Physiotherapy for Survivors of Torture

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Summary

Physiotherapy plays a unique role in the rehabilitation of people who have been profoundly traumatised. Certain precautions are needed when handling survivors of torture, but sensitive physical techniques can relieve the legacies of severe pain, dysfunction and stress. The physical medium is especially effective for people who are unable to speak of their experiences.

Torture occurs in over 90 countries throughout the world, and the incidence is increasing (BMJ editorial), 1991. Survivors seek help from the Medical Foundation for physical, emotional and vocational problems. They are survivors in the true sense: it is thought that most people die under torture, but our clients have survived not only torture, but escape from prison, and journeys through minefields, border crossings - and UK immigration, which is itself an ordeal that triggers memories of interrogation and uncertainty. Being survivors, they are highly motivated; where else would we find people who actually do all the exercises that we ask of them?

Effects of Torture

Introduction

“The pain is not like ordinary pain. With this, something happens in your heart.” Working with people who have been tortured has similarities to working with intensive care patients. There is the need for acute sensitivity to the client's responses, an extra awareness of the importance of autonomy, and an understanding of issues of power and helplessness.

Physiotherapy forms a vital link in rebuilding the personality of survivors of torture because trust can be fostered in the context of physical contact. A physical therapist who subsequently trained as a psychotherapist said: “I often lament how laborious a task it can be to cultivate a relationship with a client when it was so much more accessible in my experience as a physical therapist”(Cimini, 1990).

Mr M's notes explained that after 18 months of psychotherapy, he has never been able to put his experience into words. No more can be expected of our first session than to establish communication, and perhaps lay a foundation for him to return for further treatment. Then Mr M begins to demonstrate contorted positions on the floor. The interpreter translates his descriptions of what they did to him. The horror of what he reveals contrasts with the coolness of his delivery. The reason that he feels safe to speak is because he knows that we will work on the physical level without expectation of emotional revelations. He is not yet ready for that. But he is passing a milestone today, in that he is speaking the unspeakable. He needs acknowledgement of this, he needs to know that someone will walk the path with him, he needs to be listened to and believed, and he needs help for his back pain.

Nothing encourages torture more than war, and the Gulf War swelled the numbers of people referred to the Medical Foundation for the Care of Victims of Torture.

Formerly torture was used to obtain information or inflict punishment. Now the aim is primarily to destroy the identity of the victim (Skylv et al, 1990). Survivors show normal reactions to extremely abnormal events. They need reassurance that these reactions are not signs that they are mentally sick, but responses that can be at least partly relieved.
Survivors suffer nightmares, phobias, intractable pain, social withdrawal and a sense of meaninglessness (Turner and Gorst-Unsworth, 1990). Feelings of guilt, powerlessness and weakness become their new prison (Jacobsen and Nesti, 1990). They may freeze in the street when they see a friendly British policeman.

Anger at the torturers has had to be suppressed, so it is often turned inwards and becomes depression, compounded by a deep sense of loss. Many have lost family, friends, self-esteem, culture, health and awareness of self. "We are men without shadows," one survivor commented. "I have become a zero," said another. It is as if both internal and external worlds have disintegrated (Bustos, 1990).

When I am with people who were not tortured I cannot speak because there are no words. It is so unusual an experience. You are facing something; out of mind, out of biology, out of nature.

The mere act of survival may bring guilt (Turner and Gorst-Unsworth, 1990). This is intensified if survivors' families or friends have been punished for helping them escape, or if they themselves have given away their friends' names under torture. Guilt is compounded by a sense of shame and humiliation, which adds to the difficulty of speaking about the experience.

Survivors diagnosed with the symptoms of post-traumatic stress disorder sometimes find that this identification helps to validate their experiences. Symptoms of the syndrome include sleep disturbance, flashbacks, rage, impaired memory and emotional numbing (Turner, 1991). It occurs when normal adaptive mechanisms have been overwhelmed so that painful feelings are avoided, at least intermittently. This prevents the processing of the experience so that the condition becomes chronic and often disabling. Survivors are locked in with their memories and there is little or no tendency to spontaneous recovery (Somnier and Genefke, 1986). Resolution is also hindered by loss of the client's familiar cultural mechanisms for expressing grief.

"It's there 24 hours a day, even when I'm laughing, I'm crying inside."

The Medical Foundation is one of 40 similar organisations world-wide, providing crisis intervention as well as long-term rehabilitation. A medico-legal service documents the physical scars, a task complicated by the increasing sophistication of the torturers.

The Foundation comprises a small administrative staff supporting a large voluntary team which includes social workers, psychotherapists, general practitioners, surgeons, physiotherapists and complementary practitioners. Specialist health workers will visit as required, including a dentist who works without instruments until the clients are ready to visit a surgery, normally a forbidding experience for someone who has experienced dental torture.

The Foundation provides a safe environment for survivors who cannot seek help in an ordinary hospital, where memories would be triggered by waiting rooms, cubicles, high ceilings, uniforms, instruments, electric leads, banging of trolleys, the drawing of blood and the process of undressing (Bloch and Muller, 1990). Some survivors find it difficult to seek help from a hospital because a doctor has been present during torture in order to signal to the torturers when they can and cannot continue. Despite its name, the Medical Foundation avoids medicalising torture. Survivors are not ill, are not called patients and are not well served by drugs, so the role of medical staff is to make reports and refer to appropriate therapy. No specific model is followed, and much creative work is done, including art therapy as a form of non-verbal expression, poetry therapy which helps to link words and feelings, and group therapy in which survivors rediscover their ability to help each other. There is even a vegetable allotment, which provides, in the words of a survivor, "a kind of relaxation from thinking" (Roe, 1991).

The Foundation works with the needs of each individual and it works with the families of survivors. One client said, "The best thing the Medical Foundation did for me was to find my four children."

Despite the seriousness of the circumstances, or perhaps because of it, celebrations and tea parties are frequent, especially when there is relief at the granting of refugee status to an asylum seeker, or a birthday. For clients and staff, humour provides an essential balance to the daily experience of coming face-to-face with the unthinkable. Humour is a potent stress reliever, for example when a client convulses in giggles at the sight of the interpreter.
falling asleep during a relaxation session.

**Teamwork**

Close liaison between physiotherapists and psychotherapists is needed in this area of work. There is also a wealth of knowledge and experience within the team of complementary practitioners. Skills include massage, aromatherapy, homeopathy, Alexander technique, naturopathy and movement therapy. An occupational therapist works in the community, teaching stress management techniques. Reflexology has proved particularly successful, perhaps because it acts as a reverse form of *falaka*, a form of torture which entails beating the soles of the feet. Sceptical clients are soon won over, but not all professionals at the Foundation understand reflexology, and the reflexologist was somewhat perplexed to receive a referral for a bi-lateral amputee!

We frequently indulge in the luxury of co-working. Some clients present with intractable problems that require a combined approach:

Mr G is an artist who escaped persecution in Turkey and now presents with neck and shoulder pain, difficulty in breathing and a severe stammer. Physiotherapy and speech therapy in isolation have had limited success, so the two are combined. Physiotherapy takes the form of general and local relaxation, awareness of breathing, control of breathing and release of breath-holding. Pain and tension ease, and Mr G's paintings begin to show brighter colouring. Speech therapy is then able to relieve his stammer. Now Mr G does not cease to delight verbally at his new freedom of expression.

Survivors respond well to the holistic approach, and it is a joy to watch clients who have been contorted with pain and tension as they gradually relax in the hands of a skilled practitioner.

*Falaka* leaves barely perceptible scars, so the examining doctor works closely with a physiotherapist or osteopath to identify subtle changes in soft tissue, posture or gait that may be the only evidence.

**General Treatment**

Mr E was a British prisoner of war in Malaya 50 years ago, where he was tortured after being discovered running a clandestine radio station for other prisoners. Broken arms were left unslinted. Later he was told that nothing could be done about the deformities. After physiotherapy at the Medical Foundation, he boasts that he can put his arms behind his back and over his head for the first time in decades.

The role of physiotherapy is to help heal physical damage, to relieve stress, and to act as a bridge between mind and body. Torturers have used physical means as a point of access to the mind, and the starting point of recovery is often by physical contact. This can release remarkable powers of self-healing in the clients. Survivors are also able to gain control over symptoms by means of breathing and relaxation, a significant step because they have experienced helplessness at a profound level.

When working with people who have been through an experience that is outside the normal range of human comprehension, we must maintain vigilance in order to avoid triggering their fear. The first session may involve no physical contact. Clients have lost trust at a fundamental level, and some are so hypersensitive that they feel as if their skin is raw.

Much discussion may be needed to explain what physiotherapy is, to clarify expectations, and identify methods of communication and practice that are culturally appropriate, including checking the normal custom for saying hello and goodbye. Questions which mimic interrogation are avoided. Questions such as “Was the damage here?” are more acceptable than “What happened here?” which obliges clients to describe difficult events.

Assessment may be spread over several sessions. It is useful for the practitioner to have a good memory because note-taking can cause anxiety in the client, who may fear that notes might get into the wrong hands.

Clients are informed that because of their previous experiences, they must not feel any form of pain or discomfort during assessment and treatment. They should inform
us if anything hurts and not try to be brave. Eye contact is maintained, if culturally appropriate, to ensure that no pain is experienced, and to build trust. When survivors know that they are given full attention, and they are believed and responded to, they become more open to acceptance of help.

Abnormalities in posture and gait are common, reflecting physical or emotional trauma or both. This is compounded by guarded body language and frequent foot injuries. For clients who have blocked out memories, their muscles still remember the trauma, and many present with an armour of muscles in chronic spasm. Home advice takes into consideration that clients are hampered by their living conditions, which may be one small room in a damp hostel, with sometimes no chair and a ceiling too low to stretch upwards. Other circumstances may hinder rehabilitation; for example, they may hear news from their families that a relative has been arrested, or they may receive a negative response for their application for asylum. One letter from the Home Office can wipe out months of steady progress.

Clients need an hour for each session, and regular appointments at the same time each week. After discharge, contact is maintained for as long as necessary. Interpreters can be a support for both patient and physiotherapist in that they help bridge the gap in culture as well as language. It is useful for the interpreter to be of the same sex and approximate age as the client.

Tips when working with interpreters are:
- Arrange the chairs in a circle.
- Talk to the client, not the interpreter.
- Avoid jargon.
- Use only a few sentences at a time.
- If any extra conversation is needed with the interpreter, explain to the client what is being said.
- Provide a screen if the client undresses.
- Have briefing and debriefing sessions with the interpreter before and after the session, which help to disentangle anomalies, for example some languages use physical descriptions for expressing feelings.

When survivors are able to speak about their experiences, our response is to listen and hear, and it is not always easy to hear what they tell us. Our job is to bear witness, and also to respect any denial that clients find necessary. We create an environment in which they feel able to talk, be silent, cry, be angry or even laugh.

Ms D is an Iranian poet who has withdrawn from social contact. Her facility with words allows her to express herself with moving clarity, but this articulate barrier of words paradoxically protects her from connecting with her emotional pain. During deep relaxation she remembers a moment when her torturers showed her a photograph of herself being tortured, and she is able to cry. She responds to treatment for her pain and hyperventilation and is now actively finding new friends.

Specific Treatments

After-effects of Falaka

Survivors of falaka suffer long-standing pain which increases on walking. Objective signs include tight anterior tibial muscles, fixed tarsal bones, pivoting gait and, when severe oedema has damaged the shock-absorbing soft tissue, lumbar pain. Chronic infection may have penetrated bones and joints because at the time of injury fellow prisoners sometimes cut open wounds to relieve the swelling. Palpation for tenderness is not done because we do not want to provoke pain.

The pain is responsive to a variety of techniques such as ultrasound and interferential in selected cases, mobilisations and deep massage, re-education of
Posture and gait, strapping, wobble board exercises, and a home programme to include contrast baths and exercise for the lumbricals and other muscles as indicated. Supportive footwear and shock-absorbing insoles may be supplied. The osteopaths have found treatment of the lumbar spine to be effective.

**After-effects of Suspension**

Suspension by the hands, sometimes for days, and sometimes with the arms twisted up behind the back, causes a litany of neuromuscular problems. Nerves have been compressed, muscles are atrophied or in spasm, and the acromio-clavicular and sternoclavicular joints are subluxed. There may be ischaemic contracture or paralysis. Treatment is aimed at reducing abnormal muscle tone, mobilising appropriate joints and strengthening selected muscles.

**Hyperventilation Syndrome**

Breathing disorders are common, and exacerbated if survivors have suffered suffocation or struggled at length to avoid screaming or speaking their friends’ names. One outcome is chronic hyperventilation, a syndrome which is common but notoriously under-diagnosed in the general public (Grossman and DeSwart, 1984) and particularly frequent in torture survivors. Over-breathing heightens most forms of perception, but paradoxically enables a degree of dissociation from pain. Once the survivor is released from prison, however, hyperventilation no longer serves its original purpose, and produces alarming signs that can mimic myocardial infarcts, strokes and epilepsy.

Symptoms are irregular, paradoxical, sighing, cogwheel or statue breathing, and a kaleidoscope of other signs and symptoms throughout the body (Hough, 1991). Seemingly insignificant events such as being in an enclosed space or hearing an electric gadget can set off a vicious cycle of anxiety and hyperventilation.

Ms T presents with fatigue, insomnia, air hunger, feelings of a weight on her chest, uncoordinated gait and upper limb weakness that has left her dependent on her husband to look after their children. She says “My breathing feels separate from me, as if it’s someone else’s breath.” She relates the onset of her symptoms to watching a friend being hanged. The first physiotherapy session is spent in listening and explanation. She needs space, time, privacy and an attentive ear.

Breathing cannot be re-educated in a tense person, and the second session includes relaxation, breathing awareness, visualisation, abdominal breathing and yoga breathing techniques. She responds well to encouragement and praise because of her low confidence. She takes home some relaxation tapes in her own language.

Later she gradually learns to slow her breathing, very gently so as to avoid tension and exacerbation of disturbed breathing. Techniques that use verbal counting or breathing into bags are avoided in order to emphasise independence. She is particularly proud when she learns to control the balance of achieving air hunger but without allowing the panic.

Ms T learns to recognise stressful situations and initiate measures to control her hyperventilation. Her symptoms become negligible and she is discharged.

**Pain**

“I realised that pain can increase without end. That feeling is devastating to the mind. The desperation is hard to describe. Suddenly an entire culture collapses. Nothing is possible in such a universe. It is hard to be a survivor.”
Severe pain is a common long-term outcome of torture. Causes are:
- Physical injury.
- Stress, leading especially to headache and back pain.
- An attempt to block out the experience of intense emotional pain by a form of ‘holding on’ to physical pain.

This last form of seemingly intractable pain has similarities to the unresolved grief of some bereaved people, who fear that letting go of the grief would mean experiencing the loss. In torture survivors there may also be an element of expiation of guilt.

Appropriate treatment is given for any physical damage, and a comprehensive stress management plan is adapted to the individual lifestyle.

**Stress**

All survivors are stressed, and present with symptoms which may or may not overlap with manifestations of physical injury. It is necessary to identify organic disorders, but the concept of a divide between mind and body is inappropriate in these severely abused people. One of the best ways to still the mind is to move the body, and exercise is combined with relaxation. Relaxation techniques are taught that can be used on Department of Social Security waiting room chairs. Advice is given on diet, posture, gait and fitness training. Survivors have often denied a part of their body, and the breath is a useful medium to reconnect with themselves. Breathing is a link; it connects the emotional with the physical, and the conscious with the unconscious.

Once clients have learnt simple exercise, relaxation and breathing techniques, discussion helps them to integrate these into their lifestyle so that they can use them to control panic attacks.

Mr R rarely emerged from his hostel, suffering from severe pains, palpitations, difficulty in breathing and bouts of disabling headaches. He presents as a quiet anxious-looking man with excessive hand movements and avoidance of eye contact. At times during sessions of deep relaxation with breathing control, Mr R's body jerks violently for several minutes, followed by uncontrollable crying. He expressed embarrassment at this, and needs reassurance that it is not only acceptable but therapeutic. He feels relief after these sessions, but it is several months before he is able to explain that he is reliving his electric torture. He has not been able to express his distress in words, but can now do so physically. It takes almost a year for the symptoms to dissolve, but Mr R is now well enough to seek employment in his profession as a journalist.

Physiotherapy aims to enable survivors to take responsibility for their own life again, to free them rather than cure them. There is no cure. In the words of an Auschwitz survivor:

> “Anyone who has suffered torture remains tortured. Anyone who has suffered torture will never again be at ease in the world. The abomination of the annihilation is never extinguished. Faith in humanity is never acquired again”


**Precautions**

The intimacy of our relationship with survivors of torture is matched by the perverted intimacy of their previous relationship with the torturer, and extra care is needed in this context.

When examining survivors, we avoid coming up from behind them, we avoid bright lights, and we allow them to stay fully clothed if necessary. Undressing is not only reminiscent of preparations for torture, but degrees of modesty vary between cultures.

Techniques to avoid include electrical treatment if clients have suffered electric
shocks, ice if they have had cold torture, and water if they have been subjected to near-drowning. Acupuncture is not used because it cannot be guaranteed to be pain-free. Manipulation is used rarely because the noise can sound like joints dislocating or teeth being pulled out. There are no mirrors because many survivors find them disturbing, and no traction couch because most survivors have been tied down. Indeed, some find it difficult simply to lie down.

If there is doubt about a treatment technique, it is discussed in detail with the client and sometimes demonstrated on a volunteer such as the ever-willing interpreter. It is inadvisable to stand patients up against a wall to practise relaxation, in case they have been subjected to mock execution. Most women have been sexually tortured, and will tense up, sometimes barely perceptibly, if there is physical touch near the pelvis. We do not stand over clients and must be ever vigilant to avoid any sense of authority over them. We discuss all findings and treatment plans, ask their advice and involve them in working out methods of treatment. It can be seen that these are simply guidelines of normal good practice.

Other common-sense strategies are to resist the need to “do something” at all costs, when it might be more beneficial to listen, discuss, or simply allow the creative use of silence. “Being” is often more important than “doing”.

We must uphold confidentiality scrupulously, respect modesty, and understand that some men may at first be uncomfortable if treated by a woman. We explain that in Britain women are trained alongside men and it is common for women to hold a professional qualification. In other ways it is helpful to be a woman because most torturers are men.

Managing Ourselves

It is not easy to read clients' notes because they contain detailed documentation of grotesque practices. And it is sometimes awesome to sit beside a person who has been through an experience that is beyond our conception. To be fully present for the client, we deal with our own reactions outside the session. Regular support groups allow us to express our own outrage and distress. They also enable us to work towards maintaining a balance between sensitivity and keeping a boundary so that we do not take on board our clients' stress. Our own blocking mechanisms are a necessary protection, but these need to be conscious so that we do not unwittingly cut off from the client.

It is not unusual to feel strong warmth for survivors, which is partly our own reaction to what they have been through. This is appropriate so long as we are aware of the process, and indeed a warm atmosphere fosters the kind of relationship that is necessary for this work. Laughing together and hugging goodbye at the end of a session is acceptable and common at the Medical Foundation. Cultural differences are respected, especially sex distinctions, but people from other countries are in fact often more comfortable with physical expression of feelings than the British!

We must be wary of our rescuer instinct. Survivors must be enabled, not disabled by well-meaning attempts to do things for them. Independence is the aim.

People who work with survivors are sometimes so anxious not to perpetuate abuse that this can take the form of tolerating unacceptable time-keeping. Time has different meanings in different cultures, so it is necessary to explain in the first session the importance of arriving on time for treatment. Otherwise the next client will be kept waiting, which will trigger in him or her memories of waiting for torture, a process that has been a deliberate part of the maintenance of fear.

A carer and a victim are a potent combination. The term “survivor” is preferred to “victim”. From our side of the relationship, it helps to demystify the image, and for the client, the self concept of survivor presents a creative challenge that is more appropriate for rehabilitation. Our clients in fact appear surprisingly normal, and will chat and be easy or difficult like most patients.

Conclusion

Torture is not just the aberrant expression of sadism by individuals, nor does it just occur in a few wayward banana republics. It is an institutionalised and routine form of government
in many countries. The wretchedness of the experience follows survivors and continues to isolate them, even in the midst of family life. Children are haunted by what is done to their parents. Indeed, they too can be tortured usually in front of parents. Torture knows no boundaries.

Healing takes years, and the wound never closes completely. But with help, the memory gradually becomes less intrusive by day, and nightmares take over less of the night. Survivors learn to trust, to form relationships and to pick up their lives again. We are indeed privileged in being able to play a part in easing the emotional and physical pain of survivors of torture. There is no formula for working with the tortured, but we continue to refine our understanding of their needs, and we gain much from working with them as they seek to find a sense of creative endeavour in their lives.

Treatment of survivors is part of the curriculum of physiotherapy education in certain countries such as Denmark. Perhaps its inclusion into the British system would not only prepare us for an unexpected torture survivor who arrives in out-patients, but could enhance our handling of anxious patients in general.

My personal revenge will be to your children a right to schooling and to flowers.
My personal revenge will be this song bursting for you with no more fears.
My personal revenge will be to offer these hands you once ill-treated with all their tenderness intact.

[Thomas Borge, Sandinista Minister of the Interior, imprisoned under Samoza. Poem written in prison to his torturers.]

References


Unattributed quotes are from survivors of torture or their case notes.