The Neurological Evaluation of Torture Victims

By Marianne Juhler

The justification for a neurological evaluation of a torture victim is to be found, partly in the neurologists traditional interest in sequelae of severe stress (e.g. the socalled KZ-syndrome), partly in the torture anamnesis which often includes potentially brain-damaging situations.

Apart from the diffuse stress reaction and psychological suffering which torture inflicts on the victim, there may be acute as well as chronic symptoms and findings from the organs at which the torture was directed.

Many torture survivors have been exposed to situations which are potentially brain damaging, such as:

a. direct cranial trauma, with or without subsequent unconsciousness;
b. anoxic episodes caused by submersion or airway obstruction until the stage of fainting; and
c. electric torture with convulsions and consequently insufficient respiration. The neuropsychological examination rarely confirms suspicion of organic brain damage. Clinical/neurological examination, CT scan of the brain, and EEG are almost always normal.

Furthermore, many victims have been exposed to beating on the back, and, evidently, suspension by the arms, fractures of the extremities and beating traumas can result in injuries to the spinal marrow, the roots of the spinal nerves, and the peripheral nerves.

Symptoms

The complaints years after the torture could suggest dementia. There are great difficulties with adaptation in the asylum country and with learning a new language. Complaints of irritability, testiness or emotional exhaustion can also be typical. There are complaints of sleep disorders, intolerance to alcohol, difficulties in concentrating, and poor memory. In spite of the poor memory, a very good memory of the torture is often found, even relating to details. Another frequent complaint pertaining to the neurological field is that of back pain, often located to the loin. The pain is seldom characterized by typical radicular symptoms from the legs, even though elements are often found which could resemble radiation from the neural roots.

A thorough clinical neurological examination is sufficient to disprove the presence of the suspected polyneuropathy, as is spontaneous subsidence of symptoms along with the patient's mental improvement through psychotherapy. Generally speaking, problems which remain after significant mental improvement should be reconsidered medically.

Symptoms from the motor system mainly fall into two categories: 1) joint symptoms from overstretching by e.g. tight confinement or suspension; 2) muscular pain related to tension by general stress. Low back pain is a common symptom. During imprisonment many torture survivors have been subjected to beating on the back or forced to heavy labour. Both may lead to back problems. A large minority of torture survivors with back problems have symptoms which indicate lumbar root compression. The objective examination sometimes produces findings which support that suspicion (reflex differences, minor sensory changes, pain-related reduction of muscle power). "Hard findings" consistent with intervertebral disc herniation (actual paresis, dermatomic sensory changes) are rare.

Symptoms from the eyes are most frequently uncharacteristic visual disorders (previously called cerebral asthenopia). Furthermore, there may be visual disorders which are often related to severe headache.

There are also symptoms from the eyes which are specifically related to torture methods, e.g. chronic irritation and conjunctivitis following submersion in contaminated water, direct eye lesions, and cataract which in some cases must be suspected to be traumatically induced.

Symptoms from ears/hearing are almost always directly related to the torture method. Repeated beatings on the ears result in damage to the middle ear with subsequent conduction disorders. Labyrinth damage and all degrees of nerve deafness are also seen as direct sequelae of head trauma.

Signs

It is often mentioned (and rightly so) that psychological mechanisms are the major matter in post-torture symptoms. However, only a minority of the survivors perceive their problem to be mainly or entirely of a psychological nature. The majority experience and present their situation as a somatic disease. It is important to understand that the somatic complaint picture, irrespective of any organic basis or not, is an important (perhaps the only) access for initial treatment. The torture survivor has a right to have his situation taken seriously, and a somatic complaint which is listened to and which results in a formal medical examination may be the gateway to confidence.

The preparation for examination consists of giving the patient an understanding of the purpose of the examination, the technical procedure, the applied equipment, and of any expected after-effects. When the result of the examination is available, it is important to inform the patient of the result and any consequences thereof. When the outcome of an examination is completely normal, it is also important that the patient is told so by the doctor, since the fear of suffering from a disease thus may be removed.

Radiological examinations (myelography and/or CT scanning), if they are performed, mostly show normal conditions or minor changes which do not suggest that improvement should be sought surgically. Back problems with or without radicular symptoms will in most cases be fully amenable to physiotherapy or other conservative treatment, perhaps supported by medication therapy for a short period.

It is important to diagnose even minor hearing impairment and to establish contact to an otologist for a correct diagnosis and treatment, being e.g. reconstructive middle ear surgery or a hearing aid recommendation. In contrast to neuro-radiological findings, oto-neurological findings often indicate damage to the labyrinth.

Prior to any diagnostic procedure, it should be reconsidered whether it is really necessary to carry out the contemplated examination. In general, it is unwise to subject patients to diagnostic procedures if the same information can be obtained in a way which is simpler and less straining for the patient. In particular, this applies to torture survivors who, due to their torture experience may, suffer from pronounced fear of procedures and medical equipment. For the same reason, it is important to "institutionalize" the examination and treatment as little as possible. It will promote trust and thereby cooperation and diagnostic yield of examinations if they can take place in an atmosphere and in surroundings which are as non-technical as possible.

In conclusion, it could be said that, even if the anamnesis and the complaint picture suggest a suspicion of actual neurogenic damage, this only rarely (fortunately) prove to be true. The neuro-psychological complaint picture could be termed a "pseudo-dementia", the basis of which is the chronic psychological stress with repression, sense of guilt and insufficiency, etc., which does not leave many psychological "reserves" to tackle new tasks. Complaints of pain located to the back and the extremities are very often myogenically conditioned. Concerted action of a medical, psychotherapeutic, physiotherapeutic and social character is a logical procedure in examinations and treatment. The medical and physiotherapeutic contact is often the first contact - not least because the complaints are primarily presented as purely somatic.

References

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Examining Torture Survivors

Danish Medical Group, Amnesty International

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