

CHAPTER 5



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**MEDICAL
SERVICES**

MEDICAL SERVICES

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- EFFECTS OF Torture
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This chapter is a resource for physicians and nurses working with or planning services for torture survivors. Preceding chapters outline the purpose of torture and common torture methods. This chapter reviews the long-term effects of torture and describes roles and responsibilities for physicians, psychiatrists, and nurses who are helping torture survivors reduce trauma symptoms and rebuild their lives in the United States. These roles and responsibilities include education, documentation, assessment, treatment, referral, research, and advocacy.

While detailed discussion of specific treatment modalities are beyond the scope of this chapter, it will introduce areas deserving further exploration by health care providers. These topics include cultural competence, working with interpreters, use of medications, and improving access to care.

In addition to direct treatment approaches, physicians and psychiatrists are encouraged to integrate preventive components into their organization's programmatic strategies. Examples of such strategies are discussed in Chapter 8. Finally, this chapter describes resources and training opportunities for physicians and nurses interested in conducting med-

FOR MORE INFORMATION

For more information on psychotherapeutic issues, see **CHAPTER 6**.

For more information on preventative strategies, see **CHAPTER 8**.



VIETNAMESE REFUGEE in Thailand.

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ical and psychological forensic evaluations on asylum seekers who have been tortured.

EFFECTS OF TORTURE

The effects of torture are severe and sometimes disabling. A wide range of symptoms and levels of functioning have been associated with individuals experiencing trauma. Many factors affect symptom course and prognosis, resulting in great variability in how individuals react to severe stress.

PSYCHOLOGICAL SYMPTOMS

Two major meta-analyses (Brewin, 2000; Ozer, 2003) of the predictors of posttraumatic stress disorder (PTSD) examined the following main categories of predictors:

- Historical or static characteristics (intelligence, childhood trauma, family psychiatric history, or other prior trauma)
- Trauma severity
- Psychological processes during or immediately after the trauma (including peritraumatic dissociation — dissociative episodes around the time of the traumatic event)
- Social support and life stress after the traumatic event

Although all four categories had significant

predictors of PTSD, the strength of prediction varied across the categories. Factors closer in time to the traumatic event showed a stronger relationship to PTSD than did characteristics of the individual or their personal history.

Intensity and duration of the trauma experience are two especially important factors. In general, refugees who have endured longer periods of torture are more likely to be symptomatic and/or functionally impaired. Those with peritraumatic dissociation or a history of childhood trauma also tend to have more difficulties. Those without prior childhood trauma who had been functioning well prior to their trauma experiences generally recover over time.

Common psychiatric disorders associated with torture include posttraumatic stress disorder, major depressive disorder, substance abuse, other anxiety disorders, and sometimes paranoia or psychosis (De Jong, 2001; Hinton, 1993; Lavik, 1996; Shrestha, 1998). Examples of common trauma-related symptoms in torture survivors include the following:

- Recurrent intrusive daytime thoughts or images of the trauma
- Recurrent traumatic nightmares
- Severe emotional distress or physiological reactions to reminders of the trauma
- Feeling watchful or on guard without reason
- Exaggerated startle response
- Marked irritability
- Concentration or short-term memory problems
- Feeling distant or cut off from others
- Numbing of emotions
- Lack of interest or pleasure
- Depressed mood

- Appetite disturbance
- Energy or motivational disturbances
- Hopelessness
- Suicidal thoughts
- Avoidance of thoughts or situations that serve as reminders of the trauma
- Chronic physical complaints (e.g. headaches, body pain, gastrointestinal problems)

Trauma-related symptoms are not always readily apparent to survivors. Changes in feelings and behavior often occur subtly over time. Family members or those in close contact with survivors may most clearly observe these changes. Trauma symptoms may affect a survivor's relationships, including with family members and in work settings. Survivors' existential views of the world, of human cruelty, and of God may be severely affected by their experiences. They may never again feel the same level of trust or connection with human beings or the divine that they had prior to their torture.

PHYSICAL CONSEQUENCES AND SYMPTOMS

Physical consequences of torture can affect all organ systems, as was discovered with tortured prisoners of war in World War II (Klonoff, 1976). Torture survivors often complain about physical pain and headaches. Musculoskeletal system complaints are most commonly reported.

Symptoms and physical findings can vary depending upon which organ system was affected and how much time has passed since the torture. Specific types of torture may lead to particular physical findings, such as subcutaneous fibrosis or compartment syndrome in the feet from falanga (repetitive beating of the

“Social trauma affects individuals precisely in their social character; that is, as a totality, as a system.”

— IGNACIO MARTIN-BARO, JESUIT PSYCHOLOGIST ASSASSINATED BY THE SALVADORAN MILITARY IN 1989

soles of the feet), sexual dysfunction from trauma to the genitals, and nerve or musculoskeletal injuries from body suspension or stretching.

Head trauma with loss of consciousness is another important injury to assess secondary to its potentially profound impact on future functioning. This can result in changes in memory and attention, as well as affective instability. Some of these effects are acute, while others can be chronic and physically disabling.

Detailed information on examining torture survivors and the medical effects of torture are available in the Physicians for Human Rights (PHR) 2001 publication, *A Health Professional's Guide to Assisting Asylum Seekers*, or from the *Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* (also known as the *Istanbul Protocol*) available on the PHR web site (www.phrusa.org).

SOMATIC SYMPTOMS

Some torture survivors complain of unexplained pain and physical symptoms for which an organic cause cannot be found. These symptoms may be related to prior experiences of starvation, malnutrition, tropical infectious diseases, head injury, physical assault, or other untreated chronic illnesses.

Health care providers especially need to keep in mind the major infectious diseases present in the refugee's country of origin, the prevalence of rape among refugees, and practices of traditional

female cutting (female circumcision) in many cultural groups. A full examination is needed to rule out physical illness, yet many times such 'somatic symptoms' have an emotional origin or connection to trauma. Moreover, presenting with somatic symptoms can also be a more culturally appropriate way of seeking help

Depending upon circumstances, the presentation of physical symptoms can be seen as an index of disease or disorder, an indication of psychopathology, a symbolic condensation of emotional conflict, a culturally coded expression of distress, a medium for expressing social discontent, or a mechanism through which patients attempt to reposition themselves within their local worlds (Kirmayer, 1998). A thoughtful discussion of this complex subject is available in Kirmayer's article.

Despite possible trauma connections, the experience is quite real. The body becomes a metaphor, and emotional pain is frequently expressed physically. Survivors may complain of frequent headaches or stomach pain while a physical cause of the pain cannot be found with biomedical testing. Torture survivors frequently need help in understanding the links among torture, emotional effects, and effects on the body. Survivors are usually relieved to hear they are not abnormal, weak, or crazy, and their symptoms are a normal human reaction to extreme stress.

It is important to develop links in the survivor's mind between common pain or physical symptoms and their exacerbation by psychosocial stressors. With education

and guidance, survivors can learn to correlate these somatic symptoms with emotional trauma and stress, knowing that with time, as they begin to feel better emotionally, their physical pain may also lessen.

SYMPTOM COURSE AND PROGNOSIS

Symptoms of trauma, including physical symptoms, fluctuate in severity over time. A survivor may feel very well for long periods of time before symptoms are triggered again by a stressful event or situation. It is important for trauma survivors to understand the common association between stresses and symptom exacerbation so that they do not perceive their treatment as ineffective and understand that their increased symptoms will gradually diminish over time.

Of those seeking treatment, some will require one-time treatment, some will require intermittent treatment at various periods in their life, and others will require ongoing services. When presenting information on symptom course, duration of medication treatment, and prognosis to this third group with chronic impairment, it is useful to describe their likely treatment course as analogous to that of other chronic diseases such as diabetes or hypertension. Chronic conditions necessitate ongoing care and monitoring, and also often show fluctuations in their clinical course. Like chronic medical conditions, survivors with chronic trauma-related impairment will also require ongoing treatment and can expect periodic exacerbations in symptoms and functioning.

GRIEF AND LOSS

Finally, the loved ones of many torture survivors have been killed, or the survivors are separated from family members. During the flight to safety, there may not have been time for refugees to bury their dead in culturally appropriate ways or to mourn for them. Survivors can benefit from education on the grieving process and with encouragement to mourn the losses they have endured. Health care providers need to learn the culturally appropriate means of dealing with grief and loss in the survivor's culture. This can be discovered by asking patients and family members. Such information can be useful in determining when grieving has become inappropriate and the individual needs further assistance.

ROLES OF HEALTH CARE PROFESSIONALS

PHYSICIANS

Medical treatment by physicians is essential to healing torture survivors. Lingering body pains and physical symptoms often create daily reminders of past torture. Fears of disability and impaired functioning are also common after torture. Similarly, many survivors will experience unexplained physical or pain symptoms that lead to unnecessary and repetitive diagnostic workups. Medical providers play an important role clarifying the nature of physical symptoms in torture survivors and alleviating their complaints.

Physicians are involved in both planning and implementation of interventions con-

ducted by health care systems or specialized treatment centers. Individually, physicians work to prevent illness through educational endeavors, facilitating access to care via health systems change, and providing medical treatment to torture survivors.

Physicians may direct their educational efforts toward a number of areas. One important area includes enhancing community awareness of the effects of torture. A second area involves training other medical providers to assess and treat survivors. Finally, survivors themselves need education to alleviate their fears of medical illness and disability, help them understand the need for diagnostic testing or medications, and promote preventative information about tuberculosis, HIV, and other infectious diseases.

Physicians may also play a central role in advocating within health systems, HMOs and health insurance organizations for the provision of needed services for torture survivors. They may assist in public and political advocacy efforts aimed at increasing general resources directed to torture survivors locally, nationally, and internationally.

Finally, the provision of informed, skillful clinical services by physicians allows torture survivors to heal from illness and cope with their physical limitations, by:

- Assessing acute and chronic diseases in torture survivors
- Providing written and photographic documentation of torture-related physical injuries for legal purposes
- Treating acute and chronic diseases

in torture survivors

- Assisting with care coordination among center providers as well as treatment planning

PSYCHIATRISTS

With medical and psychiatric training, psychiatrists assist in deciphering and treating physical and psychological complaints, which, for torture survivors, are often interwoven. Trained in medical settings, acute psychiatric facilities, and psychiatric outpatient clinics, psychiatrists are familiar with providing a range of services — from handling psychiatric emergencies to leading multidisciplinary treatment teams. Outpatient training provides psychiatrists with skills to treat a variety of mental disorders and use multiple treatment modalities.

Psychiatrists are helpful in disseminating preventive information to affected communities as well as individual clients regarding the medical and psychiatric effects of torture, focusing on trauma education and coping with trauma (see “Helping Refugee Trauma Survivors in the Primary Care Setting” at www.cvt.org). Helping survivors use these coping behaviors can be essential to their recovery.

Trauma education includes describing the effects of trauma, normalizing trauma symptoms, reviewing the course of symptoms and the prognosis, destigmatizing mental health services, drawing associations between stress and exacerbated symptoms, and discussing appropriate ways to grieve losses. Education on coping with trauma includes information on



A public health nurse visited the home of a refugee woman from Iraq who had recently given birth. During the visit, the mother told the nurse that her husband suffered from anxiety and insomnia and had physical pains for which an organic cause could not be found. When the nurse asked the woman if her husband had been arrested or jailed in their home country, she began crying and stated that he had been tortured in prison and that he "has never been the same since." The nurse talked with the father about seeking help from professionals, but he was adamant about not needing assistance as he was not "crazy." After working with the family for several months, the nurse was able to make a referral to the treatment center. During a later visit to the home, the father presented the nurse with special food from his country to thank her for helping him to seek help.

the importance of regular physical activity, relaxation techniques, facilitating religious beliefs or spirituality, strengthening social connections, encouraging employment and hobbies, finding ways to find new meaning in life, and minimizing negative coping behaviors. Educating survivors about the proper use of psychotropic medications is another important task performed by psychiatrists.

Psychiatrists can also be helpful in training staff on the management of psychiatric emergencies. Moreover, they can train primary care and psychiatric providers in the community on essential aspects of recognizing, assessing, and treating torture survivors. Like other physicians, psychiatrists may also play an important role in advocating for treatment, reducing barriers to care, and increasing resources for torture survivors.

A comprehensive psychiatric assessment and timely treatment facilitates the provision of multidisciplinary treatment services. It is essential to the healing of torture survivors and includes the following:

- Standard psychiatric assessment, including: history of present illness, trauma history, past psychiatric history, review of psychiatric disorders, substance use history, family psychiatric history, past medical history, review of systems, current medications, mental status exam, pertinent lab findings, bio-psycho-social formulation, five-axis psychiatric diagnoses, and a detailed treatment plan
- Evaluation of functional impairment due to psychiatric disorders, determination of

prognosis, and completion of any disability assessments needed

- Utilization of psychiatric rating scales to assess symptom change
- Evaluation of the need for psychiatric hospitalization, including coordinating transfers of care
- Care coordination among center providers, including facilitating regular multidisciplinary treatment planning

Psychiatrists are involved in both planning and implementation of interventions conducted by health care systems or specialized treatment centers. Moreover, psychiatrists have the skills and training to provide multiple treatment modalities for torture survivors. Treatments include the following:

- Individual, group, or marital/family psychotherapy
- Psychotropic medications to alleviate trauma-related symptoms
- Dual medication management and psychotherapy visits when appropriate
- Motivational interviewing for those abusing substances
- Crisis management assessment (e.g., for acutely suicidal clients) and treatment

NURSING

As health care providers, nurses work collaboratively within a specialized torture rehabilitation center or primary care setting. They work with physicians and other health care professionals in achieving identified medical goals, such as regularly monitoring blood pressure for those with hypertension and obtaining

laboratory testing.

Nurses may also work collaboratively in managing a survivor's health care. Nursing case management is a process of ensuring that each individual survivor receives appropriate health care services both within the torture treatment center or primary care facility and in the larger community. The case manager coordinates and monitors the clinical services that the survivor receives to assure that the individual's unique health care needs are being met. Responsibilities of the nursing case manager include the following:

- Health care service planning and resource identification
- Linking clients to needed services and coordinating individual client care in the community health care system
- Client advocacy and problem-solving with the health care system
- Monitoring service delivery
- Evaluating services

Nurses educate survivors about accessing and navigating the U.S. health care system, including patient rights. As clinic managers, nurses coordinate health care services within the torture treatment center or clinic. Responsibilities of the clinic manager include:

- Coordinating internal and external health care appointments
- Maintaining needed equipment and supplies (such as medications, physical therapy supplies, etc.)
- Assessing the quality of services delivered (e.g., through chart audits

and client-satisfaction surveys)

Caring has been identified as the central unifying focus of nursing practice; it is the essence of nursing (Watson, 1999; Leininger, 1995). Care is demonstrated and practiced through the interpersonal relationship between nurse and client that preserves human dignity, wholeness, and integrity. Nurses deliver care by respecting survivors' priorities, supporting self-esteem, and minimizing potential stressors. The nature of the nurse-client relationship concerning the survivor's physical well being allows an opportunity to rebuild trust. An important article on the role of nurses in torture treatment is "The Fear Is Still in Me: Caring for Survivors of Torture" (McCullough-Zander and Larson, 2004).

ALL HEALTH CARE PROFESSIONALS

Professionals in all areas of health care are involved in documenting the effects of torture, in making outside referrals for clients, and in evaluating treatment outcomes for survivors.

Forensic documentation of the physical effects of torture is an important aspect of providing services for torture survivors and may include documenting the psychological and physical effects of torture in asylum seekers through history and physical exam, as well as photo documentation of scars or other signs of torture.

It may be appropriate to create volunteer physician treatment networks or networks for providing psychological and

medical documentation of torture for asylum seekers.

Program evaluation and research are essential to improving care for torture survivors. Research on the effects of torture, on appropriate measures of clinical change, and on how to determine treatment outcome has been limited thus far. Physicians, psychiatrists, and nurses may play a vital role by:

- Developing and implementing program evaluation and clinical outcome research strategies
- Assuring that such strategies are built into new projects or clinical programs from their inception.

PROVISION OF MEDICAL TREATMENT

CULTURAL COMPETENCE

Treating torture survivors requires cultural competence. While it is impossible to know the norms, behaviors, and attitudes of all cultures, it is possible to approach cross-cultural interchanges with curiosity and an open mind. Such an approach helps care providers build knowledge and skills over time.

Cultural competence incorporates nonjudgmental questioning of an individual's perceptions of culture as well as family nuances, sensitive awareness of behaviors and implicit meaning during personal interactions, and a commitment to expanding one's own personal knowledge base regarding country conditions and politics.

Furthermore, working across cultures necessitates re-examination of one's own

attitudes, beliefs, values and prejudices, usually hidden from conscious awareness. This awareness can help one work with torture survivors from a variety of cultures with increasing skill and comfort.

Prior international experience makes this process easier. Frequent use of informational web resources such as Human Rights Watch (www.hrw.org), Amnesty International (www.aiusa.org), the U.S. State Department (www.state.gov) and International Crisis Group (www.crisisweb.org) provide information about specific groups, their prior experiences, and current country situations.

WORKING WITH AN INTERPRETER

When preparing to work together for the first time, it is helpful for the clinician and interpreter to discuss their experiences, skills, and expectations. The clinician should explain the need to know everything the client says and the expectation that the client will be similarly informed.

Consider matching gender whenever possible due to cultural or religious issues, potential history of sexual trauma, and sociopolitically based mistrust. Factors potentially affecting the interpreter-client relationship include mem-



bership in different or previously adversarial ethnic groups, gender differences, age differences (e.g., a much younger person interpreting for an older person), and class differences.

Spatial aspects of the client-interpreter-physician triad, as well as the manner and type of questions asked, can be important. Set up the chairs in a triangle so that each person can see the others clearly. Take time to observe the interaction and rapport between interpreter and client.

When interviewing, use relatively short sentences so the interpreter can properly convey the complete content of your questions. Do not hesitate to use clarifying questions when confused, or summarizing statements to assure proper understanding of a complex story or temporal presentation of symptoms.

When attempting to discuss difficult concepts such as suicide or hallucinations, work to structure questions so they are as unambiguous as possible. Sometimes rephrasing a similar question later in the interview to recheck certain responses can help verify important information.

A more detailed discussion of working with interpreters is provided in Chapters 3

and 4. Additional detail on working with interpreters in psychiatry can be found in Westermeyer's 1989 clinical guide.

TRAUMA HISTORY ASSESSMENT

When working with refugees, immigrants, or asylum seekers, assess for trauma history. Features that alert clinicians to the possibility of a history of torture include the following:

- Status as a refugee, immigrant, or an asylum seeker
- History of civil war in country of origin
- Reluctance to divulge experiences in country of origin
- Client or family member politically active in country of origin
- Family member who has been tortured or killed
- History of being imprisoned
- Any physical scarring
- Physical symptoms with no known medical cause
- Psychiatric symptoms of trauma: depression, nightmares, emotional numbing, irritability, being easily startled, difficulty concentrating, avoidance, and trouble sleeping

Many torture survivors are reluctant to talk about their trauma history because of the shame of their experiences. They fear they will not be believed, and may attempt to minimize symptoms by trying not to recall the experiences.

In assessing for a torture history, ask an open-ended question about what happened in the survivor's country that forced him or her to leave. If appropriate, a health care provider can then ask more

FOR MORE INFORMATION

For more information on working with interpreters and a more detailed discussion of working across cultures, see **CHAPTER 3**.



direct questions about a history of being imprisoned, beaten, or attacked by soldiers or rebel groups.

MEDICAL ASSESSMENT

Torture survivors want to know what is wrong with them physically, which symptoms they can expect will improve, and what symptoms they should learn to live with. The recommended medical assessment of all refugees includes the following:

- History and complete physical exam, including genitourinary system
- Skin test for tuberculosis, and/or chest X-ray
- Vision and hearing screening
- Dental evaluation
- Stool test for ova and parasites
- Urinalysis
- Hemoglobin
- Cholesterol
- Serological test for syphilis
- Hepatitis B screening tests; possibly hepatitis A and hepatitis C screening tests
- Explanation of and offer of HIV testing
- Explanation of and offer of STD testing other than syphilis
- Immunization assessment
- Thyroid function testing

Routine events in a clinic or hospital such as electrocardiogram testing for a survivor of electrical torture, or a gynecologic exam for a rape survivor can be very stressful. Torture survivors can better tolerate tests and procedures without being severely stressed if they are given emotional support and prior education on what to expect. Emphasizing that they have control over which aspects of a physical

examination are performed or how diagnostic tests are administered is essential. Torture survivors benefit from knowing that they can stop or delay medical procedures when necessary. For some, certain procedures are best done under anesthesia.

PSYCHOSOCIAL STRESSORS

Torture survivors benefit from understanding the role of current psychosocial stressors in increasing symptoms. Most refugees have the expectation that once they are in the United States their problems will be eliminated. There is widespread perception of the United States as a safe place and one of easy opportunity.

Many torture survivors are therefore dismayed to find that their psychological and physical symptoms often are worse during their first few years in the United States because of the additional stressors of rebuilding their lives in a new place. Examples of acculturation stressors for refugees and asylum seekers include:

- Learning a new culture and possibly a new language
- Lack of social and family networks
- Financial and work difficulties
- Concerns about their legal immigration status
- Worries about family back home
- Loss of previous social status
- Changes in family members' roles (e.g., children adopting American value of independence; wife now working outside of the home)

SOCIAL STIGMA OF MENTAL ILLNESS

Torture survivors and refugees in general are often reluctant to seek mental health services.

SAMPLE ASSESSMENT QUESTIONS TO BE INCORPORATED INTO STANDARD ASSESSMENTS FOR NEW PATIENTS

IN WHAT COUNTRY were you born?

CAN YOU TELL ME what made you leave your country?

HAVE YOU EVER HAD problems because of your culture or tribe? Your political belief? Your religion? Your gender?

HAVE YOU EVER BEEN arrested or put in jail?

HAVE YOU EVER BEEN beaten or attacked by soldiers, police, or rebel groups?

HAVE YOU EVER SEEN or heard others being beaten or attacked?

HAVE ANY MEMBERS of your family been arrested or attacked because of their culture, tribe, political beliefs, or religion?

IF A HISTORY OF torture or trauma is indicated, what problems are you having now from being beaten or attacked?

This is usually due to social stigma surrounding mental illness and potential implications for themselves or their families for seeking mental health treatment. Such views are common throughout the world.

To most refugees, “mental illness” refers to persistent and usually psychotic states that they might call “crazy.” In some cultures having a family member with severe mental illness brings shame on the entire family and may diminish family members’ opportunities for marriage.

Psychotherapy and psychiatric treatments are generally unknown in most countries, which typically have only one psychiatric institution for the severely mentally ill. Education is required to modify survivors’ views of mental illness. Presenting emotional problems as a continuum of severity from low-level to severe mental health problems can be useful. Recognizing that each of us moves back and forth on this continuum depending upon current stressors such as divorce, death of a child or even severe trauma facilitates understanding of mental health concepts.

MEDICATIONS

Compliance with medications is a common barrier to treating torture survivors and refugees in general. Many refugees have either never taken Western medications or, as with antibiotics, have taken them for only short periods of time. They may lack an understanding of why medications may need to be taken for extended periods of time. Patient education on the long-term use of medications is required.

Many refugees stop taking medications

when they feel better or if they have not noticed any effects within several days. With the use of antidepressants for example, patients need to understand that it takes several weeks to notice effects. However any side effects that might occur usually happen in the first two weeks and then likely resolve. Patients need to understand that if side effects occur, dosages can be adjusted or medications changed.

Understanding how a torture survivor discusses and explains illness can help in comprehending his or her reasons for not taking medications as directed. Developing a mutual understanding of rationales for using medications is essential to ongoing compliance. Begin follow-up appointments with a nonjudgmental determination of which medications clients are presently taking and why they have chosen to discontinue other ones.

PHYSICAL THERAPY AND MASSAGE

Specialized torture treatment centers have observed benefit among their patients from physical treatment modalities such as physical therapy or massage. Primary care or other clinics treating torture survivors may consider such interventions when addressing complaints of chronic pain and physical symptoms.

Volunteer massage and physical therapists now conduct regular sessions for CVT clients referred because of chronic pain, headaches, or other sequelae from injuries. Because torture is usually directed in part toward the physical being of the victim, attention to the body can be especially ther-

apeutic, both emotionally and physically.

CONDUCTING FORENSIC EVALUATIONS ON ASYLUM SEEKERS

A growing number of physician volunteers are becoming involved in conducting forensic evaluations on torture survivors seeking asylum. Volunteer networks have sprung up throughout the United States, encouraged and often facilitated by Physicians for Human Rights. Physicians conducting psychiatric or medical evaluations provide objective, unbiased documentation of the physical and psychological effects of torture.

A Health Professional’s Guide to Assisting Asylum Seekers (Physicians for Human Rights, 2001) provides an excellent resource for physicians and mental health professionals seeking to develop the knowledge and skills needed to perform clinical evaluations on asylum seekers. It details United States asylum law, general interview considerations, physical evidence of torture, psychological evidence of torture, issues in the assessment of children that have been tortured, how to provide written documentation of medical and psychological findings, and how to provide oral testimony in court.

Much of this resource is based on recent international guidelines for medical-legal documentation of torture contained in the *Istanbul Protocol* (found on the PHR Web site). The 1999 *Istanbul Protocol* was the first document to provide international guidelines for documenting torture and was the product of three years of research,

analysis, and drafting by more than 75 forensic specialists, physicians, psychiatrists, psychologists, lawyers, and human rights monitors. This group represented 40 organizations from 15 countries.

The overall goal of medical and psychological evaluation of torture survivors is to assess the degree of consistency between an individual's account of torture and the medical and psychological findings observed during the evaluation. Both Physicians for Human Rights and Doctors of the World (www.doctorsoftheworld.org) offer training to organizations or networks of health professionals interested in conducting this work.

Professionals may contact PHR to find out whether existing networks for assisting asylum seekers are functioning in their area. It is possible to create a new network of health professionals if one is not available.

CONCLUSION

Health care professionals provide a wide array of expertise and experiences essential to the care of torture survivors. Through their care and leadership, they strive to encourage resilience among torture survivors and assure that survivors

themselves play an active role in their rehabilitation. Alleviating misinformed fears of chronic impairment and offering words of encouragement are powerful tools in regaining hope and facilitating recovery. Moreover, prescription of psychotropic medications also facilitates stabilization of acute psychiatric symptoms and improvement in overall functioning for many torture survivors.

In addition to direct service provision, health care professionals need to consider a broad array of factors that limit torture survivors from availing themselves of needed treatments.

Programs and services developed to educate high-risk communities, to minimize barriers to seeking appropriate care, and to facilitate the recognition of torture survivors in settings where they are likely to present are important adjuncts to direct services that can be guided by physicians and nurses. Finally, the forensic documentation of torture among asylum seekers, advocacy for appropriate health care, and preventing torture are also essential components in the holistic provision of professional health care for survivors of torture. ■

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IMPROVING ACCESS TO CARE AMONG TORTURE SURVIVORS

Torture survivors are often reluctant to seek medical and mental health services. Several key areas (including health systems and logistical barriers) have been identified as targets for improving the willingness of torture survivors to access appropriate treatments. Some examples of issues and strategies to improve access to care are described below.

MENTAL HEALTH SERVICES IN PRIMARY CARE CLINICS

Some primary care clinics, which are a part of the health system most people are comfortable using, are beginning to incorporate mental health services into their clinics. Torture survivors may have less resistance to mental health care when these services are in the same location and not differentiated from other health care.

SAME-DAY PATIENT VISITS

In many countries, health care visits are not scheduled in advance. Individuals travel to their provider on the day they wish to be seen, arriving as early as possible, and wait their turn. Despite sometimes waiting many hours, patients at least know they can be seen on the day when their symptoms or concerns are greatest. Some



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U.S. health care clinics are beginning to accommodate same-day patient visits.

PATIENT EDUCATION

Education about the effects of trauma and ways of coping is essential to recovery. Primary care clinics are often a major intervention point where large numbers of torture survivors can be reached. As such, it may be helpful for primary care clinics to allot 45 to 60 minutes for the provision of individual or group trauma education by appropriate staff. As with diabetes education, using a designated staff member to conduct patient education sessions can be helpful.

CHILD CARE

Logistical barriers often prevent torture survivors from receiving care. The availability of evening

appointments is important for many in low-paying jobs with difficulties taking time off work. Helping women to problem-solve around child care issues or providing child care at the clinic can also be helpful.

TRANSPORTATION

Lack of transportation is another common logistical barrier. Taking the bus to appointments, especially with children, in the winter, or when in pain, is difficult. Helping survivors to explore community programs or health care plans providing alternative transportation, or even using community or church volunteers to provide transportation can help alleviate this common problem.

MUTUAL ASSISTANCE ASSOCIATIONS

Establishing long-term relationships with staff at local refugee community organizations can sometimes improve a survivor communities' willingness to access care. Moreover, mutual assistance associations (MAAs) may provide important adjunct services to their community members and become an important referral source for health care providers. Staff at MAAs can also serve as a cultural resource to health care clinics.