Presentation of Recent Torture Survivors to a Family Practice Center

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A case series of three patients who recently arrived from Guatemala with histories and examinations consistent with torture is reported. A description of the clinical presentation of torture survivors is given, with recommendations for care by the family physician. The epidemiology and prevention of torture and human rights abuses are discussed. Survivors require interventions in the following spheres: biological, ie, physical signs of trauma; psychological, eg, post-traumatic stress; and social, ie, international prevention of torture by governments.

KEY WORDS. Torture; human rights; refugees. *(J Fam Pract 1997; 44:209-212)*

Practicing family physicians may encounter refugee patients who have survived torture in their country of origin. Most often, these patients present with physical signs or psychological effects: anxiety, insomnia, depression, or the classic presentation of post-traumatic stress disorder (Table 1). Three patients were treated at the Department of Family Practice clinics of Cook County Hospital in 1996 for a variety of manifestations of recent torture. They illustrate the diversity of presentation and the profound effects torture can have on physical and mental health.

Case Presentations

Case 1: In January 1996, a 34-year-old Central American refugee suffering from anxiety and depression was referred to a family practice training site of the Cook County Hospital Family Practice Department. On further questioning he was found to have been subjected to arbitrary arrest and torture by the military government of his country of origin. During his interrogation he was held incommunicado and had a testicle crushed. During this time three of his brothers disappeared as well. He was forced to watch 15 soldiers attack a village, executing a group of children, without being able to respond. He was able to escape the country after living in hiding for 2 years. His level of anxiety does not allow him to function in society. The status of his asylum petition is uncertain, although supported by examinations at our health center.

Case 2: A 35-year-old woman was seen in the Dr Jorge Prieto Family Health Center after having escaped detention by the military in Guatemala. She

TABLE 1

Symptoms of Post-traumatic Stress Disorder

The traumatic event can be persistently reexperienced
Intrusive recollections of the event
Distressing dreams of the event
Reliving the experience
Intense psychological distress at exposure to new events that may symbolize or resemble an aspect of the trauma
Persistent avoidance of stimuli associated with the trauma
Efforts to avoid thoughts or feelings associated with the trauma
Efforts to avoid activities that arouse recollections of the trauma
Inability to recall important aspects of the trauma
Diminished interest in activities
Feelings of detachment from others
Restricted range of emotions
Sense of a foreshortened future
Persistent symptoms of increased arousal
Difficulty falling or staying asleep
Irritability and hypervigilance
Difficulty concentrating
Exaggerated startle response
Physiological reactivity

Adapted with permission from *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.* Washington, DC: American Psychiatric Association, 1994.

Submitted, revised, December 6, 1996.
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reported that she had been abducted 2 months earlier, at which time she was raped multiple times, struck repeatedly, and subjected to cigarette burns over much of her arms and legs. After having been transported out of Guatemala by family members, the patient was referred to the family practice center for anxiety and acute infections of the multiple wounds. She was seen jointly by a family physician (T.G.) and a family therapist (A.M.) for acute care as well as psychotherapy for PTSD.

Case 3: A 30-year-old Guatemalan man was seen at Cook County Hospital 1 month after having been brought to a police station in Guatemala, where he was interrogated and beaten severely. He was seen in the Cook County Emergency Center and was found to have recent healing wounds, a ruptured left tympanic membrane, and tenderness of the abdomen, arm, leg, and pelvis. Radiography showed a fracture of the 11th rib, but otherwise his chest was normal; findings on a computed tomography scan of his head were normal.

Discussion

Perhaps the most devastating experiences refugees can face, even beyond starvation, war, detention, and loss of family, is torture. Torture is defined as ". . .the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason."[1] More than 100 countries of the world practice torture, according to a report from Amnesty International in 1994.

Torture can be understood as the methodical destruction of personality, family, formal and informal institutions, and community in order to control persons and communities that a government considers dangerous to its interests. We estimate that for every person who was physically tortured, five have been psychologically tortured. For example, when the military in Guatemala "disappears" a father, his wife, children, extended family, and friends are psychologically tortured and prone to develop psychological symptoms.[2] The rebuilding of these elements is key in treatment. Cases are often not recognized, in part because of the hesitation of victims to report the abuses, as well as the tendency of health care providers to psychologically withdraw from the survivor. One source estimates that of foreign-born patients seen in large urban health maintenance organizations, 5% to 10% have been tortured.[3]

Clinical Presentation

Torture survivors commonly present with both physical and psychological sequelae of trauma. Among psychological effects, most common are anxiety, insomnia, depression, and post-traumatic stress disorder (PTSD). Originally known as "shell shock" and "battle fatigue," patients with PTSD experience persistent intrusions of unwanted memories, anxiety, and nightmares.[4] Researchers have developed a screening instrument for PTSD for use with refugees.[5] Patients often experience symptoms of hyperarousal[6] (Table 1). Torture survivors may attempt to avoid triggers of the memories, leading to a numbing of emotion, or, conversely, may place themselves at risk for further trauma. Torture survivors are often unable or afraid to divulge their experiences to physicians or others viewed as authority figures, because of uncertain immigration status and because governmental authorities as well as physicians in some countries were involved in their torture. Finally, survivors of torture may present only with chronic pain, headache, depression, or somatic complaints, particularly if the torture they experienced took place in the remote past.[7]

The types of torture most commonly inflicted have been documented, with beatings, humiliation, and application of electricity predominating.[8] The physical sequelae are determined by the type of abuse suffered by the survivor[9] (Table 2). For example, *falanga* (repetitive striking of the soles of the feet) will produce damage to the foot and the ankles. Recurrent pulmonary infections, gastrointestinal effects of trauma and contaminated food, hematuria, musculoskeletal injuries, and head and ear trauma are common. Electric shocks can produce characteristic scars and in some cases cardiac arrest. Female victims are often subject to rape, venereal diseases, mutilation, and miscarriage.[10] These abuses are often not reportable in the country of origin and frequently not recognized later. In most cases, little physical trace of torture remains, as more sophisticated techniques conceal its use.

Primary Care for Survivors

Family physicians can implement several specific interventions. They may represent the only medical contact with the torture survivor. The first step in the

approach to possible survivors of torture is demonstration of empathy. A detailed description of the violence inflicted (debriefing) may or may not be indicated at the initial visit, but openness to hearing the history is important. Although describing the trauma experienced may provide relief, the emotional expression also may lead to an acute crisis or reliving of experiences, necessitating urgent consultation by an experienced therapist. The family physician can ask refugees why they left their country of origin and whether a trauma has been experienced. Knowing about the country of origin can at times indicate to the physician patterns of torture induced by specific repressive regimes. Finally, the physician should attempt to convey a belief in the reality of violence and victimization and our collective vulnerability. It should be communicated that this violence is unacceptable and that the role of the state is to *protect* individual safety.

Treatment of physical problems is best accomplished by a multidisciplinary team, often including psychiatry/psychology, social work, nursing, and other specialties such as orthopedics. Appropriate screening tests and radiologic studies depend on area of origin and risks (PPD, hepatitis B, VDRL, HIV, ova and parasites). In the acute stage after trauma, benzodiazepines may be needed to reduce PTSD symptoms, but should not be used indiscriminately. Alternatively, tricyclic antidepressants may be indicated for depression or chronic pain, in addition to support, rest, relaxation (individual or group), and physical therapy.[11] Self-help groups with other refugees or survivors are useful.

Sophisticated torture techniques often include the constant repetition that no one will believe the victim. A caring, supportive and nonjudgmental approach by the family physician will help stop the voice of the torturer saying that "no one cares." Many survivors of torture feel that they are "going crazy." It is important to normalize these symptoms by telling them that these symptoms are reactions to an abnormal social situation. Torture survivors can be helped to find ways to reassert control over medical decisions, their own symptoms, and their lives after this experience of extreme powerlessness. Support for primary care services for torture survivors and other refugees is required, particularly in view of recent state initiatives attempting to limit access to health care for undocumented immigrants.

Social and Cultural Environment

Survivors need to rebuild social and family relationships to regain the network of social and cultural structures that sustain us. Often, traditional societies have extended families and communities that provide a supportive, healing environment that values the strengths needed to survive traumatic experiences. Involvement in the cultural and political activities of their communities may allow survivors to reconnect and integrate while rejecting specific abuses of human rights. Recognition of survivors by physicians on their first encounter is difficult, as patients tend to withhold sensitive political information. By having an understanding of the immigrant community and its relationship to service agencies, the family physician may have cases referred by fam-

TABLE 2

The Health Effects of Torture

Psychological/family	Depression, irritability, substance abuse,adjustment disorder, anxiety
Skin	Bruises, scars from burns and injuries
Cardiopulmonary	Chest trauma, rib fracture, infections
Gastrointestinal	Splenic rupture, liver contusion, stress ulcer, weight loss
Urologic	Hematuria, hemoglobinuria
Gynecologic	Sexual assault, uterine bleeding, amenorrhea, breast injury, salpingitis, and pregnancy
Musculoskeletal	Acute contusion, fractures and dislocations; chronic back pain, myalgias, foot trauma and pregnancy
Neurologic	Postconcussion syndrome, convulsions, skull fracture, intracranial hemorrhage, subdural hematoma, headaches, memory loss, vertigo, paresthesias, nerve injuries
Otorhinolaryngologic	Ear injuries, deafness, tinnitus
Ophthalmologic	Conjunctivitis
Dental	Broken and lost teeth, gingivitis

Adapted from: The role of the physician and the medical profession in the prevention of international torture and in the treatment of its survivors. American College of Physicians. Ann Intern Med 1995; 122:607-13.

TABLE 3

Resources for Refugees, Torture Survivors, and Their Supporters

1. US Committee for Refugees, 1717 Massachusetts Ave, NW, Suite 701, Washington, DC 20036

2. Amnesty International, 322 Eighth Ave, New York, NY 10001

3. American Association for the Advancement of Science, 1333 H St, NW, Washington, DC 20005

4. Physicians for Human Rights, 100 Boylston St, Suite 620, Boston, MA 02116

5. American Refugee Committee, 2344 Nicollet Ave South, Suite 350, Minneapolis, MN 55404

6. The Marjorie Kovler Center for the Treatment of Survivors of Torture, 4750 N Sheridan, Chicago, IL 60626.

7. The Institute for Survivors of Human Rights Abuses, 1438 W Pratt, Chicago IL 60626.

ily and community members that otherwise would not have been identified.

The role of the family physician is to be supportive to survivors and to document and treat acute medical problems. The family physician also may be called on to document his or her findings for legal purposes, such as in support of application for political refugee status. Findings should be documented in a clear, detailed manner including radiography reports and photographs.[12] Conclusions should include whether symptoms and findings are consistent with the torture narrative given. Guides are available to assist in testimony preparation.[13]

Organized groups of physicians are actively involved in the protection of human rights through documentation of torture, protection of survivors and health workers, expert testimony, and epidemiologic and toxicologic analysis[14] (Table 3). The medical community has a responsibility to condemn torture and other human rights abuses and to support the survivors. Resources are available to assist in the examination and documentation of torture and human rights abuses.[15] Specific countries, for example, Guatemala,[16] Chile, China, and Iran, have demonstrated a frequent use of state repression against dissidents, union organizers, members of religious groups, and others. Prevention of such abuses must include eradication of the practice of torture by the international community.

Summary

Three cases of torture demonstrating physical and psychological sequelae are described. Common manifestations of torture are given, including post-traumatic stress disorder, depression, anxiety, and multiple types of wounds. The worldwide epidemic of torture demands a response on the part of the individual family physician, as well as a concerted international response to government-sponsored violence in many countries.

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