



Torture survivors: What to ask, how to document

These immigrants are as numerous as patients with Parkinson's disease, but they are unlikely to be forthcoming about their past. Here's how to proceed.

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PRACTICE RECOMMENDATIONS

› *Screen for a history of torture if an individual from an immigrant group exhibits signs of depression or post-traumatic stress disorder, complains of unexplained pain, or is known to be seeking asylum. (C)*

› *Document a report of torture and any associated physical or psychological findings from your examination, and refer the individual for appropriate care. (C)*

Strength of recommendation (SOR)

- (A)** Good-quality patient-oriented evidence
- (B)** Inconsistent or limited-quality patient-oriented evidence
- (C)** Consensus, usual practice, opinion, disease-oriented evidence, case series

Nearly half of the world's 200 nations torture their citizens.¹ Although survivors have high rates of physical and psychiatric morbidity, and in coming to this country tend to live in highly concentrated refugee groups, physicians rarely discover torture histories.^{2,3}

Torture survivors may avoid speaking of it because they do not understand that treatment is available for their physical, psychiatric, and pain disorders. A lack of detection delays the diagnosis and treatment of the sequelae of torture. It may also affect their future safety: Individuals seeking asylum are deprived of the medical documentation needed to support their petitions.

Your involvement in recording histories and exam findings and in referring patients for specialized care can restore lives. It can also aid in reversing the "invisibility" of torture survivors that perpetuates inadequate clinical education, research, and development of appropriate therapies.

■ Are you caring for a survivor—and don't know it? Approximately 500,000 torture survivors live in the United States.⁴ This equals the number of individuals with Parkinson's disease and outnumbers those with multiple sclerosis.^{5,6} Physicians may encounter torture survivors in primary care settings, emergency departments, or while consulting with colleagues about patients who have specialized medical needs. There are no evidence-based guidelines for assessing and treating torture survivors. Most studies are from single institutions and have modest sample sizes. Most use univariate analyses, and the effect of confounding variables is often unexamined. Moreover, the diversity of torture survivors' cultures limits the generalizability of findings from particular groups.

In this article, we propose an approach—based on studies that address cross-cultural issues or use multicenter, multivariate, meta-analytic methods—that can enable you to better identify survivors of torture, assess and document consequent morbidities, and refer them to appropriate treatment pro-

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grams. We focus on individuals who were tortured months or years earlier rather than on recently traumatized patients.

Facts that justify targeted screening

Although the number of torture survivors is not so high as to warrant population-wide screening, the prevalence of such victims in easily identified refugee groups does justify screening in this setting. Tortured individuals are more likely to emigrate than are their unmolested fellow nationals.⁷ Six percent to 12% of immigrants from countries where torture is practiced say they have been tortured.^{2,3} Torture rates are highest in people seeking political asylum. Twenty percent to 40% of asylum-seeking refugees from Somalia, Ethiopia, Eritrea, Senegal, Sierra Leone, Tibet, and Bhutan report being tortured.⁷⁻⁹ In this context, the lack of data on refugees from countries such as Zimbabwe or Myanmar is not reassuring.

■ **The plight of children.** About 4% of torture survivors are children.^{10,11} Some are street children brutalized by police; some are tortured to terrorize family members; some belonged to "enemy" communities. Investigation is warranted if an immigrant child comes from a country where torture is common and if the child was old enough to be imprisoned or forced to serve as a child soldier before entering a safe refugee camp prior to immigration.¹² It is more appropriate to screen such children for post-traumatic stress disorder (PTSD) than torture. A meta-analysis found that 11% of refugee children (vs 9% of adults) have PTSD, regardless of whether they were tortured or experienced war or pandemic political violence.¹⁰ The American Academy of Child and Adolescent Psychiatry provides a summary of findings typically seen in children with PTSD.¹³

■ **How to broach the subject with adults.** Screening for torture survivors is reliable and takes little time. You might want to ask a question that mentions torture specifically. For example, you might say: "Some people in your situation have experienced torture. Has that ever happened to you?"^{7,2} Other questions could be less direct and fol-

low the legal definition of torture from the Convention Against Torture: "While in captivity, did you ever experience physical or mental suffering that was deliberately and systematically inflicted by a soldier, policeman, or militant, or other person acting with government approval?"^{14,15} The sensitivity and specificity of screening questions are estimated at 80% and 90%, respectively.⁸ Patient factors that can dampen sensitivity are shame and stigmatization (especially for survivors of sexual torture) and the trauma-amnestic component of PTSD. Secondary gain with regard to immigration appeals, however, rarely causes overreporting.³

If a patient answers Yes to a screening question, your responsibility is 2-fold. First, begin compiling a medical record that accurately reflects the patient's description of torture and the medical findings relevant to those statements. Accurate documentation is important because medical records are used as evidence in hearings to rule on petitions for asylum. Second, refer the patient for proper treatment that can reduce disability, pain, and psychiatric distress.

Assess physical morbidity

Torture survivors' physical symptoms and signs are as varied¹⁶⁻¹⁸ as the methods by which they have been abused.¹⁹⁻²¹ Let a patient's complaints and report of the techniques used guide your examination.^{9,14,15,22,23}

■ **Concussive trauma** is nearly universally reported. This includes beatings with fists, clubs, and batons. Caning causes horizontal lesions typically on the buttocks and back or sometimes on the backs of the legs. Whipping is typically applied to the back, where it produces downsloping lesions that curl laterally off the trunk.¹⁸ Torturers sometimes place layers of cloth over the skin before beatings to minimize incriminating cuts and scars. In men, genital beatings are so common that researchers include them with general beatings rather than categorizing them as sexual torture.²⁴ A third to half of survivors report beatings on the feet, a technique that produces chronic neuralgias and disability from fascial injuries, which can be evaluated by MRI.²⁵⁻²⁷ Prolonged pain and disability from foot beat-

ings is associated with PTSD. Concussive trauma to ears can produce hearing loss. Deformities or healed fractures may be signs of blunt force trauma. Gunfire into joints leaves bony injuries and metallic fragments.

■ **Suspension, hyperflexion.** Many survivors report being suspended by an extremity or digit or forced into positions of extreme hyperflexion, hyperextension, or rotation. A variant of suspension is the use of stress positions such as confinement in a tight box. These techniques often tear ligaments, tendons, nerves, neural plexi, or other soft tissues, or cause subluxations, dislocations (eg, reverse rotation of the shoulder), fractures, or even amputating avulsions.^{16,28} Careful examination and imaging of joints can detect such bone and soft tissue injuries.

■ **Ligatures, binding, and compression** to extremities or genitalia are used to restrain or to cause pain or injury. The long-term sequelae include scars, neuropathies, ligamentous injuries, muscle trauma, and ischemic injuries. Thumbscrews—small vises clamped on fingers, thumbs, or toes—produce destructive compressive fractures and deformities in the distal bones and joints of the fingers or toes.¹⁶

■ **Burns, electrical shock, and mutilation by cutting** are widely inflicted. Shock is applied to the skin, genitalia, or within body cavities with wires, cattle prods, or electrified grids such as bedsprings. Muscle spasms caused by intra-oral cattle prods can cause jaw dislocations. Intense shocks on the back can cause muscle spasms that result in vertebral compression fractures.¹⁶ Although nontherapeutic, biopsies of electrical scars have evidentiary value.¹⁸ Teeth are often extracted as a form of mutilation.

■ **Sexual torture** is substantially underreported. Five percent to 15% of male torture survivors report being sexually abused.^{24,29} Of these, 50% report threats of castration or rape, 33% are raped or forced to perform sex on, or in view of, others, and 10% report genital shocks or mutilation.^{24,29} Although fewer women than men are tortured, about half of women survivors report sexual torture, usually rape, sometimes in front of family members.^{30,31} Given the prevalence of rape among female torture survivors, case finding during

or before prenatal care may enable a practitioner to desensitize or sedate a woman before using gynecological instruments or techniques like paracervical injections that can trigger PTSD arousal reactions.

■ **Injurious environments.** Nearly all torture survivors report being subjected to extremes of heat or cold, a lack of water or food or sanitation or medical care, or crowding, filth, and extreme noise. Some survivors report asphyxia with a dry or wet cloth over the face or by being immersed in water. A few report being given substances that cause dystonia, diarrhea, or loss of consciousness.

Assess psychological morbidity

The distinction between physical and psychological torture is imperfect. Fear of physical violence is a psychological stressor. Psychological torture has physical sequelae such as sexual dysfunction. Psychological torture uses various methods to humiliate, degrade, or cause extreme fear (sham executions, being forced to watch torture), or to isolate or disorient (blindfolding, sleep deprivation) a prisoner.^{9,15,21} The combination of physical and psychological torture causes severe, chronic psychological morbidity.⁷ The nature and severity of this morbidity is shaped by the nature of the torture, personal resilience, social supports, stressors in life after torture, and therapy.

The main psychological sequelae of torture are PTSD, depression, anxiety disorders, and chronic pain syndromes. Of torture survivors seeking treatment, 50% to 67% have PTSD, 33% have depression, 10% have generalized anxiety disorders, and another 10% have other psychiatric diagnoses.^{32,33} Forty percent to 70% of torture survivors have chronic pain or somatoform disorders,^{7,22,31,34} making it critical that physicians screen for a history of torture with any refugee presenting with recurrent, complex, or unexplained pain.

Many tortured refugees have experienced multiple traumas, including political terror, war, and dislocation. A complex meta-analysis involving 82,000 refugees found that torture is especially correlated with PTSD, whereas stressors such as exposure to con-



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flict and displacement were more strongly associated with depression.^{35,36}

Researchers have not found correlations between the types, severity, or duration of torture (including physical vs psychological techniques) and the severity of post-torture PTSD or depression.^{7,37} Head trauma received during torture may lead to frontal and temporal cortical thinning that is highly associated with post-torture depression.³⁸ Rape during torture is associated with high levels of chronic distress and sexual dysfunction.^{30,39,40} Psychological resilience may be somewhat more robust in individuals who expected to be tortured.²¹

The social situation of resettled refugees affects the severity of psychiatric distress in torture survivors. Two large studies found that refugees were more distressed if they were institutionalized (in camps or compounds as opposed to homes), feared repatriation, were underemployed, or lacked economic opportunities in their new homeland.^{35,41} Persistent pain or physical disability related to tissue damage or a superimposed somatoform disorder correlates strongly with persistent psychiatric morbidity.⁴² Although the intensity of PTSD decreases over years, the core symptom complex often endures and may be disabling.^{32,37,43}

How to connect patients with resources

The International Rehabilitation Council for Torture Victims (www.IRCT.org) and the Center for Victims of Torture (www.CVT.org) offer links to many torture survivor treatment programs. Other torture treatment centers can be found with Web searches or through international clinics or community organizations serving specific ethnic groups. Treatment programs help clients—many of whom are uninsured and, as non-US nationals, ineligible for public entitlement programs—navigate barriers to getting help. Treatment centers must address language barriers be-

tween therapists and clients. One caution: In small ethnic communities, translators may know clients and thereby raise fears of lack of confidentiality.

■ **Treatment options.** Standard interventions recommended for torture survivors include physical therapy and cognitive behavioral therapy, especially for flashbacks and disabling social avoidance behaviors that are part of PTSD.⁷ Narrative exposure therapy, a brief psychotherapy in which the patient repeatedly retells and re-experiences painful events, shows promise.^{44,45} Psychological care for depression and anxiety, interdisciplinary pain desensitization, psychosocial supports, and assistance with asylum petitions are also important. The lack of validated torture survivor treatments reflects a paucity of research on this issue. It does not mean that standard effective therapies for PTSD or depression are ineffective.^{32,46} It is reasonable to assume that inadequate treatment of PTSD, depression, and pain disorders magnifies and prolongs the personal, familial, and social cost of torture sequelae.

■ **Following through on medical documentation.** About 41,000 people, nearly all from countries where torture is common, sought asylum from persecution in the United States in 2011.⁴⁷ The United States grants asylum if an otherwise eligible immigrant can establish a “significant possibility” of future persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.⁴⁸ This is a government determination, not a medical certification. A study of 2400 asylum seekers found that 90% who had medical documentation of past torture were granted asylum, compared with just 37% of those lacking such medical support.⁴⁹

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For more on this subject from Steven H. Miles, MD, go to http://www.ahc.umn.edu/bioethics/facstaff/miles_s/ and click on the torture survivors lecture