Manuals

Guidelines and manuals addressed to health professionals and other interdisciplinary workers helping to provide practical advice, recommendations and tools in therapy for rehabilitation for victims of torture, organized violence and suffering after traumatic assaults have been developed from many institutions, clinics and rehabilitation units.

These guides and manuals are not textbooks, and should not be, but rather offer information and knowledge taken from consensus-based experience material, more or less supplied with a focus adapted to the specific organisation.

In order to give attention to such manuals in general, and specifically on how they can be expanded upon, a chapter from a French guide titled "Treating torture victims: a guide for practitioners" is presented here. It is published in an English translation from the rehabilitation centre AVRE with support from the French Ministry of Solidarity, Health and the Family. From this guide follows chapter 5 "How to deal with torture victims".

How to deal with torture victims

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Definitions

"Torture victims are not only ashamed to confess their fear, their cries of pain and their pleas for mercy, they are also ashamed to admit what they have suffered ..."
Paul Ricœur – Preface to "L'interdit ou la torture en procès", ACAT, CERF

Torture should be seen as the cause of unease, the origin of which is difficult to identify for some patients. It is always difficult for victims to talk about their experience. It is therefore necessary to create a situation where they feel properly listened to and at ease. Other members of the family should also be taken into consideration: their partner and children will also have been shaken by the horror of what has happened. It is important to give them the time they require, or else to refer them to another specialist if you are unable to deal with them yourself.

I – Identification

Some patients who attend a consultation are suffering the after-effects of torture or highly traumatic experiences, in particular those who have come from foreign countries and have only recently arrived in France. It should be remembered that as torture victims they will have been harshly interrogated many times. It is therefore necessary to conduct this "new interrogation" with tact, and to know when to stop if the patient is unwilling to answer.

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Torture victims may only request a consultation because they have some other ailment. But very often they reveal their suffering through indirect complaints such as insomnia, headaches and diffuse and ill-defined pains. They are ashamed to admit that they have been tortured.

However, by asking a few questions you will show your patient that you are also interested in his/her past:

- Where do you come from?
- What was it like there?
  And now
- What is your status in France?
- Are you a refugee or asylum-seeker or do you have another status?
- Why did you leave your country?
- You must have experienced difficulties?
- Did you have financial difficulties or come into conflict with the authorities?

In the latter case:

- Were you arrested/imprisoned/mistreated/badly mistreated?
  Allow the patient to speak.

Perhaps (s)he will start to tell his/her story, which may be long and distressing for both you and him/her.

- If the waiting room is full or if you have to make a visit, try to interrupt him/her by explaining that you need a further consultation to be able to discuss the matter properly, and offer to deal with the patient's most pressing need.
- According to the patient, is the reason for the consultation linked to any mistreatment received or is it unrelated? Did the symptoms already exist earlier?

By showing an interest in his/her past you will very quickly enable the patient to feel that (s)he has found someone who will listen, either now or in the future.

- During a second consultation, after further investigation of the patient's experience, you may manage to relate it to the symptoms presented.
- This is not always easy: the complaints may change from one visit to the next in a disconcerting manner. You must not allow yourself to be taken in: a clinical examination will make it possible to rule out an organic disorder. Ask the patient the reason for the problem: (s)he perhaps has an explanation that a clinical examination does not reveal! The complaint may be seen as an expression of past suffering and often of depression, as is the case for all patients in fact.

Leila had been tortured ten years earlier. She said that one of her fingers was very painful, and pointed to a small scar parallel to the edge of the nail. After the torturer had put a needle under her nail she had suffered a whitlow which had been lanced. Whenever she saw the small scar she felt the pain she had suffered while being tortured.

- What if the patient has language difficulties?

The patient will probably come with a friend or a child to act as interpreter. Allow the interpreter to stay at first but ask him/her to go out for a few minutes before the end of the consultation. You may find that the patient is good enough at the new language to say things that (s)he was unable to say in front of too close a friend or relative, or someone very young. Otherwise the patient may at least make it clear to you that (s)he does not wish to speak in their presence. In this case, if possible you must request the as-

sistance of a suitably neutral interpreter for the next consultation. If you have no interpreter, you could show the patient a diagram of the human body so that (s)he can show you where the problem is. The head and the genitals will indicate difficulties that cannot be mentioned in front of a third party and which it is so difficult to talk about, even in the patient's own language.

Do not forget!
60% of the survivors of the Holocaust examined by a psychiatrist said that they did not believe they were listened to properly by the doctor they consulted, when they told him/her of their experience in the Nazi concentration camps.

II – Treatment
It will then be necessary to implement a strategy for examinations and treatment based on the following approach:

- Arrange the complaints by order of importance:
  What bothers you most?
  What do you want me to treat first?
- Arrange the therapeutic requirements by order of importance, as revealed by the clinical examination.
- Reach a compromise between the complaints and the therapeutic requirements.

You will of course treat the critical pathology from the outset, but your patient will know that (s)he can count on your ability to listen if necessary. Alternatively you may have understood that a number of major physical and psychological traumas are involved that will take time to treat. You will need to plan how to provide the treatment, or if necessary refer the patient to another specialist.

III – Referral
Depending on the clinical symptoms, the circumstances and the wishes of the patient, specialist treatment may prove necessary.

Somatic disorders
It may be advisable to refer the patient to a specialist. You must then decide how to help the patient to do this, and what information to pass on to the specialist or team that the patient is referred to.

Mental disorders
A psychiatric consultation may prove essential in order to determine which symptoms are linked to the trauma caused by torture, and which belong, for example, to a psychotic-type pathology, given that these patients may also have been tortured.

Psychological help may prevent or cure disorders linked both to the after-effects of the abuse suffered and/or to the family or environment of the refugee.

You must also decide whether the patient should be accompanied: By an interpreter? Which interpreter? A family member?

IV – Administrative and social problems
The improvement in the health of torture victims will partly depend on the results of the steps taken to resolve administrative and financial problems that they face, like any asylum-seeker or refugee. The complexity of these procedures, discouraging periods of waiting and the importance of the anticipated outcome will have an impact on any treatment provided.

Before obtaining refugee status, asylum-seekers have to go through a real obstacle course, in particular in order to:

- Obtain the right of residency within France, granted by the police headquarters.

- Establish their status as refugee, which is awarded by the French Office for the Protection of Refugees and Stateless Persons (OFPRA), which centralizes all applications.
- Refer their case to the Refugee Appeals Board (CRR) if their application is rejected by the OFPRA.
- Obtain entitlement to social welfare.
- Obtain payment of a small amount from the French unemployment benefit office (Assedic) for a period of one year, from the time that the OFPRA acknowledges receipt of their application.
- Find accommodation.
- Possibly bring their family to France.

In addition, most torture victims also face difficulties of accommodation and financial problems once their savings have run out, and once the hospitality of their fellow countrymen has reached its limit, even if they were willing to put them up for a certain time.

It is essential to work in partnership with such bodies so that the physical and psychological improvement achieved is accompanied by access to rights in a way that is as reassuring as possible.

V – Specific situations

How to deal with children

A few points to remember:

1. They always know more than their parents think

By allowing them to talk about their experience and the way they lived through the events you will enable them to bring a taboo subject out into the open. The parents often think that the reality is too difficult for their children to bear, and will be relieved to be able to talk openly about their experiences, and the children will also benefit.

2. Roles may well be reversed within the family

Children become their parents' guardians. For example, young people learn to speak the new language more quickly, making parents dependent on their young translators who are thereby able to prematurely take the role of head of the family.

3. The presence of a mental trauma should be investigated

This will be revealed in regressive, anxious or depressive personality disorders (enuresis, night terror, stammering, aloneness, or on the contrary hyperactivity etc.). In this case psychological care, possibly involving other family members, is essential.

4. Adolescents want to be treated like adults and frequently oppose all discipline imposed by their close relatives. They may show addictive behaviour, as a means of coping with their anxiety.

They suddenly find themselves in a consumer society surrounded by temptations and will make demands that their parents cannot satisfy. This leads to tensions within the family that further damage the father's self-esteem.

One solution would be to encourage them to take part in sports activities where the instructor may provide a role model for a certain time.

But it is often necessary to seek psychological support from a specialist for the age group concerned. A few sessions will be sufficient to defuse the situation and the young people will be able to devote their often surprising abilities to building their future.

5. Even if they are doing very well at school, there may be deeper problems

For example, over-investment in academic activities may be a way of compensating for feelings of guilt or emotional difficulties.

How to deal with women

Rape is increasingly common and in certain cultures the women are then ostracized by their family, although this is less severe when they are outside their country, away from the shame imposed by their society. It is understandable that they have great difficulty talking about what happened. You can reassure them by saying that they are perfectly entitled to have their own private secrets, and that they can speak about it to their husband when they feel ready, and when their husband is ready to listen. Time may be needed.

Fear of HIV infection may also cause women to keep silent about rape: a test for sexually transmitted infections must be systematically proposed.* In a number of cases this will reassure them, or if the test is positive will make it possible to take the preventive measures required and provide appropriate therapy if necessary.

Finally it should be remembered that very often female torture victims are told that they will no longer be able to have children or satisfactory sexual intercourse. They need to know whether this is true.

In this case too, a clinical examination is generally reassuring. With or without a physical element however, sexual difficulties must be taken into account to avoid weakening a couple that is already suffering, among other difficulties, the trials of exile.

One must be careful however not to see all female torture victims as rape victims who are unwilling to admit that they have been raped. Although some women may hide the truth, not all women have been raped.

Women who have come alone, who are widows or who are faced with the disappearance of their husband have a heavy weight to carry. In addition to being physically exhausted, they are often suffering from depression which will be felt by their children, who themselves show the symptoms of their mother's pathology.

These symptoms will disappear as their mother's condition improves.

How to deal with men

Contrary to common belief, men also suffer sexual abuse, almost as much as women. They have even greater difficulty talking about it because their male pride has been shaken, the abuse of the torturers has affected them deeply, and because they are not encouraged to speak about such things. In addition, in some societies homosexuality is very harshly condemned, which further encourages them to remain silent.

They often complain of haemorrhoids, anal fissure or pain in the lower abdomen, but refuse to be examined. This is often a plea for help.

Without being insistent, it is necessary to:

- Provide relief by treating the symptoms first.
- Say that you can imagine what happened to them, and that they can talk about it if they want to.
- Suggest tests for sexually transmitted infections which are essential for them and their wives.
- Treat any depression which leads to a drop in libido or even impotence.
- Deny the claims of the torturers by stating the facts (e.g. "As a doctor, I know more than they do, I assure you this will not stop you having children").

*) Objects used by the torturers may also cause infection!

How to deal with the family

If the family has arrived together or within a short space of time, they will all need to come to terms with reality. Some will do so by falling into an even deeper state of depression, some will flee from their family, brought closer together by the ordeals and seen as stifling, and some will show behavioural disorders, for example with addictive behaviours. For a certain time however, their curiosity for their new environment may lead to remission of their psychological difficulties.

But the failure to discuss what each person has experienced will negatively affect relations within the family. It may be necessary to propose psychological help in the short term, usually for a brief period. This will make it possible to see who needs greater support.

If the family has been reunited after a separation of several years, the members will have to learn to live together again.

It is therefore necessary to prepare for this: Tell your patients not to be surprised at how much their children have grown and how independent they are, and that their partner has grown used to having to cope alone.

Their anxiety and depression will be made worse by the feeling that they have changed, that they have aged prematurely and have a poor quality of life. They should be treated during the period that the family is reunited, which may also lead to the return of episodes of revivication that may be distressing for one or other family members.

Recommendation

- Speak as simply as possible about the different experiences of each family member.
- Review the positive achievements e.g. their increased safety, to help the family to get over the first few weeks. Similarly, more frequent consultations will make it possible to deal with difficulties as soon as they arise.

Under such circumstances the help of a marriage guidance counsellor or psychologist specializing in family therapy is advisable.

VI – Coping with difficult situations

Be aware

That the patient may be reluctant to undress, because that is how the torture sessions began. You must take this into account. After all, you can simply slide the stethoscope under the shirt ...

That the complaints may change from one visit to the next – which is simply a means for the patient to say that (s)he has been hurt everywhere – and that each time you go over a painful experience you remind him/her of the torture, which will bring back other pains etc.

That giving pills "to help you sleep" to someone who has nowhere to sleep may well not be very effective ...

That care is required when prescribing psychotropic drugs and any side effects must be clearly explained. Such patients are wary of anything that may reproduce the feeling of depersonalization that they experienced earlier.

That pictures, sculptures and written texts may help to express things that are too difficult to say, or for which words are inadequate to describe what one has suffered.

That an articulated model (such as are used by art students) can be used by the patient to show where the pain is, or to show what position (s)he was put in while being tortured.

Difficulty	Solution
Language	"Everything is language" – Françoise Dolto Drawing and mime can be used to communicate The term "police" can be understood in any language Observe the patient's movements, clenched or trembling hands that betray the apparent calm of his/her face etc.
The patient has a mental block (S)he is beset by strong emotions, starts to cry and can no longer speak	Do not allow an oppressive silence to take over, suggest that the patient tells this difficult story later and ask what (s)he would like you to deal with first Do not go any further for the time being. Ask the patient if something in your surgery reminds him/her of what (s)he suffered (an electrocardiograph may remind him/her of the electric shocks)
If you do not have enough time If you do not want to get involved in a case that you are afraid you will not be able to handle If you have reservations, perhaps linked to your own personal or, family experiences	Do not be ashamed to delegate, but carry out a sympathetic and careful clinical examination, according to the complaints expressed. The patient perhaps wants nothing more than to start the healing process
If the patient faces welfare or administrative difficulties	This refers to an appendix elsewhere

A few statistics concerning after-effects

No comprehensive studies have been carried out on a worldwide scale. They are all fragmented and generally concern a specific country.

It should be remembered that many patients who are torture victims have no other way of expressing their mental suffering other than through somatic complaints, both here and elsewhere.

It is therefore of interest to investigate the complaints rather than the symptoms.

A study of the most common complaints within a population of torture victims from the same country reveals that this also applies to most of our patients. In extreme situations there seems to be a universal response, regardless of the sociocultural level or geographic origin.

Physical complaints:

- headaches
- diffuse pain
- gastrointestinal pain
- specific articular pains (mainly lumbar and back)

Psychological complaints:

- sleep disorders
- attention and memory disorders
- behavioural disorders
- panic attacks

Fear of being diagnosed as mad leads such patients not to mention pseudo-hallucinatory disorders which are very common. They only refer to them later on, once a relationship of trust has been built up. The doctor may mention these him/herself and will be able to reassure the patient since we know that such symptoms are sparked by events that are themselves crazy, and that they can be treated.

A few cases

Mr A... D... was referred to us due to epileptic-type fits that were taxing for those around him and for the doctor of the hostel where they were staying.

These fits were not mentioned during our first meeting. He complained that he could not sleep for more than three hours because of fear of the nightmares in which he was being tortured again. He also complained of pain in his left hip which he said was due to the electric shocks, and of headaches, "especially when I think". Finally, he could no longer remember things and could not concentrate on a book: he kept forgetting what he had read.

All of the examinations carried out showed clearly that there was no epileptogenic source.

Photographs of his hips show a small circular mark on the head of the femur that is non-progressive and proves to be not related to the trauma described.

On the other hand, the rheumatologist whose opinion we asked thought it might be paroxysmal meralgia, which improved after a few months.

His wife said that their relationship had been transformed: he had become infantile, quick-tempered and at times almost became violent.

We learn that he had very often been on long hunger strikes which must have played a part in his mental disorders.

One day, on regaining his composure after yet another fit, he told us that while he was being tortured he had gone through a whole period when he did not know if he was dead or alive ... What exactly did he tell his torturers during that time?

The fits enable him to attract the attention and help of others, freeing him for a time form the unbearable question that he has been asking himself ever since.

The marriage ends in divorce. He has to learn a new trade suited to his physical and psychological abilities, the latter having certainly been impaired by the long periods of hypoglycaemia.

This union official was severely affected by the torture he suffered.

S.V..., a young lad, was referred by the hostel where he was staying due to his timid attitude and his screams in the night that disturbed his neighbours.

He presented himself to us after having postponed his appointment twice. He appeared terrified, jumped at the slightest noise and whispered between his teeth.

He explained to us that he had been subjected to a form of torture that involved being pricked with a needle throughout his body, which he said lasted for hours. He said that he still had the feeling that he was going to be pricked again, hence his constant vigilance and nervous tension.

He was treated with tranquilizers and gentle massage, at first only on the parts of his body he could see, and then little by little, as his confidence returned, throughout his body. His sleep improved and he learned to relax. In the space of a few months he regained his peace of mind.

Mrs. D. G... was arrested and subjected to falaka, i.e. repeated blows to the soles of the feet.

On leaving prison she had to undergo a skin graft due to skin necrosis on the soles of both feet.

In addition to insomnia she complains of pains in the knees and back as soon as she walks a little.

She refused to let us examine her feet.

At the following consultation she explained to us that she cannot look at them,

that it is too difficult for her because it reminds her of when she was tortured.

She walks on the outside edge of her feet to avoid pressing on her soles and consequently damages the heels and outside edge of her shoes.

She was provided with orthopaedic soles to support the soles of the feet, together with a few foot-massage sessions undertaken with great sensitivity and a non-aggressive approach. This relieved her pain to the extent that she was able to envisage resuming her work as a dentist, which she had previously considered impossible as it involves a standing position.

During interrogation, Mr. M. N... was subjected to "jaguar" torture*.

Since then he suffers pain in one shoulder and in the chest.

He believe that it has given him a heart condition. The ECG result was normal, but pain recurred when tensing of the pectoral muscles was antagonized: he had tendonitis which responded to anti-inflammatory drugs. In the shoulder he has the beginning of a rupture of the rotator cuff.

He tells us that a possible operation is planned, but for later: he is still too afraid of anaesthesia, "when you don't know what you might say".

Referred to a psychologist, he is able to come to terms with the meaning of this fear, which haunts him in fact.

Mr. X. D…, a yong Frenchman aged about twenty, undertook psychoanalysis due to difficulties in his relationships with others.

He asked us for a consultation as he had just learned from a member of his family that his father had been tortured by the Nazis in front of his grandparents who were members of the Resistance.

His father was about ten years old at the time. His grandparents died in a Nazi concentration camp.

X. D's childhood was marked by the violent outbursts of his father, who never mentioned what had happened to him when he was a child. X. D. believes that this provides an explanation of his own unease, and we suggest that he tells his father that he has been told about the suffering he was subjected to.

A new, peaceful relationship is established between him and his father, and X. D. was invited to take part in a pilgrimage that the children of deported members of the Resistance carry out each year.

*) Jaguar torture involves tying the feet and hands to a stick, as is done by hunters to transport large animals they have caught. Blows and electric shocks can be inflicted in this position.