

# Burnout, vicarious traumatization and its prevention

*What is burnout, what is vicarious traumatization?*

Christian Pross, MD\*

## Abstract

Previous studies on burnout and vicarious traumatization are reviewed and summarized with a list of signs and symptoms. From the author's own observations two histories of caregivers working with torture survivors are described which exemplify the risk, implications and consequences of secondary trauma. Contributing factors in the social and political framework in which caregivers operate are analyzed and possible means of prevention suggested, particularly focussing on the conflict of roles when providing evaluations on trauma victims for health and immigration authorities

Caregivers working with victims of violence carry a high risk of suffering from burnout and vicarious traumatization unless preventive factors are considered such as: self care, solid professional training in psychotherapy, therapeutic self-awareness, regular self-examination by collegial and external supervision, limiting caseload, continuing professional education and learning about new concepts in trauma, occasional research sabbaticals, keeping a balance between empathy and a proper professional distance to clients, protecting oneself against being misled by clients with fictitious PTSD. An institutional setting should be provided in which the roles of therapists and

evaluators are separated. Important factors for burnout and vicarious traumatization are the lack of social recognition for caregivers and the financial and legal outsider status of many centers. Therefore politicians and social insurance carriers should be urged to integrate facilities for traumatized refugees into the general health care system and centers should work on more alliances with the medical mainstream and academic medicine.

*Key words:* burnout, vicarious traumatization, care for caregivers

## Introduction

Symptoms of burnout include apathy, feelings of hopelessness, rapid exhaustion, disillusionment, melancholy, forgetfulness, irritability, experiencing work as a heavy burden,<sup>1</sup> an alienated, impersonal, uncaring and cynical attitude toward clients, a tendency to blame oneself coupled with a feeling of failure<sup>2</sup> (Table 1). Such phenomena are quite familiar from the normal health care system. Who has not experienced, as a patient or accompanying family member in a doctor's office or hospital, how impersonally and with what disinterest one is at times treated, and in what an insensitive and cynical tone doctors speak of suffering and illness!

A few years ago, a young doctor documented conversations between surgeons and OR nurses during operations in British hospitals and found distressing incidents

\*)

Behandlungszentrum für Folteropfer  
GSZ Moabit  
Turmstr. 21  
D-10559 Berlin  
Germany  
c.pross@bzfo.de

of contempt and obscenity. Beyond the indignation, the question arises of how this behavior can be explained. A certain amount of professional cynicism, and this is true of other professions as well, apparently serves to relieve tension and stress and helps deal with the accumulated misery and suffering with which personnel are confronted day after day in a medical environment. The line is crossed when cynicism turns into brutalization and contempt, which affects care and harms the patients. Helping has not only a noble and charitable side, but also an aggressive aspect. The following will discuss this in greater detail.

Johan Lansen has pointed out that people working with survivors of torture experience symptoms that go far beyond the usual burnout. In addition to burnout, such aid workers, like their clients, may develop symptoms of posttraumatic stress disorder (PTSD), with sleep disorders and threatening nightmares. This results in feelings of great vulnerability. Fears may arise in which less significant daily events are suddenly experienced as threatening. A growing feeling of alienation may set in, accompanied by withdrawal and isolation. The person no longer feels understood by friends and relatives and loses the confidence that good is still possible in the world; at home, they are

quiet and withdrawn, cannot regain previous feelings of security, and are disillusioned by humanity. These manifestations are known as vicarious traumatization of members of healing professions.<sup>3</sup>

Based on their studies on incest survivors Laurie Anne Pearlman and Karen Saakvitne define vicarious traumatization as a transformation of the helper's inner experience, resulting from emphatic engagement with a client's trauma material.<sup>4</sup>

### Studies of vicarious traumatization

There have so far been few studies of burnout and vicarious traumatization among those who treat victims of extreme violence. McCann and Pearlman<sup>5</sup>, who coined the phrase "vicarious traumatization," advocate the "infection model." The authors postulate that the patients' tormenting flood of memories, their nightmares, fears, despair and distrust, infect the therapist. As typical symptoms of vicarious traumatization, they see depression, cynicism, boredom, loss of sympathy and empathy, dejection. Danieli and Miller advocate a similar model, in the sense of "infectious trauma" or "emotional infection."<sup>6</sup> Figley<sup>7</sup> speaks of secondary traumatic stress reactions or "compassion fatigue" among therapists, manifested in feelings of faintness, confusion, and isolation from friends and relatives, which can create the same symptoms as PTSD and distinguishes this from chronic burnout syndrome, which can occur in all aid professionals (Table 2). Kleinman and Maeder call secondarily-traumatized therapists "wounded healers."<sup>8</sup> These are people who, through their own traumatic experiences, possess a greater capacity for empathy; however, their need to heal others helps them avoid contact with their own unprocessed traumas.

Wilson and Lindy<sup>9</sup> see these occurrences

**Table 1.** *Signs and symptoms of burnout (Lansen, Fineman and Maslach).*

---

Apathy
Feeling of hopelessness
Rapid exhaustion
Disillusionment
Melancholy
Forgetfulness
Irritability
Experiencing work as a heavy burden
Alienated, impersonal, uncaring and cynical attitude towards clients
Tendency to blame oneself
Feeling of failure

---

as lapses in the patient-therapist relationship with a summation of negative or positive countertransference reactions. On the one hand, this can manifest itself in too much detachment on the part of the therapist, who no longer shows empathy and withdraws into an intellectualizing, apparently neutral posture. On the other hand, it can be expressed in the therapist's undistanced over-identification with the patient, which leads him or her to act in concert with the patient, a disabling exaggeration of care that results in mutual dependence.

Hoppe's study of this dynamic focused on the relationship between evaluators and test subjects based on his experience as an evaluator of concentration camp survivors in the 1950s and 1960s. He distinguished four typical attitudinal patterns on the part of evaluators:

1) Total denial. The evaluator identifies with the aggressor and fends off his own fear,

**Table 2.** *Signs and symptoms of vicarious traumatization (Lansen, Pearlman and Saakvitne, Wilson and Lindy, Hoppe).*

**Symptoms of posttraumatic stress disorder:**  
– nightmares, sleeplessness, intrusions, avoidance behaviour, irritability

---

Denial of client's trauma  
Overidentification with client  
No time and energy for oneself  
Feelings of great vulnerability  
Insignificant daily events are experienced as threatening  
Feelings of alienation  
Social withdrawal  
Disconnection from loved ones  
Loss of confidence that good is still possible in the world  
Generalized despair and hopelessness  
Loss of feeling secure  
Increased sensitivity to violence  
Cynicism  
Feeling disillusioned by humanity  
Disrupted frame of reference  
Changes in identity, world view, spirituality  
Diminished self capacities  
Impaired ego resources  
Alterations in sensory experiences  
(intrusive imagery, dissociation, depersonalization)

---

shame and guilt by denying or downplaying the victim's sufferings.

2) Rationalization. The evaluator's attitude seems open and well-meaning, but he then finds no connection between the persecution and the suffering from a scientific standpoint. His lip service of understanding to the suffering helps to relieve his feelings of guilt, while the "objective" conclusions guarantee recognition as a reasonable, unbiased evaluator by the German authorities and German colleagues. Victims would associate this type of evaluator with the "nice SS man" who offered them a cigarette during interrogation.

3) Overidentification with the victim. The evaluator ties the victim to him and thus satisfies his own narcissistic and omnipotent needs. Because of his subjective and polemic statements, his evaluations are generally not recognized by the reparations offices, and thus this type of evaluator disappoints the high hopes that he raises in the victims. Hidden behind his sympathy and exaggerated empathy with the survivors is a hatred of the Nazis, who destroyed his own hopes, as well as anger at himself for not fulfilling these hopes.

4) Controlled identification. This position represents the ideal evaluator, who withholds his own judgment, sees the unbelievable experiences of concentration camp survivors as possible and credible, does not shut himself off from the unbearable terror of which he is told, feels empathy, but also observes himself critically and perceives countertransference phenomena and his own defense mechanisms.<sup>10</sup>

### Studies on helper personalities and burnout

Studies by Hawkins and Shohet,<sup>11</sup> Rioch, et al., and Guggenbühl-Graig<sup>12</sup> on helper

personalities make possible an even more far-reaching understanding of the causes of burnout. They postulate that no one acts for purely altruistic reasons in entering a helping profession, and show that it is the dark sides of the personality that can lead to early burnout, if suppressed and left unprocessed. They include in this dark side a hidden urge for power on the part of the helper, as the “healthy” one superior to the “sick and helpless” client. Power over the client helps the helper to conceal and avoid his or her own feelings of helplessness and incapacity. Thus, for example, a helper will attempt to overcome his or her own feelings of helplessness by devoting hectic activity to clients, fighting for them with the authorities, and, in his or her role as the omnipotent rescuer, essentially reducing them to the role of a child. Such altruistic care of a cancer patient can help ward off fear of one’s own death. A helper who takes on too many clients, groaning under a too-great workload and refusing to accept the support and help of colleagues, is trying through addictive overactivity to defend against his or her own neediness. Another dark side of the “selfless” helper is narcissistic lust for glory and honor, for idolization by thankful clients. A final aspect, which is particularly taboo, is a person’s own violent side. A helper who has taken on the care of violent psychotics, suicides and drug addicts may have done this because, out of unconscious motives, he acts out and controls his dark side with the help of his patients: his hidden murderous impulses, paranoid fears, confusion and despair.

## Two examples

### *Case history 1*

In his last years of practice, an expert on the evaluation of concentration camp survivors underwent an about-face in his evaluation practice. Until then, he had pled for a find-

ing of persecution harms even in doubtful cases, but now, even in obvious cases of survivor syndrome, he would conclude that they involved early-childhood psychological damage in the form of neurotic disturbance, which had simply been worsened temporarily by persecution. His evaluations came to public attention and an organization of concentration camp survivors complained to the reparations offices about what they considered his tendentious evaluations. His colleagues reported that in recent years he had withdrawn more and more from clinical work, isolated himself, and refused inquiries from colleagues and invitations to professional lectures. The tone of his evaluations was covertly aggressive towards the applicants. A colleague who was relatively close to him believed he detected depression. Thus, he said, the doctor in question had frequently expressed doubts about the results of his work as a psychiatrist and downplayed the unquestioned success of his reforms in the anachronistic German system of psychiatric care. After his retirement he brusquely burnt all bridges to his colleagues and died shortly thereafter. It must also be mentioned that this man had been a pioneer in his field; he had played an important role in the heated debates and scientific battles over so-called concentration camp syndrome in the 1960s and 1970s and had taken on the big names in German psychiatry, infected as they were by the racial-hygiene spirit of Nazism. How could one explain this about-face in his later years? My remarks are hypothetical, but there is much evidence that this colleague suffered from burnout. He had given his all in a grueling debate fought with no punches pulled, both professionally and on a political and legal level. He and other pioneers of the psychopathology of persecution were publicly defamed as unreliable evaluators who gave out positive evaluations as fa-

vors.<sup>13</sup> He may have come to a point where he was tired of being an outsider and hoped finally to be accepted by the academic mainstream. Perhaps he had also been manipulated by some of his clients. A small number of faked instances of persecution harms may have triggered a backlash, and from then on he received each applicant with great mistrust.

#### *Case history 2*

A psychologist who had made a name evaluating traumatized refugees and fighting with the authorities became, over the years, more and more the addressee for refugees who had problems with residency permits. In the country she came from, she herself had been subject to political persecution, but she spoke with evident disdain of her countrymen and claimed that the majority of them exaggerated and had not experienced particularly grave persecution. She took no patients from her homeland, only particularly difficult cases from other countries. Her office was packed during office hours. She would go through fire for her clients and for many took on the role of mother and friend. She took more applications for statements and evaluations than she could handle. Her very careful, convincing evaluations helped many people gain residency permits. For some clients, she functioned as both therapist and evaluator, which led to unresolvable conflicts of roles and loyalties. Like a typical workaholic, she worked to the brink of exhaustion. Her big-heartedness and eagerness to help were exploited, and she even gave material assistance to those in particularly great need. When she refused to give further help to an especially insistent client, he attempted to pressure her with threats of suicide. A few times, appearing as an expert witness, she felt compromised by her clients when, during proceedings before the admin-

istrative court, they suddenly gave different stories about their persecution that were completely contrary to their previous medical histories. She had difficulty explaining this, and the plausibility of her evaluations, and thus her professionalism in general, were called into question. Her initial zest ebbed, and more and more frequently she lost her temper, was aggressive to colleagues and clients, and ultimately suffered a long illness.<sup>14</sup>

The studies by Lansen, Hoppe and Shoheit help us to better understand the traps illustrated by these two cases. The psychologist who denies her own persecution attempts through her altruistic dedication to other refugees to deal with her own trauma. She fends off her own needy impulses by driving herself to the brink of exhaustion for her clients. At the same time, she gains a narcissistic benefit: she is revered by her grateful clients like a cult figure and in this way satisfies her need for love and friendship. The fact that her evaluations help many clients to achieve residency status in court gives her a feeling of power and fantasies of being an omnipotent rescuer. In turn, this raises the expectations of her clients, and word gets around that she is a life preserver for hopeless cases. She is overwhelmed with clients. When her clients lead her astray and she is exposed and exploited in court, she is forced to the painful realization that this cannot end well, that it will all fall apart sooner or later, and that the clients are not her friends. Eventually she reaches her limit, her altruistic attitude changes, she is aggressive towards clients and colleagues and escapes into illness. Additionally, her over-identification and over-involvement with the victims was accompanied, as in Hoppe, by anger at herself for not doing enough against violence and its consequences.

In one of the big rallies in the mid 1990s against xenophobic and racist Neonazi

violence in Germany a slogan was carried saying: „Dear foreigners please protect us against *these* Germans!“ Many caregivers of the postwar generation in Germany are driven by the wish to make up for the crimes of the Nazi parent generation. The slogan can be read as an appeal to foreign immigrants to absolve Germans from the sins of their Nazi parents.<sup>15</sup>

It is frequently observed that beginners in the field of psychotraumatology are in danger of starting off with highly inflated expectations. They are full of illusions that this work can help them battle the causes of violence in general or that their clients can be completely healed. This makes their disappointment all the greater when these expectations are not fulfilled and it turns out instead that the labour is often Sisyphean, marked by frequent setbacks, and that the criteria for success must be set very low.<sup>16</sup>

### **Social aspects**

I would like to add something that is lacking in the studies mentioned here: One cause of burnout in helpers who work with traumatized people is their low level of social recognition, especially in the professional establishment. Such recognition, expressed in things as profane as titles, positions and salaries, nevertheless plays a major role in the psychological health of the helper. To return to the first case history: the doctors who dealt with the suffering of concentration camp survivors in the years immediately following the war were a small minority, unrecognized by the medical academic mainstream. They pursued their studies on their own, without institutional support. The subject was taboo in society, and it did not further one's career. Only much later did a few of them receive academic honors. The same is true today for colleagues who deal with torture victims and traumatized refu-

gees. Their outsider position is apparent in the very fact that their institutions exist in a gray area outside of the normal health care system and the universities, and are understaffed and very modestly financed. Thus the people who work there feel like hamsters on a wheel. They work very hard, possess an enormous amount of knowledge and experience for which they are not well paid, and earn neither the interest nor the recognition of the professional world. They have little possibility of professional advancement. On the contrary: the subject of psychotraumatology is controlled by others who make careers with client populations that are easier to sell, such as victims of crime and traffic accidents. The issue is power and influence in society: who determines the prevailing scholarly views, who has the authority to interpret in the field of psychotraumatology? Colleagues from facilities for traumatized refugees often find their evaluations nullified by colleagues who have much less experience with these specific clients, but are considered more credible by courts and agencies merely because of their academic titles or important positions in the profession.

On the other hand, this outsider existence also has its fascinations. Torture is a taboo subject that is given a wide berth by normal people and society. They delegate the responsibility for doing something about it to institutions like centers for torture victims. There is something heroic, pioneering, missionary about the work. One is admired for this, but also dismissed as an exotic idealist. This is seductive, and it promotes narcissistic overestimation of the self. The danger exists of losing sight of reality; an elite team spirit develops in which the outside world is seen as hostile, or flatly separated into good and evil. This exaggerated self-image inevitably breeds disappointment that can be expressed in conflicts among col-

leagues. In principle, a treatment center for torture victims is a socio-medical service like any other, like child protection centers, addiction clinics, pain clinics, etc. If such centers became part of the normal health and welfare systems, this would reduce the idealistic overload and exaggerated expectations and would ease the pressure on the staff. In the Netherlands, treatment of traumatized refugees was integrated years ago into the general health care system. This form of social recognition and integration has led to noticeable relief and increased professionalization.

### **The overburdening of the evaluator role in the residency process**

The terrible stories that confront therapists and evaluators of torture survivors create spontaneous feelings of sympathy and a strong impulse to help. One is tempted to do anything possible to ease the persons' suffering and guarantee them a secure life in exile. The risk of losing professional detachment is great. In the eyes of the subjects, the evaluator has enormous power, which can mean life or death in a residency procedure: residency means life, deportation means death. This puts massive pressure on the doctor or psychologist and, from the subject's point of view, shifts onto him a responsibility that is not his. I believe that the high risk of burnout for evaluators of the traumatized is also a result of this extreme tension, of the excessive demands that follow from the role of omnipotent judge and savior that is thrust upon him. Yet it is not his job to judge the subject's credibility or the plausibility of his story of persecution, like a criminologist. The final decision is made by the judge. The authority of the doctor or psychologist, as a clinical evaluator, consists exclusively in recognizing illness, diagnosing it, and assessing causation based on patient history and clin-

ical and psychological test results. Especially in psychology and psychosomatics, one finds oneself here in the realm of probabilities. Like the reparations offices for Nazi persecutees in the past, however, the agencies – state foreigners' offices, the federal office for recognition of foreign refugees, and the pension offices (for former East German political persecutees)– require so-called “objective” information and findings.

The temptation to take an overly biased position in favor of the subject lies precisely in this overburdening of the evaluators' role. It also lies perhaps in latent feelings of guilt for being confronted from a secure position of privilege in a rich country of refuge with a person who has lost everything, partly because of actions by the country of refuge (weapons sales, economic assistance, restrictive asylum laws). Evaluators are under heavy moral pressure and fear the envy and aggressive reaction of the subject in case of a negative judgment. They may also fear being seen as heartless and being blamed for the subject's deportation and delivery to his tormentors. Negative transference where the therapist finds himself in the role of the perpetrator are particularly hard on therapists working with trauma victims. Not infrequently, colleagues who, in the process of an evaluation, reach a result other than the one desired by their subjects are berated and morally pressured by them. One refugee rejected by the treatment center took over the waiting room for days, slept by the entrance, repeatedly forced his way into the colleagues' office to show his scars, and complained to the director of the center that he was being treated like an animal.

As with treatment, there are also too few facilities and experts to evaluate reactive psychological trauma results. All facilities are overbooked and have long waiting lists. This is partly because refugees who have given up

everything in their home countries and find themselves here in exile at the lowest end of the poverty scale are confronted with an asylum process that requires detailed, consistent and coherent biographical histories of persecution. Often, because of their psychological disorders, they are unable to deliver this. The result is a pull in the direction of institutions that deal explicitly with torture. Lawyers and charitable organizations send their clients to centers for traumatized refugees as a last hope, because, supposedly, only an attestation or statement from such a center can help. Doctors and psychologists are utilized for work that lawyers and refugee counselors should actually be doing. But most clients cannot afford a lawyer, and therefore turn to psychosocial facilities that will advise them for free.

### Preventing burnout and vicarious traumatization

The most important means of preventing burnout and vicarious traumatization in the field of psychotrauma is therapeutic self-awareness through a therapy training course.

**Table 3.** *Factors of prevention.*

---

Self Care – avoid workoholism, time for hobbies, leisure, family and friends
Solid professional training in diagnosis and (psycho)therapy
Therapeutic self-awareness
Regular self-examination by collegial and external supervision
Limiting caseload
Continuing professional education and learning about new concepts in trauma
Opportunities for research and training sabbaticals
Keeping a balance between empathy and a proper professional distance to clients
Protecting caregivers against being misled by clients with fictitious PTSD
Institutional setting in which the roles of therapists and evaluators are separated
Social recognition for caregivers
Overcoming financial and legal outsider status of centers
Integration of centers into the general health care system
Alliance with medical mainstream and academic medicine

---

(Table 3). If this is lacking, it should at least be provided on the job; otherwise, early burnout is inevitable. Regular self-examination with the help of collegial and external supervision is essential for both evaluations and treatment, in order to confront helpers, in a controlled environment, with their dark side. This would aid in determining whether they have become overidentified with their clients and risk losing professional detachment, or whether they have maneuvered themselves into detached avoidance or denial of the trauma. But despite common misperceptions, supervision cannot replace training and self-awareness!

To prevent clients from exploiting and deceiving helpers, limits and proper professional distance must be maintained. The patients' information should be supplemented by third party information, by comparisons with prior statements to agencies, and the knowledge of human rights organizations about methods of persecution and torture and prison conditions, including data on countries of origin. Several detailed interviews should be held before writing a statement or evaluation, including inquiry into the incidents described from various perspectives, keeping in mind that faked histories generally cannot be maintained consistently over a long period.

A further protection against burnout consists of the institutional and personal separation of therapist and evaluator, which has not been done to a sufficient degree in many facilities due to lack of financial and staff resources. It should be demanded from funders and the responsible authorities. In Berlin, this step has already been taken: the Center for the Treatment of Torture Victims, together with other facilities and the responsible professional associations, conducts a curriculum for diagnosis and treatment of PTSD for doctors and psychologists, at the

end of which the participants receive certification. Over the long term, this will increase the hitherto very small number of evaluation experts operating in the state of Berlin, to the point where it will be possible to separate the two functions.

As a further means of prevention, it is important that individuals not be solely involved with evaluating or treating traumatized patients. Many colleagues at centers for traumatized refugees, out of a healthy instinct for self-preservation, have reduced their hours in recent years and set up offices in which they also treat less-ill patients with neurotic disorders. Politicians and social insurance carriers should be urged to integrate facilities for traumatized refugees into the general health care system, as this would in the long run avoid the expensive follow-up costs of in-patient psychiatric care in chronic cases, free the work from its ideological burdens and its niche as an exotic charity, and offer more opportunities for continuing education in other areas. Not infrequently, apathy and disinterest appear in helpers in the midst of their professional careers if they cease to continue their professional education, and instead fall into the familiar rut of routine. This is a further cause of burnout that has rarely been mentioned in the literature.<sup>17</sup> Thus a work environment must be created that encourages flexibility and creativity and promotes continuing education and qualification, for example in the form of sabbaticals for research projects and publications.

#### *References and notes*

1. Lansen J. Was tut "es" mit uns? In: Graessner S, Gurriss N, Pross C. Folter – an der Seite der Überlebenden. Unter stützung und Therapien. Munich: Verlag C.H. Beck, 1996:253-70.
2. Fineman and Maslach cited in: Hawkins P, Shohet R. Supervision in the helping professions: an individual, group and organizational approach.

- Buckingham: Open University Press, 2000:21.
3. Lansen cited in Hawkins & Shohet 2000.
4. Pearlman LA, Saakvitne KW. Trauma and the therapist. Countertransference and vicarious traumatization in psychotherapy with incest survivors. In: Saakvitne KW, Pearlman LA. Transforming the pain. A workbook on vicarious traumatization. New York, London: W.W. Norton & Company, 1995.
5. McCann L, Pearlman LA. Vicarious traumatization: a framework for understanding the psychological effects of working with victims. *J Trauma Stress* 1990;3(1):131-49.
6. Danieli and Miller cited in: Bustos E. Stellvertretende Traumatisierung, verwundete Heiler oder die unvermeidbare intersubjektive Erfahrung in der psychotherapeutischen Arbeit mit traumatisierten Flüchtlingen. Lecture at conference of the BAFF, Berlin, 1999. (Unpublished).
7. Figley CR, ed. Compassion fatigue, coping with secondary traumatic stress disorder in those who treat the traumatized. New York: Brunner and Mazel, 1995.
8. Kleinman and Maeder cited in Bustos 1999.
9. Wilson JP, Lindy JD. Countertransference in the treatment of PTSD. New York: Guilford Press, 1994.
10. Hoppe KD. The emotional reactions of psychiatrists when confronting holocaust survivors of persecution. In: Lindon J, ed. Psychoanalytic forum, Vol. III. New York: Science House, 1969:187.
11. Hawkins & Shohet 2000:8ff.
12. Cited in Hawkins & Shohet 2000.
13. Pross C. Wiedergutmachung – Der Kleinkrieg gegen die Opfer. Berlin: Philo-Verlagsgesellschaft, 2001:168ff.
14. The examples are taken from the author's own observations. Facts and details have been changed.
15. Pross C. The shadow of the past in our work with traumatized refugees. Presentation at the 9th Nordic Conference on Refugee Health Care in Bornholm/Denmark, May 19-21, 1995.
16. Edelwich and Brodsky cited in Hawkins & Shohet 2000:21.
17. Hawkins & Shohet 2000:21.

# PTSD symptom changes in refugees

*PTSD symptom changes after immigration:  
A preliminary follow-up study in refugees*

Rebecca Meghan Davis, PhD student in Forensic Clinical Psychology\* &  
Henry Davis, IV, PhD- Clinical Psychology\*\*

## Abstract

Extreme traumatic events such as a threatened death or serious injury are common experiences for refugees, many of whom display levels of Post-traumatic Stress Disorder (PTSD). Our preliminary investigation of 19 refugees examined whether acceptance of an individual application for Convention Refugee status is a factor in recovery from PTSD. Based on the traumatic experiences identified with the Harvard Trauma Questionnaire, differential rates of recovery from PTSD and generalized distress were prospectively compared in refugees who had either received acceptance in their application for refugee status (n = 10) or had been denied status (n = 9). PTSD was diagnosed according to criteria outlined in the DSM-IV and distress was measured with the Brief Symptom Inventory.<sup>1-3</sup> Unique to this study was the assessment of the refugee Claimant prior to his or her individual appearance before the Immigration and Refugee Board in Canada. The data support the hypothesis that a positive outcome for the hearing would significantly relate to a reduced DSM-IV PTSD symptom count and to a reduced generalized distress. Participants who received a positive hearing outcome showed significant recovery relative to those who were denied refugee status. Notwithstanding the small sample size, the

results are discussed in terms of how the promise of future freedom from persecution combines with making actual disclosures before the Immigration and Refugee Board to start the process of rehabilitation.

*Key words:* PTSD, depression, refugee, rehabilitation, cognitive-behavioural therapy, hearing

## Introduction

It is widely recognized that the incidence of psychiatric disorders is significantly higher among immigrants and refugees. In fact, the reporting of physical and psychological trauma is required for an individual to claim legal recognition as a refugee. The high rate of Posttraumatic Stress Disorder (PTSD) among refugees is not surprising. The prevalence of PTSD in refugees is usually reported to range from approximately 25% to 70%.<sup>2, 4-6</sup> Relatively high rates of PTSD are found among refugees after resettlement.<sup>7-10</sup> Although epidemiological data for PTSD has established the expected prevalence for this disorder, little longitudinal research has been done on PTSD among refugees.

An extensive amount of literature documents the psychological status of Convention Refugees once they take residence in the new country. No research has yet examined resettled refugees both prior to and following the Immigration and Refugee Board

\*)  
Sam Houston State University

\*\*) Private Practice in Calgary  
Alberta  
Canada  
hdavis@cia.com

hearing which determines whether the refugee receives permanent resident status. This is surprising given that an analysis of the long-term course of PTSD in affected persons is essential for treatment. Weine et al. examined the course of PTSD in this population after North American resettlement.<sup>8</sup> They assessed 34 Bosnian refugees during the early phase of their resettlement in Connecticut. Each of the refugees was diagnosed with PTSD and was assessed one year later. At the 1-year follow-up, 15 of the 25 participants still met the criteria for PTSD. Even though all 25 participants showed significant decreases on severity, eight showed increases in the number of PTSD symptoms.

Several other studies have indirectly addressed the issue of the prognosis of PTSD. Ekblad and Roth examined the incidence of PTSD in multicultural immigrant and refugee patients in the analysis of the efficacy of treatment interventions.<sup>7</sup> At the 1-year follow-up, following the completion of treatment, two-thirds of the patients were still diagnosed with PTSD. These results are significant as the majority of immigrants and refugees were still experiencing PTSD symptoms even after receiving treatment indicating the treatment-resistant nature of PTSD in this population. Another study that is worthy to note was carried out by the Harvard Program in Refugee Trauma; it too involved psychiatric intervention over a 6-month time period.<sup>6</sup> Their sample of 52 Southeast Asian refugees showed only modest symptom improvement at post-test. Confounding variables, including variables associated with the migration process and with bereavement, may explain the apparent chronicity of PTSD in this population.

The present research was designed as a preliminary investigation into the course of distress and PTSD among refugees who file individual applications for Convention Refu-

gee Status or Humanitarian and Compassionate review. Participants were assessed both before and after testifying at their individual hearing before the Immigration and Refugee Board or after presenting a brief before the Federal Court (in addition to the initial hearing). A refugee hearing, itself, can be construed as an intervening variable between the baseline and follow-up assessments. The study addressed, therefore, whether the severity of PTSD and severity of distress changed relative to interventions where the Claimant had been required to present written and oral testimony to a lawyer and immigration officials.

## Methodology

### *Participants*

The participants were 19 Convention Refugee Claimants, drawn from consecutive legal referrals to a community-based forensic psychologist over a 48-month period. The small sample was deemed acceptable since the research objective was to conduct only a preliminary investigation. All contacted individuals agreed to participate and each person followed through; there was no attrition. For each participant a psychological assessment had been requested by the attorney representing the Claimant. Each Claimant met the criteria for PTSD in a structured interview and each had completed the Brief Symptom Inventory as part of the forensic evaluation (BSI).<sup>3</sup> After the hearing the individual was contacted by the first author (research assistant) and asked to consent to participate in this research; thus, each participant was assessed twice. The first (assessment) interview was conducted by the forensic psychologist and the second (research) interview by the first author. The research assistant knew the legal status of the refugee at the time of the second interview. There were two reasons for the initial psychological

evaluation: First, all Claimants were assessed for the same reason, to determine whether the well-founded fear of persecution and the psychological status of the individual would preclude his or her ability to live a psychologically healthy life by relocating within the country of origin. Second, for those Claimants who were refused refugee status at the hearing, the legal question was different and took one of two forms: a) the Claimant was asked if he or she would face unusual, disproportionate and undeserved psychological adversity if returned to the country of origin or b) the Claimant was asked if the history of suffering was so extreme as to leave him or her facing unusual psychological risks in every region of the country of origin. Thus, all participants had made claims before the Canadian Immigration and Refugee Board to the effect that each believed that he/she met criteria laid out in the Geneva Convention.

In some cases it was necessary for an interpreter to be present at the interviews if the Claimant was not fluent in English. Before the research phase, each Claimant was asked for written, informed consent to participate in the research.

Of 19 individuals who agreed to participate in the follow-up assessment 10 had received Board acceptance as Convention Refugees while 9 had been denied refugee status and were awaiting further legal proceedings. There were 13 males and 6 females; 12 participants were married. The mean age of the participants was 33.6 years; their ages ranged from 22 to 54 years. The country of origin for the participants included Pakistan ( $n = 6$ ), Bangladesh ( $n = 3$ ), Ghana ( $n = 3$ ) to India ( $n = 2$ ). The remaining five participants were from Lebanon, Yugoslavia, Trinidad, Nicaragua and Syria. The mean time period between the baseline clinical interview and the follow-up reassessment was 13

months ( $SD = 10$  months) while the average elapsed time between entry into Canada and the research interview was 36 months ( $SD = 7$  months). The small sample size precluded matching of groups on variables such as the number of traumatic events, or length of time between refugee hearing and the second clinical interview.

### Materials and design

The forensic assessment had been performed over 1 to 2 sessions, each lasting 2 to 3 hours. All 19 participants met the full criteria for PTSD.<sup>1</sup> The frequency of DSM-IV symptoms on Criteria D, E, and F were recorded using PTSD Symptom Checklist (SCID); this enabled the estimation of PTSD symptom severity at follow-up. Included in the baseline clinical assessment was an exploration of the history of traumatic experiences constituting the fear of persecution, as well as an administration of the BSI and Section I of the Harvard Trauma Questionnaire (HTQ).<sup>1-3</sup> The HTQ is widely used in the assessment of refugee trauma. This questionnaire is given in three sections covering a delineation and description of traumatic experience as well as the rating of DSM-IV criteria for PTSD. Interrater reliability exceeds 0.90 and 1-week test-retest reliability is 0.92 for the rating of the incidence of trauma events. The BSI was administered to measure degree of overall psychological distress. Global Distress was measured on the BSI with the Global Severity Index (GSI) – which averages severity across 9 symptom dimensions – and the Positive Symptom Distress Index (PSDI) – which averages severity across all 53 items. The BSI is a 53-item, self-report symptom inventory. The parent instrument of the BSI, the Hopkins Symptom Checklist-25 (HSCL-25), has been well-validated as a measure of generalized distress.<sup>11-13</sup> Each BSI symptom

item was rated on a 4-point scale ranging from not at all (0) to extremely (4) for the degree that it is experienced within the past seven days. The BSI manual reports test-retest reliability for GSI and PSDI of 0.90 and 0.87, respectively. Positive utility of these measures has been found in previous PTSD research.<sup>7, 14, 15</sup>

At follow-up, PTSD and BSI responses were again evaluated. One accepted Claimant did not complete the second BSI.

### Analysis

Paired-samples t-tests were used to analyze group changes between baseline and follow-up on PTSD, PSDI, and GSI measures.

### Results

Because this is a preliminary and small sample, the hearing outcome, pre-hearing, and post-hearing diagnoses of PTSD, and measures of trauma are presented for each participant in Table 1.

The two groups were not statistically different with regard to baseline PTSD symptom checklist frequencies, and scores on the BSI and the HTQ. No significant correlations were found between age and the dependent measures ( $p > 0.05$ ). Of 17 traumatic experiences specified in the HTQ the mean number of distinct traumatic situations experienced by the participants was 5.00 with a range from 3 to 10. The mean of total traumatic HTQ incidents experienced was 14.10. (Each traumatic situation might have been repeated yielding multiple incidents per refugee. For example, a person may have been imprisoned 5 times to yield 5 incidents.) The four most frequent traumatic experiences (facts accepted by the Immigration and Refugee Board) were torture or assault (89% of participants), serious injury (74%), witnessing murder of friend or family (58%), and witnessing murder of a stranger or strangers (47%).

The present study demonstrated that

**Table 1.** PTSD and scores on measures of trauma at baseline (T1) and follow-up (T2).

Refugee	Refugee status	Months since hearing	PTSD		SCID		PSDI		GSI	
			T1	T2	T1	T2	T1	T2	T1	T2
1	Y <sup>a</sup>	24	Y	N	15	1	3.50	1.00	3.10	0.08
2	Y	<1	Y	Y	14	11	2.20	2.77	2.80	2.77
3	Y	12	Y	N	12	3	3.00	1.54	2.50	1.02
4	Y	<1	Y	N	12	4	2.55	1.15	1.39	0.43
5	Y	3	Y	N	9	3	2.71	1.20	0.75	0.34
6	Y	10	Y	N	13	6	3.81	2.50	2.28	0.38
7	Y	33	Y	N	11	0	2.55	1.25	1.39	0.09
8	Y	1	Y	N	15	4	2.49	1.59	2.02	1.02
9	Y	3	Y	N	13	0	1.98	3.00	1.76	0.06
10	Y	1	Y	N	12	4	-	-	-	-
11	N	9	Y	Y	15	11	3.45	2.28	3.30	1.58
12	N	8	Y	Y	12	11	2.75	2.21	2.49	2.21
13	N	1	Y	Y	10	13	2.70	1.78	2.30	1.37
14	N	4	Y	Y	11	13	2.80	5.83	2.72	5.00
15	N	1	Y	Y	10	13	2.70	2.24	2.30	1.94
16	N	7	Y	Y	12	11	2.80	2.37	2.00	1.37
17	N	9	Y	N	11	6	2.00	1.83	1.77	1.38
18	N	1	Y	Y	11	14	2.46	2.25	2.37	2.21
19	N	4	Y	Y	11	13	2.70	2.67	2.60	2.57

<sup>a</sup>) Throughout, Y is positive for the category and N is negative. For example, a Y status indicates acceptance of the refugee claim.

when the Immigration and Refugee Board designates the individual as a Convention Refugee this can be critical leading to a reduction in the symptom expression in PTSD and in the general levels of distress in refugee Claimants. Positive hearing outcomes had significant positive relationships to PTSD and distress reduction first brought on by the experience of trauma. As shown in Table 2 and discussed below the paired t-test showed positive distress level changes from baseline to follow-up for those accepted but not for those denied status.

#### PTSD

There were no significant baseline differences between the groups in baseline PTSD symptom checklist frequencies. All participants met DSM-IV criteria for PTSD. The mean number of Criteria D, E, F symptoms for PTSD was 11.9 with a range of 9 to 15. One quarter of the refugees endorsed more than 14 of the 17 PTSD criteria D, E, and F symptoms.

At follow-up (Table 2), after the hearing, the attainment of Convention Refugee status was related to a decreased rate of PTSD diagnosis and to a decreased PTSD symptom count. Of 10 participants who had been

accepted as Convention Refugees only one still met the criteria for PTSD at the time of the research interview. Twenty percent of those accepted no longer displayed any symptoms of PTSD. The significance of the decrease in PTSD symptoms at follow-up was confirmed by paired t-test ( $t(9) = 9.16, p < 0.01$ ). The 95 percent confidence interval of the difference was 6.85-11.34. In contrast, the denial of Convention Refugee status at follow-up failed to relate significantly to either PTSD diagnosis or to symptom frequency change (paired t-test,  $p \geq 0.05$ ). Eight of the 9 Claimants who were denied Convention Refugee status still met the criteria for PTSD when reassessed. Among denied Claimants the most frequently reported PTSD symptoms included efforts to avoid thoughts, feelings, conversations, activities, places or people that arouse recollections (40%) and sleep impairment (40%). Thirty-three percent of refugees whose claims were denied endorsed 14 of the 17 PTSD symptoms. All reported experiencing recurrent intrusive distressing recollections as well as dreams, intense distress upon exposure to cues, efforts avoiding thoughts, feelings or conversations and places that arouse recollections, detachment or estrangement, and sleep impairment.

**Table 2.** Analysis of trauma scores at initial interview and follow-up

Variable		Baseline		Follow-up		Paired t-test
		M	SD	M	SD	
PTSD	Accepted	14.60	1.84	5.50	2.99	9.16 **
	Denied	13.44	1.51	13.89	2.57	0.65
PSDI <sup>a</sup>	Accepted	2.69	0.47	1.78	0.78	2.50 *
	Denied	2.71	0.38	2.61	1.24	0.24
GSI <sup>a</sup>	Accepted	2.12	0.73	0.77	0.83	5.35 **
	Denied	2.43	0.44	2.18	1.14	0.69

\*  $p < .05$ , two-tailed. \*\*  $p < .01$ , two-tailed.

<sup>a</sup> One participant who was denied status had not completed the BSI.

PSDI and GSI

At baseline, the mean for PSDI was well above the suggested cutoff for significant distress of 8 and there were no significant differences between the groups on either PSDI or GSI. At follow-up, results indicate a positive association between hearing outcomes and levels of global distress. Accepted Claimants showed reduced PSDI levels at the time of the research interview relative to baseline ( $t(9) = 2.50, p < 0.05$ ). The 95 percent confidence interval of the difference was 0.07-1.75. No change was seen among denied Claimants.

Similar results were demonstrated on the GSI scores. Symptom reductions from baseline were found for those who were accepted ( $t(9) = 5.35, p < 0.01$ ) but not for those who had been denied ( $p > 0.05$ ). The 95 percent confidence interval of this significant difference was 0.77-1.94.

## Discussion

Few prospective studies have been conducted on the course of PTSD and general symptom distress in a refugee population starting at a point prior to legal resolution of the refugee claim. The refugees in the present study were similar to those studied elsewhere; the majority had been detained or imprisoned and tortured by state authorities or by individual persons acting out their loyalty to religious or political affiliations. Nearly all Claimants had legally accepted physical evidence of assault and torture and most had received medical care relative to PTSD and major depression. Nearly half had witnessed the homicide of others in the same circumstance while more than half had witnessed the homicide of a family member. The Canadian Immigration and Refugee Board had concluded that each Claimant had asserted a credible fear of persecution. All had migrated internally before fleeing to another country.

The data suggest that the acceptance of an application for Convention Refugee status may have a significant impact on the course of PTSD and generalized distress. Positive outcomes of the refugee hearing were associated with PTSD remission and the reduction of distress due to prior traumatic events. The follow-up revealed significant reductions of symptom distress among those 10 Claimants who had received positive legal decisions on their claims compared to baseline assessments. Moreover, the only (accepted) Claimant who still met the criteria for PTSD at follow-up had only received notification of his acceptance a few weeks prior to our reassessment. By comparison, the denial of a Claimant's application for Convention Refugee status was consistently associated with both maintained levels of PTSD and with severe psychological distress. The group of 9 participants who were denied Convention Refugee status showed no change in PTSD status and generalized distress levels at the time of the research interview.

It should be emphasized that PTSD symptoms were not eliminated among accepted Claimants. It appears simply that with the alleviation of apprehensions about the future, these persons became less likely to focus on the past. Unfortunately, it was not possible to collect behavioral data from all Claimants on work performance, leisure enjoyment, and other behavioral indices of symptomatic improvement.

These substantial improvements in mental health appear attributable to both an intervening process variable, the formal refugee hearing, and to the outcome of the hearing. When taken with other published research on settled refugees, our data suggest that the assurance of security in the host country combines with the individual refugee hearing itself to facilitate mental health

improvement. The provision of safety does not appear to be a sufficient condition for rehabilitation.

Convergent evidence in support of this logic stems from survey studies of resettled refugees. Among refugees who may not have received a formal hearing in the host country, the rates of PTSD remain high, even over a long term. Unfortunately, researchers do not generally provide sufficient subject history to indicate if the refugee ever appeared individually before a refugee board. For instance, in a study of Cambodian refugees, 1-year after resettlement, 60% still met the criteria for PTSD but the manner in which they obtained refugee status is unknown.<sup>6</sup>

It appears that the individual claims were not made and that resettlement to North America had been expedited with consideration of a group of persons following their departure from refugee camps in Thailand. In other words, after the identities and proof of citizenship had been evaluated, the group as a whole may have been granted refugee status on the basis of the known and accepted plight of the class of persecuted Cambodian persons. When this occurs, such Claimants may never formally present the full (verbal and written) personal beliefs which underlie the fear of persecution. Similarly, in the recent survey of Bosnian refugees in Australia, 70% had PTSD. Again the researchers did not clarify this point, but it is likely that the high levels of residual PTSD will arise in a group whose claims are never processed on an individual basis.<sup>9</sup> In yet another study of persons whose claims had likely been expedited, Carlson and Rosser-Hogan examined the mental health status of Cambodian refugees 10 years subsequent to resettlement and found PTSD in 86% of 50 adults.<sup>16</sup>

A malingered interpretation for the present data is possible: it is possible that

PTSD symptoms in our cohort of denied Claimants remained over-reported at the time of the follow-up assessment because of their possible benefit for future legal recourse. This explanation is not favored in light of the more obvious fact that most of our full sample of Claimants had accepted evidence of assault and torture; if denied, a Claimant is returned and can reasonably expect future, additional trauma. Importantly, once the history of torture is accepted in a hearing it does not have to be re-determined; and, continued rumination about the details of persecution for those Claimants in our denied cohort would not, therefore, affect the outcome of future case appeals or a Federal Court appeal. Those appeals are made on other grounds and do not revisit the original legal question of whether the individual has a reasonable fear of persecution in any part of the country of origin. It is not initially relevant if an individual is upset while residing in Canada.

The literature on domestic trauma and civil and criminal law has a bearing on our understanding of the present results. Some studies have examined the relationship between the outcome of a civil or criminal trial and the recovery from motor vehicle accident and sexual assault traumas.<sup>17-19</sup> The Albany MVA project examined accident-related predictors of the development and chronic suffering from PTSD among motor vehicle accident victims.<sup>17</sup> The best predictor of the presence of PTSD symptoms 1-4 months after an accident was the status of any ongoing litigation and at a 12-month follow-up. Those MVA survivors whose litigation settlements were settled (positively or negatively) had lower PTSD symptom levels than those whose litigation settlements were still pending. These data support our thinking that the completion of an individualized court process may promote recovery from trauma.

Similar inferences are possible in research on victims of sexual assault. Sales et al. performed one of the only studies examining the relationship between the victims of sexual assault recovery and legal outcomes.<sup>18</sup> In line with the present reasoning, a decision by a sexual assault victim to prosecute appears to be associated with better long-term adjustment and higher self-esteem – irrespective of the outcome of prosecution. This is an outcome. Significantly, persons who prosecute are not differentiated from those who do not prosecute by baseline psychological adjustment measures such as self-esteem, depression or social adjustment.<sup>19</sup> Methodological problems in this research still make causal conclusions impossible. For example, 85% of sexual assault cases do not result in prosecution and researchers generally do not compare those who do and those who do not prosecute. Simply laying charges should not be (but often is) considered a positive outcome; this is analogous to simply applying for refugee status.<sup>20</sup> A full comparison of the present results to the rape victimization studies is unfortunately not possible.

Still other variables may affect PTSD symptom recovery in refugees. These include the passage of time and acculturation.<sup>9,21</sup> The literature indicates that many refugees will show elevated levels of PTSD even after 10 years of resettlement. It is thus important to ask whether the formal hearing in some way combines with assurances of safety to affect symptom recovery. Based on the results of the present study one may tentatively conclude that non-specific factors, as reviewed by Rousseau, in the hearing itself may exert effects on the recovery from PTSD.<sup>22</sup> In fact, if a claim that a person has been persecuted is accepted this does not mean that the claim to Refugee status will also be accepted. For instance, it may be that the individual is deemed to have been

persecuted but that this person is denied refugee status if the Board determines that he has the ability to avail himself of state protection by moving to a different region of the country. In interpreting our results it is important to remember that persecution was accepted by the refugee board as part of the fact base for each participant in our study.

At the refugee hearing the individual is asked to tell his or her story. Hanscom indicates that one of the most powerful therapeutic influences on recovery from trauma is listening to the victim and enabling a person's written and verbal expression of emotions.<sup>23</sup> Telling and re-telling the story is integral to re-exposure, cognitive-behavior therapy, and writing-based treatments and is as important to therapy as it is to the very process of initially filing for refugee status.<sup>24-27,28</sup> Legal disclosures require a Claimant to write out and to talk about emotional and factual aspects of traumatic experiences, in explicit form, for multiple periods of 15-20 minutes, each, for 3-4 consecutive days before numerous different authorities. In addition, the Claimant may prepare with a lawyer for 3-20 hours and may even interview with a forensic psychologist for several hours. This, in itself, because it involves intentional re-exposure and emotional re-processing, may reduce distress and negative affect.<sup>24,29</sup> In fact, vividness of recall is associated with positive outcome in writing and re-telling therapies.<sup>29,30</sup>

Meta-analyses of therapy with trauma victims support these generalizations leaving the conclusion that the filing for refugee status has the core conditions of a writing and re-telling, cognitive therapy.<sup>8,24,27, 30-31</sup> Memory exposure and written expression of memory are critical to rehabilitation. For instance, Foa and her colleagues reported reductions in state anxiety, depression, and social adjustment resulting from prolonged

exposure and it is suggested that the effect of verbal disclosure is to enhance one's sense of control over the traumatic memory thereby producing increased self-confidence, self-esteem and self-efficacy.<sup>31</sup> Other treatment approaches involving writing and re-telling trauma memories have been used with female rape victims.<sup>30</sup> This approach allows for the articulation of the trauma into a verbal narrative, for enhancing clarity, and for reducing avoidance of the traumatic experience.<sup>24,29-31</sup> Reviews of effective trauma therapies describe eight effective cognitive-behavioural techniques, each involving disclosure.<sup>27,32-33</sup>

In preliminary studies it is important to remember that ethnicity imbalances (the majority of our participants were from the sub-Indian continent), small sample sizes, and gender imbalances may limit the generalizability of the findings. Thus, the present results would most confidently be applied to males from India, Pakistan and Bangladesh. Still, the findings may be taken to indicate a fruitful direction for future studies. Such future research must ask whether our data are attributable to sample size, ethnicity, our use of interpreters, the absence of back-translated symptom questionnaires, differences between individuals on the number of traumatic events, and time lags between entry into Canada and the second (research) interview.<sup>15,34</sup> It is not thought that these variables threaten the integrity of the study. However, work beyond this very preliminary investigation will require more experimental control.

Overall, however, our data may suggest that the individualized legal process can be rehabilitative. It requires the decision to file a legal application to become a Convention Refugee in the first place, together with intentional re-exposure to traumatic memory through re-writing and reviewing both the

emotional and factual aspects of the trauma, and the re-telling of the trauma to multiple audiences. All of these factors combine over time to promote adaptive coping in the same manner as formal cognitive-behavioural treatment. Sadly, for the person who is denied refugee status the process does not appear to have rehabilitative benefit rendering the conclusion that the claims process may be a necessary but not sufficient condition for the recovery of the Claimant. The promise of future safety also appears necessary for rehabilitation.

---

This article is dedicated the memory of Maria deKrasinska, M.S.W. As a long-time champion for refugees, her work in Canada over roughly 20 years as a counselor of the victims of persecution and torture and her advocacy for the mental health of these persons enabled hope for many.

### References

#### References

1. Diagnostic and statistical manual of mental disorders. 4th ed. Washington, DC: American Psychiatric Association, 1994.
2. Mollica RF, Caspi-Yavin Y. Measuring symptoms of torture and torture-related symptoms. *Psychol Assess* 1991;3:581-7.
3. Derogatis LR. The Brief Symptom Inventory (BSI): administration, scoring, and procedures manual. Baltimore: Johns Hopkins University School of Medicine, 1993.
4. Kinzie JD, Boehnlein JK, Leung PK, Moore LJ, Riley C, Smith, D. The prevalence of posttraumatic stress disorder and its clinical significance among Southeast Asian Refugees. *Am J Psychiatry* 1990;147:1567-72.
5. Kinzie JD, Manson SM. The use of self-rating scales in cross-cultural psychiatry. *Hospital and Community Psychiatry* 1987;38:190-6.
6. Harvard Program in Refugee Trauma & Ruke NGO. Trauma and disability: long-term recovery of Bosnian refugees. Cambridge: MA Harvard School of Public Health, 1996.
7. Ekbal S, Roth G. Diagnosing posttraumatic stress disorder in multicultural patients in Stockholm psychiatric clinic. *J Nerv Ment Dis* 1997;185:102-7.
8. Weine SM, Vojvoda D, Becker DF, McGlashan TH, Hodzic E, Laub D et al. PTSD symptoms in

- Bosnian refugees 1-year after resettlement in the United States. *Am J Psychiatry* 1998;155:562-4.
9. Momartin S, Silove D, Manicavasagar V, Steel Z. Comorbidity of PTSD and depression: associations with trauma exposure, symptom severity and functional impairment in Bosnian refugees resettled in Australia. *J Affect Disord* 2004;80:231-8.
  10. Mollica RF, Wusak G, Lavelle J, Truong T, Tor, Svang Yang T. Assessing symptom change in Southeast Asian refugee survivors of mass violence and torture. *Am J Psychiatry* 1990;147:83-8.
  11. Parloff MB, Kelman HC, Frank JD. Comfort, effectiveness & self-awareness as criteria for improvement in psychotherapy. *Am J Psychiatry* 1954;111:343-51.
  12. Piersma HL, Boes JL, Reaume WM. Unidimensionality of the Brief Symptom Inventory (BSI) in adult and adolescent inpatients. *J Pers Assess* 1997;63:338-44.
  13. Davis RM, Davis H. Examination of the factor structure of the Brief Symptom Inventory in refugee claimants, 2005 (submitted).
  14. Mollica RF, Wyshack G, Lavelle J. The psychosocial impact of war trauma and torture on Southeast Asian refugees. *Am J Psychiatry* 1987;144:1567-72.
  15. Wilson JP, Keane TM. Assessing psychological trauma and PTSD. New York: Guilford Press, 1997.
  16. Carlson EB, Rosser-Hogan R. Mental health status of Cambodian refugees ten years after leaving their homes. *Am J Orthopsychiatry* 1993;63:223-31.
  17. Blanchard EB, Hickling, EJ. After the crash: assessment and treatment of motor vehicle accident survivors. Washington, DC: American Psychological Association, 1997.
  18. Sales E, Baum M, Shore B. Victim readjustment following assault. *Journal of Social Issues* 1984;40:117-36.
  19. Cluss PA, Boughton J, Frank E, Stewart BD, West D. The rape victim: psychological correlates of participation in the legal process. *Criminal Justice and Behavior* 1983;10:342-57.
  20. Frazier PA, Haney B. Sexual assault cases in the legal system: police, prosecution, and victim perspectives. *Law Hum Behav* 1996;20:607-28.
  21. Gorman, W. Refugee survivors of torture: trauma and treatment. *Prof Psychol Res Pr* 2001;32:443-51.
  22. Rousseau C, Crepeau F, Foxen P, Houle F. The complexity of determining refugeehood: a multi-disciplinary analysis of the decision-making process of the Canadian Immigration and Refugee Board. *J Refug Stud* 2002;15:43-70.
  23. Hanscom KL. Treating survivors of war trauma and torture. *Am Psychol* 2001;56:1032-9.
  24. Esterling BA, L'Abate L, Murray EJ, Pennebaker JW. Empirical foundations for writing in prevention and psychotherapy: mental and physical health outcomes. *Clin Psychol Rev* 1999;19:79-96.
  25. Greenberg MA, Stone AA. Writing about disclosed versus undisclosed traumas: immediate and long-term effects on mood and health. *J Pers Soc Psychol* 1992;63:75-84.
  26. Pennebaker JW, Beall SK. Confronting a traumatic event: toward an understanding of inhibition and disease. *J Abnorm Psychol* 1986;95:274-81.
  27. Neuner F, Schauer M, Klaschik C, Karunakara U, Elbert T. A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. *J Consult Clin Psychol* 2004;72:579-87.
  28. Pennebaker JW. Writing about emotional experiences as a therapeutic process. *Psychol Sci* 1997;8:162-6.
  29. Pennebaker JW, Kiecolt-Glaser JK, Glaser R. Disclosure of traumas and immune function: health implications for psychotherapy. *J Consult Clin Psychol* 1988;56:239-45.
  30. Resick PA, Schnicke MK. Cognitive processing therapy for sexual assault victims. *J Consult Clin Psychol* 1992;60:748-56.
  31. Foa EB, Rothbaum BO, Riggs DS, Murdock TB. Treatment of posttraumatic stress disorder in rape victims: a comparison between cognitive-behavioral procedures and counselling. *J Consult Clin Psychol* 1991;59:715-23.
  32. Ochberg FM. Post-traumatic therapy. *Psychotherapy* 1991;28:5-15.
  33. Rothbaum BO, Meadows EA, Resick PA, Foy DW. Cognitive-behavioral therapy. In: Foa EB, Keane TM, Friedman MJ, eds. *Effective treatments for PTSD*. New York: The Guilford Press, 2000.
  34. Pernice R. Methodological issues in research with refugees and immigrants. *Prof Psychol Res Pr* 1994;25:207-13.

# Self-harming behaviour and dissociation in complex PTSD:

*Case study of a male tortured refugee*

Shakeh Momartin, PhD Research Psychologist\* & Mariano Coello, Clinical Psychologist

*Keywords:* torture, PTSD, rape, disturbed sexuality

## Introduction

Self-harming behaviour has been found to be related to experiences of torture and life-threatening events among some refugee populations.<sup>1</sup> The issue of intractable pain<sup>2</sup>, specifically associated with torture sequelae has had a central role in the identification of clusters denoting increased self-harming and risk-taking behaviour among traumatized refugees. The pathological environment of prolonged abuse such as incarceration and rape, fosters the development of a remarkable array of psychiatric symptoms.

The identification of Posttraumatic Stress Disorder (PTSD) in refugee populations,<sup>3,4</sup> and reactive dysthymia or major depression,<sup>5</sup> associated with combat experiences,<sup>6</sup> together with stressors related to captivity, incarceration and torture<sup>7</sup>, have suggested a focus on comorbidity issues with respect to PTSD in refugee populations. Kramer et al.<sup>6</sup> reported that Vietnam veterans with diagnosis of PTSD plus depression exhibited more suicidal and self-harming behaviour than those with PTSD alone or

depression alone. Ferrada-Noli et al.<sup>7</sup> found that among refugee samples, 56% corresponded to subjects diagnosed with both PTSD and a depressive disorder.

There have been some, albeit limited, studies on the high prevalence of passive self-destructive behaviour<sup>8</sup> and frequent suicidal ideations containing expressions of self-condemnation, guilt, anger or obsessive re-enactment of a torture theme. Some clear associations have been found between torture methods and the preferred suicidal methods. For example, Ferrada-Noli et al.<sup>2</sup> found interesting associations in a sample of 65 refugees who had survived torture. They found that out of 18 of the cases who had been subjected to blunt violence to the head and body, 14 reported jumping from a height or in front of a train as the content of suicidal ideation, of the 6 cases subjected to water torture (submarino) 5 reported drowning as the content of suicidal ideation, of the 5 cases subjected to sharp force torture, 4 had attempted stabbing themselves and of the 3 cases subjected to asphyctic torture, 2 had considered hanging as a method of suicide.

Repetition of harm following prolonged traumatization has been noted to be sequelae of severe trauma.<sup>9</sup> Many traumatized people expose themselves, seemingly compulsively, to situations reminiscent of

---

\*)  
NSW Service for the Treatment and Rehabilitation of  
Torture and Trauma Survivors (STARTTS)  
smomartin@optusnet.com.au

the original trauma. Van der Kolk<sup>10</sup> has reviewed the topic in depth noting that the repetitive phenomena may take the form of intrusive memories, somato-sensory reliving experiences or behavioural re-enactments of the trauma. These behavioural re-enactments are rarely consciously understood to be related to earlier life experiences. This “repetition compulsion” has received surprisingly little systematic exploration during the 70 years since its discovery, though it is regularly described in the clinical literature.<sup>11,12</sup> Freud thought that the aim of repetition was to gain mastery, but clinical experience has shown that this rarely happens, instead, repetition causes further suffering for the victims or for people in their surroundings. Van der Kolk<sup>10</sup> reported a case of a Vietnam veteran who had accidentally shot a friend during the war, and every year, on the exact anniversary of the event, he would commit armed robbery, staging a hold-up, provoking gunfire from the police.

In an attempt to systematize these scattered observations, Horowitz<sup>13</sup> suggested that there may be an identifiable “posttraumatic character disorder” following certain forms of severe trauma whereas others such as Marmar<sup>14</sup> and Herman<sup>15</sup> have proposed the introduction of a category of “Complex PTSD”. Roth et al.<sup>16</sup> suggests that Complex PTSD is needed to describe some specific symptoms of long term trauma which are particular to captivity such as concentration camps, prisoner of war camps, prostitution brothels or child abuse. The first requirement for the diagnosis is that the individual experiences a prolonged period (months to years) of total control by another person/ persons. The other criteria are symptoms that tend to result from chronic victimization. According to Herman<sup>16</sup> these symptoms include:

*Alterations in:*

- a) Emotional regulation, which may include symptoms such as persistent sadness, suicidal preoccupations, explosive anger and difficulty modulating sexual involvement.
- b) Dissociation, having episodes in which one feels removed from one’s mental processes or body.
- c) Self-perception, which may include a sense of helplessness, shame, guilt, stigma and a sense of being completely different than other human beings.
- d) The perception of the perpetrator, such as attributing total power to the perpetrator or becoming preoccupied by the relationship to the perpetrator, including a preoccupation with re-enactment of trauma.
- e) Relations with others, including isolation, distrust and a repeated search for a rescuer.
- f) One’s system of meanings, which may include either sometimes sustaining faith or at other times sense of hopelessness and despair.

In addition, survivors of extreme trauma may use excessive alcohol, drugs or sex as a way of distraction and removing themselves from the trauma and alleviating psychological and emotional pain. They might also engage in self-mutilation and other forms of self-harm. For a substantial proportion of traumatized patients, the combination of Complex PTSD and depression causes people to seek psychological treatment.<sup>17</sup>

Although these findings are important, the associations found between specific forms of torture with the contents of self-harming behaviour deserve further study. To date, there have been no studies which focus on the specifications to the complicated path leading to re-enactment or reliving of the torture experiences. In the following case-

study, the case of a Mr. “X”, a male survivor of severe torture, specifically multiple rapes, some possible suggestions for the re-enactment, reliving and high risk-taking behaviour have been proposed. The purpose of the study has been explained in detail to the patient who consented to his story being written and disseminated to other professionals. The case is incredibly intense and complicated. The complete story is more extensive than the scope of this article. For the purpose of this article only some of the main issues namely anger, dissociation and extreme sexual acts as self-harming behaviour will be discussed. Other important issues such as his obsessional behaviour, coping mechanisms and the use of sex as coping, will be discussed in a future paper.

### Case study: brief background

A male in his early sixties was referred to The New South Wales Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) by a Sydney based sexual health clinic consultant who became concerned about the person’s request for an elective bilateral orchidectomy. The patient could not explain the urgency behind the request, however he mentioned that he was a survivor of torture.

Initial assessment indicated that he was born and raised in a healthy, happy and functional family, where he always felt loved and cared for. Mr. “X” described his early life as uneventful and denied any sexual or physical abuse. He was married with young children, working in public service in a relatively junior position, when he was arrested at around the age of 40, with alleged political charges, although he denied any connection to political or religious activities. He was imprisoned for two and a half years, tortured and raped by 5 prison-guards all through the duration of incarceration. Some

of the torture methods that he experienced were:

- Multiple rapes and other sexual violence by the prison guards
- Inserting a hose in his rectum, forcing hot water inside to wash and discharge excreta (almost 3 times a week)
- In case of accidental defecation at the time of rape, he would be subjected to severe beating and electric shocks
- Beaten on soles of feet with batons (Falanga)
- Mock execution numerous times
- Noise torture
- Starvation
- Fed excreta
- Placed in cold, then hot water
- witnessing murders of friends.

He was finally released when he signed a false confession. For the next several years, while staying his own home country, he lived plagued by hate, sadness, and a sense of betrayal and intense anger towards his wife who had left the country with the children during his incarceration. He started compulsively following strange women in the streets, swearing, degrading and humiliating them. According to him, after every “swearing session”, he felt revitalized and invigorated. During this time, Mr. “X” experienced recurrent nightmares, flashbacks of the rapes by the prison guards, continuously reliving and feeling that he was in the cell being raped, and would “wake up” trying to punch the imaginary person off his body. He had two significant dissociative episodes where:

- 1) he broke the shower screen and the door with his own hands, unable to recall the event,
- 2) he broke a large glass wall in his house with his own hands, and did not know

how it happened (realised only by the injuries/bleeding on his own hands). He speculated that it might have been a way for him to “break free” of the pain that he was enduring.

At around the same time, he started having homosexual fantasies which he resisted for a while. Consequently, he started an extremely promiscuous behaviour, frequenting female prostitutes in order to “fix” his homosexual ideations. He came to Australia in 2002. By coming to Australia, he lost the limited social network and support that he had in his country. His feelings of anger and abandonment and the dissociative episodes increased, where he would find himself in the middle of the highway at midnight, only “waking up” from the cold breeze.

### Assessment

Over the course of six evaluative sessions, the mental state of Mr. “X” was assessed by administration of the Structured Clinical Interview for DSM-IV Axis I Disorder (SCID-IV)<sup>18</sup> as a screening for mood disorder and anxiety disorders. The SCID-IV is a structured clinical interview developed to determine the presence of psychiatric disorders as identified in the 4th edition of the Diagnostic and Statistical Manual current and past lifetime episodes of psychopathology. Moreover, the Structured Interview for Disorders of Extreme Stress (SIDES)<sup>19</sup> was used. This is a specific measure for complex PTSD and provides a comprehensive assessment of trauma history, past and current functioning and symptoms such as dissociation, disruption in self-perception, disorders in relationships, affect regulation and somatization. Moreover, the Hopkins Symptom Checklist-25 (HSCL-25)<sup>20</sup> was used at pre-intervention, intervention and post-intervention periods, in order to evalu-

ate intervention efficacy. The HSCL-25 is a well-known and widely used self-report instrument which measures levels of anxiety and depression.

The patient was also referred to a physician who assessed him for general medical conditions, and results indicated no evidence of physical impairments or dementia.

### Clinical presentation

Mr. “X” presented as a reasonably healthy man of medium build, wearing casual clothing. He was punctual, polite, pleasant and engaging. His speech had regular tone and rhythm but was often slow, as he appeared to be very deliberate in his choice of words. His affect was somewhat restricted, with a normal range; it varied in accordance with the content of the dialogue. His thought process was linear and clear. He acknowledged self-harming ideations but denied suicidal thoughts at the time of the examination. There was no evidence of psychotic symptoms. His capacity for self-reflection, insight and judgment were adequate and appropriate to the context of the consultation. In general, his thinking about a number of topics appeared to be flexible throughout the interview, yet he was concrete and fixed. His manner, punctuality and general behaviour has been consistent over the course of his treatment.

### Psychological review of symptoms

Following a complete assessment of the presenting symptoms, some of the psychological symptoms at the time of assessment at STARTTS were: Depressed mood most of the day, fatigue and loss of energy, diminished ability to concentrate, suicidal ideation, psychomotor agitation, lack of sleep and significant weight loss. He insisted that homosexual fantasies were causing his night-walking, and that he was going “crazy”.

He reported that he was unable to cry and grieve for his traumatic past, which was adding to his distress. He felt that crying would seem like he was losing control over his emotions, hence he would stop himself from crying.

As most of the rapes and other torture occurred during night time, he was experiencing fear of the night, where he would lock himself at home at night refusing to answer the door or the telephone. At night, he would run all the way home from the train and reach home out of breath, sweating and shaking. Also, he experienced an intense phobic reaction to groups of males in the streets. If he saw a few men walking in the street together, he would hide until they walked away. He reported shaking, sweating, heart pounding, acting and feeling as if they were about to attack him.

### **Risk taking behaviour**

Mr. "X" reported that before presenting to STARTTS, he had begun frequenting male "baths" where he had sexual relationships with numerous men. He tried to have as many sexual partners as possible, regardless of the use of protection, in order to record the number of encounters on his calendar. He revealed that the reason for this ritual was to collect (almost as a trophy) more sexual encounters than he had had in prison. If he were to miss a day of the "baths", he would compensate by staying for 48 hours without sufficient food or sleep on the next visit, in order to collect numbers of sexual encounters.

An interesting psychological symptom is that he had recurrent nightmares about the 5 prison-guards raping him, where he woke up shaking, screaming and had trouble breathing. On the other hand, when in the "baths", he experienced and enjoyed having sexual fantasies about the same men who

violated him. During assessment, he referred to himself as "Dr. Jekyll and Mr. Hyde".

Although having a very low threshold for pain (e.g. fainting at the slightest discomfort), when in the baths he reported volunteering to receive severe beatings and engaging in violent sexual acts for what he assumed could be up to 45 minutes, which he later did not remember. He only "woke up" after the act, when the sexual partner left, and he realised he had been bleeding. He expressed that he did not have any suicidal plans, however, if he were to accidentally die during a "violent session", that would be a desirable outcome for him.

### **Treatment**

Compulsive repetition of the trauma usually is an unconscious process that, although it may provide a temporary sense of mastery or even pleasure, ultimately perpetuates chronic feelings of helplessness and a subjective sense of being "bad" and out of control. The goal of the treatment is gaining control over one's current life, rather than repeating trauma in action, mood, or somatic states.

Mr. "X" has been visiting STARTTS for weekly sessions for a year and a half for support and treatment. Parts of the "Phase Oriented" treatment programme specific to complex PTSD by Luxenberg et al.<sup>17</sup> were adopted for this patient.

As initially his numerous phobias were affecting his everyday life a Stabilization Phase was necessary to assist the patient in making sense of his experiences. In this phase, the treatment was supportive and reparative rather than explorative. Basic psychoeducation about the effects of trauma on individuals and his symptomatology was provided. It included a rationale and explanation for the specific symptoms: the flashbacks, nightmares, panic attacks and

intense fear. He was encouraged to keep a Mood Diary in order to record his feelings, different moods, thinking pattern and daily experiences. Such identification allowed him to begin evaluating realistically the amount of danger actually present in his current environment, rather than continually experiencing panic attacks in situations. Issues of safety were discussed in detail. In a few months following the commencement of sessions, he was able to identify flashbacks, nightmares and anxiety provoking situations, and explain to himself that these were merely reactions of his past experiences. He started expressing that the behaviour was pathological but no longer inexplicable.

In this *first phase*, recovery and safety were also focal issues. An additional strategy was to teach the patient relaxation and distraction techniques so that he would be able to perform the exercises without help from the therapist. Progressive muscle relaxation, deep breathing and guided imagery were introduced to the patient. During the end of phase one, the symptoms of panic regarding crowds, men in the street and neighbours were eliminated and his Hopkins Anxiety rating decreased from 3.4 (highly symptomatic) to 1.2 (non-symptomatic). Also the anger reaction towards women had subsided.

*Phase Two:* This stage involved the processing and grieving of traumatic memories and exploring the traumatic events in depth. The aim was to integrate the traumatic memories into a coherent narration of the patient's life, along with desensitization of the intense negative affect associated with these memories. This stage is the longest as it incorporates allowing the patient to express his feelings, re-live the traumatic events and re-tell his story. This helped him in desensitisation of the trauma facilitating the gradual decrease of painful memories.<sup>5</sup>

This stage helped address the alter-

ations in the individual's meaning systems by instilling a sense of hope for the future that it is no longer merged with a traumatic past. Because of the severe and complicated nature of the present case, exposure-based treatment, as advised by Luxenburg<sup>17</sup> was not used. Instead, close attention was paid for signs or accounts of dissociation, helping the patient in "grounding" himself. As the dissociation usually happened at night at his home, the patient was taught techniques to deal with the episodes using identified objects (blanket and a family picture) to ground and reassociate himself. A contract was prepared by the patient and the therapist as an agreement regarding suicidal ideation and the steps which he could take if and when thoughts of ending his life would come to his mind. An important positive outcome of this stage, perceived by him, was that he became able to cry and express his pain while telling his story.

*Phase Three:* This stage involved reconnection and integration of his experiences at the level of faith, vision of life, perception of self and others as well as personal and social values which he found important. Unencumbered by many of the initial after-effects of chronic trauma, attention was now shifted out into the world of relationships. New friendships, membership with various associations, hobbies and activities were explored and encouraged. Consequently, the patient became connected with his religious group, cultural association and a support group for refugees. This does not mean that traumatic material was no longer present, but it was not the preliminary focus of this phase of treatment. Moreover, it no longer consumed the patient's life or sense of self.

By this stage, he had stopped writing the number of sexual encounters on the calendar, agreeing that this was increasing his risk-taking behaviour. Moreover, during the

last few months, he has refused unprotected sexual encounters.

Another major positive outcome of this stage was regarding his dissociative episodes. He has encountered two situations over the last three months where he “woke up” during a violent sexual act and realised what was happening. He stopped the person before further bleeding occurred and went to the hospital for treatment. Feeling the pain during the violent act was new and frightening to him, however he expressed that it made him feel “human”.

### Discussion

Survivors of rape who seek professional help present with a variety of symptoms. Detailed inventories of their symptoms reveal significant pathology in multiple domains: somatic, cognitive, affective, behavioural and relational.

In a torture setting, the victim’s perception is not that torture is transient or non-lethal. To the contrary, what is perceived by the victim is the threat of his/her physical annihilation through the systematic repetition of torture, a threat which is often verbalized by the torturer. In addition to inducing terror, the perpetrator seeks to destroy the victim’s sense of autonomy.<sup>15</sup> In the present case, the insertion of water, forceful emptying of the intestines and beating in case of defecation is an ultimate act of controlling the victim’s body and bodily functions. Narrowing in the range of initiative becomes habitual with prolonged captivity and must be unlearned after the prisoner is liberated.<sup>15</sup>

The patient continually referred to himself as a non-human, which is supported by other authors such as Niederland<sup>21</sup> who in his clinical observations of concentration camp survivors, noted that alterations of personal identity were a constant feature of the survivor syndrome. While the majority of

his patients complained “I am now a different person”, the most severely harmed stated simply, “I am not a person”. The essential element in the facilitation of the emotional process during treatment is the rehearsal of the emotional reaction. The patient should be encouraged and allowed to express feelings of shame and disgust in revealing the sexual traumatisation.<sup>22</sup> Helping the victim “digest” the traumatic events, accepting what happened, and listening empathically could help the patient find himself again.<sup>22</sup>

By inviting physical and sexual pain, our patient essentially re-enacts the rape scenes. He may wish to re-enact the “inconclusive” pathway of the injury caused by the perpetrator, and complete the task by ending his own suffering. The association between mode of torture and content of suicidal ideation may be understood in terms of the psychodynamic concept of compulsive repetition of a past trauma<sup>23</sup>. The endeavour is to reach control over one’s life. To reach a solution of the unsolved horrifying event or to obtain satisfaction not experienced, or belatedly to master anxiety or guilt. They are likely to repeat the experience in order to gain a sense of mastery over their initial experience of victimization, as well as to be able to attach meaning to it, such as gaining back control and mastering their own fears and emotions.

Horowitz<sup>24</sup> found that trauma victims alternated between compulsively repeating the event through flashbacks or nightmares and denying it. Thus, it appears as if the mind attempts to organise and process overwhelming stimuli to reach control. Studying this intriguing association using larger samples, may help find new answers to the complicated issue of self-harm dynamics.

The rage of the imprisoned person also increases the symptoms.<sup>25</sup> During captivity the patient could not express anger at the

perpetrator, to do so would jeopardise survival. Even after release he may have continued to fear retribution for any expression of anger against the captor. Moreover, he carried a burden of anger against his wife and children who remained indifferent and failed to help. Herman,<sup>15</sup> stated that internalization of rage may result in a malignant self-hatred, risk-taking and self-harming behaviour. Hence, one of the main therapeutic goals should be to express and re-tell the story as a way of dealing with the anger which is deep-seated in his psyche.

People in captivity become adept practitioners of the art of altered consciousness.<sup>9</sup> Through the practice of dissociation, voluntary thought suppression, minimization and denial, they learn to alter an unbearable reality. Prisoners frequently instruct one another in the induction of trance states. These methods are consciously applied to withstand hunger, cold and pain.<sup>26,27</sup> During prolonged confinement and isolation, some prisoners are able to develop trance capabilities ordinarily seen only in extremely hypnotizable people, including the ability to form positive and negative hallucinations and to dissociate parts of the personality.<sup>15</sup> Disturbances in time, sense, memory and concentration are almost universally reported.<sup>28-30,31</sup> The rupture in continuity between present and past frequently persists even after the prisoner is released. The prisoner may give the appearance of returning to ordinary time, while psychologically remaining bound in the timelessness of the prison.<sup>32</sup>

In situations of captivity, the perpetrator becomes the most powerful person in the life of the victim, and the psychology of victim is shaped over time by the actions and beliefs of the perpetrator. The methods which enable one human being to control another are remarkably consistent. The methods of establishing control over another person are

based upon the systematic and repetitive infliction of physical and, most importantly, psychological trauma. These methods are assigned to instil terror and helplessness, to destroy the victim's sense of self in relation to others, and to foster a pathologic attachment to the perpetrator. Fear is also increased by unpredictable outbursts of violence towards the victim and by inconsistent enforcement of numerous trivial demands, submissions and petty rules.

Repetitive phenomena in the present case study is an interesting yet disturbing fact which has also been observed and noted by other authors. After prolonged and repeated trauma our patient had victimized himself by placing himself in risk of repeated harm. This is consistent with other findings where about 10% of psychiatric patients are thought to injure themselves deliberately<sup>33</sup>, or by self-mutilation which appears to be quite distinct from attempted suicide.<sup>12,31</sup>

### Conclusion

To date, the situation of the patient has definitely improved, although his request for orchidectomy stands. He still has sexual relationships with men, although with protection and without violence. Despite enjoying the sexual relationship, he expresses that he despises every one of these men and would never want to have a social/friendly relationship with them, somewhat distancing himself from them. His anxiety and depression symptoms have also subsided. In the last two months, he has been feeling intense internal pain during sex. Following our referrals to three medical specialists in three different hospitals, no physical reason has been found for his pain.

Is it possible that the pain was always present but concealed by dissociation? His road to recovery is long and arduous. The pain and suffering which he carried with

him for years, are deeply embedded in his psyche, which in turn protected him by masking the memories.

This case has undeniably been incredibly difficult, challenging and emotionally draining for the therapists. We, the therapists, have constantly been confronted by issues of transference, mixed feelings of helplessness, compassion, sympathy, commiseration, empathy, fear and guilt for not “helping” him fast enough. We have tried to cope with these feelings by maintaining regular supervision sessions, debriefing after sessions and discussing, observing and exploring our own feelings as they emerge. The case is ongoing and he will undeniably need further long-term therapy and support. By sharing this case, we hope to relay the clinical issues of the patient, and also briefly elicit the emotional experiences that therapists have to deal with in such complicated cases, which we will detail in a later article. We hope that this article will assist in informing and increasing awareness of the serious issue of male rape, torture and its sequelae, in prison settings. Perhaps one day our patient and other survivors might feel some peace and serenity.

#### References

- Hougen HP, Kelstrup J, Petersen HD, Rasmussen OV. Sequelae to torture: a controlled study of torture victims living in exile. *Forensic Sci Int* 1988;36:153-60.
- Ferrada-Noli M, Asberg M, Ormstad K. Suicidal behavior after severe trauma. Part 2: the association between methods of torture and of suicidal ideation in posttraumatic stress disorder. *J Trauma Stress* 1999;11:3-16.
- Silove D. The psychosocial effects of torture, mass human rights violations and refugee trauma. Toward an integrated conceptual framework. *J Nerv Ment Dis* 1999;187:200-7.
- Mollica RF, McInnes K, Sarajlic N, Lavelle J, Sarajlic I, Massagli M. Disability associated with psychiatric comorbidity and health status in Bosnian refugees living in Croatia. *JAMA* 1999;282:433-9.
- Hardy C. An act of force: male rape victims. *Torture* 2002;12(1):19-23.
- Kramer TL, Lindy JD, Green BL, Grace MC. The comorbidity of post-traumatic stress disorder and suicidality in Vietnam veterans. *Suicide Life Threat Behav* 1994;24:58-67.
- Ferrada-Noli M. Post-traumatic stress disorder and suicidal behaviour in immigrants to Sweden. Stockholm: Karolinska Institute, 1996.
- Ferrada-Noli M, Asberg M, Ormstad, K, Lundin T, Sundbom E. Suicidal behaviour after severe trauma. Part 1: PTSD diagnoses, psychiatric comorbidity and assessments of suicidal behaviour. *J Trauma Stress* 1998;11:103-12.
- Herman JL. Complex PTSD, a syndrome in survivors of prolonged and repeated trauma. *J Trauma Stress* 1995;5:88-100.
- Van der Kolk BA. Compulsion to repeat the trauma: re-enactment, revictimization, and masochism. *Psychiatry North America* 1989;12:389-411.
- Blank AS. The unconscious flashback to the war in Vietnam veterans. In: Sonnenberg SM, Blank AS, Talbot JA, eds. *Stress and recovery of Vietnam veterans*. Washington, DC: American Psychiatric Press, 1985.
- Brett EA, Ostroff R. Imagery in post-traumatic stress disorder: an overview. *Am J Psychiatry* 1985;142:417-24.
- Horowitz M. *Stress response syndromes*. New Jersey: Jason Aronson, 1986.
- Marmar CR. Brief dynamic psychotherapy of posttraumatic stress disorder. *Psychiatry Annual* 1991;21:405-14.
- Herman JL. *Trauma and recovery*. New York: Basic Books, 1992.
- Roth S, Newman E, Pelcovitz D, van der Kolk B, Mandel FS. Complex PTSD in victims exposed to sexual and physical abuse: results from the DSM-IV field trial for posttraumatic stress disorder. *J Trauma Stress* 1997;10:539-55.
- Luxenberg T, Spinazzola JH, Hunt C, van der Kolk B. Complex Trauma and Disorders of Extreme Stress (DESNOS) diagnosis. *Directions in Psychiatry* 2001;21:373-414.
- First MB, Spitzer RL, Gibbon M, Williams JBW. *Structured clinical interview for DSM-IV axis I disorders: user's guide*. New York: American Psychiatric Press, 1997.
- Pelcovitz D, van der Kolk B, Roth S, Mandel F, Kaplan S, Resick P. Development of a criteria set and a Structured Interview for Disorder of Extreme Stress (SIDES). San Francisco: Cleis Press, 1997.
- Hesbacher T, Rickels K, Morris RJ. Psychiat-

- ric illness in family practice. *J Clin Psychiatry* 1984;41:6-10.
21. Niederland WG. Clinical observations on the 'survivor syndrome'. *Int J Psychoanal* 1968;49:313-5.
  22. Turner S. Surviving sexual assault and sexual torture. In: Mezey GC, King MB, eds. *Male victims of sexual assault*. Oxford: Oxford University Press, 1992.
  23. Greenson R. *The techniques and practice of psychoanalysis*. New York: International Universities Press, 1967.
  24. Horowitz M. *Stress response syndromes*. New York: Jason Aronson, 1976.
  25. Hilberman E. The "wife-beater's wife" reconsidered. *Am J Psychiatry* 1980;137:1336-47.
  26. Partnoy A. *The Little School: tales of disappearance and survival in Argentina*. San Fransisco: Cleis Press, 1986.
  27. Sharansky N. *Fear no evil*. New York: Random House, 1988.
  28. Allodi F. Physical and psychiatric effects of torture: two medical studies. In: Stover E, Nightingale E, eds. *The breaking of bodies and minds: torture psychiatric abuse and the health professions*. New York: Freeman, 1985.
  29. Silove D, Kinzie D. *Survivors of war trauma, mass violence and civilian terror: an overview*. Rockville: Maryland National Institute of Mental Health, 1998.
  30. Kinzie JD, Fredrickson RH, Ben R, Fleck J, Karls W. Posttraumatic stress disorder among survivors of Cambodian concentration camps. *Am J Psychiatry* 1984;141:645-50.
  31. Terr LC. Chowchilla revisited: the effects of psychic trauma four years after a school-bus kidnapping. *Am J Psychiatry* 1983;140:1543-50.
  32. Jaffe R. Dissociative phenomena in former concentration camp inmates. *International Psychoanalysis* 1968;49:310-2.
  33. Favaza AR, Conterio K. The plight of chronic self-mutilators. *Community Ment Health J* 1988;24:22-30.

# Domestic violence against women – an international concern

*With reference to the situation in Mauritius*

A.K. Agnihotri, MD, M. Agnihotri, MD, N. Jeebun, MD & B. Purwar, MD\*

## Abstract

Domestic violence is a pattern of assault and coercive behavior including physical, sexual and psychological attacks, by a person against his/her own intimate partner. Women are more frequently the victims. After a global overview of the prevalence and nature of domestic violence against women especially in Mauritius, this article provides a discussion about health problems and risk factors among the female victims with the objective of giving preventive measures to eradicate it from society. NGOs, along with legislative measures, have proven helpful in improving quality of life and preventing violence-related injuries among women. The health sector also plays an important role as part of multi-sector efforts in early detection and prevention of cases of domestic violence. Psychiatrists are in a unique position for early identification of such patients as well as intervention.

*Key words:* domestic, violence, women, prevention, health problems

## Introduction

Despite having equal rights and status in most countries, violence against women is still rampant and homes become torture

chambers for women.<sup>1</sup> Domestic violence is one of the most common forms of torture in women<sup>2</sup> and is a major international social and public health problem in both developed and developing countries. The United Nations defines “domestic violence” as violence that occurs within the private sphere, mainly between individuals who are related through intimacy, blood, or law.<sup>3</sup> According to a report by the UN International Children’s Fund (UNICEF), up to half of the world’s female population has suffered abuse at the hands of those closest to them at some point in their lives.<sup>4</sup> Domestic violence is a pervasive violence of women’s human rights and has been resistant to social advances because of its “hidden” nature. Such violence is a problem in every country of the world and



\*)  
Departments of Forensic Medicine, Pathology and  
Physiology  
Medical College, Belle-Rive  
Mauritius

almost universally under-reported. It has no relation with race, class or educational status.<sup>5</sup> The Massachusetts-based Women's Rights Network (WRN)<sup>6</sup> was founded in 1995 in response to the need to develop collaborative, cross-cultural and international strategies to eliminate domestic violence. To date, the WRN offers a resource center documenting strategies used around the world to end domestic violence.

This study has been conducted to review the global scenario of domestic violence with special reference to the statistics in Mauritius. It will also address the factors leading to that violence with the objective to plan preventive strategies for avoiding such a crime.

### **Global scenario of domestic violence**

Females can suffer from violence throughout their "life cycle" as fetuses may be aborted just because they are female, infants may be killed because they are female, girls may be neglected or subjected to various other types of abuse, adolescents may be raped, married women may be beaten, raped or killed by their husbands and widows may be neglected. The female infanticide and sex selective abortions that are caused by son preference have led to an imbalance in sex ratios characterized by millions of females "missing" from populations in Asia, China and North Africa. India is the site of approximately 5000 dowry related deaths each year.<sup>7</sup> A survey of 1842 rural women of reproductive age in India revealed that both men and women consider wife beating acceptable and that 40% of all wives have been beaten by their husbands.<sup>8</sup> The Indian government and other institutions are handicapped by lack of statistical data on the extent of domestic violence.<sup>9</sup> In Bangladesh, a study carried out in a remote rural area during December 2000 indicates that 50.5%

of the women were reported to be battered by their husbands and 2.1% by other family members.<sup>10</sup> In China,<sup>11</sup> the territory's police said that reported acts of violence between couples had risen 40% in a year.

A study about the severity of domestic violence in Korea showed that battering occurred more than once a month; on the other hand, the Korean Women's Hotline revealed that 42% of those interviewed had been assaulted more than once a week.<sup>12</sup>

In the United Kingdom, two small studies reported lifetime prevalence of domestic violence against women of 39 and 60%.<sup>13,14</sup> A community survey found that 23% of women had been physically assaulted by a partner or former partner, with 4% experiencing violence within the previous 12 months.<sup>15</sup>

In Spain, women are often the victims of violence and of domestic violence. In 1993, 86 violent deaths and 200,000 cases of abuse by a partner were reported.<sup>16</sup>

In Serbia, a study conducted on violence against women by the staff at the SOS Hotline for Women and Children Victims of Violence showed that almost all the callers (94%) were victims of violence from family members or intimate partners.<sup>17</sup>

In Arab and Islamic<sup>18</sup> countries, domestic violence is not yet considered a major concern, despite its increasing frequency and serious consequences. Surveys in Egypt, Palestine, Israel and Tunisia show that at least one out of three women is beaten by her husband. According to these people, domestic violence is a private matter and usually, a justifiable response to misbehavior on the part of the wife. Selective experts from the "Koran" are used to prove that men who beat their wives are following God's commandments.

In South Africa,<sup>19</sup> a cross-sectional study of violence against women was undertaken

in 1998 to measure the prevalence of physical, sexual and emotional abuse of women in households. Interviews with 1306 women had a response rate of 90.3% of eligible women. The lifetime prevalence of experiencing physical violence from a current or ex-husband or boyfriend was 24.6%, and 9.5% had been assaulted in the previous year.

In a survey of 5109 women of reproductive age in the Rakai District of Uganda, 30% of women had experienced physical threats or physical abuse from their current partner.<sup>20</sup>

The study conducted in Nigeria on 308 Igbo women showed that 78.8% of the women have been battered by their male counterparts, out of whom 58.9% reported battering during pregnancy, and 21.3% reported having been forced to have sexual intercourse.<sup>21</sup>

In North America,<sup>22</sup> where women have equal rights and status, violence against women is still present in the society. 40-51% of women experience some type of violence in their lifetime including child abuse, physical violence, rape and domestic violence. The perpetrator is most likely to be a current or former partner. It is also estimated that each year in the United States, four million women experience a serious assault by their partner, and the victim-related economic cost of partner violence is about US\$ 67 billion.<sup>23</sup> Annual prevalence of IPV (domestic violence) in Canada was found to range from 0.4% to 23%, with severe violence occurring from 2% to 10% annually.<sup>24</sup>

In Central America, women have developed a feministic critical consciousness of the negative responses to their personal and political transformation.<sup>25</sup> The Mexican Association against Violence towards Women (COVAC) surveyed 3300 men and women aged 18-65 years in Mexico City, and

nine other cities, in 1995 to assess public opinion regarding domestic violence. They found that 74% of the abused persons were women.<sup>26</sup> But there is no legislation in Mexico specifically against domestic violence.

The situation in Brazil, like many other countries, is one in which domestic violence is against the law, but in practice regularly tolerated. According to San Pablo Catholic University, only 2% of criminal complaints for domestic violence against women lead to conviction of the aggressor.<sup>27</sup>

In response to this global problem, more than 160 countries have ratified the UN's Convention on the Elimination of All Forms of Violence against Women, and many countries have included provisions to protect women against violence in their constitutions and criminal codes. However, only 44 countries specifically protect women against domestic violence.<sup>8</sup>

### **Violence against women in Mauritius**

The sample of this study includes 1510 cases of domestic violence against women in the year 1999 and 1235 cases in the year 2000. All the cases were obtained from the records of the Domestic Violence International Unit in Mauritius. An analysis was made to understand the trends and pattern of such cases in this country.

#### *Scenario in Mauritius*

The estimated resident population of the island of Mauritius on December 31, 2000 was 1,157,789 (577,958 males and 579,831 females), that is there were 1873 more females than males.<sup>28</sup> Mauritius offers equality of opportunity and access to education, health, social services and employment for both boys and girls without disparity. However, problems such as domestic violence have retained our attention as they affect mostly women. In 1997, the Government of

Mauritius introduced the Protection from Domestic Violence Act which has enabled thousand of silent women to break their silence and to benefit from legal protection. According to this Act,<sup>29</sup> “domestic violence” includes:

- Willfully causing or attempting to cause physical injury.
- Willfully or knowingly placing or attempting to place the spouse in fear of physical injury to himself/herself or to one of his/her children.
- Intimidation, harassment, maltreatment, brutality or cruelty.
- Compelling the spouse by force or threat to engage in conduct or act, sexual or otherwise, from which the spouse has a right to abstain.
- Confining or detaining the spouse against will.
- Any harm or threat to cause harm to a child of the spouse.
- Causing or attempting to cause damage to the spouse’s property.

**Table 1.** *Nature of domestic violence against women.*

Nature of problems	Number of cases	
	1999, N=1510	2000, N=1235
1. Verbal abuse	1452	1199
2. Physical assault	1256	1067
3. Threatening behavior	1242	973
4. Ill-treatment	1190	1076
5. Harassment	1069	1025
6. Damage	750	625
7. Irresponsibility	641	539
8. Offensive behavior	540	366
9. Sexual abuse	281	222

**Table 2.** *Causes of domestic violence against women.*

Causes	Number of cases	
	1999, N=1510	2000, N=1235
1. Quarrelsome	1173	1035
2. Dominant nature	909	665
3. Alcohol	871	697
4. Finance	665	514
5. Extramarital affairs	384	302

Structures for the provision of 24 hours service, free legal assistance, and psychological counselling to the victims of domestic violence have also been set up. An analysis of data reported by the Domestic Violence Interventional Unit in 1999 and 2000 showed that domestic violence has decreased, as shown in Table 1.<sup>30</sup> The prevalence of domestic violence against women in 2000 is estimated at about 0.2% and violence is found to be more prevalent in the age group 20-49 years.

As far as the stated cause of domestic violence is concerned, “quarrelsome” is found in the majority of the cases followed by alcoholism and male dominant nature (Table 2).<sup>30,31</sup>

## Discussion

Domestic violence is a significant problem all over the world which adversely affects the health and safety of millions of women throughout their lifespan. Such an assault is also termed as intimate partner violence. It occurs mainly in three forms: physical, sexual and mental. Vandello and Cohen<sup>32</sup> explain how domestic violence may be implicitly or explicitly sanctioned and reinforced in cultures where honor is a salient organizing theme, by giving three general predictions: a) female identity damages a man’s reputation, particularly in honor cultures; b) this reputation can be partially restored through the use of violence; and c) women in honor cultures are expected to remain loyal in the face of jealousy-related violence.

Low prevalence of domestic violence against women in Mauritius as compared to other countries is due to many reasons. First and foremost is the fact that many cases are not reported, as women in Mauritius still consider it to be a social stigma. They are not very open about their private lives, especially if they are being tortured. Other

factors such as low unemployment, lack of obvious gender discrimination, relatively low poverty, and a high rate of literacy could be contributing to the low prevalence of domestic violence in Mauritius. As opposed to India, there is no dowry system in marriages in Mauritius, thus further reducing the prevalence.

### **Health problems**

The women victimized by domestic violence suffer from more health problems than non-victimized women.<sup>33</sup> The common health problems associated with domestic violence are as follows:

#### *Physical health effects*

Battered women are more likely to have been injured in the head, face, neck, thorax, breasts and abdomen than women injured in other ways<sup>34</sup>. Physical assault ranges from slaps, punches and kicks to assaults with a weapon and homicide. Mortality associated with domestic violence also includes suicide of women. The injuries, fear, and stress associated with violence can result in chronic health problems such as chronic pain (e.g. headache, back pain), recurrent central nervous system symptoms including fainting and seizures, gastrointestinal disorders like loss of appetite, eating disorders or chronic irritable bowel syndrome, and also cardiac problems such as hypertension and chest pain.<sup>35</sup>

#### Gynecological problems

The common gynecological problems include sexually-transmitted diseases, vaginal bleeding or infection, fibroids, decreased sexual desire, genital irritation, pain on intercourse, chronic pelvic pain and urinary-tract infections.<sup>36</sup> Forced sex (direct force or lack of lubrication) and forced participation in degrading sexual acts, such as unnatural

sex, have consequences that could explain higher prevalence of gynecological problems among battered women.<sup>37</sup> The combination of physical and sexual abuse that characterizes the experiences of at least 40-45% of battered women puts these women at an even higher risk for health problems than the women only physically assaulted.<sup>38</sup>

#### *Mental health effects*

Depression and post-traumatic stress disorder are the most prevalent mental health problems of domestic violence.<sup>39</sup> These are mainly associated with emotionally abusive behaviours such as prohibiting a woman from seeing her family and friends, ongoing belittlement, humiliation, or intimidation, economic restrictions such as preventing a woman from working, or confiscating her earning and other controlling behavior, fear and stress due to physical abuse and forced sex. In a Canadian population based study, Ratner found that in addition to depression, abused women have also been associated with anxiety, insomnia and social dysfunction<sup>40</sup>. Alcohol and drug abuse are the other mental health sequelae seen in battered women in industrialized countries.<sup>41</sup>

#### *Health problems due to abuse during pregnancy*

Domestic violence among pregnant women is a global health issue. According to JC Campbell,<sup>42</sup> intimate partner violence (domestic violence) has been noted in 3-13% of pregnancies in many studies around the world, and is associated with detrimental outcomes to mother and fetus. Prevalence of violence among pregnant women in developing countries ranges from 4% to 29% and low birth weight is found to be an important consequence of violence.<sup>43</sup> Other health problems related to the fetus are preterm delivery, fetal distress, ante partum hemorrhage

and pre-eclampsia.<sup>44</sup> Fetal death due to elective termination of pregnancy has also been related to domestic violence.<sup>45</sup> The main risk factors observed for abuse during pregnancy are low socio-economic status, low education in both parents and unplanned pregnancy.

#### *Health problems in children*

Children of battered women are also affected. They often suffer from psychological disorders and tend to reflect the same vis-à-vis their spouses when they grown up.

Suppression of the immune system as a result of stress and mental health disorders, such as depression, or both conditions, are observed to be reasonable but untested casual hypothesis.<sup>42</sup>

#### **Risk factors**

Risk of violence is greatest in societies where the use of domestic violence in many situations is a socially-accepted norm. Women accept physical and emotional abuse as a husband's right, causing women to view some violent behavior as less violent. They may not speak out against the violence because they depend upon the husband for economic support and their cultural dignity. In many countries, the battered women who leave such an abusive marriage relationship are at risk of losing their income, children, shelter, land and social standing. The important risk factors for domestic violence against women are listed as follows:

- Poverty and associated stress are the key contributors that increase the risk of domestic violence through the effects on conflict, women's power and male identity.<sup>46</sup>
- Relationships full of conflict especially those in which conflicts occur about finances, jealousy and women's gender role transgressions are more prone to

domestic violence as compared to peaceful relationships. The frequency of verbal disagreements and of high levels of conflict in relationships is strongly associated with physical violence.<sup>47</sup>

- Women who are more empowered educationally, economically and socially are most protected.
- Violence against women is seen not only as a male dominant nature over women, but also as being rooted in male vulnerability stemming from social expectations of manhood that are unattainable because of factors such as poverty experienced by men.<sup>48</sup>
- Alcohol consumption by the partner is associated with increased risk of all forms of domestic violence.<sup>49</sup> Alcohol is thought to reduce inhibitions, cloud judgment and impair the ability to interpret social cues.

#### **Screening of women for domestic violence**

Domestic violence against women is associated with many negative health consequences for women. Therefore, the health sectors could play an important role in screening all patients who could be subjected to domestic violence. In recent years, many health professional associations have issued guidelines for clinicians on how to identify women who are abused. The patient should be examined alone in a safe private environment. Physicians should routinely screen women for domestic violence.<sup>50</sup> The STaT questions for the screening of the victims of domestic violence (intimate partner violence) are:<sup>51</sup>

- 1) Have you ever been in a relationship where your partner has pushed or Slapped you?
- 2) Have you ever been in a relationship where your partner Threatened you with violence? and

- 3) Have you ever been in a relationship where your partner has thrown, broken or punched Things?

These three questions when used together can effectively identify lifetime intimate partner violence and will aid clinicians' efforts to identify abuse in women. Obstetrician-gynecologists are in a unique position to identify such patients and to provide interventions.<sup>52</sup> The seriousness of wife-battering is examined in four categories: a) initial manifestations; b) frequency; c) patterns; and d) repercussions.<sup>53</sup>

#### *Role of psychiatrist*

As the majority of women who are victims of domestic violence suffer from great mental trauma, they need to seek the help of a psychiatrist. Routine questioning by the psychiatrist is very important because patients are not likely to disclose domestic violence spontaneously. All reported cases need a risk assessment. The presence of psychiatric illness, like morbid jealousy in the batterer, has to be born in mind as it is of great significance in risk assessment. The principles of management include establishing the victim's safety, treating mental illness, providing information about local resources and assessing current and future risk.

The following methodology can be employed by the psychiatrist:

- Interviewing the patient alone, without her partner present.
- Asking simple, direct questions in a confidential setting.
- Encouraging the victim to talk about the incidence.

If the victim does not answer or discuss the topic, then clinical findings should be looked for that may indicate domestic violence, and

the danger to the victim should be assessed before she leaves the medical setting. If the patient is in danger, she should be advised to stay with friends or family with whom she wants to stay.

Patients should be encouraged to take legal action and advised to be protected from further abuse. After patient safety has been ensured, then provision should be made for appropriate treatment and psychological interventions.

#### **Preventive strategies**

Domestic violence affects all aspects of women's lives and undermines the basis for sustainable human development while violating women's human rights. It can be prevented. Primary prevention projects are derived to avoid the occurrence of a violent act, but if it has already occurred it is necessary to avoid its repetition through secondary prevention projects. Tertiary prevention is applied in order to avoid major damages with the aim at improving the quality of life of those already traumatized.<sup>54</sup> The UN Development Fund for women has selected 23 projects in 18 developing countries to be beneficiaries of a \$ 1.2 million trust fund dedicated to violence against women. The projects offer a variety of approaches for preventing and eliminating domestic violence suffered by a third of the women in developing countries. They involve awareness-raising and advocacy, capacity-building, literacy, training, action research and prevention/deterrence activities.<sup>55</sup> The WHO is developing population-based data, innovative research methods, an inventory and assessment of interventions, policy guidelines, and information and advocacy materials to combat domestic violence.<sup>56</sup>

#### **Mauritius**

In Mauritius, important factors responsible

for domestic violence against women are quarrelsome, male dominant nature, alcohol, finance and extramarital affairs.

Mauritius is a signatory of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and is a party to the Beijing Platform of Action. In 1997, Mauritius signed the Gender and Development Declaration of the SADC Heads of State and subsequent Addendum on the Prevention and Eradication of Violence against Women and Children in 1998. The Protection from Domestic Violence Act which was enacted in 1997 provides legal protection in situations of actual or threatening violence (physical, verbal, sexual or psychological) among spouses.<sup>57</sup>

### Important preventive strategies

In our view, based on knowledge from the Mauritius situation, focus is found essential at the following prevention strategies:

- Create an atmosphere of non-tolerance of domestic violence. It can be achieved by enhancing legal literacy and human rights education for men and women by establishing the legal reforms needed to eliminate discrimination based on sex and giving every woman protection from domestic violence.
- Empowering women and improving their status in society. This objective can be fulfilled by improving the image of women in the media, enhancing women's participation in decision and policy, uplifting the economic empowerment of women, encouraging girls to join technical, science and vocational streams, and promoting sexual equality in the school environment and employment.
- Changing community norms. It is mainly done by raising gender issues in the society and promoting men's groups which

address issues of male violence against women.

- Elimination of risk factors: The main risk factors for domestic violence are poverty and male partner's alcohol consumption. The first aim should be to examine the extent and causes of poverty among women so as to introduce measures to improve the economic conditions of women. This can be achieved by creating employment for women. Health-promotion activities and legislative measures can play an important role in reducing alcohol consumption.
- Preventing violence-related injuries. Incarceration of violent men and issuing an "interim order" (protection order, occupation order or tenancy order) are necessary components for the prevention of violence-related injuries. Advocacy and connections with community agencies have proven helpful in improving quality of life and preventing violence-related injuries.<sup>50</sup>
- Improving the ability of physicians to identify the victims of domestic violence and the proper registration of patients in hospitals due to intentional injuries serve as useful tools in the monitoring of general violence prevention.
- Apart from obstetrician-gynecologists, psychiatrists play a major role in prevention of domestic violence against women. They can offer counselling to the male counterpart as well.

### Conclusion

Our study shows that hardly any country in the world is free from this major cause of concern as domestic violence against women. All attempts to eradicate this unacceptable crime should be encouraged by all countries. This would result not only in better health of women, but also in a better

health and quality of life for the whole family and of course the whole nation.

Domestic violence against women is a demonstration of male power juxtaposed against the lesser power of women. Ideologies of male superiority legitimize the disciplining of women by men, often for transgressions of conservative female gender roles, and sometimes by the use of force in this process. Husbands usually believe that they have an absolute right over the sexuality of their wives.

In response to all these problems, women's organizations have focused worldwide attention on domestic violence against women as a violation of human rights and are working in collaboration with responsible governments for the Convention on the Elimination of All Forms of Discrimination against Women. In our view, training of medical personnel to deal with the victims of domestic violence with proper universal screening, empowering women (education and employment), changing community norms, reducing risk factors such as poverty and alcohol consumption, research and monitoring, and strict legislative measures would be helpful in the eradication of domestic violence against women.

### Acknowledgements

We thank Dr. (Mrs.) MS Naga, MRCPsych, DPM (Lond) Psychiatrist, Victoria Hospital, Ministry of Health & Quality of life, Mauritius, for her participation regarding the role of the psychiatrist in the screening of domestic violence cases and Miss Daareawo Razia Banu, MBBS student, who helped us in providing material for the study.

### References

1. Kira I. Assessing and responding to secondary traumatization in the survivors' families. *Torture* 2004;14:38-45.
2. Rand MR. Violence-related injuries treated in hospital emergency departments. Bureau of justice statistics special report. Washington, DC: US Department of Justice, 1997.
3. Johnson C. Domestic violence: the cost to society, challenge to development. *Gend Action* 1997;1(4):2-3.
4. Half of world's women are victim of domestic violence. *Reprowatch* 2000;23(5-6):6.
5. Levack A, Blankson-seck N. Exploring the impact of domestic violence on reproductive health. *AVSC News* 1999 spring;37:1, 4.
6. Slote K, Cuthbert C. Women's Rights Network (WRN). *Violence Against Women* 1997;3(1):76-80.
7. Violence against women: an issue of human rights. *Gend Action* 1997;1(4):1, 4, 8.
8. Otoo-oyortey N. A battered women needs more than biological help. *IPPF Med Bull* 1997;31(3):5-6.
9. Patterns and responses to violence against women in India. *Gend Action* 1997;1(4):5.
10. Bhuiya A, Sharmin T, Hanifi SM. Nature of domestic violence against women in a rural area of Bangladesh: implication for preventive interventions. *J Health Popul Nutr* 2003;21(1):48-54.
11. Luard T. China brides bear brunt of violence. *BBC News Online*. <http://news.bbc.co.uk/2/low/asia-pacific/3109292.stm>
12. Wha-soon B. A study on the prevention of and countermeasures against domestic violence. *Womens Stud Forum* 1994;10:148-71.
13. McGibbon A, Cooper L, Kelly L. What support? Hammersmith and Fulham council community police committee domestic violence. London: Polytechnic of North London, 1989.
14. Stanko E, Crisp D, Hale C, Lucraft H. Counting the costs: estimating the impact of domestic violence in the London Borough of Hackney. London: The children's Society and Hackney Safer Cities, 1997.
15. Mirrlees-Black C. Domestic violence: finding from a new British crime survey self-completion questionnaire. London: Home Office, 1999.
16. Galindo E, Serrano N. Spain. Women in the world. *Womens Health News* 1994 Aug;23:8.
17. Mrsevic Z, Hughes DM. Violence against women in Belgrade, Serbia: SOS Hotline 1990-1993. *Violence Against Women* 1997;3(2):101-28.
18. Douki S, Nacef F, Belhadj A, Bousker A, Ghachem R. Violence against women in Arab and Islamic countries. *Arch Women Ment Health* 2003;6:165-71.
19. Jewkes R, Levin J, Penn-Kekana L. Risk factors for domestic violence: findings from a South Africa cross-sectional study. *Soc Sci Med* 2002;55:1603-17.

20. Koenig MA et al. Domestic violence in rural Uganda: evidence from community based study. *Bull World Health Organ* 2003;81:53-60.
21. Okemgbo CN, Omideyi AK, Odimegwu CO. Prevalence, patterns and correlates of domestic violence in selected Igbo communities of Imo State, Nigeria. *Afr J Reprod Health* 2002;6:101-14.
22. Robinson GE. Violence against women in North America. *Arch Women Ment Health* 2003;6:185-91.
23. Donovan RJ, Paterson D, Francas M. Targeting male perpetrators of intimate partner violence: Western Australia's "Freedom from Fear" campaign. *Soc Mar Q* 1999;5:128-44.
24. Clark JP, Du Mont J. Intimate partner violence and health: a critique of Canadian prevalence studies. *Can J Public Health* 2003;94(1):52-8.
25. Profitt NJ. Resisting violence against women in Central America: the experience of a feminist collective. *Can Soc Work Rev* 1994;11(1):103-15.
26. Association Mexicana Contra la Violencia hacia las Mujeres. Violence in the family: survey. *Este Pais* 1996;64:20-5.
27. Spotlight on: domestic violence: seeking Government Accountability. *feminist.com* 1995-2002.
28. Health Statistic Annual IX. Island of Mauritius: Ministry of Health and Quality of Life, 2000.
29. The Protection From Domestic Violence Act. Act No. 6 of 1997.
30. Statistics. Republic of Mauritius: Ministry of Women's Rights, Child development and Family Welfare, 2001:41.
31. Women and men in figures. Republic of Mauritius: Ministry of Women, Family Welfare and Child Development, 2000:41.
32. Vandello JA, Cohen D. Male honor and female fidelity: implicit cultural scripts that perpetuate domestic violence. *J Pers Soc Psychol* 2003;84:997-1010.
33. Helweg-Larsen K, Kruse M. Violence against women and consequent health problems: a register-based study. *Scand J Public Health* 2003;31:51-7.
34. Grisso JA, Schwarz DF, Hirschinger N et al. Violent injuries among women in an urban area. *N Engl J Med* 1999;341:1899-905.
35. Coker AL, Smith PH, Bethea L, King MR, McKeown RE. Physical health consequences of physical and psychological intimate partner violence. *Arch Fam Med* 2000;9:451-7.
36. Letourneau EJ, Holmes M, Chasendunn-Roark J. Gynecological health consequences to victims of interpersonal violence. *Women's Health Issues* 1999;9:115-20.
37. Campbell JC, Soeken K. Forced sex and intimate partner violence: effects on women' health. *Violence against women* 1999;5:1017-35.
38. Collett BJ, Cordle CJ, Stuart CR, Jagger C. A comparative study of women with chronic pelvic pain, chronic non-pelvic pain and those with no history of pain attending general practitioners. *Br J Obstet Gynaecol* 1998;105:87-92.
39. Cascardi M, O'Leary KD, Schlee KA. Co-occurrence and correlates of posttraumatic stress disorder and major depression in physically abused women. *J Fam Violence* 1999;14:227-50.
40. Ratner PA. The incidence of wife abuse and mental health status in abused wives in Edmonton, Alberta. *Can J Public Health* 1993;84:246-9.
41. Golding JM. Intimate partner violence as a risk factor for mental disorder: a meta-analysis. *J Fam Viol* 1999;14:99-132.
42. Campbell JC. Health consequences of intimate partner violence. *Lancet* 2002;359:1331-6.
43. Nasir K, Hyder AA. Violence against pregnant women in developing countries: review of evidence. *Eur J Public Health* 2003;13:105-7.
44. Gazmararian JA, Petersen R, Spitz AM, Goodwin MM, Saltzman LE, Marks JS. Violence and reproductive health: current knowledge and future research directions. *Matern Child Health J* 2000;4:79-84.
45. Glander SS, Moore ML, Michielutte R, Parson LH. The prevalence of domestic violence among women seeking abortion. *Obstet Gynecol* 1998;91:1002-6.
46. Jewkes R. Intimate partner violence: causes and prevention. *Lancet* 2002;359:1423-9.
47. Stets JE. Verbal and physical aggression in marriage. *J marriage Fam* 1990;52:501-14.
48. Bourgois P. In search of masculinity violence, respect and sexuality among Puerto Rican crack dealers. *B J Criminol* 1996;36:412-27.
49. Hoffman KL, Demo DH, Edwards JN. Physical wife abuse in a non-western society: an integrated theoretical approach. *J Marriage Fam* 1994;56:131-46.
50. Punukollu M. Domestic violence: screening made practical. *J Fam Pract* 2003;52:537-43.
51. Paranjape A, Liebschutz J. STaT: a three-question screen for intimate partner violence. *J Womens Health (Larchmt)* 2003;12:233-9.
52. Jones RF 3rd, Horan DL. The American College of Obstetricians and Gynecologists: responding to violence against women. *Int J Gynaecol Obstet* 2002;78(Suppl 1):75-7.
53. Wha-Soon B. A study on the prevention of and countermeasures against domestic violence. *Women's Stud Forum* 1994;10:148-71.

54. Concha A. In process citation. *Biomedica (Bago)* 2002 Dec;Suppl 2:347-61.
55. Shattering the silence of violence against women. *UN Chron* 1998;1:15-7.
56. Turmen T. The health dimensions. *UN Chron* 1998;1:18-9.
57. National Gender Action Plan. Government Republic of Mauritius, 2000.

# The physical and psychological effects of torture in Kurds seeking asylum in the United Kingdom

Lloyd Bradley, MRCP\* & Nouran Tawfiq, MSc\*\*

## Abstract

There were over 2000 applications for asylum from Turkish nationals to the UK in 2003. A large proportion of these were persons of Kurdish origin, many of whom claimed to have suffered torture. We sought to evaluate the physical and psychological effects of torture in those with physical injuries.

A total of 97 Kurdish asylum seekers requiring medical evaluation for evidence of torture were examined and interviewed in the presence of an interpreter. Physical injuries, pain, disability and psychopathology were documented for each.

A wide variety of injuries and psychological disorders were documented. Posttraumatic stress disorder, major depression and organic brain damage were present in a substantial proportion of those surveyed. Methods of torture not previously documented were revealed.

There are long term healthcare needs of this population, which are complex and require a multidisciplinary approach. Survivors of torture may be disadvantaged in the asylum process because of organic brain damage or major psychological disturbance.

*Keywords:* torture, posttraumatic stress disorder, pain

## Introduction

The institutionalised use of torture by the Turkish state to suppress political dissent has been well documented. The state's suppression of its many ethnic minorities, particularly its large Kurdish population has led to widespread claims of human rights abuses and a steady exodus of political refugees claiming to have suffered torture. There were over 2000 applications for asylum from Turkey in 2003 (Home Office statistics).

Turkey's wish to join the EU has acted as a catalyst for the creation of legislation to prevent the use of torture while at the same time releasing information about many of the methods used by its practitioners. For example although there has been a decline in reported cases in detention there has been a corresponding rise in complaints of torture outside of formal detention centres<sup>1</sup>. The vast majority of individuals presenting to the legal practice from which this sample was drawn, are Kurds originally from

---

\*)  
Department of Rehabilitation Medicine  
Box 120, Disablement Service Centre  
Addenbrookes Hospital  
Cambridge CB2 2QQ,  
United Kingdom  
lloyd.bradley@addenbrookes.nhs.uk

\*\*)   
Trott and Gentry Solicitors  
90/92 Islington High Street  
London N1 8EG  
United Kingdom

the southeast of Turkey. Without exception they allege that they have suffered beatings at the hands of Turkish security forces for expressing their Kurdish ethnicity or political affiliation. Clients who live in a village invariably report being lined up in the village square and beaten, sometimes with rifle butts or truncheons. These beatings are often accompanied by attempts to humiliate the victim in front of the group, for example victims will be forced to strip naked in front of the village, crawl in the snow or beat one another. This survey represents an attempt to systematically document the physical and psychological effects of torture on Kurds seeking asylum in the United Kingdom.

### Methods

A retrospective analysis was performed with the records of 97 Kurdish asylum seekers from Turkey who were referred for medical evaluation of allegations of torture through a legal practice in North London, The United Kingdom. At the time of interview a full physical examination and psychological assessment were performed on each patient in accordance with established guidelines as proposed by the Medical Foundation for the Victims of Torture (UK)<sup>2</sup>. In order to allow patients to feel comfortable and recall as much detail as possible about their experiences, interviews were unstructured, although the specific symptoms of depression and posttraumatic stress disorder (PTSD) were evaluated in terms of the DSM (IV) criteria<sup>3</sup> for the diagnosis of these disorders, by explicitly asking about the presence or absence of the symptoms that define these disorders in this diagnostic framework. Chronic pain and disability were not asked about directly, although these problems were recorded where they had been raised by patients during the assessment.

An initial examination of any injuries

volunteered by the patient was followed by a general physical examination. In none of the cases was any incidental injuries seen ascribed to previously forgotten torture.

The nature of the alleged torture employed was recorded in each case, and compared for consistency with physical injuries, which were present. Incidental physical injuries from unrelated causes were not recorded. In all cases, the patient was accompanied by a translator.

### Results

The mean age of individuals undergoing evaluation was 30 with a range of 16 to 64 years. There were 14 women (14%) in the sample. The patients were all ethnic Kurds from Eastern Turkey. They had all had one or more episode of detention by the police or military authorities, during which time the torture was carried out. The mean time from the episodes of torture to presentation was two years with a range of one month to eight years.

#### *Physical injuries*

Only one patient had no physical injuries. The others had a range of burns, lacerations, grazes, gunshot wounds, blast wounds and stab wounds.

A total of 18 individuals (18%) had scars from deliberately inflicted burns. Eight of these were from one or more cigarette burn.

The majority of the patients (65%) had sustained facial or dental injuries as a result of torture. These ranged from missing or broken front teeth, to loss of an eye resulting from blunt trauma. The average number of facial injuries sustained was 1.8 per individual.

Scars on the limbs and torso were less common, with around half (49%) of the patients seen having no scars in these areas. The nature of these lesions varied between

cuts to the hands as a result of attempting to protect the face and head when being beaten with a blunt instrument, to multiple lacerations. One individual had over 30 linear scars to his torso, resulting from being cut multiple times with a bayonet. Another individual had 16 scars, sustained in a similar manner. The mean number of scars to the torso and limbs, where present, was 3.3.

29% of patients had fractures. Two of these had multiple fractures (wrist and shoulder, wrist and fingers). The relative proportions of fracture types sustained are shown (Figure 1). The fractures were all sustained as the result of trauma from blunt instruments during detention.

16% of patients had multiple shearing scars across the front of the lower legs, reportedly the result of traumatic impact from heavy boots.

In 14% of cases penetrating stab wounds were present. These were usually to the legs or torso. Multiple stab wounds were present in four cases. The injuries were all sustained from fixed bayonets. None were of sufficient depth to warrant major surgical intervention at the time that the injuries were sustained.

5% of patients had localised burns resulting from electric shock torture. Two of

these cases involved application of the electrodes to the genitals, two had electrodes applied to the lower limbs and one to the upper limb, leading to a unilateral brachial plexopathy (this is a recognised complication of electrical injury to the upper limbs)<sup>4</sup>.

30% of the women in the sample were sexually assaulted in detention. Only two men reported sexual assault. One was anally raped with a glass bottle, while the other suffered genital mutilation with a knife.

5% of patients suffered complete hearing loss in one ear as a result of blunt trauma to the side of the head.

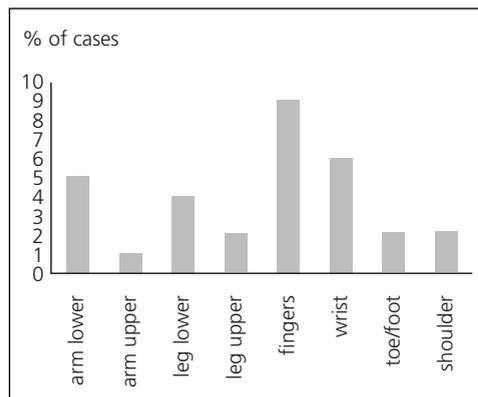
Three patients were shot in the legs; one was shot in the chest. In no case did their injuries receive urgent medical attention or follow-up. In all cases the bullet produced an exit and entry wound, and did not lead to longer term medical complications.

Two patients had stretch marks clearly visible across the anterior surface of both shoulders. These individuals had been bound with their arms behind them in forced internal rotation and extension for approximately an hour.

12% of the patients interviewed are disabled by their physical injuries in terms of being unable to work or carry out their activities of daily living unassisted.

22% of patients had chronic pain of sufficient severity to interfere with their sleep or activities of daily living. Of these around half were back pain and half were headache. There was no correlation between head trauma and the development of chronic headache ( $\chi^2=0.687$ ). None of the patients with chronic pain had other neurological signs or symptoms. There was no correlation between sex and the development of chronic pain ( $\chi^2=0.167$ ).

There were two unusual injuries from novel forms of torture, which have not been previously documented (case 1 and 2).



**Figure 1.** The percentage of individuals in the case series with fractures by location of injury.

*Psychological effects*

14% of patients had symptoms, which fulfilled the DSM criteria<sup>3</sup> for posttraumatic stress disorder. A number of others had nightmares and flashbacks of their experiences, but these were not associated with the other features of PTSD.

7% fulfilled the diagnostic criteria<sup>3</sup> for a major depressive episode. Again almost all of the patients interviewed reported low mood and fatigue, but did not fulfil the other criteria for a diagnosis of major depression to be made.

7% fulfilled the diagnostic criteria for generalised anxiety disorder<sup>3</sup> (without posttraumatic stress disorder). Almost all of the patients reported some physical symptoms of anxiety or other psychological difficulties, which do not fulfil DSM diagnostic criteria.

There was no association between the development of chronic pain and psychological problems ( $\chi^2=0.653$ ). There was no correlation between sex and the development of psychological problems ( $\chi^2=0.541$ ), although psychological problems occurred with greater frequency in women who had been sexually abused, this did not reach significance ( $\chi^2=0.071$ ).

6% of patients who had suffered closed head injury with subsequent disturbance of consciousness demonstrated the features of organic brain damage, with memory problems, emotional lability and impaired concentration and attention. None of the patients who had not suffered head injuries reported these problems.

One patient developed a disabling stutter following his experiences in detention, which led to difficulties in communication when he was attempting to claim asylum.

*Case 1*

In early 2001, SK, a 43 year-old man, was awoken in the night by the local police

banging on his door. He was accused of collaboration with a local guerrilla group, arrested and taken to a nearby police station. Upon arrival in the police cells, he was hit across the face with a baton, leaving a 4 cm linear scar on his mandible. He was tied to a chair, and a metal clamp was applied to his tongue. This was tightened, and traction was applied for between five and ten minutes, before being removed. The tongue has subsequently become chronically painful with altered taste sensation and obvious scarification on the superior aspect. Unable to offer the police any information on the activities of which he had been accused, he was thrown to the floor of the cell, and kicked repeatedly about the head and body. This has left him with scars over both legs and chronic low back pain. Although there are no neurological deficits, local spinal tenderness or limitation of movement, the pain is sufficiently severe to produce difficulties in walking over long distances. He suffers with generalised anxiety and difficulty sleeping. After two days in a cell, alone without food or water, he was released. No charges were ever formally brought.

*Case 2*

In early 2003, AK, 39, was arrested with a group of eight other men from the village where he lived. They were taken to a police station. They were not informed of any charges or accusations against them. The men were all beaten with batons and kicked, before being locked in a small cell for a day. The men were taken out of the cell individually. AK was one of the last to be called. He was taken into a brightly lit room and bound to a table. Two policemen held his eyes open while a third directed a high pressure jet of water into his face from close range. This lasted for around five minutes. The water was turned off, and a bright desk lamp was

placed a few inches from his face. His eyes were, again, forcibly held open, and he was made to look into the light for around ten minutes. By this point he had lost sight in both eyes. He was taken from the police station in a truck, and dumped on a hillside near his village. His visual acuity gradually returned over the following weeks, although it is still limited to 20/30 bilaterally. He has periorbital oedema and corneal scarring. Fundoscopy is normal. He experiences daily discomfort and “grittiness” in both eyes, although he reports no psychological problems.

### Interpretation

There are a many different forms of torture alleged by Kurdish refugees from Turkey. These results are similar to previous data on torture survivors from Turkey<sup>5</sup>.

This survey did not include those individuals without visible injuries, as would be the case with victims of falaka (suspension by the ankles and beating the soles of the feet) or forced submersion in water. Patients regularly report being forced to walk around immediately after receiving falaka, sometimes in salty water, in order to prevent swelling and disguise evidence of torture having taken place. Although bone scintigraphy has been used to evaluate such injuries<sup>6</sup>, this diagnostic modality was not available to the authors. Many clients allege the use of electric shock, normally administered to genitalia or fingertips. In some cases a method known as Palestinian Hanging is used. This involves tying the victim's wrists together behind his back and then inserting a stick or pole between the victim's arms and back. He is then suspended from the stick so that all of the victim's body weight is borne by the chest and shoulders. Therefore, this survey is likely to underestimate the total burden of psychopathology on the survivors

of torture from this population, given that the sample group was referred for evaluation of physical injuries in the first instance.

Sexual assault is commonly reported in female patients and there is a strong association with the subsequent development of psychological problems. The possibility of sexual assault having occurred should be considered in the assessment of torture survivors as this may assist in the assessment of individuals at high risk for the development of mental illness. Although only two men in this sample reported sexual assault, this may relate to a reluctance to discuss such issues as has been described in other populations<sup>7</sup>.

PTSD and depression occur in all demographic groups without a clear association with the type of torture inflicted. This is consistent with data on torture survivors from other populations<sup>8</sup>. Obviously the susceptibility of individuals to the development of problems like this will depend on more than the nature of the physical abuse, itself<sup>9</sup>. It is clear that there is a need for the deployment of psychological and psychiatric services for torture survivors, but these needs are not always being met<sup>10</sup>. The high level of occurrence of psychological symptoms not covered in DSM criteria is also noted<sup>11</sup>.

Chronic pain has previously been documented in torture survivors as a specific neuropathic sequel of certain types of torture<sup>12</sup>. None of the individuals with chronic pain in this sample had the features of classical neuropathic pain. There was also no correlation between psychopathology and the manifestation of the symptoms. The proportions of sufferers of headache and low back pain are in keeping with previously published data<sup>5</sup>.

Although bayonet wounds and evidence of gunshot injuries may also be seen in the context of armed conflict, these injuries in this series were ascribed to the process of

torture. It may be the case where the torture is not “planned” as such, that those perpetrating such actions use whatever instruments are available.

Navigation of the asylum process requires a number of interviews and appeals. None of the individuals in this sample spoke English, and over a quarter show evidence of major psychopathology or organic brain damage, thus limiting their capacity for concentration and comprehension further. The particular difficulties with recall that occur with depression<sup>13</sup> and traumatic brain injury<sup>14</sup> may present particular challenges where claimants’ accounts are repeatedly sought and scrutinised for inconsistencies. Neuropsychological assessment of torture survivors claiming asylum may be appropriate in this context to prevent those with cognitive dysfunction being disadvantaged.

There remains a question of how the roles of medical and legal specialists are defined within the context of attempting to prove that torture has taken place. Obviously, the presence or absence of a particular scar does not prove that torture has taken place. Nor, indeed, does the absence of physical injuries or psychological trauma mean that torture has not taken place. Unfortunately, the harmonisation of asylum law across Europe means that the onus is placed upon the claimant to convince a legal authority that there is a danger present in their country of origin. Evidence of torture having taken place would clearly support such a proposition, but it should not be a requirement. Many of the individuals examined in this group had coincidental injuries that were not the result of physical abuse. In every case, the individual concerned did not attempt to ascribe such wounds to torture having taken place. While this does not and cannot prove the veracity of the accounts, it does suggest that there is substance in the

accounts given by the claimants. Further work is required to define the process of “proving” the existence of torture in asylum claimants in different countries.

The variable combinations of chronic pain, disability, psychological disturbance and unusual physical injuries mean that the healthcare needs of this population of torture survivors are complex and require a multidisciplinary approach in their evaluation and management<sup>15</sup>. The appropriate collection and analysis of data on torture survivors seeking asylum can assist in the organisation of provision of such services. Such data would also allow the patterns of development of novel torture techniques (case 1 and 2) to be monitored.

#### References

1. Eradicating torture in Turkey’s police stations: analysis and recommendations. Human Rights Watch Briefing Paper, September 2004.
2. Medical foundation. Guidelines for the examination of survivors of torture. 2003.
3. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th ed. American Psychiatric Publishing Inc., 1994.
4. Suematsu N, Matsuura J, Atsuta Y. Brachial plexus injury caused by electric current through the ulnar nerve. Case report and review of the literature. *Arch Orthop Trauma Surg* 1989;108:400-2.
5. Moisander PA, Edston E. Torture and its sequelae – a comparison between victims from six countries. *Forensic Sci Int* 2003;137(2-3):133-40.
6. Lok V, Tunca M, Kumanlioglu K, Kapkin E, Dirik G. Bone scintigraphy as clue to previous torture. *Lancet* 1991;337:846-7.
7. Oosterhoff P, Zwanikken P, Ketting E. Sexual torture of men in Croatia and other conflict situations: an open secret. *Reprod Health Matters* 2004;12(23):68-77.
8. Thompson M, McGorry P. Psychological sequelae of torture and trauma in Chilean and Salvadorean migrants: a pilot study. *Aust N Z J Psychiatry* 1995;29:84-95.
9. Basoglu M, Mineka S, Paker M, Aker T, Livanou M, Gok S. Psychological preparedness for trauma as a protective factor in survivors of torture. *Psychol Med* 1997;27:1421-33.

10. Silove D. The challenges facing mental health programs for post-conflict and refugee communities. *Prehospital Disaster Med* 2004;19(1):90-6.
11. Wenzel T, Griengl H, Stompe T, Mirzaei S, Kiefer W. Psychological disorders in survivors of torture: exhaustion, impairment and depression. *Psychopathology* 2000;33:292-6.
12. Thomsen AB, Eriksen J, Smidt-Nielsen K. Chronic pain in torture survivors. *Forensic Sci Int* 2000;108:155-63.
13. Marvel CL, Paradiso S. Cognitive and neurological impairment in mood disorders. *Psychiatr Clin North Am* 2004;27(1):19-viii.
14. Capruso DX, Levin HS. Cognitive impairment following closed head injury. *Neurol Clin* 1992;10:879-93.
15. McGorry P. Working with survivors of torture and trauma: the Victorian Foundation for Survivors of Torture in perspective. *Aust N Z J Psychiatry* 1995;29:463-72.

# Medical physical examination in connection with torture

Section III\*

Ole V. Rasmussen, MD, DMSc\*\*, Stine Amris, MD, Margriet Blaauw, MD, MIH & Lis Danielsen, MD, DMSc

## Neurological

Acute central nerves neurological problems are associated with severe beatings to the head. In 200 torture victims 58% had received severe beating to the head and 1/4 of those consequently lost consciousness<sup>1</sup>. Headache was the most frequently reported symptom present in more than 50% of the examined persons. A significant correlation between severe beating on the head and headache was found. Likewise there was a significant association to the symptom vertigo present in 20% of the persons.

Violent shaking may produce cerebral injuries identical to those seen in the shaken baby syndrome: cerebral oedema, subdural haematoma and retinal haemorrhages. The first fatal instance of “shaken adult syndrome” was reported by Pounder and Path<sup>32</sup>.

Acute peripheral nerves symptoms are most often reported after handcuffs or tight

ropes at the wrist. Lesions of the brachial plexus, especially the lower roots, have been mentioned after suspension, and damage of the long thoracic nerve has been reported after “Palestinian hanging”<sup>18</sup>.

Many of the long lasting symptoms like loss of concentration, headache, memory disturbance, and vertigo, could be explained by chronic, organic brain damage<sup>33</sup> and call for a neurophysiological evaluation in order to evaluate the specific symptoms. It should, however, be born in mind that many of these symptoms are also related to PTSD.

Moreno and Grodin<sup>20</sup> have published a detailed review article on torture and its neurological sequelae.

## Cardiopulmonary

Acute symptoms include dyspnoea, chest pain, cough, expectoration and palpitation.

Certain types of torture lead particularly to pulmonary complications. Beatings to the chest can cause damage to the thoracic wall, including rib fractures, and severely reduce respiration. Often the consequence will be pneumonia. “Wet submarino” is associated with the potential risk of producing acute lung symptoms due to aspiration of contaminated water. Harsh prison conditions in humid, cold and dark cells probably often facilitate pneumonia, bronchitis or pulmonary tuberculosis.

\*)

First section was published in TORTURE vol. 14, no. 1. Second section in TORTURE vol. 15, no. 1

\*\*)

International Rehabilitation Council for Torture Victims  
Borgergade 13  
PO Box 9040  
DK-1022 Copenhagen K  
Denmark  
irct@irct.org

Electrical torture may produce cardiac arrest if the current passes through the heart<sup>34</sup>.

Long lasting symptoms in a follow-up study of 22 Greek torture victims<sup>35</sup> showed that attacks of tachycardia, palpitations and/or dyspnoea, also combined with anxiety, were found in 6 out of 22; pain in the thorax, including angina and muscular pain in 5 out of 22; and chronic bronchitis (cough, exertion dyspnoea) in 8 out of 22 persons. These findings highlight the importance of follow-up studies on torture victims.

Significant ECG changes have been observed in US soldiers held in detention camps in Serbia<sup>36</sup>

### **Gastrointestinal**

Acute torture related symptoms are described after having a foreign body inserted into the anus. Lesions of the anus and rectum have been described as a consequence of the torture. The lesions give rise to pain and bleeding. Obstipation is often a secondary symptom to anal pain. On examination of the anus, the following findings should be looked for and documented<sup>8</sup>:

- i Fissures tend to be non-specific findings as they can occur in a number of “normal” situations (constipation, poor hygiene). However, when seen in an acute situation (i.e. within 72 hours) fissures are a more specific finding and can be considered evidence of penetration.
- ii Rectal tears with or without bleeding may be noted.
- iii Disruption of the rural pattern may manifest as smooth fan-shaped scarring. When these scars are seen out of midline (i.e. not at 12 or 6 o'clock), they can be an indication of penetrating trauma.
- iv Skin tags, which can be the result of healing trauma.

- v Purulent discharge from the anus. Cultures should be taken for gonorrhoea and chlamydia in all cases of alleged rectal penetration, regardless of whether a discharge is noted.

Acute gastroduodenal haemorrhage has been reported by a small number of torture victim survivors, and may be explained by the extreme stress.

Acute gastrointestinal symptoms such as abdominal pain, epigastric discomfort, diarrhoea, vomiting, etc. are associated with torture and imprisonment. These symptoms must be considered to be of mixed aetiology, in which mechanisms caused by the stressful situation may be a factor. Insufficient or unappetising food, restriction of liquids and lack of exercise may also be factors related to these gastrointestinal symptoms during imprisonment.

The incidence of gastrointestinal symptoms in the torture victims at the time of medical examination was the same as that of control groups and of the population at large.<sup>1</sup>

### **Urological**

Severe beating to the kidney region can give rise to development of haematoma in and/or around the kidney. In many cases the lesion is accompanied by haematuria.

Direct trauma to the urethral mucous membrane either by beating or electric torture in the urethra also produce haematuria. Beating at the scrotum can injure testes with subsequent atrophial<sup>33</sup>.

Haemoglobinuria can be mistaken with haematuria. Haemoglobinuria has been described in runners due to “footstrike” hemolysis<sup>37</sup>. The same mechanism might explain the “Haematuria” in some of the torture victims. Falanga in particular (beating on the soles of the feet) is somewhat similar to the

constant friction of the feet as they strike the ground in runners. Among 34 persons with acute renal failure admitted to hospital after alleged torture in Police interrogation centres in Kashmir, only those who were beaten on soles had evidence of haemoglobinuria<sup>38</sup>.

To distinguish haemoglobinuria from haematuria a centrifuge of the urine should be done. The erythrocyte will precipitate, which will not be the case of haemoglobinuria.

Myoglobinuria occurs as a result of rhabdomyolysis, destruction of the muscle tissue, and may be caused by beating, or electrical torture<sup>39</sup>. The urine is red or brownish and could be mistaken for blood.

Myoglobinuria is a potential dangerous condition as it causes damage to the kidneys with serious risk of acute renal failure<sup>40</sup>.

Dysuria is a frequent complaint among torture victims, probably caused by torture instruments in some of the cases, and by cold and poor hygienic conditions in the rest.

Long lasting bladder and/or kidney complaints have not been reported more frequently in torture survivors than in control groups.

### **Otorhinolaryngological**

The type of torture that carries a high risk of damaging the hearing functions is beating, particularly in the form of “teléfono” in which both ears are beaten simultaneously with the flat of the hand.

“Teléfono” produced immediate as well as long lasting symptoms from the ear<sup>1</sup>. It produces a shock wave against the eardrum, probably very similar to the one produced by explosions. Kerr<sup>41</sup> describes the clinical observations after blast injuries in Belfast:

“Usually sensorineural deafness occurs accompanied by tinnitus. In mild cases this tinnitus and deafness may recover fully in

a matter of hours. Severe cases may never recover fully. Perforation of the tympanic membrane is common and occurs in pars tensa which is the lower five-sixths of the tympanic membrane. These perforations vary in appearance and may be linear tears, small holes or subtotal defects. From time to time, there is also damage to the ossicular chain.

Especially high frequency sensorineural deafness occurs with preserved normal hearing for the speech frequencies. The hearing loss may recover up to six months after the explosion.”

### **Ophthalmological**

Acute eye symptoms in torture survivors are conjunctivitis, probably caused by dirty cloths used for blindfolding which the victims often had to wear day and night for many days.

Very few long lasting eye symptoms, possibly related to torture, have been described.

Perron-Buscail, Lesueur, Chollet, and Arne<sup>42</sup> observed opacities in the cornea 10 years after electric torture in the eyes, influencing the vision.

### **Gynaecological examination**

Throughout history sexual harassment of women has been a weapon of war and power<sup>43</sup>. In many countries, acts of sexual violence are a common method of torture or inhuman treatment inflicted on women<sup>44</sup>. It is found that female victims of torture are raped more often than men although men are also frequently subjected to rape<sup>45</sup>. Gender-based and sexual violence of refugees is a frequently hidden problem. Violence might have taken place during the conflict, the flight, or in the country or place of asylum. There might have been random acts of sexual assault by enemy troops, or border guards, or rape may be used as a deliberate

act of war. Women may have been forced to offer sex for survival, or in exchange for food, shelter or protection. Young girls and women who are alone are often at greatest risk<sup>46</sup>. Refugee women from any age may be raped, women over 60 years of age or children<sup>42</sup>. It must be emphasised that genderbased violence and rape may be only one among many traumas that women have suffered, and that physical consequences are often accompanied by psychological and social consequences.

The impact of gender-based abuse on physical health can be immediate and long-term. However, women who are abused rarely seek medical care for acute trauma<sup>48</sup>. Seeking medical care is often not an option for refugee and internally displaced women. Many victims of sexual violence and rape never talk of sexual violence. Barriers for seeking medical care may be reduced by ensuring a sufficient number of female health care workers, and by training health professionals working with refugees and torture victims to recognise victims of sexual violence and rape. It is important to allow the victim sufficient time to disclose the trauma. Even when refugees do not directly seek assistance, they often present multiple somatic, mental and social complaints.

Before gynaecological examination the purpose of the examination should be clear: is it to identify treatment needs or is it to document alleged sexual abused? In case of documentation of human rights abuses for legal purposes it is essential to collect detailed information. It is important that the alleged victim gives her informed consent. When examining victims of sexual violence, every precaution should be taken to minimise retraumatisation. A safe and confidential environment should be ensured. Cultural differences, religion and traditional beliefs may affect the meaning given to experiences,

the symptoms expressed, and how people cope with the violent experiences<sup>50</sup>.

A detailed medical, obstetric and gynaecological history should be taken, including questions on sexual activity, menstruation, and contraception. Physical signs after sexual violations and rape depend very much on the interval between the assault and the examination. Immediately after the rape of a woman semen may be detected. She may have injuries all over her body. There may be bruises and bite marks, on the lips, neck, shoulders, buttocks, and breasts. The vulva, vagina, the anus, and the urethra should be carefully examined and special attention should be paid to the perineum. There may be external signs of perineal tears, with laceration of the margin of the vaginal introitus or anus. Where injuries are gross, fistulae between vagina and the rectum may be seen. The presence and condition of a hymen should be noted<sup>51</sup>. After electrical torture and/or blows in the genital region, haematuria may be found, due to injuries to the urethra and bladder<sup>52</sup>. Most of the acute symptoms disappear in time, and it may not be possible to differentiate scars of the perineum from scars after childbirth or scars following a sexually transmitted disease.

Later, women may present themselves with complaints of vaginal bleeding, decreased sexual desire, genital irritation, pain during intercourse and urinary tract infections<sup>53</sup>. Sexual torture may leave traces in the musculo-skeletal system, structural injuries, functional disturbances, and dysfunctioning of the pelvic joints in women. They often have lumbar pain, and complain about pains in the genitalia, menstrual disturbances, and sexual problems<sup>54</sup>.

Damage to the genitals is most severe in girls under 15, and in girls and women who have previously been subjected to female genital mutilation. These girls and women

are also at higher risk of contracting Sexually Transmitted Diseases (STDs) or Human Immuno-deficiency Virus (HIV). Health care workers should always consider sexually transmitted diseases after rape. Soldiers, even during peacetime, have STD infection rates 2 to 5 times higher than those of civilian populations. The chance of infection is therefore considerable for women who have been raped by soldiers<sup>55</sup>. Consequences of pregnancy and delivery, as well as of an unsafe abortion must be considered. The most frequent complications are incomplete abortion, sepsis, haemorrhage, and intra-abdominal injury, such as puncturing or tearing of the uterus<sup>56</sup>.

#### **Examination of children\***

Many cases of torture of children have been documented by human rights organisations and it is feared that those cases form only the tip of the iceberg<sup>57</sup>. However, there is a general disbelief that torture can be perpetrated against children. A reason for this disbelief may be that the Western concept of a child as an economically dependent, politically uninvolved individual fits very few children in the world<sup>58</sup>. Torture and sexual abuse of children are widespread, particularly in conflicts dominated by ethnicity<sup>59</sup>. The girl child is double susceptible to violence, because of her gender and because of her age<sup>60</sup>.

Children may be secondary torture victims, because of the violence or torture perpetrated against one or more of their relatives. They may also be primary victims. As there are many reports on how children have been subjected to the same torture methods

as adults, it may be expected that they have similar physical symptoms as adults. Still, very little is known of physical consequences of torture that are typical for children. What are the implications of torture for a growing body? How does torture affect the development of a child?

Children should be examined in a way appropriate for their age, nevertheless, the health professional should realise that for many of the world's children, childhood ends long before they reach the age of eighteen, the age when according to most international standards they become adults. Their stories on the violence suffered by them should be respected and taken seriously. However, they often prefer to stay silent, move away, and hide and bury their experiences<sup>61</sup>. Children may react to trauma with depression, sleep disturbances, nightmares, anxiety, fears, learning problems, posttraumatic stress disorder, and feelings of guilt and self-blame<sup>62</sup>. When examining refugee children attention should be paid to general health signs, and specifically to signs of malnutrition. Malnutrition in refugee children is often caused by a chronic lack of food, but it may also be a sign of child abuse. In the differential diagnosis, it is important to distinguish severe weight loss from chronic pyogenic or urinary infections, tuberculosis, syphilis, AIDS, and tropical infestations<sup>63</sup>.

After a traumatic event children may suffer from enuresis and, less frequently, from encopresis<sup>64</sup>. Nocturnal enuresis is rather common in children of school age. It occurs more often in boys than in girls. There is a strong association with a family history of bedwetting. Regressive enuresis (occurs after children were previously dry) can be triggered by stressful events. Physical examination and urinalysis are indicated to exclude organic damages, but organic pathology can be found in only a very small number of

\*) The definition of "child" in the UN Convention on the Rights of the Child states: "For the purpose of the present Convention, a 'child' means every human being below the age of eighteen years, unless, under the law applicable to the child, majority is attained earlier."

cases. Possible differential diagnoses are urinary tract infections (especially in girls) and diabetes mellitus. Encopresis is less common than enuresis. It is a problem that in most cases develops as a result of long-standing constipation. It may represent emotional problems. As in the case of enuresis, organic defects are rarely found, but should be excluded.

It could facilitate the recognition of physical consequences of torture if health professionals are familiar with the physical consequences of other non-accidental injuries in children. The shaken infant syndrome has been described as occurring only in very young children, seldom older than 2 years of age. However, symptoms similar to the shaken infant syndrome have been diagnosed in an adult who had been subjected to shaking during interrogation<sup>32</sup>. There has been no systematic study of morbidity amongst the many people who have been submitted to shaking during interrogation.

### **Future research**

The preventive effect of teaching the principles of the Istanbul protocol to the medical and legal profession in countries where torture is practised should be studied.

Descriptions of changes in the skin following torture have been performed in several areas of the world, particularly in the recent quarter of a century. As with other skin changes, a systematic registration, photographs included, is important also for the years to come in order to obtain a continuously increasing background to be able to support an allegation of torture as objectively as possible.

Since our knowledge of specific histologic alterations in the skin following an electrical injury, epidermal changes included, is mainly based on experiments on fully anaesthetised pigs, while only a few hu-

man cases have been examined, it would be of importance for the preventive influence of our studies, following a local anaesthesia, to obtain a 3-4 mm punch biopsy from electrically influenced areas of the human skin. Histologic examination of skin biopsies is used as routine method in the diagnosis of skin diseases.

Most of the published literature on the musculo-skeletal consequences of torture is descriptive, listing symptoms and signs without diagnoses. Research focusing on the aetiology and pathogenesis of the long-lasting symptoms, including pain, is missing, and systematic information on dimensions of health other than reporting of symptoms and illness, e.g. health related quality of life including physical functional ability in torture victims, is not available.

Future research related to the specific musculo-skeletal consequences of physical torture should include systematic clinical and radiodiagnostic evaluation in order to establish diagnosis for documentation and rehabilitation purposes. It should also focus on overall physical function and other aspects of health-related interference with quality of life.

Long lasting physical sequelae should be systematically examined including a control group.

Research on the effects of torture on children is still in an early stage. Most studies describe the psychological consequences of torture. Further research would be needed to learn more about the prevalence of torture cases among children and the consequences that torture has on a growing body, in order to develop effective rehabilitation programs that also reach these least visible victims of torture.

*References for section II and III\**

References for section I follow the article section I, volume 14, no. 1/2004

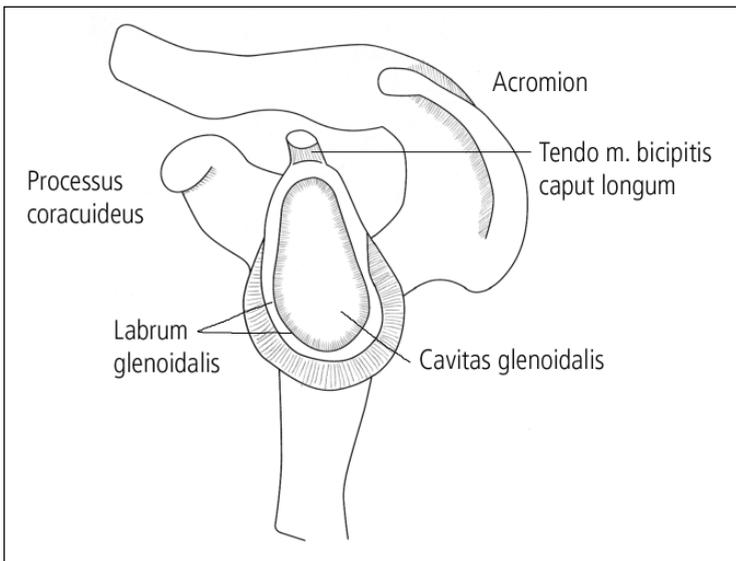
1. Rasmussen OV. Medical aspects of torture [doctoral dissertation]. Dan Med Bull 1990;37(suppl. 1).
8. Allden K, Baykal T, Iacopino V, Kirschner R, Özkalıpci Ö, Peel M et al, eds. Istanbul Protocol: manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment. Geneva, Switzerland: United Nations. Office of the High Commissioner for Human Rights, 2001.
13. Forrest DM. Examination for the late physical after effects of torture. J Clin Forensic Med 1999;6:4-13.
18. Forrest DM. Examination following specific forms of torture. In: Peel M, Iacopino V, eds. The medical documentation of torture. London: Greenwich Medical Media, 2002:159-69.
19. Edston E. Spåren på kroppen kan avslöja tortyr [The traces on the body reveal torture]. Läkartidningen 1999;96:628-31.
20. Moreno A, Grodin MA. Torture and its neurological sequelae. Spinal Cord 2002;40:213-23.
21. Skylv G. Physical sequelae of torture. In: Basoglu M, ed. Torture and its consequences: current treatment approaches. Cambridge: Cambridge University Press, 1992:38-55.
22. Almekinders LC. Anti-inflammatory treatment of muscular injuries in sport. Sports Medicine 1999;28:383-8.
23. Allodi F. Physical and psychiatric effects of torture: Canadian study. In: Stover E, Nightingale E, eds. The breaking of bodies and minds: torture, psychiatric abuses and the health professions. New York: WH Freeman and Co., 1985:66-78.
24. Randall G, Lutz E, Quiroga J. Long-term physical and psychological sequelae of torture on 44 victims examined in the United States. In: Stover E, Nightingale E, eds. The breaking of bodies and minds: torture, psychiatric abuse and the health profession. New York: WH Freeman and Co., 1985:58-66
25. Aytaclar S, LökV. Radiodiagnostic approaches in the documentation of torture. In: Peel M, Iacopino V, eds. The medical documentation of torture. London: Greenwich Medical Media, 2002:207-20.
26. Thomsen AB, Eriksen J, Smidt-Nielsen K. Chronic pain in torture survivors. Forensic Sci Int 2000;108:155-63.
27. Amris K, Prip K. Falanga torture. Diagnosis, assessment and treatment. Copenhagen, Denmark: Rehabilitation and Research Centre for Torture Victims, 2001.
28. Bro-Rasmussen F, Rasmussen OV. Falanga tortur. Ugeskr Læger 1978;140:3197-202.
29. Skylv G. Falanga: diagnosis and treatment of late sequelae. Torture 1993;3:11-5.
30. Amris K, Prip K. Torturoffer -- et liv i smerte [Torture victim -- a life in pain]. In: Fasting U, Lunderoff L, eds. Smertes og smertebehandling i klinisk praksis. Copenhagen, Denmark: Munksgaard, 2001:106-29.
31. Savnik A, Amris K, Rogind H, Prip K, Daneskiold-Samsøe B, Bojsen-Møller F et al. MRI of the plantar structures of the foot after falanga torture. Eur Radiol 2000;10:1655-9.
32. Pounder DJ, Path MR. Shaken adult syndrome. Am J Forensic Med Pathol 1997;18:321-4.
33. Abildgaard U, Daugaard G, Marcussen H, Jess P, Petersen, HD, Wallach M. Chronic organic psycho-syndrome in Greek torture victims. Dan Med Bull 1984;31:239-42.
34. Danielsen L, Karlsmark T, Thomsen HK, Thomsen JL, Balding LE. Diagnosis of electrical skin injuries: a review and a description of a case. Am J Forensic Med Pathol 1991;12:222-6.
35. Petersen HD, Abildgaard U, Daugaard G, Jess P, Marcussen H, Wallach M. Psychological and physical long-term effects of torture. Scandinavian Journal of Social Medicine 1985;13:89-93.
36. Corovic N, Durakovic Z, Zavalic M, Zrinscak J. Electrocardiographic changes in ex-prisoners of war released from detention camps. Int J Legal Med 2000;113:197-200.
37. Eichner ER. Runner's macrocytosis: a clue to footstrike hemolysis. Am J Med 1985;78:321-5.
38. Malik GH, Reshi AR, Najar MS, Ahmad A, Masood T. Further observations on acute renal failure following torture. Nephrol Dial Transplant 1995;10:98-202.
39. Simpson MA. Methods of investigating allegations of electric shock torture: lessons from South Africa. Torture 1994;4:27-9.
40. Malik GH, Sirwal IA, Reshi AR, Najar MS, Tanvir M, Altaf M. Acute renal failure following physical torture. Nephron 1993;63:434-7.
41. Kerr AG. Blast injuries to the ear. Practitioner 1978;221:677-82.
42. Perron-Buscaïl A, Lesueur L, Chollet P, Arne JL. Les brûlures électriques corneennes: etude anatomoclinique a propos d'un cas [Electric burns of the cornea. anatomoclinical study apropos of a case]. Journal Francais d'Ophthalmologie 1995;18:384-6.
43. Axelsen E, Sveaas N. Psychotherapeutic under-

- standing of women exposed to sexual violence in political detention. *Nordisk Sexologi* 1994;12:1-12.
44. Broken bodies, shattered minds: torture and ill-treatment of women. London: Amnesty International, 2001.
  45. Allodi F, Stiasny MB. Women as torture victims. *Can J Psychiatry* 1990;35:144-8.
  46. Reproductive health during conflict and displacement: a guide for programme managers. Geneva, Switzerland: WHO, Department of Reproductive Health and Research, 2000:109-37.
  47. Mental health of refugees. Geneva, Switzerland: WHO, 1996:123-31.
  48. PATH. Program for Appropriate Technology in Health. Violence against women: effects on reproductive health [special issue]. *Outlook* 2002;20(1).
  49. Van Willigen LHM. Incidence and consequences of sexual violence in refugees: considerations for general health care. *Nordisk Sexologi* 1992;10:85-91.
  50. Kane S. Working with victims of organised violence from different cultures: a Red Cross and Red Crescent Guide. Geneva, Switzerland: International Federation of Red Cross and Red Crescent Societies, 1995.
  51. Knight B. Deaths associated with sexual offences. In: Knight B. *Forensic pathology*. London: Arnold, 1991:385-93.
  52. Lunde I, Ortmann J. Sexual torture and the treatment of its consequences. In: Basoglu M, ed. *Torture and its consequences: current treatment approaches*. Cambridge, UK: Cambridge University Press, 1992:310-29.
  53. Campbell J. Health consequences of intimate partner violence. *Lancet* 2002;359:1331-6.
  54. Arcel LT. Torture, cruel, inhuman, and degrading treatment of women: psychological consequences. *Torture* 2002;12:5-19.
  55. Machel G. The impact of armed conflict on children: a critical review of progress made and obstacles encountered in increasing protection for war-affected children. Report presented at the International Conference on War-Affected Children, Winnipeg, Canada, September 2000. Retrieved April 2, 2003 from: [www.waraffected-children.gc.ca/machel-en.asp](http://www.waraffected-children.gc.ca/machel-en.asp).
  56. World Health Day, safe motherhood: address unsafe abortion. (WHD 98.10). Geneva, Switzerland: WHO, 1998.
  57. Hidden scandal, secret shame: torture and ill-treatment of children. London: Amnesty International, 2000.
  58. Reynolds P. Activism, politics and the punishment of children. In: Van Bueren G, ed. *Childhood abused: protecting children against torture, cruel and inhuman and degrading treatment and punishment*. Dartmouth, UK: Ashgate, 1998:43-56.
  59. Southall D, Kamran A. Protecting children from armed conflict The UN convention needs an enforcing arm. *BMJ* 1998;316:1549-50.
  60. Chinkin C. Torture of the girl-child. In: Van Bueren G, ed. *Childhood abused: protecting children against torture, cruel and inhuman and degrading treatment and punishment*. Dartmouth, UK: Ashgate, 1998:81-106.
  61. Protacio-Marcelino E, de la Cruz T, Balanon FA, Camacho AZ, Yacat JA. Child abuse in the Philippines: an integrated literature review and annotated bibliography. Quezon City, Philippines: University of the Philippines, Centre for Integrative and Development Studies, 2000.
  62. Pynoos RS, Kinzie JD, Gordon M. Children, adolescents, and families exposed to torture and related trauma. In: Gerrity E, Keane TM, Tuma F, eds. *The mental health consequences of torture*. New York: Kluwer Academic/Plenum Publishers, 2001:211-25.
  63. Morley D. Malnutrition in children. In: Lankinen KS, Bergstrom S, Mäkela PH, Peltomaa M, eds. *Health and disease in developing countries*. London: MacMillan, 1994:297-304.
  64. Kaffman M, Elizur E. Bereavement responses of kibbutz and non-kibbutz children following the death of the father. *J Child Psychol Psychiatry* 1983;24:435-42.

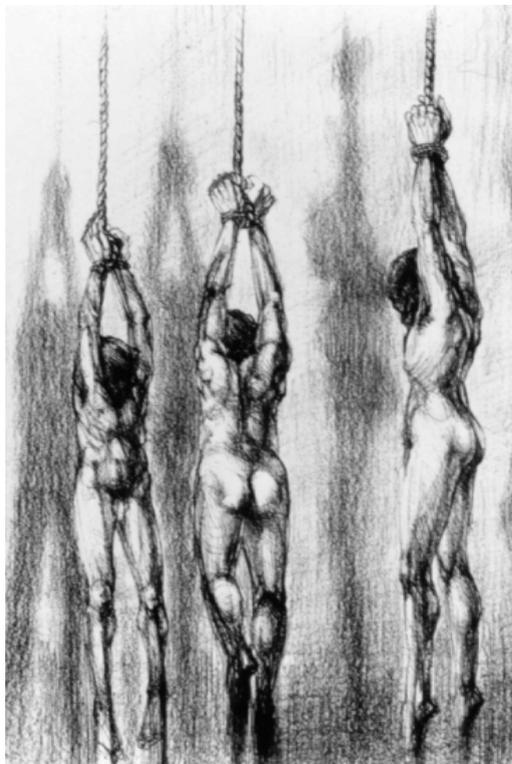
## Errata

In the article “Medical physical examination in connection with torture, section II”, TORTURE vol. 15 no. 1, three pictures

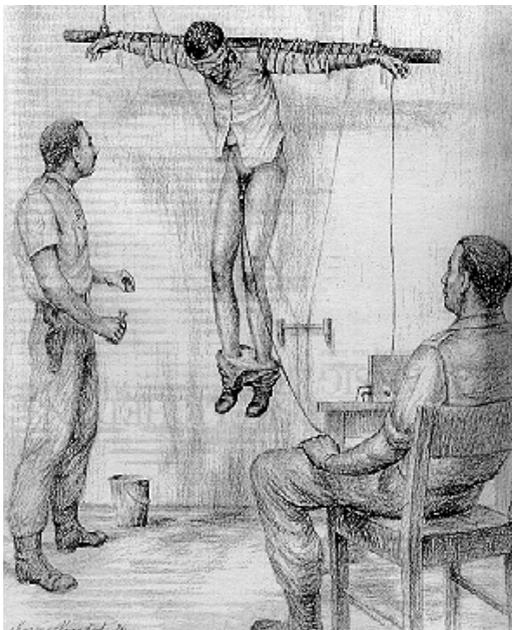
were unfortunately incorrect selected. Figure 5, 7 and 9 are to be substituted with the following Figure 5, 7 and 9.



*Figure 5.* Frontal section through the shoulder joint.



*Figure 7.* Suspension with the arms in forward flexion.



*Figure 9.* Crucifixion. The shoulder joint in abduction.

# The medical aspects of the UN Convention against Torture

Ole Vedel Rasmussen, MD,DMSc\*

## Introduction

The Committee against Torture (CAT), is one of seven treaty bodies in the UN system. Table 1 gives an overview of the treaty bodies: when they entered into force, the number of experts and the number of State Parties to the Convention. A treaty body is “a committee of independent experts appointed to monitor the implementation by States Parties of the core international human rights treaties. They are called “treaty bodies” because each is created in accordance with the provisions of the treaty, which it oversees. In many important respects, they are independent of the United Nations system, although they receive support from the United Nations Secretariat and report to the General Assembly”<sup>1</sup>.

The UN Convention against Torture and Cruel, Inhuman or Degrading Treatment or

Punishment (UNCAT) was adopted in 1984 and entered into force on 26 June 1987.

The CAT consist of ten experts nominated and elected by the State Parties, consideration being given to equitable geographical distribution and to the usefulness of the participation of some persons having legal experience. The experts should be of high moral standing and recognized competence in the field of human rights and serve in their personal capacity (article 17 of the Convention)<sup>2</sup>.

The Committee meets twice a year in Geneva.

When a State Party has ratified the Convention it becomes legally binding and the Convention must be implemented in the national law.

The Convention has 33 articles: 1-16 contain the substantive part, 17-24 deal with the mandate and 25-33 deal with technical matters.

Since its first meeting in CAT in 1987, and up to now, one of the ten members has been a medical doctor. These medical members were also members of the European Council of the Committee for the Prevention of Torture (CPT), and consultants at the International Rehabilitation Council for Torture Victims (IRCT). The work in CPT and IRCT gave first hand information on the medical consequences of torture

\*)

Member of the Council of Europe (COE) Committee for the Prevention of Torture (CPT), Former member of the UN Committee against Torture (CAT), Senior Medical Consultant of the International Rehabilitation Council for Torture Victims (IRCT)\*\*

\*\*)

IRCT,  
Borgergade 13  
P.O. Box 9049  
DK-1022 Copenhagen K  
Denmark  
irct@irct.org

and medical aspects of conditions in places where persons are deprived of their liberty.

This article will deal with the medical aspects of the UN Convention against Torture (UNCAT).

### **The report system from State Parties under article 19 of UNCAT**

The State Party shall submit their initial report one year after ratifying the UNCAT. Thereafter every fourth year. The authors draft guidelines on the form and context of initial reports that have been adopted by CAT in May 2005<sup>3</sup>. A decision is taken by CAT, one year in advance of receiving the reports, as to which ones will be examined during the plenary session. Priority is given to initial reports and State Parties that have been examined in relation to article 20 of the UNCAT (systematic torture). Based upon the State Party report CAT sends a list of issues to the State Party (except initial reports) and asks the State Party to give a reply in writing before the session or to give an oral answer in the session where the report is examined. After the reply the two rapporteurs and the other members of CAT may ask additional questions. The next day the State Party gives their reply to the additional questions. Both sessions are open sessions.

CAT meets in closed sessions to discuss its conclusions and recommendations.

CAT pays very close attention to information received by International and National Non Governmental Organisations (NGO's). Shadow or Alternative reports should be received three weeks in advance of the session, and these reports are also sent to the State Party. Often National Rehabilitation Centres for Torture Victims supply CAT with important information on torture occurring in the country.

The day before the State Party is to be examined by CAT, International and National NGO's are invited to a one-hour semi-open session with the members of the committee, and simultaneous translation is available.

### **Articles on the UNCAT of specific importance for the medical profession**

#### *Article 1*

In order to establish the validity of persons allegedly tortured, a medical examination should be carried out as soon as possible after the alleged torture (the medical examination will be dealt with further in relation to article 11). It is important to keep in mind that the torture definition has four key elements:

**Table 1.** *The seven treaty bodies in the UN (update 7.10.2005).*

Name	Entry into force	No. of experts	No. of State Parties
Committee Against Torture (CAT) .....	26.6.1987	10	140
Human Rights Committee (HRC).....	23.3.1976	18	154
Committee on Economic, Social and Cultural Rights (CESCR).....	3.1.1976	18	151
Committee of the Rights of the Child (CRC).....	2.9.1990	18	192
Committee on the Elimination of Discrimination Against Women (CEDAW).....	3.9.1981	23	180 (1.9.2005)
Committee on the Elimination of Racial Discrimination (CERD) .....	4.9.1969	18	170
Committee on Migrant Workers (CMW) ..	1.7.2003	10	33

- 1) Any act by which severe pain or suffering, whether physical or mental, is inflicted
- 2) It is intentionally inflicted
- 3) It has a purpose
- 4) It is done by a public official or other persons acting in an official capacity

#### *Article 2*

Paragraph 3 of this article is also important for the medical profession: "An order from a superior officer or public authority may not be invoked as a justification of torture".

Medical examination of torture victims has found a high degree of allegation of medical participation in torture. Rasmussen 1990<sup>4</sup> found that 41 of the 200 examined torture victims reported medical involvement (20%). Varying degrees took place:

- 1) Non therapeutic administration of drugs
- 2) Medical personnel present during the torture
- 3) Medical resuscitation during the torture
- 4) Medical attention resulting in hospitalisation
- 5) Medical attention and treatment

Smidt-Nielsen 1998<sup>5</sup> found a higher degree in his study: participation in 41% of the examined torture victims.

International declarations such as the World Medical Association's Declaration of Tokyo and the UN Principles of Medical Ethics (1982) clearly condemn medical participation in torture, but have no automatic legal binding for individual doctors or medical associations. These declarations serve as international guidelines only. The national medical associations will have to incorporate international conventions and declarations into their national rules to which the medical profession is responsible.

#### *Article 3*

The medical aspects of returning a person to another state where there are substantial grounds for believing that he would be in danger of being subjected to torture will be dealt with in relation to article 22.

#### *Article 10*

"Each State Party shall ensure that the education and information regarding the prohibition against torture are fully included in the training of law enforcement personnel, public officials and other persons who may be involved in the custody, interrogation or treatment of any individual subjected to any form of arrest, detention or imprisonment".

It is important that the State Party has a programme on training medical personnel dealing with detained persons or asylum seekers to detect physical and/or mental consequences of torture. A medical examination before and after police interrogation is an important way to assure that torture was not being used during the interrogation in order to obtain confession or for any other reason.

When dealing with article 11 the medical examination of detained persons will be dealt with further.

National Rehabilitation Centres for torture victims around the world can play a very important role in education and information regarding the prohibition against torture. The centres daily work with torture victims gives them unique inside information regarding all aspects of torture.

A special target group is the medical doctors working in prisons, police, army and refugee centres.

IRCT is offering training. One recent example: Following a recommendation of the UN's special rapporteur on torture, Mr van Bowen, after a visit to Uzbekistan, presented a list of 22 recommendations. One

of the recommendations is “to train medical staff working in the penitentiary system to recognise torture and ill-treatment”. In 2005 the IRCT, together with the World Health Organisation (WHO) carried out training for prison doctors and forensic experts in Uzbekistan. The project also included training health professionals in treatment and rehabilitation of torture victims.

#### *Article 11*

Article 11, similar to articles 10, 12 and 13 related to article 16, “shall apply with the substitution for reference to torture of references to other forms of cruel, inhuman or degrading treatment or punishment”. The article contains many important obligations, which are crucial for the prevention of torture. Three important safeguards for a person detained by the police are:

- 1) Access to a lawyer from the outset of the arrest
- 2) Access to a doctor – of one’s own choice
- 3) Right to inform, without delay, a close relative or a third party of their choice of their situation, either directly or through a police officer

In the case of foreign nationals consular notification should be granted.

When it comes to the treatment of persons deprived of their liberty the following rules and principles should be reflected in the domestic law and practise of the state: the Standard Minimum Rules for the Treatment of Prisoners; the Basic Principles for the Treatment of Prisoners; the Body of Principles for the Protection of All Persons under any Form of detention or Imprisonment; Principles of Medical Ethics relevant to the role of Health Personnel, particularly Physicians, in the Protection of Prisoners

and Detainees against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment; and the Code of Conduct for Law Enforcement Officials<sup>6</sup>.

In order to systematically review in places where people are deprived of their liberty, a national independent monitoring mechanism should be established. More information on the recommendations for such a mechanism can be found in the UN’s Optional Protocol to UNCAT (OPCAT)<sup>7</sup>. The OPCAT is very similar to the CPT. When ratifying the OPCAT the State party is obliged to create a National Independent Visiting Mechanism in addition to the International Visiting Mechanism. Fortyeight countries have signed and 13 ratified the OPCAT (October 2005).\*

In order for OPCAT to enter into force it must be ratified by 20 countries. CPT entered into force on February 1, 1989<sup>8</sup>. Today all members of the COE have ratified the Convention (45 States). It is important to notice that CPT, during their visits, with very few exceptions, has medical expertise on the visiting delegation. The main task for the medical delegate will be to look into the medical treatment offered to the persons deprived of their liberty, to examine their medical files and see whether any injuries upon arrival or during the stay in the establishment have been recorded. The medical delegate should also have talks in private with inmates and staff. CPT strongly recommends that a medical certificate by the prison doctor should be issued if the inmate presents physical or mental signs. A medical examination by the prison doctor within 24 hours of the prisoner’s arrival is crucial to detect any signs of torture inflicted by the police prior to the arrival at the prison. In addition to the recording of the medical examination in the medical file and the issuing of a medical certificate, with a copy to the

\*) Update just before publishing.

inmate, a register should be kept. The medical certificate should include:

- 1) The allegations
- 2) The medical findings
- 3) The doctors conclusion in the light of 1 and 2: If there is consistency and the degree of support to the alleged report of torture: a) high, b) moderate, c) slight and d) no support

In case of consistency the person should be referred to a medical specialist on examination of torture victims, who should carry out a thorough examination and report following the “Istanbul Protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment”<sup>8</sup>.

#### *Article 12*

“Prompt and impartial investigation when there is reason to believe that torture or cruel or inhuman or degrading treatment or punishment has been committed”<sup>2</sup>.

Such an investigation should include a thorough medical examination following the guidelines in the Istanbul Protocol<sup>9</sup>.

The IRCT has, together with Human Rights Foundation Turkey, the World Medical Association and the Physicians for Human Rights USA, in the last part of 2004 and first part of 2005, carried out a 1-week training seminar on the Istanbul Protocol in five countries: Mexico, Morocco, Uganda, Georgia and Sri Lanka. In each seminar 50 medical doctors and 25 lawyers participated.

The overall objective of these seminars was to bring perpetrators violating UNCAT to trial and combat impunity<sup>9</sup>.

#### *Article 14*

“Ensure in its legal system that victims of an act of torture obtains redress and adequate

compensation including the means for as full rehabilitation as possible”.

We use to talk about the three M’s:

- 1) Moral (~ redress)
- 2) Money (~ compensation)
- 3) Medical (~ rehabilitation)

About 200 medical centres and programmes for rehabilitation of torture victims exist around the world. It should be emphasised that a State Party, when ratifying the UN CAT, has a legal obligation to ensure that rehabilitation programmes exist in the country for victims of torture. Many countries make contributions to national rehabilitation centres.

The UN has a voluntary fund for victims of torture<sup>10</sup>. The board of the fund has never had a medical member since its creation in 1981.

#### *Article 16*

This article imposes upon the States the obligation to prohibit acts of cruel, inhuman or degrading treatment or punishment.

In this connection the role of the medical profession is to look into the living conditions where persons are deprived of their liberty. Special interest should be mentioned of: overcrowding, inter-prison violence, disciplinary measures against inmates, medical and sanitary conditions, common illnesses and their treatment, access to food and conditions of detention of minors.

#### *Article 20*

The CAT investigations for information of systematic torture in a State Party. Only seven such investigations have been carried out, and the last is still covered by confidentiality. The other six are: Turkey, Egypt, Peru, Sri Lanka, Mexico and Serbia Montenegro. The investigation of Turkey did not include

a medical doctor during the visit to the country in 1992. The examination of Egypt included the medical member of CAT, but no visit was granted by the State Party. In the last four countries a visit was carried out and a medical doctor was a member of the visiting delegation.

#### *Article 22*

Individual complaints to CAT are being dealt with in closed session but the final decision is being published in CAT's Annual Reports. The majority of the cases deal with complaints regarding article 3: "No State Party shall expel, return or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture".

Very often the complainant has been evaluated by a medical doctor and a medical certificate has been issued describing allegations of earlier torture in the country. It is therefore convenient that a medical doctor with knowledge of torture and its consequences is a member of CAT in order to evaluate the medical certificate and explain it to the other members.

#### **Discussion**

The medical work against torture began in 1974<sup>11</sup>. The work took place in international and national NGO's. In the beginning it concentrated on documenting torture.

Medical examination of torture victims added evidence to reports on torture<sup>12</sup>. The only way to stop torture was to put pressure on the government by exposing them to torture allegations. The usual reaction by the government was that the allegations were unfounded, communistic propaganda done by leftist activists.

The UNCAT changed this situation. It now became possible to confront the government with the allegations of torture in public

sessions, and the conclusions and recommendations by the Committee became a tool that national and international NGO's could use in their constant effort to stop torture. The state parties were repeatedly reminded that, by ratifying the convention, it became legally binding.

The weaknesses of the UNCAT is that:

- There is no obligation to ratify the Convention.
- Although the convention stipulates the initial report is to be submitted one year after ratification, this very seldom happens, and countries have been more than 15 years late in their reporting obligation. CAT can do nothing, and the suggestion to exclude countries not living up to their obligations is out of the question.
- CAT can only deal with a country when their report is being examined, and there are very few exceptions to the rule.
- The permanent staff of the Committee is small and this makes it impossible to monitor the situation in all countries that are party to the convention. One improvement has, however, recently been developed by the new rules of procedures which allowed CAT to examine a State Party without a report.
- There is a very considerable number of overdue reports.

The initial report is extremely important in order to enter into a dialogue with the country, and OHCHR's technical support cooperation offers assistance to State Parties in writing their report. IRCT has also been involved in such training in Zambia, Kenya, Nepal and Uganda.

The OPCAT is a very attractive body which could strengthen the weaknesses of the UNCAT by monitoring the situation with regular visits to the country, to which

the country cannot object. It is therefore of paramount importance that the OPCAT enter into force, especially in countries where CPT is not operating.

### Conclusions

In conclusion, it should be stressed that the UNCAT is extremely relevant for the medical profession as it includes all of the most important aspects of the medical work against torture:

- Medical examination and documentation of torture.
- Treatment and rehabilitation of torture victims.
- Education and information regarding the prohibition against torture to medical and law enforcement personnel.
- Keeping under systematic review interrogation rules and arrangements for the custody and treatment of persons deprived of their liberty.
- Work against impunity together with the legal profession.
- Inclusion of the prevention of inhuman and degrading treatment and punishment into medical work.
- Prevention for the medical profession from becoming involved in torture.

### References

1. <http://www.ohchr.org/english/bodies/index.htm>
2. <http://www.ohchr.org/english/law/cat.htm>
3. CAT/C/4/Rev.3, 18 July 2005.
4. Rasmussen OV. Medical Aspects of Torture. Danish Medical Bulletin 1990; 37 (supp 1): 1-88. (Thesis).
5. Smidt-Nielsen K. Participation of health personnel in torture. Torture 1998; 8: 91-4.
6. Human rights : a compilation of international instruments. Volume 1, 1st part, Universal instruments /UN. Office of the High Commissioner for Human Rights. - New York : United Nations, 2002.
7. <http://www.ohchr.org/english/law/cat-one.htm>
8. <http://www.cpt.coe.int/en>
9. <http://www.irct.org>
10. <http://www.ohchr.org/english/about/funds/torture>
11. Marcussen H, Genefke I. From AP's medical groups towards cross-disciplinary collaboration against torture: an overview through 25 years. Torture 2000; 4:103-5.
12. Rasmussen OV, Helweg-Larsen K, Kelstrup J, Carlé P, Rehof LA. The medical component in fact-finding mission. Dan Med Bull 1990; 37: 371-4.

## Sir,

I am writing in response to the review in *Torture*, vol. 15, No. 1, 2005<sup>1</sup> of the report on US torture by Physicians for Human Rights, reviewed by Gretchen Borchelt and Christian Pross. Furthermore I am writing in response to the PHR report itself, “Break them down”<sup>2</sup>.

The report and the review miss important aspects of the use of psychology in US torture. This is not the fault of the authors because the US government has sought to hide the extent of the use of psychology and psychologists. The authors all accept that US torture, psychological or physical, is for interrogation; this is asserted by the US government, and accepted by the media and the general public. The facts are more horrible, but uncovering them is revealing about US intentions. If these facts become public, there will be even more US opposition to the torture.

Some of US torture is undoubtedly for interrogation – but some is for experiment with involuntary human subjects, and most is for control by terror. Specifically, torture in Guantanamo, Cuba, is for experiment, and torture in Iraq is for political control by terror.

### **About Cuba**

We know there are many psychologists in the US military, and have been for years. The CIA’s manual on torture in interrogation, unearthed through the Freedom of Information Act in the 1970s, was clearly written by a psychologist – and there have been many revelations since then. We also know military psychologists read the literature of the torture treatment movement (see the bibliogra-

phy on the Iraq War Clinicians Website)<sup>3</sup>.

We can then assume they are familiar with the research of Saporta and van der Kolk in 1992 in which rats, living in conditions similar to Guantanamo, became self-destructive – just as Guantanamo prisoners have, with many documented attempts at suicide. Since prisoners’ behavior was predictable, this amounts variously to murder, or extra-judicial killing, or criminal negligence. That this is an experiment with humans also is consistent with the long-term imprisonment in an isolated place with no international oversight of prisoners who had first undergone complete interrogation in Afghanistan (see a book written by an interrogator: “The interrogators”, Little, Brown and Co., 2004). The experimental aspect to the torture also explains why many have been held there who did not have the slightest information, according to military personnel in media reports. Apparently they are not tortured for what they know, but for what they can teach.

### **About Iraq**

Torture at Abu Ghraib and other prisons is policy, not accident, and it is for political control, as evidenced by several facts:

- 1) Very large numbers of prisoners go through Iraqi prisons, too many to interrogate – some 50,000 according to a New York Times report in March, 2005.
- 2) Very few have information, or are even interrogated, again according to media reports from US military sources.
- 3) Prisoners are not killed, they are released into the public where they can be seen after torture.
- 4) We have seen massive torture for control before – Central

America and other places come to mind.

5) Finally, the Stanford Prison Experiment of 1973 has been well known to psychologists for over 30 years – and it is this experiment that seems to inform the structure of Abu Ghraib.

In the Stanford Experiment, student volunteers, screened to eliminate pathology, were at random assigned roles as guards or prisoners, were suddenly but voluntarily placed in a specially built hidden jail, and were given no instructions as to how to act. In a few days psychologists had to stop the experiment, as the guards became increasingly aggressive and the most aggressive on each shift were tacitly allowed to set the bar for brutality. The psychologists discovered that placing normal people in a pathological situation – the stress of a prison – would produce what we recognize as torture. The advantage to the US Administration is that there are no orders to torture, so there is complete deniability – all that is needed is creation of a prison, made worse by having no outside observers, few guards and many prisoners, and placed in a war zone – and with a little indirect verbal encouragement, guards (and psychologists and doctors) will torture. It cannot be an accident that General Geoffrey Miller, formerly at Guantanamo, was put in charge of U.S. prisons in Iraq.

Torture for control by terror has always been to shore up long-term military control. The US is building its own military bases in Iraq. Together, these two facts imply a long occupation – and more torture. The choices need to be clearly revealed to the US public, and the world, which may wish to make other choices.

Gerald Gray, LCSW\*

#### References

1. Systematic Use of Psychological Torture by US Forces, *Torture* 2005-1; volume 15, p. 66-70
2. The report “Break Them Down, Systematic Use of Psychological Torture by US Forces” can in full extension be accessed at [www.phrusa.org/research/torture/news\\_2005-05-01.html](http://www.phrusa.org/research/torture/news_2005-05-01.html)
3. [www.ncptsd.va.gov/war/guide/index.html](http://www.ncptsd.va.gov/war/guide/index.html)

---

\*)Institute for Redress & Recovery  
Santa Clara University  
California  
[Gerald.Gray@aaci.org](mailto:Gerald.Gray@aaci.org)