



The psychological impact of torture

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British Journal of Pain
7(2) 101–106
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DOI: 10.1177/2049463713483596
bjp.sagepub.com



Abstract

Many refugees in the developed world are survivors of torture and present with health needs without their traumatic experience being disclosed or identified. Chronic pain is a common problem, as are symptoms of post-traumatic stress disorder (PTSD), anxiety, depression, and other distress. Current circumstances, particularly poverty, uncertainty about asylum, separation from or loss of family and roles, and difficulties settling in the host country, all contribute to current psychological problems and exacerbate existing ones. Psychological treatment studies tend to be focused either on PTSD diagnosis and use protocol-driven treatment, usually in the developed world, or on multiple problems using multimodal treatment including advocacy and welfare interventions, usually in the developing world. Reviews of both of these, and some of the major criticisms, are described. Psychological interventions tend to produce medium-sized changes in targeted measures of distress, when compared with waiting lists or standard treatment, but these may fall well short of enabling recovery, and long-term follow-up is rare. A human rights context, with reference to cultural difference in expressing distress and seeking help, and with reference to the personal meaning of torture, is essential as a basis for formulating treatment initiatives based on the evidence reviewed.

Summary points

- Refugees with a history of torture may have a wide range of psychological and social difficulties which do not easily fit within diagnostic categories.
- Torture and its sequelae can have multiple meanings and, in the clinical context, it is the interpretation of the torture survivor that matters.
- There are doubts about applying the concept and measures of post-traumatic stress disorder: symptoms should be assessed separately.
- Current circumstances can be as important as trauma history in understanding the psychological state of a torture survivor.
- Cognitive behavioural therapy and narrative exposure therapy seem equally effective in reducing trauma symptoms, and to a lesser extent, depression.

Keywords

Asylum seeker, post-traumatic stress disorder (PTSD), refugee, trauma

Torture as context

Torture is variously defined, but the most widely used definition is Article 1 of the 1984 United Nations Convention Against Torture:

Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person

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for such purposes as obtaining from him or a third person, information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

United Nations Convention Against Torture, Article 1.1¹

This definition has been extended to include violence by unofficial agents, as in civil conflict, but all definitions refer to intentional infliction of pain and/or suffering.

Given the centrality of pain, the intensity of many profoundly cruel and destructive torture practices, and the distress at the time of infliction, it is unsurprising that chronic pain is a common result in survivors.² Psychological effects can also last or develop later, and we would not endorse the common practice of distinguishing between physical and psychological torture methods and torture effects, since the effects of any torture on health are widespread, and assuming specific effects in physical or psychological domains is inconsistent with the evidence (United Nations).³ Pain clinicians, therefore, are likely to encounter torture survivors with persistent pain and with psychological problems, commonly in the context of social and financial difficulties.

Under-recognition by generalist and specialist healthcare workers of torture survivors is the norm,⁴ and disclosure occurs in only a minority of cases, and rarely at first meeting. Most patients have described their experiences mainly to immigration officials and may well anticipate scepticism and hostile questions. Doctors, psychologists, or other health workers may even have been present at their torture. However, the alert clinician who is aware of (or who carries out a quick search on the Internet) political, ethnic, or religious persecution in a patient's country of origin can raise the topic and ask the patient if he or she were affected. A positive response can be followed by more specific questions. Even if the individual does not feel prepared, or trust the clinician sufficiently, to disclose at that time, he or she has in effect an invitation to disclose. Fearing the patient's disclosure can be a deterrent to asking such questions, and the account can be very distressing for the clinician, who needs to be prepared to handle it.

The context of torture, for both pain and psychological difficulties, is very important and the meanings of the experience differ enormously among torture survivors, from feelings of defeat and despair to pride

in survival and resilience. There is no substitute for asking the patient. Torture is widespread and not confined to any one ethnic, national, or geographic group, but practised throughout the world. The physical and psychological consequences are often compounded by further trauma and challenges to resources during flight, on arrival and in detention in the host country, and in current circumstances. Long-term psychological problems reported by survivors of torture are usually classified as trauma, anxiety, depression, and, more rarely, problems of a psychotic nature, but health problems including pain are very frequent, and may include serious disease such as tuberculosis or human immunodeficiency virus with a background of poor nutrition and severe and immunocompromising stress. The normal buffers of social support and financial resources have almost always been lost on fleeing the home country, and even basic communication in English may be a struggle.

A refugee is defined by being outside his or her country and being unable to return there because of 'a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion' (UNHCR).⁵ Asylum is protection given under the 1951 United Nations Convention Relating to the Status of Refugees. However, the country to which application for asylum is made forms its own judgement of whether or not the fear is 'well-founded', and may return unsuccessful asylum applicants to persecution, torture, and death.

The process of claiming asylum is slow and bureaucratic, although the decision may be made and acted upon suddenly; many adverse decisions are successfully appealed.⁶ To either applicants or their advocates, the system does not seem to be fair or accountable.⁷ While awaiting the decision, the applicant may be put in detention for days or months, again without being given a reason, and there is plentiful evidence of re-traumatisation by this imprisonment.⁸ Out of detention, the asylum seeker is offered accommodation anywhere in the UK without the right to choose where he or she lives, and is entitled to free health care and to a proportion of income support: currently less than £40 per week for a single person over 18 (UK Borders Agency, 2013).⁹ He or she is not permitted to work, so paying for phone calls in pursuit of the asylum claim or to family members abroad often means going hungry. Once asylum is granted, the refugee can seek work, and is entitled to welfare, but accommodation is no longer provided, and many become homeless at this point until confirmation of their civil status allows them to claim benefits. Such difficulties can contribute substantially to the mental health problems experienced by the asylum seeker.⁸

There is no clear planning to address the health and welfare needs of refugees, including those seeking asylum. Much arises in the voluntary sector, so is unevenly provided across the country and is increasingly dependent on unpaid help or diverting resources into fundraising as statutory funding decreases. In the USA, Campbell¹⁰ calculated that although there were probably as many torture survivors in the country as Vietnam veterans, only the latter had received extensive development of services specific to their needs.

Psychological problems following torture

The applicability of psychiatric diagnostic categories is vigorously debated.^{10,11} Diagnoses are defined in the *Diagnostic and Statistical Manual of Mental Disorders* (http://www.2shared.com/document/4aLsR1RA/Diagnostic_and_Statistical_Man.html), used mainly in the USA, and the International Classification of Diseases (www.who.int/classifications/icd/), used more in Europe. In particular, the applicability of the concept and measures of post-traumatic stress disorder (PTSD) is disputed. At one level, there is always a question about applying diagnostic categories and descriptions of symptoms or behaviour developed in Western societies to people from the developing countries with very different personal, political, or religious beliefs and perspectives. One of the most marked differences is between individualist societies where realisation of personal goals often takes priority over the needs of kin and societal expectations, and collectivist societies in which the needs of family and prescribed roles take precedence over personal preferences. Another evident difference is the belief in a subsequent life in which suffering in this life is rewarded, and this has emerged in some studies of torture survivors in South East Asia.

On a different level, the development of the diagnosis of PTSD for American veterans of the Vietnam War can be understood as a political act which labelled the collective distress of a defeated USA as individual psychopathology. Proponents of this view point to the depoliticisation of the distress of torture survivors by describing their distress, disturbance, and profound sense of injustice in psychiatric terms.¹¹ These are not only conceptual issues but affect treatment, since recovery is associated with reconstruction of social and cultural networks, economic supports, and respect for human rights.

The rich research on treatment of PTSDs in veterans has substantially informed treatment offered to torture survivors. It is more appropriate than extrapolation from work with civilian survivors of single events as individuals (assault, accidents) or as communities or

groups (natural or man-made disasters). Some literature distinguishes between single-event trauma (type 1) and prolonged and repeated trauma, such as torture (type 2). There is no doubt that (disregarding concerns about the diagnosis) rates of PTSD are much higher in refugees than among people of a similar age in the countries where the refugees settle, and that, among refugees, rates of PTSD are even higher among those seeking asylum.^{12,13}

The argument that torture causes unique problems waxes and wanes, and is often associated with claims to particular expertise in treatment, and therefore claims on funding, but Gurr et al.¹⁴ describe how torture targets the person as a whole – physically, emotionally, and socially – so that PTSD is an inadequate description of the magnitude and complexity of the effects of torture. When the diagnosis of PTSD is applied, some survivors of torture who have very severe symptoms related to trauma may still not reach the criteria for diagnosis. Categories such as ‘complex trauma’ have been proposed, and it may be that the next iterations of the diagnostic compendia may modify the criteria.

Other than post-traumatic stress symptoms, torture survivors have elevated rates of anxiety, depression, and adjustment problems,¹⁵ including outbreaks of anger and violence directed towards family members.¹⁰ Symptoms should always be understood in the context above. No diagnostic terminology encapsulates the deep distrust of others which many torture survivors have developed, nor the destruction of all that gave their lives meaning. Guilt and shame about humiliation during torture, and about the survivor’s inability to withstand it, as well as guilt at surviving, are common problems which discourage disclosure. On top of this, uncertainty about the future, including the possibility of being sent back to the country in which the survivor was tortured, and the lack of any close confidant or even of any social support, compound the stress. Some current conditions are identifiable as additional risk factors: social isolation, poverty, unemployment, institutional accommodation, and pain can all predict higher levels of emotional distress in torture survivors.^{16,17}

Treatment of psychological problems

There are few reviews of treatment of trauma-related disorders in torture survivors, and more of refugees, among whom may be an unknown or undisclosed number of torture survivors. A helpful distinction is between studies of treatment for PTSD, often defining the population by diagnosis at baseline, and studies of multimodal treatment, and they will be described in that order.

The main treatments for PTSD are cognitive behavioural therapy (CBT), and narrative exposure therapy (NET). In fact, CBT often includes exposure sessions, and was recommended by the National Institute for Health and Clinical Excellence¹⁸ for the treatment of post-traumatic stress in non-refugee populations. Exposure is the practice of systematic attention to feared and avoided cues related to the trauma, with the aim of extinguishing the learned association between those cues and the responses. However, this is simpler where there was a single event rather than multiple events, even though in a single event fear may be generated by multiple cues in several modalities (visual, auditory, olfactory, tactile, proprioceptive). Some of the concerns about applying exposure are elaborated in the review by Nickerson et al.¹⁹

CBT typically includes an educational component, normalising physical and psychological reactions to traumatic events, and challenging interpretation of cues, including intrusive images and thoughts, as threatening. NET draws on the practice of writing testimony, developed particularly with refugees from Latin America in the 1970s, which was mainly for the purpose of witnessing and validating experiences, and advocacy on their behalf. However, creating a coherent account of traumatic events from often fragmentary and painful memories, usually in several sessions, has an element of exposure, and may recontextualise them in the politics or conflicts of the time, normalising them to some extent. The combination (as NET) of imaginal exposure and creating a narrative, which may be used as a public statement, is a more recent development but appears to be as effective as CBT. NET is well described in a review by Robjant and Fazel,²⁰ who argue its suitability for people who have suffered prolonged trauma. Their review encompasses adult and child treatments, and reviews studies separately by low/middle-income countries (in refugee camps, or after the conflict has ended) and high-income countries, and they discuss treatment outcomes other than PTSD.

A review in 2004²¹ found only one randomised controlled trial (RCT) of psychological treatment in this population, but more recent reviews^{12,19} identified about 10. Participants are defined by meeting the diagnosis of PTSD at baseline, and most studies took place in the developed world, among resettling torture survivors. CBT, NET, and exposure, in various combinations, were compared with active controls (the most comparable of which was supportive counselling) or with waiting lists or treatment as usual (which does not control for non-specific effects of an intervention). All showed benefits with effect sizes around 1 (although confidence intervals were often not provided), not only for PTSD symptoms but also some for anxiety, depression, and physical health measures. There were no

systematic differences between treatment types. Confidence in the findings is somewhat modified by methodological problems: small numbers, lack of concealment of allocation, and non-blind assessment of outcomes. Combination of CBT with pharmacotherapy, compared with pharmacotherapy alone, showed no difference (see ref. 22), and there were no trials of eye movement desensitisation, which is one of the recommended treatments for non-refugee populations with PTSD¹⁸; it uses sensory stimulation to disrupt the association between recalled traumatic memories and negative emotions.

Where the focus is broader than PTSD, interventions are often multimodal and there are too few randomised controlled trials to combine in meta-analyses. Multimodal interventions are the commonest clinical service, in both high-income and low/medium-income countries, although they are often much briefer in the latter. Interventions are designed on the basis of breadth of need of torture survivors, not on testing a therapeutically rigorous intervention. Mental health interventions, often based more on counselling than CBT or formal psychotherapy, are combined with legal and welfare advice and advocacy, practical assistance, language classes, social services, and similar services. In a review of mental health and social support interventions in humanitarian settings, Tol et al.¹³ found the most common were individual, family, or group counselling; facilitation of community and social support; and provision of child-friendly spaces. Evidence from meta-analysis of trials of building support was good, but participants were not identified as torture survivors, so effectiveness with this group is unknown.

A recent systematic review of community-based interventions²³ describes various group activities with outcomes including quantity of social support and daily functioning, but although the trials recruited refugees who had been subjected to trauma, there were no studies specifically with torture survivors. A review of interventions with torture survivors²⁴ found some 40 studies, of which 11 were RCTs with a focus on trauma symptoms; they demonstrated improvement in those symptoms, but, as with the PTSD reviews above, did not indicate superiority of any particular treatment or method of delivery. McFarlane and Kaplan²⁴ were critical of the focus on PTSD, and of the assumption that a statistically significant reduction in symptoms or numbers meeting diagnostic criteria was equivalent to clinical significance for participants. They also expressed scepticism about the cultural relevance of the model and measurement instruments. They argue for attention to current status, from living conditions to risk of being returned to torture and death; current losses and separation; and the influence of political changes in the country from which the torture survivor fled and where

his or her family may still live. All these can have very significant impacts on the outcome of treatment, a familiar issue for clinicians but largely ignored in trials. Lastly, they argue that while psychological and physical well-being are important outcomes, they still represent problems in medical terms, where the purpose of torture is to destroy social meaning, and the proper context of any treatment is a human rights perspective.

Torture survivors in healthcare settings

For the clinician, in medicine rather than in psychiatry, it is useful to recognise that symptoms of post-traumatic stress can complicate presentation and treatment. Pain predicts greater severity of both PTSD symptoms and major depression,²⁵ and intrusive memories and flashbacks can exacerbate existing pain. While under-recognition and undertreatment of torture survivors is common, there are useful guidelines for good medical practice,²⁶ although not specifically concerned with pain, and for good psychological practice (Jaranson 2001, reproduced in ref. 10).

Most people die during torture; many survivors are too disabled and destitute to find their way to safety. A large element of chance, and, to a lesser extent, resources and resilience, enable a minority to arrive in developed countries. Nevertheless, they often present multiple and complex problems, which the clinician can find overwhelming. For all these reasons, an interdisciplinary approach to assessment and treatment is therefore recommended, guarding against either disregarding significant psychological distress as inevitable in torture survivors or discounting physical symptoms by attributing them to psychological origin.

Rehabilitation and reparation are part of the rights of the torture survivor under the United Nations Convention, yet far less attention is paid to health needs on a national or international basis than to legal and civil claims. Collaborative efforts are needed, involving survivors themselves, to understand better the usefulness and limitations of existing assessment instruments and treatment methods. Some excellent studies exist, such as that by Elsass et al.,²⁷ who interviewed Tibetan Lamas on the quantification of suffering in scales used to evaluate intervention with Tibetan torture survivors.

Education of medical and other healthcare personnel needs to address issues concerning treatment of torture survivors, who will be seen in all possible settings but not necessarily recognised or treated adequately. Teaching on ethics is also important, since medical students can have worryingly tolerant views of torture, and medical and healthcare staff complicity continues in

many countries.²⁸ Medical staff are often in a key position to try to prevent torture, and to help those who have survived.

Acknowledgements

We are grateful to Nimisha Patel and Blerina Kellezi for sharing literature searches that are part of ongoing collaborative work.

Conflict of interest

The authors declare that there is no conflict of interest.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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