The Mental Health Consequences of Torture

Edited by

Ellen Gerrity

National Institute of Mental Health
Bethesda, Maryland

Terence M. Keane

Boston University School of Medicine
Boston, Massachusetts

and

Farris Tuma

National Institute of Mental Health
Bethesda, Maryland

Kluwer Academic / Plenum Publishers
New York, Boston, Dordrecht, London, Moscow

21

Future Directions

ELLEN GERRITY, TERENCE M. KEANE, FARRIS TUMA, AND SISTER DIANNA ORTIZ

The heart of this book is a summary of what is known about the mental health consequences of torture and other violent and traumatic events. Central to this review are the research recommendations and their implications for treatment, research, and policy. The contributors made a concerted effort to gather and present this information within a scientific context that included the experiences of survivors, clinicians, policymakers, and researchers.

In this final chapter, selected research findings from each section of this book are used to point to a direction for the future. The intention is to help shape research that will provide a greater understanding of the mental health consequences of this most horrific experience and to develop effective services, treatment programs, and relevant policies for survivors of torture. Each contributor summarized the strongest scientific or clinical findings of relevance to research, service delivery, treatment, or policy. The reader is referred to the individual chapters for further information on the specific issues highlighted here.

ELLEN GERRITY • National Institute of Mental Health, Neuroscience Center Building, Bethesda, Maryland 20892. **TERENCE M. KEANE** • Department of Psychiatry, Boston University School of Medicine, Boston, Massachusetts 02130. **FARRIS TUMA** • National Institute of Mental Health, Neuroscience Center Building, Bethesda, Maryland 20892. **SISTER DIANNA ORTIZ** • Guatemalan Human Rights Commission, Washington, D.C. 20017.

The Mental Health Consequences of Torture, edited by Ellen Gerrity, Terence M. Keane, and Farris Tuma. Kluwer Academic/Plenum Publishers, New York, 2001.

SUMMARY OF SELECTED RESEARCH FINDINGS

- Precise estimates of the extent of torture are not available at present, and epidemiological studies specifically focused on torture experiences are greatly needed to enhance this knowledge base. Estimates of torture among refugees alone range from 5% to 35% of the world's 14 million refugees, although millions more internally displaced persons and asylees are also at risk. A report from Amnesty International in 1999 stated that systematic use of torture and severe ill treatment was ongoing in 121 of the world's 204 countries. Thus, the experience of torture—how widespread it is, how to help survivors, and how to prevent it—represents a severely understudied area that deserves greater attention from policymakers, researchers, and clinicians.
- Torture survivors can be found in virtually all countries that receive refugees and asylees, but these survivors represent only a small proportion of the number of torture survivors worldwide. Epidemiological studies that focus on the prevalence of torture in various countries need to look beyond at-risk populations (i.e., refugees) to the general population to obtain the most accurate estimates. For example, population surveys or key informant studies with health clinics or treatment providers could be conducted to determine the size of the population of torture survivors in a particular region.
- The experience of torture can result in the development of a wide range of psychological, behavioral, and medical problems, including specific psychiatric conditions, such as posttraumatic stress disorder (PTSD), depression, anxiety disorders, and psychotic conditions. Torture also can lead to sleep disorders, sexual dysfunction, chronic irritability, physical illness, and a disruption of interpersonal relations as well as occupational, family, and social functioning. Often torture occurs in the context of many other life stressors, such as war, terrorism, loss of family and community, and financial setbacks, all of which can be extremely severe stressors. Research suggests that torture exerts an independent effect separate from the effects of the stressful context within which it usually occurs.
- Survivors of torture can recover to the point where they resume functioning at home and at work, but many have severe difficulties. An inability to resume normal functioning exacts a long-standing toll on personal and economic viability. Risk-factor studies have not yet demonstrated specific factors associated with difficulties in recovery, but there is some suggestion that situations that are more unexpected and less controllable are potentially much more likely to result in long-term impairments for individuals. Additional studies of risk factors and resilience are needed to further address these questions.
- Torture can have persistent and lifelong effects. Data from several research programs in the United States, Europe, and the Middle East indicate that the effects of torture can extend throughout the life of the

survivor, affecting his or her psychological, familial, and economic functioning. Studies of former prisoners of war and Holocaust survivors confirm that without appropriate intervention, the negative effects of systematic torture can persist throughout the life of the individual.

- Studies conducted over the past 10 years strongly suggest that people who develop PTSD may also experience serious neurobiological changes, including (a) changes in the body's ability to respond to stress (through alterations in stress hormones); (b) changes in attention and arousal (through changes in neurotransmitter systems); (c) changes in the body's response to infection and disease (through changes in the immune system); (d) the development of an imbalance in the noradrenergic system; (e) heightened psychophysiologic arousal and reactivity; and (f) possible changes in the hippocampus, an area in the brain related to contextual memory. Thus, the development of PTSD has direct implications for the functioning of numerous biological systems essential to human functioning. These neurobiological abnormalities may be responsible for the chronic physical health problems often associated with PTSD and depression.
- Over the past several years, assessment instruments have been developed and refined that attempt to measure the extent of exposure to torture and related traumatic events. Other well-established diagnostic instruments that measure PTSD, depression, and other psychiatric conditions are valuable clinical and research tools. Though difficult to develop, sensitive and scientifically based screening instruments are critically important to advance this field and to more accurately assess the mental health consequences of torture.
- As a form of torture, rape and sexual assault have severely negative outcomes. Most commonly used against women, rape may also be systematically used against both men and women and is frequently used to terrorize communities in which there is political unrest and war. The effects of rape are felt by the survivor herself, her spouse or partner, her children, and others in the surrounding community. Research has shown that rape can lead to the development of PTSD, depression, substance abuse, panic disorder, and other psychiatric conditions. Rape can also lead to higher rates of somatic problems and utilization of scarce and expensive health care services. For some survivors, the effect of rape is lifelong and recovery can be slow and, in some cases, negligible. Treatment studies with survivors of acute rape experiences have shown promising outcomes, particularly when professional and paraprofessional staff are available and cognitive–behavioral methods are employed. Research is needed on treatment for adults and children exposed to multiple or long-term rape or sexual assault and on the value of pharmacologic treatment with survivors of rape.
- Treatments specifically focused on torture recovery are in an early stage of development. Most treatments for torture survivors were developed within clinical settings, often under extremely challenging conditions, and many

have yet to be fully tested and evaluated. Most psychiatric treatment was provided as part of other health care for refugees. Therefore, multiple methods and treatments were used and involved behavioral, psychopharmacological, psychodynamic, and cognitive methods. Individual, family, and group therapies have also been employed. More recently, treatment programs were developed in neuropsychiatric settings in which empirical tests of treatment efficacy were possible. Initial studies supporting the use of behavioral and cognitive–behavioral interventions appear encouraging. Much more work is needed on the psychiatric treatment of torture survivors and their psychosocial problems and associated impairments.

- Few studies have directly investigated the effectiveness of psychopharmacological interventions for torture survivors. An accurate clinical diagnosis is critical to determine the best medication regimen for the particular pattern of symptoms experienced by each torture survivor. Antidepressant medications, such as selective serotonin reuptake inhibitors, antianxiety agents, and antipsychotic medications, may play a role in the appropriate treatment of a torture survivor. The psychopharmacologist also needs to be aware of potential gender, racial, and cultural differences in response to medications. Pharmacokinetic differences in the metabolism of medications among racial and ethnic groups are well known and need to be considered when prescribing. Finally, the torture survivor's views about medication have been known to be an integral part of the treatment decision-making process. Torture survivors may be open to accepting psychotropic medication, for example, to lessen depression, while also exploring traditional medicines, such as natural remedies prepared by folk healers. Others favor alternative forms of therapy, such as bodywork, massage, aroma or sound therapy, special breathing, and relaxation exercises.
- The cost of disabilities that result from torture and related traumatic events is now being quantified using contemporary econometric methods. As these methods become widely accepted, the exact economic toll of torture on the individual, the family, the community, and the society can be more accurately calculated. The concept of disability adjusted life years, when applied to torture and its aftereffects, may prove to be an important contribution to the measurement of broad-based economic costs associated with torture. The use of these kinds of methods has also begun to show evidence, as it has done with depression, of the economic value of providing treatment and rehabilitation for torture survivors as an important part of broader discussions of the need for care.
- Children and adolescents have experienced torture directly or indirectly (through witnessing the torture of others, especially parents and loved ones). Research has shown that children and adolescents who have been exposed to torture can be identified through sensitive case-finding methods using standardized assessment instruments. These screening methods can also help determine the severity of distress (e.g., PTSD, depression, conduct disorder) among such children and adolescents. A comprehensive

approach is needed to help shape developmentally appropriate interventions for optimal healing and recovery of children.

- A family can be severely disrupted by the torture of one or more of its members. In some instances, the parents of traumatized children may also have been tortured or otherwise traumatized, and problems in the parent–child relationships and the family interaction patterns may result. Changes in the course of the child's development are frequently observed in families that have been traumatized and are often an ongoing and serious concern for such families. Interventions geared to remediating developmental changes may prove to be the most effective for the resumption of stable family functioning. In many cases, working with the entire family may be the most beneficial approach, for both the child's recovery and the recovery of the family.
- Research suggests that in relatively stable social contexts, school-based interventions for children and adolescents are among the most enduring because of the involvement of teachers, counselors, and peers in the behavior change process. School-based programs may be most valuable when the parents and siblings are also traumatized, and their daily home functioning is disorganized. Working with the school may result in the most favorable outcomes; however, the conditions in the society must be stable enough to support such interventions. Further research is needed on effective interventions for children and adolescents in refugee camps or in situations in which conflicts are ongoing.
- In settings where few mental health professionals are available, alternative approaches are needed to assist torture survivors with their mental health needs. These alternative approaches may involve (a) using primary care providers (including indigenous providers), (b) training paraprofessionals, (c) involving spiritual or religious leaders, and (d) using whatever media or technology might be available (i.e., radio or television). In some settings, viable mental health programs have been developed by identifying social or political leaders in the communities, training them in methods of education and intervention, and assisting them in providing self-help tools to the communities they serve.
- Timely access to mental health care for torture survivors is an important part of recovery. Programs that are integrated into a well-functioning primary care system that is accessible may optimize effectiveness and improve overall outcomes for the survivors. However, such care needs to be delivered by well-trained providers who are informed of the issues associated with the treatment of torture survivors. It is also important that they possess knowledge not only of the country in which the person was tortured but also of the survivor's culture.
- Many torture survivors are refugees who live in limbo, housed in camps until decisions are made regarding their future. Such uncertain and often uncomfortable circumstances put these populations at high risk for further exposure to trauma, while leaving untreated the consequences of their

earlier experiences. Mental health services for torture survivors in these camps should be a standard part of the primary health care services that are made available in the camps.

- The establishment of specialized mental health care for torture survivors in more developed countries has special advantages. Well-trained staff and focused services can be made available locally, and consultants can be made available worldwide. Specialists with backgrounds and experience in PTSD, depression, and other related conditions and providers who are trained in the culture of the targeted population are particularly needed to ensure that the most effective interventions can be offered.
- Conclusions drawn from research on crime victims suggest that the processes associated with restitution, reparation, and restoration may be expected to improve survivors' satisfaction with the system that has been created to promote justice. Timely communication regarding the disposition of cases involving perpetrators and allowing survivors to have input into the decision-making processes regarding restitution, reparation, and restoration may be expected to enhance the recovery process. This research also suggests that efforts to bring together the survivor and the perpetrator may prove of value in the recovery process. In such a meeting, the perpetrator would be obligated to hear directly what the effects of his or her violent actions have been on the survivor, the survivor's family, the community, and the whole society. The principles of restorative justice appear to be applicable to survivors of torture and other human rights abuses. These include the opportunity for public testimony, governmental apology, and reparations to survivors.
- Cultural and language differences often appear when providing care to torture survivors and refugees, and they must be addressed for services to be effective. It is likely that with each situation professionals will need to explore the cultural nuances and the meaning of the experiences of the survivors. Whether survivors are African, Asian, Southeast Asian, Latin American, North American, or European, they will interpret their experiences with a unique worldview. Interventions that incorporate relevant language and cultural factors into treatment will optimize outcomes. A powerful issue for the torture survivor could be the role that governments and health care professionals might have played in the torture experience itself. Understanding and dealing with this issue in a sensitive manner may be critical to the delivery of effective treatments that can be accepted by the survivors.
- Research priorities should include studies of the mechanisms associated with traumatization, risk factors for the development of persistent psychiatric disorders, factors related to resilience and posttorture recovery, the interaction of torture and related stressors such as refugee status and acculturation, the effects of impunity for those responsible for torture, and psychosocial and psychopharmacological interventions. The direct involvement of survivors in the development of research priorities and

implementation of research studies is an integral part of conducting meaningful research in this area of science, research that will lead toward improved treatment, service delivery, and human rights policies.

CONCLUSION

Torture has existed throughout history and in diverse forms, including imprisonment, crucifixion, beatings, solitary confinement, and genocidal rape. It has left a permanent legacy on every continent and culture, past and present. History has recorded at least some of the faces and names of those who have borne witness to torture with their bodies and their lives—the early Christians, slaves, the indigenous of many countries, and victims and survivors of the Holocaust, to name only a few.

The diversity of victims throughout the centuries suggests what is obvious: No one is immune to torture. People of any time, ethnicity, age, religion, gender, and social class can be touched by it. Those affected include not only those directly victimized, but also their families, communities, and societies. The swath torture cuts through humanity today is wide and deep. The governments of more than 120 countries engage in torture or similar ill treatment. While the enormity of this crime has led so often to despair and apathy, even its most horrifying effects have failed to completely destroy hope and responsive action to confront it.

Mental health professionals have begun to show that substantial recovery from the effects of torture is possible. In recent years, they have conducted wide-ranging research into torture and its crippling effects and investigated the effects of many forms of severe trauma. They have acknowledged the importance of the issue and the need to understand it. Research into torture has increased, and a new important development has occurred: Torture survivors are not simply, as in the past, subjects to be observed and evaluated. Many mental health professionals now understand that survivors must be among the evaluators and are central to the development of meaningful research and treatment.

In an effort to better understand torture and its effects, the National Institute of Mental Health brought together researchers, clinicians, and policymakers with torture survivors. Mental health professionals listened to the views and experiences of torture survivors from Asia, Africa, North and South America, and Europe. This exchange provided a wide window for the nontortured to receive a glimpse into the survivors' world. Survivors viewed these meetings as a ray of hope in what is often the dark midnight of their own despair; the mental health professionals viewed these meetings as a rare and generous gift, one that seared the soul but also opened the mind and vision to what is needed to shape a better profession and practice. Survivors had the opportunity to reclaim their voice, to define themselves and their own behavior, and to exercise their right to speak for themselves. The mental health professionals had the opportunity to review their own preconceived beliefs, to accept the gift of the reality of the survivor, and to engage in a dialogue that was painful, gratifying, and educational.

Torture has the ability to reduce one to silence. At times, its sole purpose is to punish those who express their views and to send a message to those who otherwise might dare to speak. During the torture, answers are criticized as "wrong" and therefore punishable. After the torture, survivors emerge from that experience of ultimate cruelty with the feeling that no one cares about them and that no one will believe them. To be asked to share their views and to be listened to, cared about, and believed can be a powerful healing experience in itself for survivors. While survivors and mental health professionals certainly do not always agree on every point, they have been able to come together, listen, converse, and learn from one another.

This volume is a public testament to the reality of torture and its consequences. This subject deserves the most serious consideration by those in many professions to reduce the silence that has too often surrounded it. Torture can challenge our most basic concepts about the nature of human beings and reduce people to feelings of helplessness, despair, guilt, and denial.

This work has been an effort to break through the wall of silence and to bring the scientific and decision-making communities together with the general public to share this information. Much of what these diverse communities know of torture is included in these pages and is accompanied by recommendations for future research. These conclusions are drawn not only by academicians and other professionals but also by survivors themselves.

Finally, we conclude with the hope that many who work in this field will find the information in this book of value in their work. All who read this work will recognize that increasing our knowledge of the effects of torture and providing appropriate services for survivors and their families are only two of the issues that challenge us. Research and treatment for torture survivors would not be necessary if torture could be prevented from ever occurring, and thus it is prevention—the abolishment of torture in our world—that would be the ultimate cure.

As noted at the opening of this book, this work is dedicated to those who experience the horror of torture—past, present, and future—and to those who work to end it.