatic Stress Disorder**

Traumatic event

Experience or exposure to events involving actual or threatened death or serious injury, or a threat to the physical integrity of self or others

Response involved intense fear, helplessness, or horror

Reexperiencing or reliving of the initial event (≥1 of these)

Recurrent, intrusive, and distressing recollections of the event, such as images, thoughts, or perceptions

Recurrent distressing dreams of the event

Acting or feeling as if the traumatic event were recurring, that is, reliving, illusions, hallucinations, and dissociative flashback episodes

Great distress when exposed to cues that provoke memories of the trauma

Physiologic responses when exposed to cues that provoke memories of the experience

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness

Patient avoids any activities, feelings, or anything that may provoke memories of the experience; survivors may avoid engaging in many of life's important activities and may not feel involved with others; they may experience a lack of feeling and a sense that they may not have a normal life course

Persistent symptoms of increased arousal

Sleep difficulties, anger, hypervigilance

*Adapted from the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition.[19]

involvement of a physician in their torture.[15] Physicians who participate in torture may examine victims and report their weaknesses to the torturers; they resuscitate and treat them to allow further abuse; they falsify death certificates; and, despite the Hippocratic Oath or its equivalent, they do not overtly protest.

Many survivors are afraid to talk, especially about what happened, for fear of reexperiencing the trauma. They may be afraid of repercussions to themselves or family or of bringing pain to those they love. Some may fear not being believed or, if they are, of being ostracized—for example, if they were raped. Shame and guilt may interfere with acknowledging the torture experience.

Because survivors of torture have at one time felt so helpless, the act of placing themselves in the passive role with any authority figure such as a physician may provoke anger or withdrawal. Guarded histories may also reflect an attempt to protect the physician from the horror that they carry within. Psychosomatic symptoms may reflect the need to hide their heinous experience from themselves as well as others.

It is important for physicians to become aware of these vulnerabilities and to recognize that the patient-physician interaction can be structured in such a way as to minimize the stress and promote open responses. Good medical care for refugees and torture survivors depends on obtaining a complete history that reflects the trauma experience. Table 7 describes key issues that should be considered.

Training for health and mental health professionals is available through programs developed by such organizations as Survivors International and Physicians for Human Rights.

Conclusion

The treatment of patients who have had exposure to war violence and torture poses a special problem for primary care physicians. Symptoms of illness may be vague and persistent; signs of torture can be subtle and may be overlooked if patients cannot talk about the trauma. Physicians are faced with the dilemma of making a decision as to whether it is critical to pursue a line of questioning that may reveal horrors and memories that cause patients considerable pain. Yet, if the signs and symptoms suggest that trauma underlies the presenting problem, a physician is bound to explore the area in a gentle way that makes it clear that he or she is open to hearing the story. It is critical that if these questions are explored, there must be time set aside to do so. This may necessitate an additional visit. When the presenting symptom is not relevant to the torture history, it may be that exploration is optional. Clearly, however, in an ongoing therapeutic relationship, a shared knowledge of what happened will likely enable the physician to offer more comprehensive and thoughtful care for the patient.

It is important that patients not be retraumatized by the process of history taking. Physicians working with refugees who may have experienced torture can enhance their knowledge both by literature review and training. In addition, using the consultative or referral resources of mental health professionals trained to work with torture survivors results in a collaboration that can maxi-

TABLE 7.—*Interviewing Torture Survivors*

The Setting
As un–cell-like as possible
Comfortable climatic conditions
All objects in view (no screens)
Awareness that anxiety can be triggered by seemingly innocent objects
The Process
Waiting for appointments may trigger patient anxiety because of the remembered waiting for torture
Decrease anxiety by explaining who you are, what your role is, and how the interview and examination will work; it is critical to diminish the element of surprise, especially with certain examinations or treatments such as venipuncture or pelvic examination
Give patient some sense of control—for example, to take a break or use washroom
Questioning should be done gently
Questions should be tactful but direct—for example, "People with memory problems or bad dreams have often been tortured or traumatized. Is this something that has happened to you?"
Acknowledge that disclosure is difficult
Educate patient about symptoms—that it is common to feel that the symptoms are indications of mental illness; offer reassurance that these are normal reactions to abnormal events
Correct misperceptions—for example, sexual torture usually does not result in impotence or sterility
Interpreters
Use interpreters, but be aware that problems exist with using family members, fellow nationals, or North Americans who may miss cultural nuances; sensitivity is critical
Education
Teach about the North American health care system
Refer for psychological counseling and know referral centers
Refer for social services

mize the prospects of recovery. Various psychotherapeutic techniques and psychopharmacologic interventions have effectively alleviated war trauma symptoms.

It is not easy to learn about war trauma. It is more difficult to hear stories of torture. Even physicians who have been trained to hear and see the worst may not be prepared for the evil that humanity can impose on itself. It is not uncommon for those who treat torture survivors to experience depression, anxiety, nightmares, and irritability. A willingness to talk with colleagues about these patients goes a long way in ameliorating these responses. In addition, knowing the resources for patients affords physicians the opportunity to both learn about torture and find assistance in dealing with difficult issues.

Torture is one of the new epidemics that is sweeping the world. The mass migration of people across continents and over oceans means that we must be prepared to diagnose and compassionately treat the many survivors for whom the sanctuary of the United States can provide only partial safety. With our help, refugee survivors of torture may at last find some measure of security and well-being.

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