Problem Underrecognized

Torture *from page 1*

dra Crosby, assistant professor of medicine at Boston University, 142 foreign-born patients were screened at a primary health care clinic. "Fully 11% of participants reported a history of torture that was consistent with the [United Nations] definition of torture," wrote Dr. Crosby and her colleagues. Yet only 39% of these reported that their health care provider had ever asked about torture (J. Gen. Intern. Med. 2006;21:764-8).

Dr. Alejandro Moreno led the second study, conducted at the Boston Center for Refugee Health and Human Rights. In a 3-year period, the center cared for 146 refugees. Of these, 84% reported being tortured in their home country. More than 70% had major depression and 58% exhibited symptoms of posttraumatic stress disorder (J. Immigr. Minor Health 2006;8:163-71).

The Danish study included 142 people seeking political asylum in that country. Of these 45% reported having been tortured (Torture 2008;18:77-86).

Part of the problem of underrecognition may be America's cultural-centric way of looking at the world, said Dr. David Bedell, a Lone Tree, Iowa, family physician who spent nearly 10 years working in El Salvador during the height of that country's civil war. Although he now works in a region most would consider "typical America," he continues to meet patients whose past lives are anything but typical.

Dr. Bedell, who is also a clinical associate professor of family medicine at the University of Iowa, Iowa City, sees a surprisingly diverse population of patients from Mexico, Central America, and Bosnia.

"Every state is getting a huge growth of immigrants," he said. It's not unusual for cities to have dense clusters of immigrants from the same country. "People tend to move where they have family or friends already established," he said.

As their patients become increasingly diverse, family physicians must diversify their diagnostic skills, he said. Survivors of torture may present with a complex pattern of physical and psychological symptoms, or they may come in simply for routine health needs, but few will volunteer to share that part of their past.

Trust is the foundation of sharing, which is the only path to recovery, he said, relating the story of a young woman from Central America who came to him for prenatal care. She answered no to a routine initial question about domestic violence, but a different picture emerged over the course of her pregnancy.

"As she began to trust me, eventually she started talking about how she had been imprisoned and raped. She described the pressure and humiliation she felt, and how she lost her self-respect and began to feel that somehow, the torture was her own fault," Dr. Bedell said.

The United Nations defines torture as the infliction of severe pain or suffering, either physically or mentally, to punish or to obtain a confession or information, done by or with the consent of a public authority. Torture methods, however, do not only include direct physical or mental abuse, Dr. Engberg said.

"One very effective method is to force a person to watch another one being tortured, or to threaten harm to that person's children, parents, or friends," she noted. Sleep deprivation, isolation for long periods, and mock executions are other methods that don't leave physical signs.

Whether the torture is direct or indirect, it affects people in similar ways. "Patients can present with a complex picture of somatic and psychiatric illnesses," Dr. Engberg said. "They may present with musculoskeletal pain, neurological, psychological, and emotional problems. Sleep [disorders], depression, cognitive problems, sexual dysfunction, and substance abuse are also common."

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It's common for these patients to have nightmares or anxiety or to become aroused and frightened at things that don't seem particularly threatening to anyone else. "In taking care of their normal health problems, you are going to know that something is going on underneath," Dr. Bedell said.

Others, however, do not have obvious symptoms "and you'll have no idea of their history unless you ask," he said. Because of the reticence to disclose, both Dr. Bedell and Dr. Engberg recommend screening for torture in certain high-risk groups. "I wouldn't advocate asking every patient who comes into your office, but I do think there has to be an increasing awareness as we become a more global community," Dr. Bedell said.

Dr. Engberg said that screening is most appropriate for specific groups: "Those who are refugees or have political asylum status, for instance, and those who are from a minority group in their native country or who belong to a minority political party. If the country has been in civil war, if the patient has lived in a refugee camp or been a prisoner of war, or has been involved in an antigovernment movement, all are at risk of having been tortured."

Dr. Bedell approaches the subject of torture in much the same way he does that of domestic abuse. One strategy is to ask whether any of the patient's friends or family members have been tortured. "If they do say they know someone who has been tortured, you can follow up on it gently." Ask about symptoms of PTSD, and if those are positive, then over time, "you will want to find out more about the experience that caused it," he added. ■

Disclosures: *Dr. Bedell and Dr. Engberg reported having no conflicts of interest.*

Vets' PTSD, Depression Worsen During Year After Combat

BY MARY ANN MOON

FROM THE ARCHIVES OF GENERAL PSYCHIATRY

Instead of fading as time passes, mental health problems, including posttraumatic stress disorder and depression, actually increase late in the year after combat veterans return from serving in Iraq, according to a report in the June issue of the Archives of General Psychiatry.

In a cross-sectional study of more than 13,000 returning veterans of ground combat, both PTSD and depression not only persisted, they actually increased between 3 months and 12 months after return from duty in Iraq.

"Despite efforts to systematically assess soldiers following deployment, dispel stigma, encourage treatment, and improve access to care, the prevalence rates . . . showed increases. . . . These data make clear that at 12 months, many combat soldiers have not psychologically recovered," said Jeffrey L. Thomas, Ph.D., Walter Reed Army Institute of Research, Silver Spring, Md., and his associates.

PTSD and depression both were associated with increases in aggressive behaviors and misuse of alcohol in these patients, and half of those affected reported serious functional impairment. Since it is "a virtual certainty" that veterans who remain in the service will have to deploy again to combat zones—usually after 1 year of "dwell time" away from combat—"a sizable proportion" will be struggling with their symptoms when they redeploy, the investigators noted.

Dr. Thomas and his colleagues collected anonymous survey data from 4,933 active-duty soldiers at 3-4 months after they returned from ground combat, 4,024 active-duty soldiers at 12 months after return, 2,684 National Guard soldiers from ground combat units at 3-4 months after return, and 1,585 National Guard soldiers from the same ground combat units at 12 months after return.

The researchers assessed PTSD symptoms (collected on the 17-item PTSD Checklist) according to seven case definitions of the disorder, as well as depression symptoms (collected on the 9-item Patient Health Questionnaire) using three case definitions of depression.

From 8% to 14% of all soldiers reported serious functional impairment because of either PTSD or depression symptoms 1 year after returning from combat, Dr. Thomas and his colleagues said (Arch. Gen. Psychiatry 2010;67:614-23).

With the least stringent diagnostic criteria, PTSD prevalence 1 year after return from active combat ranged from 21% to 31%. With the most stringent criteria, which included only patients with high symptom rates and serious functional impairment, PTSD prevalence ranged from 6% to 11%.

The least stringent diagnostic criteria yielded a depression prevalence rate at 1 year from 12% to 16%; with the most stringent criteria, depression prevalence ranged from 5% to 8%.

National Guard soldiers had a higher prevalence of both disorders than did active-duty soldiers by all criteria and at all time points. The estimated prevalence of either depression or PTSD based on strict DSM-IV criteria was 23% for active-duty soldiers and 28% for National Guard soldiers at 1 year.

This difference is likely related to the fact that National Guard soldiers immediately return to civilian life upon return from combat duty, so they must make a more difficult adjustment, have less access to veterans' health care, and have less support from combat-exposed peers than active-duty soldiers who remain in the military, the investigators noted.

Comorbid aggression and alcohol misuse were common across all case definitions, with approximately half of soldiers who had PTSD or depression reporting that they had kicked or smashed something, slammed doors, threatened someone with physical violence, gotten into a fight, needed to cut down on their drinking, and had drunk more than they meant to since returning from combat.

"These findings indicate that it may be beneficial to screen for alcohol and aggressive behaviors when soldiers present for treatment of PTSD or depression," Dr. Thomas and his associates said. ■

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