Physiotherapy with Torture Survivors

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Summary

With rising numbers of asylum seekers, and among them a significant number of torture survivors, physiotherapists are increasingly likely to receive referrals for patients with torture related problems. While torture survivors evoke compassion and the wish to help in health professionals, it is also easy to feel overwhelmed or underskilled in relation to the complexity of psychological and cultural issues, and to assume that they can only be treated in a specialised unit, such as the Medical Foundation for Victims of Torture. This paper explores the role of physiotherapists in the rehabilitation of such clients, through incorporation of psychological, social and cultural concerns in assessment and treatment procedures, so that their skills and knowledge are as accessible to this patient group as to any other.

Although the treatment of these clients requires a number of special considerations, the right care generally offers them the chance of remarkable recovery from both physical and mental traumas.

Introduction

The Medical Foundation for the Care of Victims of Torture ("The Medical Foundation"):  

- Provides survivors of torture in the UK with medical treatment, social assistance and therapeutic support.
- Documents evidence of torture.
- Provides training for health professionals, educators and others in the UK and overseas in working with survivors of torture.

Language and Culture

For torture survivors whose first language is not English, the presence of an interpreter is recommended and is often essential. Even when the client's understanding is fairly good, interpreting allows expression of subtler experiences and feelings. A skilled interpreter also provides a cultural and advocacy role, hearing or understanding words in a cultural context that can be shared before or after the session. Interpreting means the session takes longer and may result in the assessment taking more than one session to complete. The interpreter does not have to be of the same sex as the client but it is important to check sensitivities on this, particularly before any examination or intervention. Care should be taken when working with interpreters to ensure that all present understand and agree that confidentiality will apply to both physiotherapist and interpreter.
Setting

Hospitals as institutions can be reminiscent of prison or other torture settings. Being led down corridors by a stranger may provoke intense discomfort, even flashbacks, and if the patient brings a family member, trusted friend or advocate he or she should be able to accompany the patient (although not be expected to translate). Similarly, white coats, uniforms, and electrical equipment may recall torture experiences to patients. Awareness of this and particular care establishing trust and explaining procedures to the patients can help them to focus on the session and ensure there is no fear in returning for subsequent sessions.

Privacy and space are crucial in establishing trust and allaying fears of public humiliation, particularly if clients are required to undress. Deprivation of clothing is a common experience in the torture environment and being asked to undress can seem threatening. It may be helpful to provide or suggest bringing loose clothing for exercises, stretches, and relaxation sessions. Lying prone, for someone who has been tied or even raped in that position, can also feel quite threatening; again therapists should use judgement and check that clients are comfortable. If in doubt, delay that approach for one, two or even several sessions.

Therapists' Feelings, Clients' Fears

Torture evokes horror, avoidance, and a range of uncomfortable emotions, issues of asking versus not inquiring, needing to know a history without wanting to offend or re-traumatise. The clients have felt repeatedly failed by other people, acutely so in the horrific context of torture, and nurturing realistic hopes is important, if difficult.

Support for the physiotherapists themselves is valuable, whether debriefing with peers, opportunities for case discussion with colleagues, and/or supervision from psychologically trained colleagues, or reference to specialist centres like the Medical Foundation. Time to build a relationship, and to learn from the interpreter, pays off for physiotherapists and patients.

Common Torture-related Clinical Problems

It is well to remember that clients seen in the UK are indeed survivors. The range of violent traumas and areas of the body affected by torture are limited only by the extent of the wickedness of the torturers. The traumas are frequently repeated over months and years. The illustrations provided below are distressing but unfortunately common examples that physiotherapists may encounter.

The spine is frequently affected by beatings, often with early increased degenerative changes and severe postural problems among others. The neck suffers particularly if the victim has been tied to a chair and then beaten, which produces symptoms resembling those of whiplash.

Prison conditions (being kept squatting in a room with lowered ceiling or being rolled up inside a truck tyre are examples which have been encountered) may by themselves leave their legacy of dysfunctions which a physiotherapist may not normally encounter.
Hyperlaxity of the thoracic spine and symptoms in the shoulder girdles following hangings is a finding that may signify plexus brachial injuries of various degrees.

Feet beating can leave a high level of dysfunction, both with severe loss of mobility in the tarsal bones affecting arches and loss of elasticity of soft tissues.

Hyperventilation is a common disorder following either direct restriction on breathing (such as by a cloth pushed into the mouth) or as a pattern acquired under severe pain as an initial normal response to pain and intense stress and a way to dissociate from it (fainting, losing consciousness).

Headaches and sleep disturbances are also very commonly reported troubles.

Few of these horrific mistreatments necessarily leave a 'trade mark' but being aware of the circumstances of injuries helps physiotherapists to understand better the complexity of the findings.

Talking to clients in terms of dysfunction (inflammation, over-stretching, muscle weakness, loss of feeling, instability) will be more helpful than labelling diagnoses, and will also relate much better to the therapeutic intervention.

**Social and Psychological Background**

Many clients are in a precarious social situation and face urgent practical, financial or legal problems, or at worst a deportation order. The process of application for asylum due to persecution and torture is lengthy; people face many hurdles often over a period of years before their case is heard and their legal situation settled. Even without such problems, torture survivors are often in temporary and unsatisfactory accommodation, in casual work if working at all, cut off from family and others of the same culture, religion or political persuasion, and sometimes subject to racist abuse or hostility.

All these factors contribute to maintenance and exacerbation of post-traumatic stress problems and attendant problems in psychological and physical health. Items such as the length of imprisonment, the intensity of the abuse, solitary confinement, whether it was at an early age and so forth are all indications for the depth of the client's trouble and vulnerability and need for extra support.

If clients use sessions mostly to go over verbal material relating to their torture experiences, this can be an opportunity to explore with them the possibility of specialist psychological support or 'talking help' (counselling, psychotherapy, groupwork).

Without underestimating what simple listening may achieve, referral on to appropriate agencies to help is an important consideration. Support from groups from the same country of origin, whether social, political or religious, can also make an essential difference.

There can be a risk that psychological and social problems eclipse the physiotherapists' agenda, in which case the aim of the sessions and the skills of the physiotherapists need clarification, so that clients use them as effectively as possible for their overall benefit.
Assessment

Establishing trust is very important, in addition to the usual goals and tasks of assessment. Information may or may not be available through referral and/or medical report. Letting clients know what information is known and clarifying early the purpose of assessment is essential. The purpose of an NHS referral should not normally be medico-legal authentication of the report of torture; it takes time and expertise to make sense of the whole history, including knowledge of the country, background and historical events, as well as documenting symptoms and injuries.

A normal direct questioning style can recall interrogation. Instead, therapists can adopt an open listening and discussing style, picking up cues as they go along. Acknowledging experience, which may have been doubted or denied by others, can he done without insisting on a full account, but still leaving a door open for disclosure - eg 'I have read your referral by Dr X. I am aware of what you have been through and it makes very difficult reading. We do not need to go through a fully detailed history today, but do feel free to tell me anything you may feel would be useful at any time.'

It is important to assess pain in its own right, as it can be quite widespread and/or unfamiliar (unsurprisingly, as clients have often undergone multiple and severe maltreatment with which textbooks and therapists may be unfamiliar). Pain assessment should include degree of interference with daily life and goals. It is important to demonstrate belief in patients' reports of pain and dysfunction, however little they may accord with investigation results.

It can help clients if they understand that diagnosis does not necessarily lead to effective treatment, nor does lack of diagnosis imply untreatability. Sharing understanding of pain syndromes and possibilities of treatment enables provisional prognoses to be accepted.

Treatment Decisions

If clients are not at ease with a particular approach (too overwhelmed psychologically, unable to apply a technique due to a poor environment, etc), they may be able to use it later on; it is necessary to allow time for this (session time, number of sessions).

Relaxation should not be overlooked as a technique. The wide range of relaxation approaches available to physiotherapists can be explored: counting, hold/relax, feeling for support from the floor, visualising.

Combining gentle 'holds' with verbal techniques can help clients to let go better as well as provide them with useful proprioception, and at the same time give feedback to the therapists on how clients are progressing. Simple advice on sleeping positions, posture, footwear, etc all add up to substantial help.

Home exercising may be difficult in poor housing (cold, cramped, crowded, non-carpeted) but can still be aimed at and can be adapted. For example rolling a ball up and down a foot is simple and can help regain proprioception and mobility while being easy to carry out.
Mobilisations or electrotherapy are of limited value and sometimes unwise if used alone, but can be introduced to torture survivors if care is taken to leave space for proper understanding and agreement between physiotherapist and client. However, someone who has suffered electric shocks may obviously be very wary of an electrical machine and it certainly would not be a wise first choice. Techniques that involve physical touch can trigger flashbacks and panic attacks in early sessions, but can be introduced with care later on. Massage later on is equally useful alongside the relaxation process.

Classes (back pain management, hydrotherapy, Pilates, yoga, relaxation, etc) if available can often provide a larger less oppressive space than a small cubicle, although this has to be assessed individually.

**Conclusion**

This assessment/treatment/education/ self management continuum is lengthy and spread over time, making the average intervention with torture survivors much longer than normal. Each session may be longer, and will ideally include some briefing and debriefing with the interpreter at the beginning and the end. Allowance should be made for this, to maximise the chance of success of the intervention. The special needs of torture survivors need to be acknowledged by the physiotherapy department, so that interpreting services, time and flexibility can be provided.

Clients may have been denied any freedom during imprisonment and torture, and need extra leeway in expressing preferences and taking an active part in decisions to do with their health. In addition, it is rare for torture survivors not to face problems related to family and close friends, finances, housing, legal status, and psychological health, as well as physical difficulties. The accumulation of these factors increases vulnerability to further problems, and means facing existing difficulties with depleted resources. Goals may need to be modest, and progress recognised in even small changes.

Sessions can be positive experiences, which help clients to feel cared for, and to facilitate their care for themselves. This is a powerful part of healing and recovery overall for torture survivors.

**Further Reading**


Other Sources of information

Medical Foundation for the Care of Victims of Torture
96-98 Grafton Road, London NW5 3EJ, Tel 020 7813 7777, fax 020 7813 0011

Amnesty International
1 Eastern Street, London WC1 XODW. Tel 020 7413 5500

Refugee Action
3rd Floor, The Old Fire Station,
150 Waterloo Road, London SE1 8SB. Tel 020 7654 7700

Refugee Council
3 Bondway, London SW8.
Tel 020 7820 3085

Refugee Legal Centre
Sussex House, Bermondsey Street, London SE1 3XF. Tel 020 7827 9090

Key Messages

It is essential to have access to professional interpreters when working with torture survivors whose native language is not English.

Experiences of torture survivors are unusual and horrific but symptoms can be addressed so as to make a significant impact on the clients' quality of life.

Physiotherapists need to allow for the fact that treatment often takes much longer with torture survivors than with most other client groups even when presenting with similar symptoms.

Physiotherapists need to be sensitive to clients' histories and to try to select techniques that are unlikely to trigger flashbacks.