

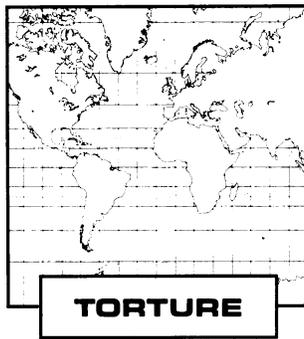
# Cross-cultural Medicine

## A Decade Later

### Working With Refugee Survivors of Torture

BARBARA CHESTER, PhD, Tucson, Arizona, and  
NEAL HOLTAN, MPH, Minneapolis, Minnesota

- Almost 100 countries worldwide use torture as a means of social control and political oppression
- In 1988, more than 2.5 million refugees sought resettlement in Western Europe and North America because of war or torture



Numerous factors must be taken into account to best provide for the health and well-being of refugee patients in developed countries. One issue that is rarely considered is the awful and not uncommon occurrence of political torture. Large numbers of refugees and other displaced persons are survivors of political torture, and health care professionals must be prepared for this possibility when treating refugee patients. The effects of torture are pervasive, and we provide some practical considerations for health professionals who care for survivors of torture. Specific challenges include problems relating to exile and resettlement, somatic symptoms and pain, and the "medicalization" of torture sequelae.

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*The real war is between our imagination and theirs. . . . Do not despair. None of them can see far enough, and so long as we do not let them violate our imagination, we will survive.*<sup>1(p99)</sup>

**D**uring 1988, more than 18 million persons fled their homelands because of internal political strife. They left their communities and families because of starvation, war, and severe human rights abuses, including political arrest, arbitrary detention, torture, and the danger of extrajudicial "disappearance" or execution. Of this vast humanity, some 2.5 million people have sought refuge in the developed countries of North America and Western Europe.<sup>2(pp4-6)</sup>

Numerous factors must be taken into account to best provide for the health and well-being of refugees in developed countries, including the effects of torture in these patients.

#### Torture

The torture and ill treatment of prisoners is a profound and extreme form of trauma practiced by governments in almost 100 countries throughout the world.<sup>3</sup> Its purpose is to achieve complete social and political control by crushing and perverting relationships within a community of people. To do this, officials of a government or their agents strategically and deliberately destroy physical, social, emotional, and spiritual cohesiveness. Torture attempts to violate the soul, spirit, and imagination of a person by inflicting pain and suffering on the body and the mind. For the torture survivor, both internal and external reality have been irrevocably transformed:

. . . [dealing with] the sometimes senseless questions for which there are no answers—and throughout, the anticipation and the fact of brute force, without limit, without end, the knowledge of being beyond the help of family or lawyer, of being totally at the mercy of those whose job is to have no mercy.<sup>3(p18)</sup>

Although other forms of trauma leave lingering and often

chronic aftereffects, confrontation with the cold, calculated, and deliberate destruction of individuals, families, and communities is beyond the usual range of our imaginations. The surreal and bizarre images indelibly etched on the minds of survivors have been described as the "un-making of the world."<sup>4</sup> Torture is an inconceivable act, and, therefore, most health professionals have no conception of what torture victims have experienced.<sup>5</sup>

When caring for refugees or displaced persons, health professionals must keep in mind that they are dealing with many cultures, values, and worldviews. Although similar symptoms and sequelae of torture are registered all over the world,<sup>6</sup> the manner of treating these patients must take culture into account.<sup>7,8</sup> For example, two women patients, one from Laos and one from South Africa, showed severe symptoms of depression, anxiety, and nonspecific somatic complaints following torture. The Lao woman interpreted both her trauma and the attendant symptoms to interference by a sorcerer during her first pregnancy. She welcomed medical intervention as a more powerful and counteractive force against the spirits that continued to plague her life. The South African woman placed both her trauma and the process of rehabilitation in a political context and was not as open to the use of medication; in fact, she objected to the "medicalization" of her symptoms.

Health professionals must remember that the entire process of becoming a refugee is severely stressful and traumatic. This may have involved arrest, detention, and possible torture and imprisonment before flight; trauma during flight, including fear of discovery, starvation, disease, dangerous animals, and land mines; and the eventual limbo of refugee or detention centers. A clinic in Boston, Massachusetts, discovered through standard interviews that its Cambodian patients had all suffered 1 or more of 16 major traumatic events, 3 of which are defined as torture by United Nations criteria.<sup>9</sup>

From the Hopi Foundation, Tucson, Arizona (Dr Chester), and the Department of Medicine, Ramsey Clinic and University of Minnesota Medical School, Minneapolis (Mr Holtan).

Reprint requests to Barbara Chester, PhD, Hopi Foundation, PO Box 65720, Tucson, AZ 85728.

Recognizing the trauma history is particularly important in the health-related fields because of the mind-body interaction that is penultimate in all forms of extreme stress. Because patients and physicians alike tend to focus on the somatic results of trauma, and many of the patients' complaints are nonspecific, they may spend years in health care systems without finding relief from distressing symptoms.

### Effects of Torture

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.<sup>10</sup>

Survivors report that the worst experience is often not the torture itself but the anticipatory fear at the moment of arrest, or between sessions of interrogation.<sup>11</sup>

Any aspect of humanity and self-identity is used against the victim in the cruelest and most painful way. In Tibet, for example, the invading Chinese forced celibate Buddhist priests and nuns to fornicate publicly.<sup>12</sup> Cambodian patients report receiving punishment for wearing eyeglasses or speaking the French language. Latin-American women describe sexual torture such as the insertion of objects, including insects and rodents, into their vaginas. Documentation also exists of the torture of children in front of their parents and torture of the fetus inside of the womb of pregnant women by forcing electric wires through the uterus.<sup>13</sup>

The consequences of such cruel treatment are extensive and affect every area of functioning. Pervasive fear, panic, shame, humiliation, nightmares, and physical pain accompany the survivor for many years. Spontaneous recovery from these symptoms appears to be poor.<sup>14</sup>

Survivors of torture tend to have symptoms in three areas: physical, psychological, and cognitive. In a 1990 report Rasmussen described the methods and the long-term effects of torture in a sample of 200 people examined during a seven-year period.<sup>11</sup> Commonly reported sequelae included skin lesions, lung infections, and tuberculosis due to poor conditions in prison; significant changes in the locomotor system, primarily due to beatings on the soles of the feet; severe headaches; gastrointestinal symptoms; bone fractures; dental problems; joint pain; and genital tract disorders in women. In addition, survivors complained of memory, concentration, and other cognitive disturbances. "Mental symptoms" including sleep disturbances, irritability, depression, and suicidal thoughts were registered in 68% of the survivors, and anxiety was common to all.<sup>11</sup> Psychiatric examinations of 41 survivors from three Latin-American countries elicited evidence of nightmares, insomnia, depression, anxiety, confusion, memory loss, and loss of concentration.<sup>15</sup> Other findings described regularly by health professionals who assess torture victims include lack of confidence and self-esteem, fear of intimacy, minimization denial, persistent shame and humiliation, despair, and loss of previously sustaining beliefs. Other symptoms, including nonspecific somatic complaints and emotional lability, are also common.<sup>5, 16-19</sup>

### Women and Children

Sexual abuse and rape figure prominently in the torture of women and girls. Reports from clinics and treatment centers in Boston, Toronto, Copenhagen, and Minneapolis indicate

that a third to two thirds of women and girls seeking treatment for the sequelae of torture report incidents of sexual violation.<sup>20</sup> Amnesty International reports that women are vulnerable to rape and other sexual violation at all points in the process, from arrest and interrogation to refuge in detention camps that contain those seeking asylum.<sup>2</sup>

Children are direct and indirect victims of armed conflict. They are separated from their parents by the political imprisonment of their fathers or mothers. In countries such as the Philippines and South Africa, many young people have been detained and tortured. In South Africa, for example, more than 460 boys and 50 girls younger than 18 years were detained during 1977 and 1978.<sup>21(pp95-98)</sup>

Children and spouses of survivors also show long-lasting effects of trauma. Children suffer withdrawal, fear, depression, regressive behavior, sleeplessness, aggressive behavior, problems in school, and somatic complaints.<sup>22</sup> During the ongoing civil war in El Salvador, more than 100,000 children have been left homeless. A recent study of 349 children visiting a clinic in San Salvador revealed that a substantial number had gastrointestinal disorders, irritability, withdrawal, insomnia, and nightmares. Of these children, almost 60% had witnessed violence to family members, 4% had been direct victims of violence, and 88% were diagnosed as having anxiety.<sup>23</sup>

### Challenges for Health Professionals

Substantial challenges exist in appropriately assessing and treating survivors of torture and their family members. Among these challenges are the extreme nature of the trauma, the fact that patients express their pain in the context of numerous cultural variations,<sup>24</sup> and the uncertain immigration and legal status of many displaced persons seen in medical settings in the United States. We describe other issues of concern as well.

#### *Reticence to Talk About Their Experiences*

Torture victims are initially reluctant to speak about their experiences, for several reasons:

- Survivors fear that they will not be believed, and the torturer reinforces this fear during interrogation;
- The torturer inflicts acts of such profound violation and humiliation that victims are ashamed to reveal the exact nature of their torments;
- Because of the phasic nature of traumatic memories, those tortured vacillate between intrusive and avoidance symptoms.<sup>25</sup> One patient was in therapy for six months before he was able to recall a particularly noxious torture session.

Because of this reticence on the part of survivors and family members, health professionals must consider the possibility of torture when examining refugees or displaced persons, particularly if they show nonspecific somatic complaints or other symptoms of severe stress.

#### *Profound Lack of Trust*

Torture victims have experienced betrayal on many levels. They have been traumatized by agents of their own governments and, in many cases, by members of their own communities. On arrival in the United States, they face skepticism and disbelief and fear deportation. They also harbor serious and valid concerns about friends and family members left behind.

It is important to explain all medical procedures, including policies designed to protect patient confidentiality. Refugees who have been tortured often feel that their credibility is contained in their legal and medical records. File documentation should be explained in detail and treated with respect. A man from North Africa, for example, was proud of the thickness of his file and was devastated when a physician casually tossed it on his desk, said that he had no time to read it, and asked the man to repeat information already contained within the document.

It is also crucial for health professionals to follow through on all promises made, with clear and concise timeframes included. Alleviating symptoms with medication often can be an aid to building a level of trust and rapport.<sup>26</sup> The need to show respect to persons whose dignity has been so violated cannot be emphasized enough. Respect can be as simple as not keeping the person waiting for long periods of time.

### *Physical Sequelae of Torture*

Because governments fear discovery, severely tortured prisoners are often confined until they are physically healed, or they are killed. In addition, more sophisticated techniques of torture, including drugs and psychological torture, are being used with greater frequency.<sup>11</sup> Health professionals must therefore be aware that chronic psychiatric indicators of distress, including depression and anxiety, may be signs of previous torture.

Sometimes physical signs of torture do exist, and health professionals must document them for the purposes of legal proceedings.<sup>27, 28(pp71-73)</sup> Beatings, whippings, cigarette burns, searing with acid, and cuts with knives and bayonets leave scars consistent with their histories. Scars can also result from deep abrasions caused by shackles or bindings. Other physical evidence of torture may be found in healed fractures of long bones, damaged teeth, or healed punctured eardrums. A unique physical sequela of electrical torture is called in Spanish a *picaña*, a small white subcutaneous scar where electricity was applied to the skin. *Falanga*, a torture involving beating the soles of the feet, can cause skeletal deformity and scars. Other methods of medical documentation of torture now being investigated include electroencephalographic studies of sleep and dream cycles, skin biopsy to differentiate electrical from other sources of burn-related scars, and levels of serum creatine kinase and myoglobin in urine.<sup>27</sup> Survivors may need a physician's documentation of these objective physical sequelae for purposes of political asylum proceedings, civil suits for damages, support for intergovernmental investigatory bodies, or to support claims for reparation.<sup>28(pp71-72)</sup> Refugees and those seeking political asylum are defined as persons fleeing as a result of a well-founded fear of persecution.<sup>29(pp30)</sup> Health professionals' support of this claim can make a tremendous difference in the ability of an undocumented alien to receive legal status in this country. Documenting mental health problems, including symptoms of post-traumatic stress disorder, is also gaining acceptance as valid evidence of a well-founded fear of persecution.<sup>28(pp72)</sup>

### *Complicity of the Medical Profession*

Health professionals should be aware of the possible complicity of medical professionals in the practice of torture. Such participation by physicians and psychologists has been documented in Chile, South Africa, the former Soviet

Union, Turkey, and Uruguay. These acts of complicity range from falsifying death certificates to designing specific types of torture, monitoring, and actually applying torture.<sup>30(pp64-65)-32</sup> In addition, the policies and strategies of the government often make the country's health care systems unsafe for victims:

... a deliberate policy of the security forces was to shoot people indiscriminately who attend demonstrations and then go to the hospital and wait for the injured to come in for treatment where they would arrest and detain them.<sup>32(pp127)</sup>

### *Exile and Resettlement*

During the past ten years, unprecedented numbers of non-English-speaking refugees have entered the United States. Various waves of refugees have arrived from Central America, Eastern Europe, the Middle and Far East, and Southeast Asia. Health professionals with patients who are refugees or displaced persons should read human rights reports such as the annual report published by Amnesty International. These advise where torture occurs during a given year and what methods of torture are documented. Torture is or has been rampant in countries as diverse as Afghanistan, Argentina, Cambodia, Chile, El Salvador, Ethiopia, Guatemala, Haiti, Iran, Nepal, Iraq, Romania, South Africa, Sri Lanka, Tibet, Turkey, and Uganda.

Torture has also become an exportable commodity. Amnesty International notes that torturers exchange information, methods, and equipment. Torture techniques are similar, with some cultural variations as to how these methods are applied.<sup>33</sup> This is true of all forms of torture but is most applicable to psychological torture where sex roles, spiritual values, and the reaction of the community are essential parts of individual identity. For example, in Bangladesh, the rape of a Muslim woman before the eyes of her husband or family is tantamount to a sentence of exile. For several tribes in South Africa, the prohibition against public gatherings significantly interfered with prescribed rituals around the grieving process.

Tortured refugees or those seeking political asylum tend to settle in areas of geographic access or in large cities. The states with the largest absolute numbers of refugees include California, Florida, Illinois, Massachusetts, New York, Texas, and Washington. The presence of large resettlement agencies in Minnesota and Wisconsin have resulted in concentrations of refugees, particularly from Southeast Asia, in these areas. People tend to join their communities in exile. A large number of Ethiopians, for example, have settled in Washington, DC, Los Angeles, and Minneapolis. There are more than 100,000 Guatemalans and 500,000 Salvadorans, most of whom are undocumented, residing in the border states of Arizona, California, and Texas.<sup>29(pp64-65)</sup>

### **Somatic Symptoms and Pain**

Torture victims tend to describe physical rather than psychological or emotional symptoms as their chief problems. Pain, usually in the head, chest, or abdomen, is often their main concern. Pain symptoms can exist for months and years after torture. The pain may relate to a specific part of the body that had been traumatized during torture, including head trauma, electrical torture to the chest and heart, or forced water drinking and blows to the abdomen. Chronic low back pain was a symptom found in most torture victims evaluated in Denmark and the United States but does not

appear to correlate with specific trauma to the back, with hanging by the limbs, or with other abuse that might be expected to injure the back. Low back pain may be analogous to a tension headache.

For some patients, the pain abates after a careful medical examination, appropriate medical tests, and reassurance from a physician that there is no permanent damage from the torture—victims are often taunted during torture that their vital organs will be severely and permanently harmed. Some patients do not improve with reassurance, however, and require analgesics for pain. Gastritis exacerbated by psychological stress can make the use of aspirin or nonsteroidal anti-inflammatory agents inadvisable. Acetaminophen seems to work as well and is relatively safe.

Because of the poor camp and prison conditions they have endured, refugees and other torture victims are at high risk for certain infectious diseases, including tuberculosis, malaria, and intestinal parasites. They may have untreated or poorly treated orthopedic injuries, sensory deficits, or dental problems, and their immunizations may be scant or out of date. These patients need a complete physical examination while disrobed and gowned in order not to miss signs of torture or illness. Appropriate laboratory tests include blood counts; screening for hepatitis B, syphilis, and tuberculosis; and stool examinations for ova and parasites. Urinalysis, thyroid function tests, fasting lipid profiles, and stool tests for occult blood are also indicated for some patients.

Adequate investigation is essential to provide a correct differential diagnosis. For example, thyroid disease can masquerade as psychiatric symptoms or vague constitutional symptoms. Common symptoms of torture, including headaches, loss of memory, and concentration deficits, can be a result of depression or of neurologic damage resulting from head trauma. A man from Eastern Europe who had been given radiation while in detention and whose depression did not respond to medication was found to have severe hypothyroidism. In another case, an agitated and anxious man from West Africa who had been tortured was noted to have labile hypertension caused by hyperaldosteronism [confidential client-case files].

## Conclusion

Health professionals must always consider the whole person, and this applies especially with refugees and other displaced persons who have been uprooted from their homes in a sudden and cataclysmic manner. Adding to the complexity of the situation are those patients who were not only displaced but tortured, as well.

Like torture survivors, the health professional assessing and treating these patients needs the courage to imagine. To facilitate the “re-making” of a survivor’s world, the health care professional must recognize the multifaceted effects of torture and displacement on the individual, family, and community.

## REFERENCES

1. Thornton L: *Imagining Argentina*. New York, NY, Bantam Books, 1988
2. *Reasonable Fear: Human Rights and United States Refugee Policy*. New York, NY, Amnesty International USA, 1990
3. *Torture in the Eighties*. London, England, Amnesty International, 1984
4. Scarry E: *The Body in Pain*. Oxford, England, Oxford University Press, 1985
5. Goldfeld A, Mollica RF, Pesavento BH, Faraone SV: The physical and psychological sequelae of torture. *JAMA* 1988; 259:2725-2729
6. Boysen G, Kardel T: Torture and the medical profession. *Torture* 1990; 1:2-4
7. Draguns RC: Advances in the methodology of cross-cultural psychiatric assessment. *Transcult Psychiatr Rev* 1977; 14:125-143
8. Triandis HC, Lambert W (Eds): *Introduction, Handbook of Cross-Cultural Psychology*. Boston, Mass, Allyn & Bacon, 1980
9. Mollica RF: The social world destroyed: The psychiatric care of the refugee trauma survivor. *In* Gruschow J, Hannibal K (Eds): *Health Services for the Treatment of Torture and Trauma Survivors*. Washington, DC, American Association for the Advancement of Science, 1990, pp 15-33
10. World Medical Association: Preamble, Declaration of Tokyo, 1975
11. Rasmussen OV: Medical aspects of torture. *Dan Med Bull* 1990; 37:1-88
12. *The Dalai Lama: Freedom in Exile: An Autobiography of the Dalai Lama*. New York, NY, Harper Row, 1991
13. Bunster-Burotto X: Surviving beyond fear: Women and torture in Latin America. *In* J Nash (Ed): *Women and Change in Latin America*. Boston, Mass, Bergin & Gervy, 1986, pp 297-325
14. Somnier F, Bloch I: Torture Treatment. Presented at the first annual conference of the Center for Victims of Torture, Minneapolis, Minnesota, June 1987
15. Allodi FA, Cowgill G: Ethical and psychiatric aspects of torture: A Canadian study. *Can J Psychiatry* 1982; 27:98-102
16. Somnier F, Geneffe I: Psychotherapy for victims of torture. *Br J Psychiatry* 1986; 149:323-329
17. Kordon DR, Edelman LI, Lagoa DM, Nicoletti E, Bozolo RC: *Psychological Effects of Political Repression*. Buenos Aires, Argentina, Planeta Publishing, 1988
18. Cathcart LM, Berger P, Knazan B: Medical examination of torture victims applying for refugee status. *Can Med Assoc J* 1979; 121:179-184
19. Rasmussen OV, Lunde I: Evaluation of investigation of 200 torture victims. *Dan Med Bull* 1980; 27:241-243
20. Chester B: That which does not destroy me: Treating survivors of political torture. *In* Sommer JF, Williams MB (Eds): *The Handbook of Post-traumatic Therapy*. Westport, Conn, Greenwood Publishers, in press
21. *Children of Apartheid*. London, England, International Defence and Aid Fund for Southern Africa, 1980
22. Reid R, Strong T: Rehabilitation of refugee victims of torture and trauma: Principles and service provision in New South Wales. *Med J Aust* 1988; 148:340-346
23. Allodi FA, Rodriguez S, Aguilar O: The Children’s Clinic of El Salvador: An Analysis of a Sample Subjected to Trauma and Deprivation. Presented at the annual meeting of the Society for Traumatic Stress Studies, San Francisco, California, October 1989
24. Holtan N: Ethnocentrism and Ethnorelativism in a Primary Care Medical Clinic for Refugees and Immigrants. Prepared for the Refugee Assistance Program: Technical Assistance Center, University of Minnesota, Minneapolis, February 1988
25. Randall GR: Efforts to document human rights-related trauma. *In* Gruschow J, Hannibal K (Eds): *Health Services for the Treatment of Torture and Trauma Survivors*. Washington, DC, American Association for the Advancement of Science, 1990, pp 43-50
26. Jaranson JM: Psychotherapeutic Medication in the Treatment of Refugees. Prepared for the Refugee Assistance Program: Technical Assistance Center, University of Minnesota, Minneapolis, April 1988
27. Allodi FA: Assessment and treatment of torture victims: A critical review. *J Nervous Ment Dis* 1991; 179:4-11
28. Randall GR, Lutz EL: *Serving Survivors of Torture*. Washington, DC, American Association for the Advancement of Science, 1991
29. Kismaric C (Ed): *Forced Out: The Agony of the Refugee in Our Time*. New York, NY, Random House, 1989
30. Weschler L: *A Miracle, a Universe: Settling Accounts With Torturers*. New York, NY, Pantheon, 1990, pp 64-65
31. Stover E, Nightingale EO: Introduction: The breaking of bodies and minds, *In* Torture, Psychiatric Abuse, and the Health Professions. New York, NY, WH Freeman, 1985, pp 12-19
32. Davis P: Medical responses to the problem of torture in South Africa. *In* Gruschow J, Hannibal K (Eds): *Health Services for the Treatment of Torture and Trauma Survivors*. Washington, DC, American Association for the Advancement of Science, 1990, pp 115-128
33. Amnesty International: *Report on Torture*. London, England, Duckworth, 1975