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Psychiatric help for survivors of torture

Stuart Turner

When asked for advice about a survivor of torture (or of some other form of organised state violence), there are at least two people to consider. In addition to the needs of the patient, those of the person asking for advice – the health professional – must be taken into account. There are some forms of violence which can damage others, even in the controlled circumstance of a consulting room. There is a context, often a community or a family, in which the person exists. This paper will first address some of these broader issues before going on to consider some of the narrower, more technical, matters of best available treatment.

Secondary traumatisation

It is important to admit honestly, and from the outset, that for some people only limited gains are possible. This is especially true for as long as the violence or the threat of further violence persists. However, even limited gains are worthwhile. If there are 12 problems, three or four of which might be relieved, it is still worthwhile to attempt such relief. One of the most common difficulties occurs when the doctor or therapist is overwhelmed by the history of torture and the reaction of the survivor. There may be times when this tends to lead to a problematic, even damaging, response. Those offering assistance may themselves feel:

- hopeless – as if they cannot start treatment at all – the large number of problems for which no treatment is apparent blinding the therapist to those problems which are treatable;
- omnipotent – as if the therapist wishes to take over completely (sometimes fed by dependency needs on the part of the survivor);
- punishing – as if they wish to reject or punish the person who is disturbing the therapist's own equilibrium;
- avoidant – a more common response than punishment but potentially damaging since it may lead to a denial of access to treatment.

These are some of the feelings that people may experience in work in this area. We all need to guard against these responses. The best advice for clinicians is to stay true to their professional therapeutic relationship and also to consider their personal supervision needs particularly carefully

Box 1. Countertransference feelings in clinicians

Hopelessness
Omnipotence
Punishment
Avoidance

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in this sort of work. This does not mean that they should not reflect on what they have heard, or act on these reflections in other settings; it simply means that allowing other issues to intrude into the treatment relationship may itself be problematic.

Diagnosis

Over the past decade, the physical and psychological effects of torture have become more clearly defined. Initially focusing on the relevance of a largely discredited concept of a torture syndrome, the debate has now shifted to the relative importance of post-traumatic stress disorder (PTSD). This is still surprisingly controversial. Some have stressed the importance of making a diagnosis of PTSD (e.g. Allodi, 1991) and of establishing treatment programmes for this condition. This approach is very helpful to the degree that we now have greater knowledge of the neurobiology, description, treatment and prognosis for PTSD. However, for a complex trauma experience such as torture, its limitations have to be accepted with equal force.

Although PTSD represents a useful diagnostic entity, it does not go far enough in explaining the wide range of symptomatology seen in torture survivors. In 1990, four common elements to the torture reaction were identified (Turner & Gorst-Unsworth, 1990). These were: PTSD (incomplete emotional processing); depressive reactions secondary to loss and adverse life events; somatoform symptoms; and probably most significant of all, the effect on personal value systems – for example, changed personal religious or political thinking or core beliefs in a just or meaningful world. In other words, PTSD is an important but insufficient diagnosis to explain the whole of the reaction to torture.

There are other limitations. Mollica & Caspi-Yavin (1992) have questioned whether PTSD is a meaningful diagnostic category in other (non-Western) cultures. De Silva (1993) emphasises the importance of the sociocultural meaning of trauma, not only in relation to issues such as shame, social networks and vulnerability, but also as an aid to therapy. However, more recently, reports confirming the importance of PTSD (and depression) in a range of cultural groups (e.g. Cambodian as well as Bosnian refugees) have emerged (Mollica *et al*, 1998; Mollica *et al*, 1999). These suggest that although the experience of the trauma itself is personal and may be significantly affected by social and cultural expectations, the PTSD response is a relatively stereotypic condition.

Following a severe, malicious and often prolonged experience such as torture undergone within a political context, many people respond with no psychiatric disorder (although the experience still has its impact); others present with several disorders. The two most common simple diagnoses are PTSD and depression. These commonly coexist (e.g. van Velsen *et al*, 1996). However, somatoform complaints, panic disorder and dissociative disorders may also be important in some people. The dissociative response to trauma, for example, is certainly not restricted to childhood trauma. It may lead to severe repetitive dissociative fugue states that have clinical and sometimes medico-legal implications.

One of the most important difficulties is inevitably to do with alteration in personal beliefs. This may affect, for example, religious or political values, and the ability to relate normally to others. In diagnostic terms, the ICD–10 diagnosis of enduring personality change after catastrophic experience is a helpful addition to the classification system (see Box 3; World

Box 2. Diagnoses of torture survivors

Many have no psychiatric condition
Common diagnoses are depression and PTSD
More complex reactions include enduring personality change

Box 3. Enduring personality change after catastrophic experience (abbreviated, from ICD–10; WHO, 1992)

This condition may occur following extreme stress (e.g. concentration camp experiences, torture and hostage situations). It may follow PTSD and is a chronic, irreversible sequel of a complex traumatic experience. It is characterised by permanent, irreversible, changes in the following domains:

- **a hostile or mistrustful attitude towards the world**
- **social withdrawal**
- **feelings of emptiness or hopelessness**
- **a chronic feeling of being 'on edge', as if constantly threatened**
- **estrangement.**

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Health Organization, 1992). It captures well some of the problems of isolation, emptiness and mistrust that may follow torture or prolonged hostage-taking. It is an example of a complex trauma reaction.

This move beyond simple psychiatric diagnoses into the realms of complex trauma reactions is helpful because it moves the survivor away from a sense of being reduced simply to a naïve categorisation and allows the individuality of the experience and, importantly, its social and political context to be considered. However, in taking this step, it is also important that the advances which have been made in the understanding of some of the simple trauma reactions and their treatment are not ignored. It is important to find the right balance, acknowledging that these conditions (especially PTSD and depression) are common and that they may be treatable, while at the same time recognising the complex and human nature of the experience and of the response. We need to avoid the hopelessness *versus* omnipotence dichotomy in 'therapeutic' responses.

Social context

Even this account is incomplete. There is too much emphasis in general on torture as a means of destroying the individual recipient. Individual diagnoses are bound up with this form of analysis. A key way of considering torture (as it is commonly applied in the 20th century) is as a means of controlling or repressing communities.

It is essential in thinking about the social effect to have a formulation of purpose. Why do states carry out torture? This is complex, but one way of looking at it is to regard torture as a form of communication. Seen in this way, it is a means of declaring to the target community (while offering denials to the majority or ruling community) that this is a form of violence to which any individual member of that group can be subjected. It may be for this reason that survivors of severe torture are released. Their presence acts as an example to others. However, it does more than this. Individuals released from torture may also act as a focus for uncertainty and mistrust. How much did they reveal? What was done to them? Were they raped? It is a form of experience that goes to the heart of our capacity to relate one to another. It tends to breed mistrust. Indeed, this combination of fear and mistrust may be a major part of the method of repression. It also leads on to some potential problems in the therapeutic setting. How can survivors trust us? What is our position in their world model? What is their prior experience of health professionals or of people in positions of authority?

Intervention

Judith Herman (1992) has identified three phases to any successful intervention with survivors of deliberate violence (see Box 4). She recognises an initial period where the focus is on safety and trust. There follows a period in which specific treatment methodologies are employed. Finally, there is a process of (re-)integration.

This is a helpful approach to organising the therapy of the torture survivor. It highlights the importance of considering trust and primary needs first. It places treatment for psychiatric disorders second. It emphasises that after symptom relief, more work is required in adaptation to the trauma before recovery can be said to have occurred.

The development of trust and a therapeutic alliance are essential components in engaging the patient. The therapist should be encouraging, patient and empathic, but also permit time for the survivor to express anger and vengefulness. The therapist may need to be prepared to declare an open commitment to supporting human rights issues in general, at the same time remaining objective with regard to the specific conflict (Turner, 1992). This commitment may need to be made explicit for some survivors to be able to trust their therapist. For therapists working in the country of repression, this often places them at considerable personal risk (Cienfuegos & Monelli, 1983). It is also important that therapists have an understanding of the cultural background from which their patient comes. This includes not only a knowledge of the social and political context of his or her country, but also the unique meaning that the

Box 4. The structure of intervention

Safety first: addressing primary needs, trust and stabilisation
Treatment:
- **medication, particularly selective serotonin reuptake inhibitor antidepressants**
- **specific psychotherapy – evidence suggests a broadly cognitive–behavioural approach (including testimony)**

Re-integration (with refugee and/or host community)

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torture and its resultant symptoms symbolise for that person. Whichever treatment the therapist adopts, it should be consistent with the cultural expectations of the survivor (Kinzie, 1989).

Primary needs

Certain basic needs are shared by all human beings. Some are more important than others. The United Nations Declaration on Human Rights includes (among others) the rights of "life, liberty and the security of the person", "the right to work", "food, clothing, housing and medical care". These constitute primary needs and in many countries (including the UK), where the convention has been ratified, these have formally been adopted as rights.

Wherever survivors of torture are to be found – in the country of torture, a neighbouring country or in a more remote context – these matters are always important. Thus, some people may be living undercover in a country of persecution, in fear, with families split apart. Others may be in large refugee camps, over the frontier, often for long periods, sometimes experiencing continuing covert persecution from violent groups. A few find their way to countries like the UK. Here, they often face extremely long delays before their applications for asylum are finally resolved and may spend substantial periods in detention centres or even in prison.

A psychiatrist should be able to acknowledge the importance of these primary needs. Quite often, in a multi-professional team, others will be charged with offering assistance with some of the practical aspects. However, a psychiatrist working with refugees should develop a sufficient familiarity with the law on asylum to be able to offer relevant professional advice to those charged with making decisions about asylum, family union and (in the interim) welfare needs. He or she should be sufficiently up to date on, for example: the complex matter of memories after severe trauma (including issues related to basic threat perception); problems of concentration in depression and PTSD; the way that people who have been raped or sexually abused often find this a shaming experience that they are reluctant to discuss (e.g. van Velsen *et al*, 1996); and the nature and importance of dissociation and chronic hyperventilation in torture survivors. Each of these issues stands to affect the competence of the survivor to provide a detailed, accurate witness statement, and may have a direct bearing on the adjudication of their case.

Often, a psychiatrist is in a unique position to comment on these technical matters in relation to any psychiatric disorders that may be present. Once again, care is required in order to ensure that the psychiatrist is serving the court and aims for the highest professional standards. It is through providing the best available evidence that fair and just decisions are most likely to be made over the long term. Unfortunately, this is an area in which few psychiatrists or other health professionals have had any formal training and in which standards of practice are often low (sometimes very low indeed). It relates to an area of primary need (safety from unjust persecution) and, bearing in mind the significance of the decision, it is vital that the best advice is made available.

Specific intervention

A number of discrete approaches to treatment have been developed. None has been adequately evaluated with this patient group and many are offered in the context of integrated treatment programmes, including medical care, dental care, physiotherapy, and psychosocial and legal support. A number of approaches have been advocated, but there is little evidence on which to make a decision. A recent meta-analysis (Sherman, 1998) of the psychotherapeutic treatment of PTSD concluded that broadly cognitive–behavioural approaches were the best supported by evidence, but also pointed out some of their limitations. Another meta-analysis (van Etten & Taylor, 1998) came to a similar conclusion but also highlighted the potential value of eye movement desensitisation and reprocessing (EMDR; Shapiro, 1995). In the context of torture survivors, PTSD is only a part of the possible psychopathology, and a broader range of approaches is almost always appropriate. This depends on the individual assessment and the diagnostic formulation. However, in this article I will restrict myself to: (a) a technique called 'testimony'; (b) other cognitive–behavioural approaches; (c) pharmacotherapy; and (d) family and group approaches.

Testimony

The testimony method was first used in Chile. It attempts to achieve a written record of the experiences of survivors, a record that is theirs to possess and to use as they wish. Gradually its therapeutic benefits became apparent and it then provided a model for psychotherapy. Its central tenet is the re-telling of the trauma story. However, the treatment is structured so that after a period of establishing

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trust, the sessions are tape-recorded and transcribed. These transcripts are the material of future sessions and are revised and developed by the survivor until at the closure, there is a comprehensive account. The survivor is an active participant in therapy, the therapist's role being one of clarification, encouragement and witnessing. By developing a complete picture from fragmented sequences, patients can learn to "identify, understand, and integrate the meaning of their political commitment and their suffering" (Cienfuegos & Monelli, 1983).

This method has been modified for use in host countries (Agger & Jensen, 1990). As testimony proceeds, psychological reactions such as aggression are addressed and symptoms are 'reframed'. For example, the guilt (associated with excessive responsibility) felt after divulging information against comrades or family can be reframed as understandable, perhaps even inevitable, in the face of extreme pain and powerlessness. Testimony typically lasts between 12 and 20 weekly sessions. Agger & Jensen (1990) stress the importance of using and maintaining refugees' political commitment and ideology in therapy. In other words, this is an approach that combines direct therapeutic exposure for the trauma (useful for PTSD) with complex reattribution of meanings to events. It takes account of the socio-political context, making it an acceptable approach for many survivors, as well as using effective ingredients of treatment for PTSD. An open trial has provided evidence of symptom reduction following an average of six out-patient sessions using testimony (Weine *et al*, 1998).

Cognitive–behavioural approaches

The fear response, triggered by cues resembling the original trauma, may be a persisting reaction to torture. Methods that tend to lead to habituation of this response would be expected to be useful in recovery and the evidence is that this is the case. Meta-analyses (Sherman, 1998; van Etten & Taylor, 1998) have shown that the trial evidence supported cognitive–behavioural approaches for PTSD.

These methods often include a strong element of direct therapeutic exposure – in much the same way as for other anxiety disorders – as well as a cognitive approach. Exposure-based approaches in PTSD have included asking survivors to audio tape sessions. They are asked to recount in detail, in the present tense and in the first person, what happened to them. Later, they are asked to replay this material as homework.

The question that has to be addressed is the degree to which these approaches are useful in the aftermath of torture. Basoglu (1992) has stressed the importance of not overwhelming the patient by covering too much material in one session, as this may interfere with emotional processing. Sherman (1998) also points out some of the limitations of the exposure paradigm.

At this stage of knowledge, no dogmatic statement can be made. However, an emphasis on control strategies (teaching people how to deal with high arousal, how to use the 'place of safety' paradigm and how to control dissociation) is likely to be especially important in the early phases of treatment in the aftermath of torture in those who do have PTSD. Exposure approaches should be introduced slowly, if at all, and monitored carefully.

There is another aspect of the exposure paradigm that may be problematic. Where shame or guilt are the dominant emotional reactions, it is possible that exposure may have the perverse effect of sensitising people to these states rather than leading to habituation. In these situations, a cognitive approach, exploring carefully the meaning of the trauma, and the distorted thinking that the torturer may have produced, is much more appropriate. This analysis is consistent with the analysis of testimony – that there is a need to combine sensitively direct therapeutic exposure and reframing or cognitive restructuring.

Pharmacotherapy

In the aftermath of torture, perhaps more than in other trauma reactions, medication undoubtedly has a place. In the presence of a depressive reaction, it has all the values of treatment of that condition. Some patients experience the usual barriers to the treatment of depression, including a failure of recognition and the half-hearted use of medication once the decision has been made to use drug treatment. However, there is one specific barrier in this group and this relates to the reaction of the doctor. Although the cause of the depression is clear enough in most cases, and it is understandable psychologically, this is no more reason to avoid treatment than it would be in the depression of terminal cancer.

There is increasing evidence to show that severe trauma can produce long-lasting neurobiological changes – especially implicating mechanisms of arousal, threat orientation and perception – and that these are associated with the clinical syndrome of PTSD. There is good evidence that antidepressant medication can be an effective method of treating this disorder as well as depression (Turner, 1999).

To date, there have been no controlled trials examining the efficacy of medication in the treatment

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of torture survivors. The current literature consists of open trials and case reports and thus treatment remains empirical. Two points need to be mentioned before describing drug treatments. First, cultural aspects of psychopharmacology need to be taken into consideration when prescribing for survivors; it has been suggested, for example, that side-effect profiles may vary. In addition, since many patients continue to show problems of adjustment, medication is appropriately given in combination with some sort of psychotherapy, for additional therapeutic benefit.

There is evidence of effectiveness of traditional antidepressant medication in the treatment of PTSD (e.g. Solomon *et al*, 1992). More recent work has indicated that reversible monoamine oxidase inhibitors (Katz *et al*, 1995) may also help but that the selective serotonin reuptake inhibitors (SSRIs; Davidson & van der Kolk, 1996) may be of particular value (van Etten & Taylor, 1998; Foa *et al*, 1999). Minor tranquillisers do not have any place in the routine treatment of PTSD. Randomised controlled trials suggest that clinicians need to be prepared to prescribe medication at doses towards the top of the therapeutic range and to wait for up to eight weeks before deciding that a particular approach is ineffective.

Family, group and other therapies

For survivors of torture, having an intact family is a blessing that many do not experience. All too often, families are separated. This may occur in the country of torture, with one or more family members in hiding. It can also affect refugees. Many refugees have described the feelings they have when they come to the UK, believing that their case would be settled quickly and that their family would be able to join them shortly afterwards, only to find that this was nowhere near the case. This is the material for survivor guilt.

Where families have been united, they may have had very different experiences. A family approach may provide a useful component in overall treatment (Figley, 1988). Family and marital therapy may be required after the family has been reunited to resolve conflicts and allow re-integration.

Expressive approaches such as play, music and art therapy may be useful in children and adults, both for assessment and treatment. There is no good evidence of efficacy, however.

For a number of reasons, group therapy has not been widely used with torture survivors, and its possible benefits have not been evaluated in any systematic way. From the practical point of view, groups in countries of asylum may lack cohesiveness, being made up of people from differing political, ethnic and linguistic backgrounds. For some, talking about personal problems in a group context is a foreign concept, and is not a culturally and politically acceptable treatment option. Despite these limitations, Fischman & Ross (1990) have developed a model for time-limited group therapy for exiled survivors of torture. They suggest that members should be as homogeneous as possible, and have shared a similar type of experience. The authors stress the importance of placing traumatic experiences in the appropriate socio-political context.

In the context of marital treatment, especially, it is important to be aware that sexual torture is widely perpetrated (against both males and females), although it is commonly not disclosed initially and may even be denied. There are often pronounced feelings of shame. Treatment must take into account the confusion and threat to sexuality that it represents (Agger, 1989). Even where specific sexual torture has not taken place, sexual difficulties appear to be common.

The setting for effective treatment

It is hardly surprising that there has been little controlled evaluation of different therapies in relation to the torture survivor, since the problems are complex and demanding. None the less, this is the only way that this area of practice will develop. Moreover, the common elements of the therapeutic process have yet to be clearly defined.

Treatment of torture survivors is greatly complicated in a bicultural setting. Since the newly arrived asylum seeker may be unable to speak the language of his or her adopted country, interpreters or (preferably) bicultural therapists become essential components in the process of assessment and treatment. They should not act merely as translators, but as culturally appropriate and empowered agents operating with a therapist (interpreter) or independently (bicultural therapist), allowing a clearer understanding of both verbal and non-verbal communication and evaluating the cultural significance of what is being said (Mollica, 1988; Kinzie, 1989). It goes without saying that a particular therapist, interpreter or bicultural worker should be acceptable.

Recent experience (in the Traumatic Stress Clinic) in establishing a bicultural project for the Bosnian community emphasises the value and acceptability of this approach. By placing this bicultural project within a specialist National Health Service (NHS) unit, the therapists also had the advantage of easy

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access to experienced clinical psychologists and psychiatrists. This is a model that certainly merits further research.

Therapy should take place as far as possible in a setting of physical and emotional safety. Delays in obtaining refugee status must be seen as barriers to effective therapy (van der Veer, 1992). At all stages, careful explanation and education are required, and anything resembling interrogation should be avoided. Thoughtful consideration is needed before performing physical examination or investigation, as procedures such as venepuncture, electrocardiogram or electroencephalogram may provide uncontrolled reminders of the torture experience.

Finally, there is the issue of treatment in a hospital setting. Admission to an in-patient unit is entirely appropriate in the unusual situation of a psychotic condition. However, for severe depression or for PTSD, it is a solution with its own problems. Imagine how it might feel to be an asylum seeker, a survivor of torture, confused at the delays, worried about family, unable to speak naturally (if at all) in the host country's language, and then to be admitted to a typical in-patient unit mixing with people who are psychotic, sometimes disturbed in thought and behaviour. It can be a terrifying experience and one that may serve to distance people further from channels of support, rather than to make these more accessible. Great care must be taken in considering this option in people who are not psychotic and in need of treatment for this condition. Instead, attention to mobilising social support networks outside hospital is more likely to be useful and is to be strongly preferred.

Barriers to successful treatment

There can be significant barriers to accessing health care. These include the lack of knowledge of the newly arrived refugee and the fear or hostility of some health professionals in countries of torture.

In clinical practice in the UK, it is the prolonged fear of the asylum seeker, whose case often passes through various levels of adjudication, that poses the biggest barrier to treatment. The process of initial decision-making is, sadly, often rather crude, and people whose cases are finally accepted may still have long delays and face extreme worries.

To take one example, a woman who has been serially raped as part of her experience of imprisonment – not because of any crime but because of her ethnicity – may find this an extremely difficult matter to disclose to officials, who do not always appear especially interested in her case. She has experienced an extreme form of violence and may be desperately afraid of what will happen to her if she is returned. However, if she has failed to disclose her rape in the initial interview, subsequent disclosure is often dismissed as indicating only that she has been helped to fabricate her case – in other words, it counts against her.

She may well have all the psychological characteristics of a rape survivor, but it is not routine for UK authorities to collect expert medical evidence in such cases. Evidence obtained by her representative (if she has one) may be hard to gather, may not initially be of expert quality and is often treated with suspicion. Instead, she has to endure long delays while her case passes through the system, and it is in this state that a psychiatrist may be asked to see her. This can seem an interminable period and be associated with profound fear. It can be hard to start any form of treatment in this condition and the initial focus is more likely to be supportive.

Re-integration

This is hard to achieve with refugees. It is a truism that refugees are people who want to return to their homes. (They have been forced into exile.) Yet, for many this is impossible and is likely always to be unsafe. People are left in an ambivalent state of mind, wanting that which they cannot have and feeling alienated in the community they do have. It is certainly a component of recovery to be able to learn the language and mix and integrate with the indigenous people. An emphasis on education and integration into prevailing health and social care systems is an important part of recovery.

Conclusions and implications for future research

Significant social and political sequelae, affecting survivors, families and whole communities, need to be considered when drawing up a treatment formulation. Only a minority of survivors actually reach the door of the mental health professional. The majority become survivors without treatment; indeed, it may be as beneficial to look at reasons for this in terms of individual, family and cultural factors as to ask what discrete ingredients seem to work in the minority who do seek treatment. Community, political and religious groups probably provide the majority of support and treatment.

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It has already been argued that there is a need to develop good research trials to guide the development of treatment in this complex area. Ethical research should be combined with attempts to improve public awareness of torture and the authorities' appreciation of the pattern of reactions and their significance to the assessment processes. However, most importantly, we need to examine ways in which torture can be prevented (Barudy, 1989; Allodi, 1991). As health workers, we also have a duty actively to resist medical involvement in the torture process.

In this paper, I have described an approach to developing a treatment plan. The complexity of the diagnostic pattern, the need to consider not only specific treatments but also the domains of primary need, and the process of re-integration have been emphasised. Finally, the settings of treatment and barriers to successful interventions have been described. It is likely that further work here will be rewarding. The development of bicultural therapists working at the heart of mainstream NHS mental health services is likely to be one particularly fruitful line to follow.

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Multiple choice questions

1. In the UN declaration, the following are included as human rights:
   a medical care
   b right to work
   c food
   d clothing
   e housing.

2. Regarding treatment of emotional disorders in refugees:
   a there is randomised trial evidence that cognitive–behavoiural therapy CBT is an effective intervention

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b it is essential to disclose the full trauma history at the outset
c exposure techniques should usually be a first step in treatment
d antidepressant drugs are often effective in reducing symptoms
e primary needs should be addressed early.

3. The phases in the treatment of people with PTSD (according to Herman) should always include:
a attention to safety
b group therapy
c re-integration
d regression to the trauma
e testimony.

4. Testimony:
a was developed in Chile
b involves the production of a narrative
c involves the production of a mock will
d includes direct therapeutic exposure
e has shown positive results in an open trial.

5. In enduring personality change after a catastrophic experience:
a changes are seen as permanent and irreversible
b there is a mistrustful attitude to the world
c vivid flashback experiences are typical
d a recognised cause would be a car accident
e there is a chronic feeling of being 'on edge'.

MCQ answers

1	2	3	4	5
a T	a F	a T	a T	a T
b T	b F	b F	b T	b T
c T	c F	c T	c F	c F
d T	d T	d F	d T	d F
e T	e T	e F	e T	e T

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