

Introduction

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The effects of the treatment of torture survivors at the Rehabilitation and Research Centre for Torture Survivors (RCT) are manifested in three major areas – psychological, somatic, and social.

Some words about PTSD

Discussion is still taking place concerning the existence of a *torture syndrome* or whether the diagnosis Post Traumatic Stress Disorder, PTSD¹, can be applied to torture survivors.

Attempts to delineate a *torture syndrome* have not been successful. The typical finding is a considerable overlapping of symptoms following very different traumatic experiences, rather than the existence of well-defined syndromes. Consequently, it appears that the response of the human organism to various stresses is confined to somewhat restricted psychological pathways.

Undoubtedly many symptoms presented by survivors are in agreement with the diagnostic criteria of PTSD, and a proportion of survivors may be diagnosed as suffering from PTSD. On the other hand, the current version of the PTSD has certain shortcomings. Its main imperfections are that:

- it excludes “changed identity or personality”
- it allows for a rather insufficient length of time from the trauma to the emergence of symptoms
- it does not cover the chronically traumatized individual.

Furthermore, PTSD reduces complex politico-historical problems to difficulties at the individual level, and it appears to be a diagnosis applicable exclusively to adults.

The reports published on long-term torture sequelae provide sufficient evidence to conclude that a hypothesis of no correlation between torture and the postulated long-term consequences must be rejected, although there are methodological shortcomings².

Terminology

However, the terminology used in the various studies differs. In a critical review of the international literature on the somatic and mental effects of torture, Goldfield et al.³ recommended the use of standardized diagnostic criteria in the evaluation of persons who have survived torture.

RCT was therefore urged in 1990 to establish an academic and multidisciplinary group – a consensus group – to come forward with a recommendation for a more uniform and defined terminology, applicable on an international scale and enabling more direct comparisons between studies.

Table 1a.

Prevalence (%) of mental symptoms among torture victims, reported in⁴:

I	Rasmussen & Lunde, 1980; Lunde, 1982
II	Allodi & Cowgill, 1982
III	Domovitch et al., 1984
IV	Lunde, Nielsen et al., 1985
V	Thorvaldsen, 1986

Table 1b.

Prevalence (%) of mental symptoms among torture victims, reported in the literature.

Symptom	Study No.*				
	I	II	III	IV	V
Self-isolation/social withdrawal ...	10	–	63	–	–
Emotional lability	–	–	30	–	11
Depression	19	71	66	60	25
Anxiety	24	88	94	42	32
Irritability/aggressiveness	30	–	63	26	18
Lack of energy	14	–	41	23	30
Insomnia	47	68	83	60	50
Nightmares	–	34	78	63	41
Impaired memory and concentration	45	–	–	66	–
Impaired memory	–	29	46	–	39
Impaired concentration	–	32	60	–	43
Sexual dysfunction	20	12	51	21	–
Number observed	135	42	53-98	38	44

In the light of the experiences of RCT during the last decade, and from an epidemiological survey (Table 1a + 1b)⁴, it was possible to arrange the most frequently occurring symptoms and signs in relation to torture into a limited number of principal terms. Having surveyed the international terminology, the consensus group found that a modification of selected mental symptoms in accordance with DSM-III-R¹ was an appropriate choice.

Table 2.

Main Groups of Psychological Symptoms (DSM-III-R).

II	Anxiety symptoms
IV	Behavior
V	Cognition
VII	Energy
VIII	Form and amount of thought/speech
IX	Mood/affect disturbance
X	Occupational and social impairment
XI	Perceptual disturbance (including hallucinations)
XII	Personality traits
XIII	Physical signs and symptoms
XIV	Sleep disturbance

The selection of the modified symptom-groups is listed in Table 2. Groups I, III, VI, and XV from the DSM-III-R symptomcategories are omitted; all multiple occurrences of symptoms should be reduced to association solely with one group, and a few symptoms should preferably be omitted or transferred to more appropriate groups in relation to the traumatology of torture⁵.

We at RCT agree with Allodi⁶ that:

Future research needs to include the conceptualization of the trauma of torture and its sequelae in broader terms, the application of standardized measurements to facilitate international comparisons and the testing of various approaches to intervention in an experimental design.

Most studies in this area have dealt with torture and its consequences. The next step in research will be to develop better treatment models. Treatment today is practised in different ways. We do not know which treatment composition is the most effective. Reports on outcome of treatment are uncontrolled and anecdotal.

The client

Clients are usually sceptical about the treatment, in particular when they are not familiar with westernized thinking. They may be reluctant to enter the psychotherapeutic process.

Obviously an exiled torture survivor must adapt to certain new cultural modes and practices, and at the same time he should be offered rehabilitation from the torture-induced trauma.

We believe at RCT that one of the prerequisites is for a client to take part in his new society, enabling him to make a free choice, e.g. that he may be able to decide again what he wants to do, and where and how he wants to live.

There are problems in evaluating psychotherapy in general, but evaluation of the treatment of the torture survivor is even more problematic. Our clients come from all over the world. However, during the last 3 years 80% of the clients at RCT come from the Middle East, mainly Muslims, but with different religious beliefs and political ideologies. We also receive clients from Poland, Chile and Vietnam. Common to all of them is the fact that they are living as refugees in a foreign country, in a culture quite different from their own. So a pertinent question would be, "To what culture do we rehabilitate our clients?"

The torture survivor has lived under inhuman and degrading circumstances during the period in which torture took place. After release, he often has to live underground until he succeeds in escaping from his home country. There have been losses of different kinds and at different levels.

After arriving in the new country, language and cultural barriers add to the natural reluctance of survivors to speak freely about their harrowing experiences. Survivors often feel ashamed of the way in which they succumbed to torture, and they are plagued by persistent fears of further attacks on themselves or their families by international

agents of the regimes from which they have fled. Another difficulty is their fear of being stigmatized as psychiatric patients, a difficulty which increases their tendency to present somatic complaints that may mask psychiatric symptoms – a diagnostic problem that is magnified in a transcultural setting.

- Do the questions mean the same in different cultures?
- Does culture influence the client's interview behaviour?

Many survivors – at least at their first contact with RCT – tend to use somatic expression for psychological discomfort, complaining of chronic diffuse headache or muscular tension, or being fearful of having a heart disease.

The reasons for this somatization may be twofold, related to culture and to torture. According to our experiences these complaints are regarded as psychosomatic, indicative of unresolved mental stress. There may be sleep disturbances, very often in connection with nightmares, in which torture experiences are repetitively relived. Many survivors allege impaired memory and difficulty in concentration. But in spite of this the experiences of torture are often remembered in the smallest detail. The feelings of guilt and shame are often linked with loss of self-esteem. Other features are sadness, worry, fatigue, emotional instability, suspiciousness, and social withdrawal. *In this context, the symptom anxiety emerges.*

The Anxiety

Anxiety is among the most evident of the survivors' mental symptoms; its prevalence ranges from 24% to 94% of the population examined, although our experience at RCT would suggest the higher rate as more realistic⁷.

Objectively the clients give the impression of being anxious, although they do not often talk about it. In our field of work, with people from various cultures, there are different ways of expressing emotion – also in the West people have difficulty in speaking about anxiety and other emotions. Culture affects the expression of emotion and the language of expression.

Moreover, unlike anxiety disorders described in DSM-III-R, the anxiety of the torture survivor is associated with conscious memories, tentatively but never really repressed, and so readily accessible to the professional outsider. Events from daily life are used in connection with the torture. After release these events will act as a stimulus triggering an anxiety or even a panic attack. The experience seems inexplicable, and therefore terrifying. In this way, through well-designed stimuli, the torture may continue even after release, so that the survivor is caught in a chronically alert state. The manifestation of anxiety in the survivor seems to be the same as anxiety in other people. Therefore it should be possible to apply rating scales such as those used for anxiety elsewhere.

When the person is released, he or she has thus been forced into the role of a victim. Long-term complaints indicate that after release these victims have to undergo a new adaptation in order to return to their former identity. However, it seems as if their capacity to use different coping strategies in a flexible way, depending on the situation, is restricted.

Trautman's description⁸ of the chronic anxiety syndrome in survivors from the concentration camps has much in common with our experiences concerning anxiety in torture survivors:

If they show anxiety and other manifestations today, we cannot blame such persistent symptoms on constitutional weakness or inherited disposition.

The goal of the seminar

The idea behind the seminar was to assemble experts from the fields of:

- anxiety
- coping, and
- evaluation.

It was hoped that their treatment theories could be applied to the world of the torture survivor with the purpose of developing instruments of evaluation and methods of treatment.

The seminar was the first step in the development of methods for evaluation of the effect of psychotherapy as part of a rehabilitation programme for torture survivors.

This supplementum presents the contributions from the seminar. However, the contribution from Professor Leo Eitinger, Norway, has already been printed in a shorter version in *TORTURE* vol. 2.1 pp. 21-23 and is therefore not reprinted in this supplementum.

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Conceptualizing anxiety in torture survivors

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