Psychological Sequelae of Torture

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Introduction

Although much has been written about the history and methods of torture and moving testimonies have been produced by individuals and groups of survivors, there have been few attempts to produce an explanatory model which systematically deals with the common physical and psychosocial sequelae. Never has this been more important (Pilisuk & Ober, 1976). Torture is prohibited by the United Nations Universal Declaration of Human Rights (United Nations [UN], 1948) and the Convention against Torture (UN, 1984), yet it is widely used by state authorities throughout the world as an instrument of interrogation and systematic repression (British Medical Association, 1986). Amnesty International (1987a) has reported the use of "brutal torture and ill-treatment" in over 90 countries in the 1980's.

Developments in the social and clinical sciences during this century have provided the opportunity for advancement in our understanding of the long-term reactions to torture. In this chapter, one approach is outlined. It is based on our personal experience of working in a London-based centre, the Medical Foundation for the Care of Victims of Torture (Turner, 1989) and in an academic traumatic stress clinic.

Torture is not a new phenomenon. It has been mentioned in ancient Greek and Roman law. In the thirteenth century, at the beginning of its resurgence in Europe, torture was defined as the "inquiry after truth by means of torment." Confession was seen as the most important of the proofs of guilt and in the presence of other indicators, torture was perceived as a legitimate means of obtaining confession (Peters, 1985).

Changes in legal practice and philosophy have reduced the central importance of personal confessions in the legal process. Similarly, advances in forensic sciences and in the techniques of investigating crime have provided powerful alternative ways of obtaining evidence. Peters (1985) asserts that the increasing dependence on torture in the twentieth century is a result of changing concepts of political crime during this period. Usually, the current use of torture appears to be part of a process of systematic repression of dissent by a regime acting within its own country (Martin-Baro, 1988).

So torture has been defined in broader terms, as for example, "the deliberate infliction of pain by one person on another in an attempt to break down the will of the victim" (Stover & Nightingale, 1985). Similarly, the World Medical Association (1975) has defined torture 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 purpose.

Finally, under the terms of a recent UN convention (UN, 1984), the position is made clear: Torture is always carried out "by or at the instigation of or with the consent or

acquiescence of a public official or other person acting in an official capacity." It is in its nature, therefore, an action of a state against an individual, and moreover an action usually outside the normal process of criminal investigation and punishment.

Of course, states have other means at their disposal to impose political change on groups of people or even on whole communities. The concept of organised state violence has recently been introduced to include other forms of persecution in addition to torture. Derived in part from the Universal Declaration of Human Rights (UN, 1948), it includes imprisonment without trial, mock executions, hostage taking, or any other form of violent deprivation of liberty carried out for political or repressive purposes (Van Geuns, 1987).

It is our contention that torture, in common with many other forms of organised violence, is an activity with particularly complex social, psychological, and physical sequelae. The man, woman, or child who survives torture has not merely been the victim of physical injury or threat of death, such as occur in a natural disaster (and these are disturbing enough), but has also received the focused attention of an adversary who is determined to cause the maximal psychological change. This perversion of an intimate relationship (Ritterman, 1987; Schlapobersky & Bamber, 1988) will often include the deliberate intention to disrupt the normal healing process and leave the survivor condemned to a life of misery.

However, it is not just the individual who suffers. For every person tortured there are mothers and fathers, wives and children, and friends and relatives who wait in uncertainty and fear (Cohn et al, 1985).

Unlike other forms of trauma, the primary aim of torture is to effect a specific psychological change in each person. The desired effect will vary for different people in different situations. Although subjugation of the will of the victim to that of the torturer is the common theme, for some it will be one aspect of interrogation, for others it will be punishment, and for many it will form part of the process of political or religious repression. It would be naive to assume that torturers do not achieve some of their aims. Indeed, one way of approaching an understanding of the types of reaction to this form of extreme trauma is to consider what it was that the torturer was attempting to achieve and on whom.

Psychological responses described in survivors of torture are protean. They include impaired memory and concentration, headache, anxiety, depression, sleeplessness with nightmares and other intrusive phenomena, emotional numbing, sexual disturbances, rage, social withdrawal, lack of energy, apathy, and helplessness (e.g., Abildgaard et al., 1984; Allodi & Cowgill, 1982; Cathcart, Berger, & Knazan, 1979; Ramussen & Lunde, 1980). In a recent interview, Goldfeld, Mollica, Pesavento, and Faraone (1988) have attempted to introduce some order by breaking down these symptoms into three categories: cognitive, psychological, and neurovegetative (Table 58.1). Although this approach is useful in describing common elements of the reactions to torture, it lacks a theoretical basis and has little heuristic value. The range of symptoms listed is very wide, includes features of many of the common psychiatric conditions, and is hard to interpret as representing a single disorder.

Many torture victims continue to have physical and psychological symptoms for long periods (Petersen et al., 1985). Some will have developed ways of responding to torture (e.g., the induction of altered states of consciousness during torture by hyperventilation) which persist as maladaptive behaviours following release; these may come to dominate these individuals' symptom profiles. In addition, there may be differences in the capacity to resist the torturer between those who were actively engaged in resistance prior to torture and those who were picked up at random or by mistake, or between people of different cultures (Kinzie, 1985). Any systematic account must allow for these and other variables.

We therefore reject the notion of a single "torture syndrome" (Allodi & Cowgill, 1982; Basoglu & Marks, 1988). Not only are individual reactions more complex - it must be acknowledged that torture has effects on communities and on whole societies.

We believe that it is more helpful to conceptualise the common sequelae of torture under four distinct headings that form dimensions of the torture reaction. As will be discussed later, they are not only of heuristic value, they also stand to have important implications for treatment.

Table 58.1 The Psychological Symptoms Commonly Reported Following Torture

- Cognitive symptoms
  - Confusion/disorientation
  - Memory disturbance
  - Impaired reading
  - Poor concentration
- Psychological symptoms
  - Anxiety
  - Depression
  - Irritability/aggressiveness
  - Emotional liability
  - Self-isolation/social withdrawal
- Neurovegetative symptoms
  - Lack of energy
  - Insomnia
  - Nightmares
  - Sexual dysfunction

Note: Adapted from "The Physical and Psychological Sequelae of Torture" by A.E. Goldfeld, R.F. Mollica, B.H. Pesavento, and S.V. Faraone, 1988 Journal of the American Medical Association, 259, p 2727. Goldfeld et al, list the relative frequencies of these symptoms in the main published clinical surveys (n=294).

Direct (Individual) Responses to Torture

Incomplete Emotional and Cognitive Processing

The conceptual development of the post-traumatic neuroses in different settings has been reviewed comprehensively (Wilson, 1989; Horowitz, 1976; Kinston & Rosser, 1974; Raphael, 1986; Raphael & Middleton, 1988; Trimble, 1981; Wilson, 1989). The evidence obtained from all these sources points to the conclusion that similar stress response syndromes are found as sequelae to a wide range of traumatic events. It also became evident that, although premorbid personality was not necessarily unimportant (McFarlane, 1987), these reactions may occur in any one who is exposed to sufficient stress (Wilson, 1988a). Some have reported a dose-related effect to trauma (e.g., Shore, Tatum, & Vollmer, 1986, following the Mount St. Helens volcano eruption). Horowitz (1976) points out that the phrase "everyone has his breaking point" is derived from experience with reactions to combat. Lifton and Oslan (1976) were able to write of the Buffalo Creek flood disaster that the psychological impact had been so extensive that no one in Buffalo Creek was unaffected.

The two central features of the specific traumatic stress response syndrome are (1) the compulsive tendency toward repetition of some aspect of the disturbing experience (as thoughts of the original event, as feelings associated with the experience or as behavioural re-enactments), and (2) the avoidance of internal or external representations which recall or resemble the traumatic episode (Horowitz, 1976). There are several differing theoretical explanations for these phenomena (Basoglu & Marks, 1988; Brett & Ostroff, 1985; Wilson, 1989; Wirtz & Harrell, 1987).

Horowitz (1976) preferred a cognitive and emotional processing model. He suggested that painful experiences need to be processed in the mind, in the same way as any other formative experience. In this view, he is supported by Rachman (1980), who wrote of emotional processing as a normal way of dealing with affective material; sometimes this processing may be arrested or incomplete and it is then a source of continuing distress for the individual. Horowitz suggested that there are natural (protective) limits to the rate of cognitive and emotional processing. He wrote of "massive ideational denial and emotional numbing" as being the opposite phenomena to intrusive repetitiousness. Material which threatens to overwhelm the person leads to the invocation of these defensive mechanisms. In his theoretical and descriptive work, Horowitz pointed to a cyclical process in which the individual shifts between avoidance and a state of emotional distress associated with these intrusions into consciousness. In extreme cases, a state of denial and even patchy amnesia for the traumatic event may be induced. To move on from this condition and complete the task of processing requires the intrusion of manageable chunks ("doses") of this material into consciousness. In this way, successful processing is accompanied by a phasic process of intrusion that alternates with denial. Of course, the traumatic event may be brought into consciousness not just by internal systems but also by external stimuli which resemble the circumstances of the traumatic episode; there may be frank avoidance of such stimuli.

Subsequently, the criteria for post-traumatic stress disorder (PTSD) have been modified in the revised edition of the Diagnostic and Statistical Manual (DSM-III-R) (American Psychiatric Association [APA], 1987). They are now based more closely on this

etiological model.

Those elements central to PTSD, the intrusions, the avoidance, and the hyperarousal phenomena, undoubtedly occur in people who have been subjected to torture (Mollica, Wyshak, & Lavelle, 1987b). In torture, where the infliction of physical and psychological pain can continue over many months, the reactions may be particularly severe. The deliberate application of pain at a time which suits the torturer and which is intended to have the maximum impact on the victim makes it much more difficult for the victim to mount any satisfactory defence. It may be predicted that survivors of torture are less able to control their later intrusive recollections than others who have experienced major trauma.

Indeed, it is likely to be the aim of the torturer to overwhelm the normal cognitive and emotional processing mechanisms. Factors which stand to impede emotional processing have been described (Rachman, 1980) and several of these are common in torture. The induction of high arousal levels, fatigue, sleeplessness, and the irregularity of presentation of dangerous, intense, uncontrollable traumata are all said to militate against successful processing. Many of these factors appear to be manipulated deliberately by torturers to achieve this effect. Some survivors have learned (often by chance) alternative methods of reducing the pain of torture. These behaviours may include hyperventilation as a way of dissociating from the impact of the violence (see Chapter 60, in this volume).

The impact of prolonged exposure to painful stimuli, and the ever-present threat of a recurrence of attack, also lead to a state of chronic anxiety during detention. Following release, survivors are often vulnerable to repeated arrests, and even if they escape the country where torture took place, they may equally be subject to detention and forcible repatriation. It is the fear of further persecution and torture which drives people into exile and refuge. They may deal with these chronic anxiety symptoms by using the increasingly maladaptive responses that were learned during the torture. These avoidance behaviours appear to differ from those seen in war veterans, who may more commonly resort to the use of excessive drugs and alcohol (Yager, Laufer, & Gallops, 1984). Differences between combat and torture survivors may include not only the degree of access to these chemical agents during the traumatic process, but also cultural and philosophical factors. For example, those tortured because of their political beliefs may have a strength of personal commitment to a cause which is lacking in many combat troops.

Depressive Reactions and Life Events

Even in other fields of work with survivors of trauma, PTSD has been recognised to be an insufficient diagnosis to explain all the reactions reported. For example, Shore et al. (1986), in the study of the Mount St. Helens volcano disaster, reported increased rates of generalised anxiety and major depression as well as PTSD. McFarlane (1984) found that the two common disorders following the Australian bushfires were PTSD and major depression.

Intimately involved in the experience of torture are many emotionally charged processes chiefly concerned with loss. The survivors of torture may have lost body parts (e.g., a limb or an eye), a normal bodily function, or bodily health. They are likely to have lost

work, status, family, and credibility. Even if they succeed in resisting torture, their colleagues are likely to be suspicious of them. If they stay in the same region, they know that there is the continuing threat of repeated detention and torture. They know that there is a similar threat to their families and friends. If they leave the region to seek asylum elsewhere, the losses are compounded (Miserez, 1988; UN, 1951). Torture, therefore, must be seen not only as a very important life event in its own right, but also as the cause of many others.

In the context of torture, the depressive reaction is a common sequel and is almost certainly related to these loss events (Brown & Harris, 1978). This is particularly likely when the individual is examined as an asylum seeker or refugee (Kinzie, Fredrickson, Ben, Fleck, & Karls, 1984). In a recent series of 52 Southeast Asian refugees reported by Mollica et al. (1987b), only one had PTSD alone; the remaining 25 individuals with PTSD also had another diagnosis, usually major affective disorder. Major depression was the single most common diagnosis, being present in 37 of the 52 subjects. Those Cambodian widows who had experienced at least two of the three traumata of rape, loss of spouse, or loss of children had the highest levels of depressive symptoms. They perceived themselves as socially isolated and living in hostile social world.

Somatic Symptoms

Symptoms suggestive of physical illness and the signs of cognitive impairment are common following torture (Cathcart et al., 1979; Ramussen & Lunde, 1980; Rasmussen & Marcussen, 1982). The physical sequelae are often the obvious and direct consequences of torture (Goldfeld et al., 1988). One example is the pain on walking experienced by someone who has been subjected to falaka, in which the soles of the feet are beaten repeatedly with a light cane or whip. It has been demonstrated that certain physical signs are specific to certain physical tortures and could not have been caused in any other way (Goldfeld et al., 1988; Gordon & Mant, 1984; see also Chapter 64, in this volume). These are of particular importance in the medical documentation and verification of the survivor's torture story.

However, in a person whose body has been tortured as a way of gaining control over his or her mind, somatic symptoms may have a multitude of meanings. Not infrequently they appear to be intimately related to a disturbed emotional state. It is important not to dismiss them lightly. A thoughtful clinical assessment is needed which does not rely on physical investigation. For example, in a person who has survived electrical torture, special care is required before advocating even a simple investigation such as an electrocardiograph (ECG).

Hyperventilation is not uncommon in survivors of torture and may be an important mechanism involved in the production of physical symptoms (see Chapter 60, in this volume). Similarly, sexual dysfunction is often reported in survivors of torture but so far the etiological mechanisms are unclear (Lunde, Ramussen, Lindholm, & Wagner, 1980). Although sexual violence is a common form of torture especially in women and female adolescents (Goldfeld et al., 1988), dysfunction may also occur in those victims who have not experienced sexual torture. It is likely that the symptom has a complex etiology, with psychological processes being more important than organic factors.

Similarly, the etiology of cognitive impairment following torture is unknown. Thygesen

(1980) believed the symptoms experienced by the concentration camp survivors (Table 58.2) to be an expression of an organic damage which affected the brain. Physical and mental symptoms were reported in over 50% of cases with a significant disability assessment. The risk factors for the "dementia" which he believed to be present were older age, greater weight loss during detention, and lowered social class.

It was the surprising resemblance between the psychological syndromes affecting war sailors and concentration camp survivors which challenged this view (Askevold, 1980). War sailors had been exposed to psychological stress but had not endured the physical privation of the concentration camp; they had been well fed and well looked after although they had frequently faced threats of death in action. Of particular importance was the finding that even apparently "organic" sequelae, such as memory impairment and reduced concentration, were obvious in people with the "war sailor" syndrome (95.8% and 89.1% respectively). This suggested that it was not the physical hardship of the concentration camp, but the psychological impact of living under continued threat of death and personal disaster which was the crucial factor.

Thus, cognitive impairment (especially associated with PTSD) is likely to be a consequence of two processes. There are often changes in the person's emotional state which stand to affect concentration and the processing of cognitive information. There may also be organic brain damage from direct injury, electrical torture, malnutrition, or chronic illness. In survivors of torture, there is often a history of multiple head injuries (Goldfeld et al., 1988). The relative importance of the emotional and organic factors is unknown.

Table 58.2 Main Symptoms of Concentration Camp Syndrome

Physical:
Weight loss
Pathological fatigue
Periodic or constant diarrhoea
Dizziness
Headache
Hot flushes, nightly sweating
Sleep disturbances
Reduced sexual potency

Mental:
Depression/moodiness
Lability
Nightmares/other fear phenomena
Reduction in memory and/or ability to concentrate

Note: Adapted from "The Concentration Camp Syndrome" by P. Thygesen, 1980, *Danish Medical Bulletin*, 27, pp. 226-227.

Existential Dilemma

The existential dilemma may be the most important and enduring of the psychological reactions to torture, although the most difficult to conceptualise in medical terms. With torture, as with some other forms of extreme trauma, it is impossible to ignore the

broader social and political dimensions. People are tortured for a purpose. Often it is not that the individual has important information or that a confession is required. If a regime is acting outside the usual rules of law, there are other simpler ways of investigation and people may be punished or killed ("disappeared") without proof being required. It seems that torture is used for a combination of reasons, but chief amongst these are punishment and systematic repression of whole communities. Membership of a political, social, tribal, or religious group may be sufficient reason in itself for a person to be detained and tortured (Stover & Nightingale, 1985).

Torture is a "catastrophic existential event" (Bendfeldt-Zachrisson, 1985). Survivors of torture face the double dilemma both of coming to terms with the full reality of torture in their world and also of surviving unchanged the insidious pressure of the torturer to change, to act or react in relation to the torturer's wishes.

The need to live in a world of such unremitting cruelty is the material of testimony and autobiography (e.g., Levi, 1987). The purpose of existence itself is challenged by the fact of torture.

It is probably in this area that early experiences and political or religious cultures are likely to have the strongest effects. Individual differences in reactions to other forms of severe trauma have been reported. For example, there appears to be increased emotional disturbance in black rather than in white soldiers who took part in the atrocities in Vietnam (Yager et al., 1984). This finding was interpreted (with some additional anecdotal evidence) as indicating that those who were more able to dehumanise their victims (to identify less well with them) were less severely affected themselves.

Similarly, in surviving torture, those who are able to retain some of their human values may have the best outcome. One man recalled how, when he himself was in prison and was being severely tortured, he comforted another victim whose torture he had witnessed with these words: "Old man, I cannot defend you now. But whilst we are here in prison I shall teach you to read and write, and that will be our victory" (Schlapoberskly & Bamber, 1988).

The trauma of torture may have important unconscious meanings. Ullman and Brothers (1988) argued that, in some cases, before the traumatic event, an individual may maintain fragile narcissistic fantasies of omnipotence which are completely shattered by the traumatic experience. This is seen in the fragmentation and disintegration of the self (and has been postulated as an explanation for the dissociative elements of the traumatic stress reaction). Frequently, for whatever reason, survivors of torture seen in the United Kingdom report that one of the most difficult tasks in the recovery process is not the control of evident symptoms but the rebuilding of their shattered sense of self.

Survival may bring its own guilt. A man who persisted in asking where his brother was being detained under one repressive regime was later detained himself and killed. He went to the security forces to ask about his brother once too often and never came back; his brother survived and is now alive and living in the United Kingdom, living with the guilt of his brother's death.

Following release, those who are able to obtain sufficient peer support or who are able to return to active religious or political groups may be able to overcome or suppress some of the broader aspects of torture in their internal lives. Those who are affected by torture and who have to seek asylum elsewhere may find themselves in a loveless world in which they can find little personal meaning or fulfilment. To some extent, they must come to reconcile the "new self" with the "new reality" of the external world.

The survivors may have to face victimisation. They may have the experience of being blamed for their own condition. Similar processes have happened in the past. In World War I, for example, physical explanations for symptoms of "daze, fear, trembling, nightmares, and inability to function" were preferred; psychological mechanisms were seen to resemble weakness and a cowardice (Horowitz, 1976). Shell shock was attributed to a combination of concussion and cerebrovascular damage, which was brought on by proximity to loud explosions. Some of the attempted "cures" of traumatic stress reactions, based on this understanding of the reaction as a combination of physical damage and psychological inferiority, were barbaric. Showalter (1987) reported the use of coercive treatments. Lewis Yealland, for example, is said to have described, with "complacent pride", his clinic in London. One young man, a veteran of Mons, Marne, Ypres, Hill 60, Neuve Chapelle, Loos, and Armentieres had collapsed and subsequently had been mute. For nine months he had resisted all efforts at "cure": including hypnotism, electric shocks to his neck and throat, hot plates in his mouth, and cigarette burns on the tip of his tongue." Yealland, by a process of electric shocks of increasing intensity and the use of military discipline, managed to return this man's speech (Yealland, 1918, quoted in Showalter, 1987).

Following World War II, the survivors of concentration camps and the Holocaust had their own shattering histories to recount (Eitinger, 1980). However, even after the survivors had been seen and interviewed, there was debate about the validity of offering compensation based on disturbed psychological states. Many survivors were assessed only on the basis of physical handicaps. The early views of Sigmund Freud had indicated that stress reactions in adult life were often merely the reactivation of some childhood conflict or trauma which had not been dealt with completely at the time (Horowitz, 1976). If this was the case, how could their adult experiences of life in a camp be seen as causal of neurosis? It was argued that those who developed neuroses did so because of a prior constitutional deficiency. The medico-legal council eventually made a ruling (with important political and financial consequences) that "there cannot, in our opinion, be any doubt that the distress described here must be regarded as illness in the normal medical meaning of the word" (quoted by Thygessen, 1980).

It has been said that these existential aspects of the post-torture condition are a form of "bondage" through which the torturer ensures that his interventions will persist. Seen in this way, the work of rehabilitation is centred on the task of "freeing" survivors from these existential chains (Schlapobersky & Bamber, 1988).

Survivors of torture may gain the greatest support from each other. Another survivor has described the members of a self-help group he attended in this way: “This is a chain, one link and then another. It will be a great chain. When we eventually shake this chain it will be like thunder. You will hear thunder. The world will stop to listen, humanity will come to its senses and there will be no more torture.” (Schlapobersky & Bamber,

1988).

In making this assertion, he is trying to reclaim for himself and his colleagues personal meanings, to find their ways out of the existential despair he and others had experienced and to stake his claims on the future he would like to see.

Indirect (Social) Responses to Torture

The problems arising in the survivor's community cannot be ignored and may be construed under some of the same dimensions as for the individual. (Table 58.3).
For example, close relatives of a man or woman undergoing torture have their own psychological reactions to deal with. These include incomplete emotional processing, depression, and the existential dilemma.

Young children of victims of torture have been reported to show social withdrawal, chronic fear, depressive moods, clinging and overdependent behaviour, sleep disorders, somatic complaints, and an arrest or regression in social habits or school performance (Allodi, 1980). In another series of Chilean children who were being treated in Denmark, common symptoms included anxiety, oversensitivity to noise, sleep disturbance and nightmares, secondary nocturnal enuresis, anorexia, somatic symptoms, depression, and difficulty in social relationships (Cohn, Holzer, Koch, & Severin, 1980; Cohn et al., 1985). Others have reported symptoms of PTSD in school-aged children following a fatal sniper attack on the elementary school playground (Pynoos et al., 1987) and in adolescent survivors of the Pol Pot regime in Cambodia (Sack, Angell, Kinzie, & Rath, 1986).

Torture thus has important effects not just on the individual victim but on others who were not directly traumatised. There are also profound existential changes, described by some children of Holocaust survivors, and by many who have seen people close to them suffer torture and persecution.

In Argentina, a group of relatives (Argentina's National Commission on Disappeared People, 1986) provides a tragic example of people who were unable to discover the fate of the "disappeared". Were the disappeared people really dead? Were they being tortured? Were they still living in secret camps? How could these relatives begin to work through their feelings of grief when they could not know the reality?

In countries subject to repression and torture on a very large scale, whole communities may be affected. Torture and killing of individuals may have a striking effect on the social and political life of a country or region (Martin-Baro, 1988). This is certain to be one of the primary aims of the regime responsible for the violence, including torture, against its citizens.

The often arbitrary nature of the process is another destabilising factor. In Cambodia, under Pol Pot, there was mass genocide. Amnesty International (1983) reported that intellectuals "were singled out for particularly harsh treatment and in many regions of the country were summarily executed.". The same report indicated that intellectuals were "often crudely identified as those that wore spectacles."

In countries which practice torture, there is often no real democratic option for change, and non-violent political dissent is sufficient reason for individuals to be detained and tortured. To be effective as a social control, it has to be widely known that behaviour perceived as difficult or subversive to the authority of the regime is likely to lead to this sort of extreme response.

In one example of torture affecting a doctor, the reason was explained. The doctor, working in a poor district, was shot and wounded, then arrested. He was told that his wife and two daughters had already been captured and "disappeared". He was hooded and taken to a torture centre.

Then I heard another voice. This one said he was the "Colonel". He told me they knew I was not involved with terrorism or the guerrillas, but that they were going to torture me because I opposed the regime because: "I hadn't understood that in Argentina there was no room for any opposition to the process of National Reorganisation." He then added: "You're going to pay dearly for it ... the poor won't have any goody-goodies to look after them any more!" (Argentina's National Commission on Disappeared People, 1986).

Table 58.3. The Dimensions of the Torture Reaction

Psychological reactions	Personal sequelae	Immediate social network	Broader political effects
Incomplete emotional and cognitive processing	++	+	-
Depressive reactions	++	++	+
Somatic symptoms	++	-	-
Existential dilemma	++	++	++

++ Very likely; + Likely; - Unlikely.

A Personal Series

Scrutinising the detailed case notes of the first 20 people who were subjected to torture and referred to a psychiatrist (Stuart W. Turner) at the Medical Foundation revealed a long list of tortures (Table 58.4). Nine subjects were from Iran, and the remainder came from Iraq, Ghana, Peru, Angola, Chile, Uganda, and South Africa. Only one had a history of psychiatric treatment prior to torture. The mean age was 34 and the sex ratio was 18 men to 2 women.

Eighteen (90%) had evidence of PTSD, 14 (70%) met the criteria for major depression, and four (20%) had clinical evidence of a chronic hyperventilation disorder (confirmed by reproducing symptoms on voluntary over-breathing). Two (10%) were frankly psychotic: one had a manic illness and the other had a paranoid psychosis. It has to be said that all were referred to a psychiatrist; the sample was therefore highly selected. However, it does illustrate the complexity of the reactions, with most people having multiple diagnoses.

Table 58.4 Methods of Torture in a Retrospective Case Note Survey (n = 20)

Torture	Incidence	Percentage
Beating, slapping, kicking, punching	16	80
Striking with heavy cables or belts	9	45
Falaka[a]	5	25
Hood or blindfolded	5	25
Striking with rifle butts	4	20
Electric shocks	5	25
Mock executions	4	20
Food withheld or restricted	4	20
Burns (cigarettes, hot liquid, or chemical)	3	15
Suspension	3	15
Cold water showers	3	15
Sexual molestation	3	15
Bad or rancid food	3	15
Sleep deprivation	2	10
Telefono[b]	1	5
Tear gas in cell	1	5
Walking on thorns	1	5
Pins under thumbnails	1	5
Handcuffed to post, arms twisted behind back	1	5
Finger chopped off	1	5

[a]In falaka, the soles of the feet are beaten with a cane or flexible whip over long periods. One man gave a typical description of this. He said that he would usually be strapped prone to a bench and have the soles of his feet beaten with a cane. After these sessions, his feet would be swollen and eventually became blackened. The pain was described as appalling. His feet became infected. Even now, some years later, he has painful feet which limit his ability to walk long distances.

[b]In telefono, there is violent boxing of the ears, which often leads of permanent hearing impairment.

The case histories that follow illustrate some of the psychological reactions.

Incomplete Emotional and Cognitive Processing

A 35-year-old man described his detention and torture in Iran. He reported nightmares which disturbed his sleep. During the day, he tried to avoid things which reminded him of his torture. One of the worst experiences for him had been being forced to witness the torture of children. Now, whenever he saw an adult showing anger or hitting a child, he was reminded of his detention and felt extremely distressed. He described anxiety symptoms including a marked startle response.

Major Depression

A 31-year-old survivor of torture, in fear for his life, described a crisis he had experienced. He developed hypochondriacal delusions. His concentration was impaired. He had almost no interests and no enjoyment. He appeared miserable. He had thought of killing himself. He had sleep disturbance with both early morning

wakening and latency. He had lost his appetite and about 20 kilograms in weight. He made a very good symptomatic response to a tricyclic antidepressive drug.

Somatic Symptoms

A 30-year-old man had survived severe torture including frequent beatings and electrical torture. He remained extremely troubled by his experiences, with disturbed sleep, nightmares, anxiety symptoms, and irritability. However, he also found that he could be quite forgetful. For example, he often forgot names and addresses that he would previously have remembered easily. On assessment, his concentration was impaired, and he made several errors in tests of memory including being able to recall only two out of three objects at three minutes on a cued recall test. There were both physical and psychological explanations, either of which could explain his pattern of poor concentration and impaired memory. All of these symptoms may well be a direct manifestation of PTSD.

Existential Dilemma

Another survivor of torture had been forced to give information which led to the detention of some colleagues in his political group. As a refugee in the UK, he reported symptoms of PTSD, but more than anything else, he gave a sense of utter hopelessness and loss of direction in his life. For him the world would never, could never be the same again. His purpose in living had been destroyed.

Choices Facing Health Professionals

Eight (40%) of these survivors reported seeing a doctor during their period of detention. Some were transferred to hospital and later were returned to the detention centre. Others were seen by doctors in prison. One said, "The doctor took no notice of the wounds people presented with following beating or other ill treatments." One woman required surgery; this was carried out at the local hospital but, although she accepts that it was the right thing to do, she said that at no point was she asked to give consent. Many more victims saw doctors following their release; it is hard to see how torture on any scale can be carried out without the medical and allied professionals having some concrete evidence of this.

An example of how forensic examiners can inhibit the abuse of detainees is said to have taken place in Northern Ireland between 1977 and 1979 (Stover & Nightingale, 1985). Here the Forensic Medical Officers Association made confidential reports, then public statements, finally leading to threats of resignation. This action led to important changes in practice and a marked reduction in allegations of assault.

Of course, speaking out under certain regimes may be fraught with considerable personal danger. Doctors themselves have been subject to torture or state killing. Several doctors who were tortured have been seen at the foundation. Recently, there have been reports of detentions of doctors in Iran, protesting about changes to the organisation and autonomy of their professional body (Amnesty International, 1987b).

Thus, health professionals and others who work in countries where torture is practised may become involved and implicated in the procedure. They have their own existential dilemmas.

Rational Approach to Treatment of the Individual Survivor

As noted sensitively in Chapter 65 in this volume, the principles of post-traumatic therapy (PTT) must include the initial establishment of trust in order for therapy to proceed. It is only in such a context that the treatment outlined below can be undertaken.

Approaches designed to have an effect only on intrusive and avoidance phenomena are rare in practice. Perhaps the nearest analogies are guided mourning in bereavement (Ramsay, 1975) and exposure-based treatments in the anxiety-based disorders (Basoglu & Marks, 1988; Wirtz & Harrell, 1987). These behavioural approaches have yet to be tested adequately in survivors of torture and thus warrant great caution. Although it may be predicted that some measures such as these are of value in the specific features of the reaction (especially on any phobic avoidance), they are unlikely to prove popular as the only method of treatment. They involve planned re-exposure to memories and memorabilia of torture. Without an adequate therapeutic alliance, in which many of the more general aspects of the person's situation can be examined, this would be impossible. However, as an adjunctive therapy, in certain people, they may prove to be very useful.

It is hardly surprising to report that antidepressive medication has been successfully used in some patients with post-traumatic neuroses (arising from torture and other causes). Boehnlein, Kinzie, Ben, and Fleck (1985) reported on a group of 12 Cambodian concentration camp survivors who met the DSM-III (APA, 1980) criteria for PTSD. They found that tricyclic antidepressants were helpful in treating the "depression" as well as the PTSD symptoms of nightmares, startle reactions, and intrusive thoughts. Avoidance symptoms responded much less well. Imipramine has been successfully used for night terrors associated with the post-traumatic syndrome (Marshall, 1975). A monoamine oxidase inhibitor (phenelzine) has been successfully used in combat PTSD (Hogben & Cornfield, 1981; Levenson, Lanman, & Rankin, 1982), again probably having the greatest effect on anxiety symptoms (including panic attacks) and sleep disturbance. However, in a group of 25 Israelis, benefit appeared to be marginal (Lerer et al., 1987). It appeared that those who responded best were patients with additional diagnoses of mood disorder or panic disorder. The common coexistence of more than one diagnostic category must be considered in the design of further research in this field (see Chapter 66 in this volume).

The use of testimony has developed as a common intervention in survivors of torture (see Chapter 55 in this volume for a discussion). It is a way of systematically reordering the survivor's view of what has happened. It is aimed at helping the person to assimilate the experience of torture and to work toward a restoration of self-esteem. The process of healing requires that the individual be able to see him- or herself once again as (to some degree) in charge of his or her destiny. This involves making that person's previous history (in terms of political commitment, work, and personal relationships) meaningful again. This formal use of testimony is said to act by restoring affective ties, by orienting aggression in a constructive manner, and by integrating fragmented experiences. In this way, the possibilities for personal growth are reopened (Cienfuegos & Monelli, 1983).

Similar methods have been applied successfully in other countries. In Denmark, for example, one group is using what is essentially a cognitive approach. They regard torture as having the aim of converting "political pain into private pain." The purpose of their treatment, which is based on the testimony method, is to "focus on reverting the private pain with a relief in symptoms and a reestablishment in ideological consciousness." This is done through a process of "reframing" which is akin to cognitive restructuring (Jensen & Agger, 1988). Similar approaches have been successful in survivors of sexual torture (Agger, 1988). Work at the Indochinese psychiatric clinic in Massachusetts also confirms the central importance of looking at the "trauma story" in therapy (Mollica & Lavelle, 1986; Mollica et al., 1987b). At the International Centre for Rehabilitation of Torture Victims (RCT) in Copenhagen, a psychotherapeutic approach is used which includes the recounting of the torture story in detail (Somnier & Genefke, 1986). This is said to lead to a transformation away from the role of victim and toward the greater expression of creativity.

All these authors describe the effects of the testimony in terms of changes in personal outlook. After experiencing torture, people need to regain a sense of direction in their lives, and they often need to relearn their personal scale of values. In many cases, not only have survivors suffered frank barbarity, they have also witnessed others being tortured and often killed, and for many the worst aspect is that they have been forced to give information or to stand helplessly and watch the rape or torture of those they love. Inevitably, these events have profound effects on personal philosophies. Making a testimony statement may be the first step in asserting a right to recovery. It may help to set in context the meaning of their own actions within a broad social and political framework.

However, it is also possible that describing the events in detail is beneficial for other reasons. Writing about traumatic events has been shown to reduce medical consultations by students (Pennebaker & Beall, 1986), possibly by facilitating emotional processing. It may have a direct effect on intrusive memories and experiences, and the associated need to avoid recall.

Therapy may be best carried out in family units or in other social groups. Children often come from families in which others may also show signs of PTSD and depression (Sack et al., 1986) and are probably best treated in family units (Allodi, 1980; Svendsen, 1985). All involved will have to come to terms with a world in which torture is not only theoretically possible, but is also a stark reality in their own lives.

Similarly, treatment must take into account the effects of the cultural base both of individuals and groups. Questionnaires have been translated for use in other languages (e.g. Kinzie et al., 1982; Mollica, Wyshak, & Lavelle, 1987a). There may be striking differences in the use of words to describe emotions, in cross-cultural diagnostic patterns, and in interpreting common cultural belief systems between people of different ethnic and cultural backgrounds (Westermeyer, 1985). The common need to use an interpreter may present its own difficulties (Marcos, 1979). The formal training of community workers may be a better approach where the numbers of people from one or more cultures are sufficiently large.

In the early work of the Medical Foundation, an emphasis on group work emerged in which survivors of torture would help each other through a process of self-help and mutual support. Political factors had to be taken into account. Generally, no more than one person from any single country could be included in a group for reasons of personal safety. Paradoxically, this meeting of people from different cultures and backgrounds was often extremely powerful. The person best able to talk to the condition of a survivor of torture may be another survivor.

Conclusion

In this attempt at a synthesis, it is suggested that the type and severity of individual reactions to torture can be conceptualised under four main headings. Incomplete emotional and cognitive processing with intrusive, avoidance, and hyperarousal symptoms is common, although it may be atypical with the development of unusual defensive mechanisms, including chronic hyperventilation disorder. On theoretical grounds, it may also be predicted that successful avoidance behaviour would be disrupted by the method of torture and that intrusive features would predominate. Depressive reactions constitute another characteristic reaction, particularly in people who seek asylum in other countries. There are somatic symptoms, including the apparently "organic" signs of cognitive impairment. These somatic features are likely to have many causes. For example, they may be the direct consequence of the physical method of torture; they may be related to a maladaptive response following torture, such as the chronic hyperventilation syndrome; they may be intimately associated with a person's emotional condition, or they may be part of a dissociative phenomenon. Finally, the existential dilemma of the survivor may be the dominant feature and may be the most difficult for the person to overcome. It requires a broadly political perspective, and some clinicians have found success using a method based on personal testimony.

There are implications for treatment in the many different treatment approaches that have been attempted with survivors of torture. For each individual, the predominant reaction is likely to guide the choice of initial treatment. If the social, political, and existential changes dominate, then a longer and more difficult process of healing and readaptation is required. During this time, the knowledge that others are in the same position and are struggling to reach their own understandings may be essential, and the group therapeutic approach over substantial periods of time may be the ideal way of dealing with these problems.

Also, it must be acknowledged that the individual does not exist in isolation. The consequences of torture will affect others; specifically, this includes children and other family members, local networks, and even whole communities. The survivor may view others differently, for example, being unable to trust. There may also be changes in the way the person is perceived by friends and relatives.

It is hoped that this extensive review will act as a stimulus to urgently needed public research directed at understanding reactions to torture and at identifying the most appropriate ways of intervening. There is a risk that publishing material about the sequelae of torture will better inform the people who order or perpetrate these acts of violence. We believe that it would be naïve to assume that the more sophisticated

torture schools do not themselves engage in research designed to evaluate their own activities. The greater risk, therefore, is the perpetuation of ignorance in the general public and in those who are called to help survivors of torture either in their own countries, or, commonly, as refugees.

Medical and other health professionals can no longer pretend or turn a blind eye to the problem of torture (Best, 1986). It is impossible to imagine a setting in which torture could take place without health care personnel being informed (Stover & Nightingale, 1985). Even if they are not involved at the time of torture, they will be asked to help people following their detention. There is, therefore, a particular professional duty in safe countries to define good methods of practice and to support colleagues who are practising defiantly in more dangerous parts of the world.

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