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PSYCHOLOGICAL EVIDENCE OF TORTURE

*How to conduct an interview with a detainee to document
mental health consequences of torture or ill-treatment*

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TABLE OF CONTENTS

I. Overview of signs and symptoms that can result from torture, and conditions that can contribute to deterioration (checklist)..... 4

- A. The interview 4
 - Common Psychological Responses (adapted from the Istanbul Protocol) 4
 - 1. Re-experiencing the trauma 4
 - 2. Avoidance and emotional numbing 4
 - 3. Hyperarousal 5
 - 4. Symptoms of depression 5
 - 5. Damaged self-concept and foreshortened future 5
 - 6. Dissociation, depersonalisation and atypical behaviour 5
 - 7. Somatic complaints 5
 - 8. Sexual dysfunction 6
 - 9. Psychosis 6
 - 10. Substance abuse 6
 - 11. Neuropsychological impairment 6
- B. Questions that can be asked 7
- C. Places of detention and regime 7

II. Mental health consequences of torture 9

- A. Preliminary remarks 9
- B. Limitations 10
- C. Retraumatization 11
- D. Incidence 12
- E. Chronification 14
- F. Vicarious traumatization 14
- G. Detention 15
- H. Protective factors 16
- I. What to observe and what to ask to detect PTSD 16
- J. Course and prognosis 17
- K. Treatment 17
- L. Evidence 18

III. Appendix 20

- Diagnostic Classification (adapted from the Istanbul Protocol) 20
- 1. Depressive disorders 20
- 2. Posttraumatic stress disorder 21
- 3. Enduring personality change 22
- 4. Substance abuse 23
- 5. Other diagnoses 23

I. Overview of signs and symptoms that can result from torture, and conditions that can contribute to deterioration (checklist)

A. The interview

1. Establish as much trust and confidence as possible within the limits of a CPT visit. Explaining the task of the CPT, the rule of confidentiality and the voluntary nature of the interview may facilitate the creation of a secure, though temporary, relationship. If psychological trauma symptoms appear, the interviewer should acknowledge the need for more time to complete the interview. To open up for the psychological pain of torture, and then be on your way, without any word of reassurance or sense of closure, is of course unacceptable.
2. Questions about psychological consequences of “trauma” are easier both to ask and answer when they are part of a routine line of questioning. Questions should be open and non-leading, but specific questions may also have to be asked to elicit the history of trauma.

Common Psychological Responses (adapted from the Istanbul Protocol)

1. Re-experiencing the trauma

- a) Flashbacks or intrusive memories, i.e. the subjective sense that the traumatic event is happening all over again, even while the person is awake and conscious.
- b) Recurrent frightening dreams or nightmares that include elements of the traumatic event(s) in either their original or symbolic form.
- c) Physiological or psychological stress reactions at exposure to cues that symbolize or resemble the trauma. This may include lack of trust and fear of persons of authority, including physicians and psychologists. In countries or situations where authorities participate in human rights violations, lack of trust and fear of authority figures should not be assumed to be pathological.

2. Avoidance and emotional numbing

- a) Avoidance of any thoughts, conversations, activities, places or people that arouse recollection of the trauma
- b) Profound emotional constriction
- c) Profound personal detachment and social withdrawal
- d) Inability to recall an important aspect of the trauma

3. Hyperarousal

- a) Difficulty falling or staying asleep
- b) Irritability or outbursts of anger
- c) Difficulty concentrating
- d) Hypervigilance
- e) Exaggerated startle response
- f) Generalized anxiety
- g) Shortness of breath, sweating, dry mouth, dizziness
- h) Gastrointestinal distress

4. Symptoms of depression

- a) Depressed mood
- b) Markedly diminished interest or pleasure in activities
- c) Appetite disturbance and resulting weight loss, or weight gain
- d) Insomnia or hypersomnia
- e) Psychomotor agitation or retardation
- f) Fatigue and loss of energy
- g) Difficulty in attention, concentration and memory
- h) Feelings and thoughts of worthlessness, guilt and hopelessness
- i) Thoughts of death and dying, suicidal ideation, suicide attempts

5. Damaged self-concept and foreshortened future

- a) A subjective feeling of having been irreparably damaged and of having undergone an irreversible personality change
- b) A sense of foreshortened future: not expecting to have a career, marriage, children or a normal life span

6. Dissociation, depersonalisation and atypical behaviour

- a) Dissociation: a disruption in the integration of consciousness, self-perception, memory and actions. A person may be cut off or unaware of certain actions or may feel split in two and feel as if observing him or herself from a distance.
- b) Depersonalisation: feeling detached from oneself or one's body
- c) Impulse control problems, resulting in behaviours that the survivor considers highly atypical with respect to his or her pre-trauma personality. A previously cautious individual may engage in high-risk behaviour.

7. Somatic complaints

Somatic symptoms such as pain and headache and other physical complaints, with or without objective findings, are common problems among torture victims. Pain may be the only presenting complaint. It may shift in location and vary in intensity. Somatic symptoms, such as pain of all kinds, may be a direct physical consequence of torture, or of psychological origin, or both.

The chronic pain syndrome is exacerbated by a vicious circle of inactivity, insomnia and use of analgesics. Typical somatic complaints include:

- a) Headaches: a history of beatings to the head and other head injuries are very common among torture survivors. These injuries often lead to post-traumatic headaches that are chronic in nature. Headaches may also be caused by or exacerbated by tension and stress.
- b) Back pain
- c) Musculoskeletal pain and tenderness, diffuse and non-specific

8. Sexual dysfunction

Sexual dysfunction is common among survivors of torture, particularly among those who have suffered sexual torture or rape, but not exclusively. It can be linked to depression and posttraumatic stress disorder, but can be a direct result of an assault. Hypnotics or alcohol abuse can occur in this context.

9. Psychosis

Cultural and linguistic differences may be confused with psychotic symptoms. Before labelling someone as psychotic, one must evaluate the symptoms within the individual's unique cultural context. Psychotic reactions may be brief or prolonged. The psychotic symptoms may occur while the person is detained and tortured as well as afterwards. The following is a list of possible findings:

- a) Delusions
- b) Hallucinations: auditory, visual, tactile, olfactory
- c) Bizarre ideation and behaviour
- d) Illusions or perceptual distortions
- e) Paranoia and delusions of persecution
- f) Recurrence of psychotic disorders or mood disorders with psychotic features may develop among those who have a past history of mental illness.

10. Substance abuse

Alcohol and drug abuse often develops secondarily in torture survivors as a way of obliterating traumatic memories, regulating affect and managing anxiety.

11. Neuropsychological impairment

Torture can involve physical trauma that leads to various levels of brain impairment. Blows to the head, suffocation, and prolonged malnutrition may have long-term neurological and neuropsychological consequences that may not be readily assessed.

B. Questions that can be asked

Open-ended questions are preferable, such as “Can you tell me what concerns you the most?” or “It would be helpful to us if you are willing to tell us what has happened, but it is up to you, we understand if it is too difficult to talk about it.” Often it is useful to ask 2-3 “yes or no” questions, and then an open question. Open questions usually have to be interspersed with specific questions¹:

Have you experienced an event that has caused you to fear for your life or safety? Do you feel up to describing the event? Can you remember all or most parts of the event? Was the event psychologically frightening or did it include physical or sexual violence?

Do you have thoughts about the event that keep returning? Do you feel you are in control of these thoughts? How do you feel when you have these thoughts and memories? Do these memories upset you? Do they cause fear or physical discomfort?

How is your sleep? Have you had recurring dreams or nightmares about the event?

Do you find that you try to avoid thoughts, memories, places or things that can remind you of the event, because it causes discomfort or bad memories? How is your memory and concentration now?

Does anything interest you or amuse you? Do you feel numb and don't feel normal feelings? Do you startle easily and are you careful not to be caught off guard? Do you easily get angry or irritated now? How were you before the event?

C. Places of detention and regime

3. Are detainees assessed on arrival in a way that might elicit the psychological consequences of torture? Can any psychiatric disorder be diagnosed on arrival or later? Are the symptoms known among the medical staff? Is PTSD recognized in the country? Would such symptoms cause stigmatisation or have other negative effects?
4. Is there any possibility of treatment in the establishment, or in the country? Is it recognized by the medical community that PTSD, depression and anxiety are treatable disorders?
5. Are psychiatrists or psychologists available? Do they have an understanding of the detainees' needs in this regard?
6. Remember that physical torture can cause psychological symptoms.
7. Re-traumatisation can be caused by any trauma that reminds the victim directly or indirectly of the original torture.

¹ Developed from the diagnostic criteria of PTSD and depression as described in the DSM-IV

8. When visiting places with a tradition for physical torture methods, it should be borne in mind that more sophisticated methods of torture can have been developed, leaving no physical signs of the torture, only psychological consequences. This suspicion may arise when there has been a reduction in the incidence of torture with physical consequences.
9. While some methods of ill-treatment are relatively easily exposed and documented, other methods of ill-treatment may be used, which cause frustration, despair or fright, and are degrading, but can be hidden or secret. These more subtle methods of ill treatment should be checked, such as discrimination (e.g. of vulnerable prisoners), individual ill-treatment (mobbing), threats of retaliation for disclosure, prison secrets, inter-prisoner violence etc. This should be suspected especially in establishments with insufficient segregation possibilities, understaffing or recruitment problems.
10. The country's legal system may make claims of psychological consequences of torture difficult to raise, and courts may have refuted such claims, e.g. of criminal liability or disciplinary sanctions of perpetrators, or claims for financial compensation for victims. If it is well known that making allegations of this sort is futile, then they will not be volunteered. Such legal practice would also influence other parts of the legal system, such as insurance claims, so this state of affairs in the country and its court practice could be checked in various ways.

II. Mental health consequences of torture

A. Preliminary remarks

11. Torture may have severe consequences and burden the victim with serious health problems and disability, without leaving any physical evidence. Psychological symptoms may be the only evidence of torture or ill-treatment. Therefore the visiting CPT delegation should be able to assess whether a person deprived of his or her freedom by the authorities shows psychological trauma symptoms and whether this evidence is in accordance with any allegations of ill-treatment. A second reason for the CPT to focus on psychological trauma symptoms is that they may indicate serious and common medical problems in places of detention. In addition, they may indicate treatable diseases, so it would be important to assess whether adequate treatment is available.
12. The aim of this text is to aid the knowledgeable interviewer to determine whether psychological consequences of trauma are present, to assist in determining the occurrence of torture or ill treatment.
13. What usually makes an experience traumatic is a sense of horror, utter helplessness, serious injury or the threat of physical injury or death. Different categories of trauma cause similar psychological symptoms. Therefore the study of trauma in general is helpful for the understanding of psychological consequences of torture. The use of strict diagnostic criteria allows precise treatment prescription and prognostic prediction. Victims who reach a high level of trauma symptoms, i.e. fulfil the diagnostic criteria for posttraumatic stress disorder, have a worse prognosis than those that do not, even though they have considerable trauma symptoms. However, care should be taken not to reduce a natural response to severe stress into a medical disorder. A majority of trauma victims show a natural decline in “symptoms” or even complete recovery. It goes without saying that being a torture victim is not a psychopathological condition.
14. Traumatized individuals are often passive, shy and non-assertive. They find it painful to describe their trauma and may therefore, understandably, refrain from a detailed description. A prisoner who has been subjected to violence may have many reasons not to volunteer this information. This difficulty is especially evident in the case of posttraumatic stress disorder (PTSD). It is important to realize that the tortured person may not only decide not to disclose the traumatic experience, but may also be unable to do so, because of neuropsychological deficits. Such a disability can be caused by a psychological trauma, as well as by physical torture.
15. Disclosure of a traumatic event may require the establishment of trust and confidence between patient and physician². To obtain a fairly complete description of the trauma, it is often necessary to establish a secure relationship at the outset. This can of course be difficult in the setting of a CPT visit, but should not be ruled out. Explaining the task of the CPT and the rule of confidentiality may help in this context. The doctor could

² Davidson, J.R.T. (2001). Recognition and Treatment of Posttraumatic Stress Disorder. *Journal of the American Medical Association*, 286, 584-588.

raise concern that the patient's medical problems might be related to "trauma". Routine questioning about traumatic events is recommended.

16. Sexual violence is a particularly sensitive issue, but one that can be pursued with a line of questioning, if a relatively secure interview relationship and environment have been created. It may be helpful if either the interviewer or the interpreter is of the same sex as the victim. The presence of a doctor of the other sex may be accepted, but perhaps not an interpreter, especially in the case of physical examination, but also when sex-related issues are discussed.
17. Feelings of self-blame are common in victims, especially if favours were granted in exchange. Prostitution, voluntary or not, will be the last secret to be disclosed. Denials are to be expected, and should not be taken at face value. However, for someone sexually abused, e.g. a vulnerable prisoner, questions about the abuse will not come as a surprise, and might be a relief. Disclosure may be difficult if the abuse is ongoing and there is a danger of retaliation, but if the allegations may lead to transfer to a safer setting, more openness is to be expected.

B. Limitations

18. Because of the nature of trauma symptoms, it cannot be expected that the whole history of the traumatic event, or all the symptoms will be elicited in one interview. The memories are per definition fragmented, and the impossibility to recollect important details of the event are part of the syndrome. Also, the strong feelings connected to the memories can cause pain and re-traumatization. When only one interview is possible it is important to realize these limitations. One should not try to pressure a traumatized person to describe details of the trauma if he/she does not seem up to it, or seems to be in pain.
19. If the interviewed person on the other hand, goes into a long and detailed monologue on the trauma, the interviewer has the obligation to limit the flow of narration, because such flooding can also cause deterioration. The interviewed person might be relating the events for the first time, and may not be aware of the possible psychological consequences. This deterioration may not be evident until later and may last for several days. It should be asked whether this is the first time the details of the trauma are recounted, and if that is the case and the details are extensive, then the person should be warned that there might be some discomfort after the interview and that such discomfort is normal.

C. **Retraumatization**

*“We know that many refugees and asylum seekers are themselves torture victims – the way in which they are being treated promotes severe re-traumatization and violates all international principles of the rights of refugees. The closing of borders and the long-term detention of such people places their right to rehabilitation at stake.”*³

20. The main risk factor causing a higher incidence of PTSD after trauma is prior trauma. The risk is irrespective of the type of trauma. For example, the risk of a physical accident causing PTSD symptoms in an adult is higher if there is a history of abuse in childhood. This means that those that have been subjected to torture previously are at high risk of developing symptoms and disability as a result of the trauma of detention, especially if it is carried out in a forceful manner or leads to other forms of ill-treatment.
21. Arbitrary trauma, occurring after the original trauma situation has ceased, can contribute to causing PTSD. Traffic accidents and violence in post-war civil life was a causative factor for Gulf War veterans with PTSD.
22. Social factors in exile, particularly the level of affective social support, have been shown to be important in determining the severity of both PTSD and depression⁴. This was particularly the case for the 55 torture victims among 84 male refugees in one study. Poor social support was a stronger predictor of depression than the trauma.

³ Jens Modvig, IRCT Secretary-General, quoted in the IRCT Annual Report 2001, p. 28.

⁴ Gorst-Unsworth, C., Goldenberg, E. Psychological sequelae of torture and organised violence suffered by refugees from Iraq. Trauma-related factors compared with social factors in exile. British Journal of Psychiatry 1998; 172: 90-94.

D. Incidence

23. Posttraumatic stress disorder is a common disease, with a lifetime prevalence of 1 - 9% in specific populations. Over a third of rape or assault victims report lifetime PTSD, and prospective studies show that 47% of sexual assault and 22% of nonsexual assault victims meet criteria for PTSD 3 months post-assault. Almost half of concentration camp survivors have long-standing PTSD, and in some studies the prevalence is even higher.
24. A study of refugees in the Netherlands⁵ showed that in spite of a high rate of torture events, refugees often contributed their psychological distress to the post-migration situation. Therefore the authors concluded that paying attention only to health complaints and to past violent experiences, was too limited an approach in responding to the needs of refugees. They pointed out that the stress was not “post-“, but rather ongoing. Also, relatively few refugees are diagnosed with PTSD, in spite of torture events, perhaps because some of the diagnostic criteria, such as avoidance behaviour, do not apply to detained persons.
25. On the other hand, one of the few studies of trauma among prisoners demonstrated that 81% of female prisoners currently suffered from a posttraumatic stress disorder⁶. The traumatic events experienced included rape or sexual assault by 71%, childhood sexual abuse by 55 per cent and physical assault by 32 per cent. Symptoms often preceded the history of criminal behaviour. Many of their crimes related to the need to support their drug abuse, which often represented an attempt to self-medicate their traumatic symptoms. Thus, victims became perpetrators, and were consequently re-victimized. Re-victimization is a common predicament of trauma victims.
26. Studies of prisoners have found childhood maltreatment to be more strongly associated with depression and substance dependence among women than among men. Also, the severity of substance misuse and problems associated with it are stronger predictors of female rates of criminal activity than male rates. The authors suggested a female empowerment treatment model to help women attain control over their lives.⁷
27. A study of former political prisoners showed that 64% suffered chronic depression and anxiety, somatic complaints and increased arousal.⁸ Another study of 146 former political prisoners from the former German Democratic Republic who had been imprisoned for 38 months on average, showed they had higher levels of not only post-traumatic symptomatology but also of other anxiety disorders and dissociation, than an age- and sex

⁵ Hondius AJK et al. (2000). Health Problems Among Latin-American and Middle-Eastern Refugees in the Netherlands: Relations With Violence Exposure and ongoing Sociopsychological Strain. *Journal of Traumatic Stress*, 13, 619-634.

⁶ Raeside, C.W.J. (1994). Post traumatic Stress Disorder in a Female Prison Population, RANZCP Dissertation. Cited in: McFarlane, A. Attitudes to Victims: Issues for Medicine, the Law and Society. Australian Institute of Criminology Symposium 1994.

⁷ McClelland, D.S., Farabee, D., and Crouch, B.M. Early Victimization, Drug Use, and Criminality. A Comparison of Male and Female Prisoners. (1997). *Criminal Justice and Behavior*, 24:455-76.

⁸ Bauer, M. et al. (1993). Long-term mental sequelae of political imprisonment in East Germany. *Journal of Nervous and Mental Disease*. 181(4):257-62.

matched comparison group. Intrusive recollections and hyperarousal were more common than avoidance and numbing symptoms.⁹

28. A study of torture victims from 6 countries¹⁰ showed great variation between countries in the physical methods used for torture. In spite of this variation, there was a high prevalence of PTSD in victims from all countries, varying between 69-92%. A high number was assessed as being at risk of suicide, ranging from 26-42%, the highest risk being among Turkish victims of torture.
29. A survey of 526 tortured refugees and a control group of the same size showed a lifetime prevalence of PTSD of 73.7% among tortured and 14.5% among non-tortured refugees.¹¹ Persistent (somatoform) pain disorder was common in both groups, with a prevalence of 56.2 and 26.8%, respectively. Affective disorders had a prevalence of 35.6 and 15.6% respectively, and dissociative disorders 19.4 and 4.6% respectively. Tortured women were more likely than men to have anxiety, somatoform, affective or dissociative disorders. 5 of every 6 tortured refugees had suffered from a psychiatric disorder.
30. Victims who have suffered isolation or blindfolding, impact torture and other physical torture, may have more PTSD intrusion symptoms, while victims of sexual torture describe more avoidance phenomena¹². Isolation and blindfolding was also associated with subsequent arousal symptoms in this study of 100 survivors.
31. A study from Croatia showed a high level of depression among PTSD patients that had been tortured, and had combat experience, when compared with a PTSD patients with combat experience that had not been tortured. The level of depression correlated mainly with the perceived threat of torture¹³.
32. A study of 131 displaced Kosovans, of whom over half had experienced torture, showed the torture was associated with poor coping; that depression, anxiety and aggression were associated with PTSD symptoms; and that females were at greater risk of developing psychiatric symptoms subsequent to torture¹⁴. The need for early assessment and a gender perspective on coping strategies was emphasised.

⁹ Maercker, A., Schutzwohl, M. Long-term effects of political imprisonment: a group comparison study. *Soc Psychiatr Epidemiol.* 1997 Nov;(3):435-42.

¹⁰ Moisander, P.A., Edston, E. Torture and its sequel – a comparison between victims from six countries. *Forensic Science International.* (2003) In Press.

¹¹ Van Ommeren, M., de Jong, J., Sharma, B., Komproe, I., Thapa, S.B., Cardena, E. Psychiatric disorders among tortured Bhutanese refugees in Nepal. *Archives of General Psychiatry.* 2001; 58 (5), 475-82.

¹² Ramsay, R., Gorst-Unsworth, C., Turner, S. Psychiatric morbidity in survivors of organized state violence including torture. A retrospective series. *British Journal of Psychiatry* 1993; 162: 55-59.

¹³ Roncevik-Grzeta, I., Franciskovic, T., Moro, L., Kastelan, A. Depression and torture. *Military Medicine* 2001; 166 (6), 530-33.

¹⁴ Ekblad, S., Prochazka, H., Roth, G., Psychological impact of torture: a 3-month follow-up of mass-evacuated Kosovan adults in Sweden. Lessons learned for prevention. *Acta Psychiatrica Scand* 2002; 106 (Suppl. 412): 30-36.

E. Chronification

33. The younger the age at which the trauma occurs, and the longer its duration, the more likely people are to have long-term problems with the regulation of anger, anxiety and sexual impulses. The lack or loss of self-regulation is a far-reaching effect of trauma.¹⁵ The intensity of affect responses to stressors leads to withdrawal and numbness, punctuated by intermittent excessive responses to traumatic reminder.
34. A study of 22 prisoners of war that had survived prolonged brutality indicated that psychiatric symptoms documented more than 3 decades ago had persisted in severity and chronicity. In addition to complaints of cognitive deficits and bodily discomfort, most common among POW survivors were symptoms of suspiciousness, apprehension, confusion, isolation, detachment, and hostility, when compared to combat veteran controls.¹⁶
35. Some studies indicate that the prevalence of mental disorder after torture increases with rising age. A prospective study showed increasing rates of PTSD during a study period of 4 years among men who had been prisoners of war in World War II and the Korean War¹⁷. A large group had originally experienced a period of recovery, although some only after 20 year delay. 11% had recovered and subsequently suffered a reactivation of their PTSD.
36. A 10-year follow up study, showed that 90% of torture victims had psychological symptoms, including emotional instability, depression, passivity, fatigue and disturbed sleep¹⁸. 8 of 22 victims had a chronic organic psychosyndrome, with cognitive deficiencies, sleep disturbance, psychological lability and vegetative symptoms.

F. Vicarious traumatization

37. The task of eliciting information on traumatic experience can itself cause psychological strain for the interviewer and interpreter, a risk that should not be taken lightly, because of the possible consequences.

¹⁵ Van der Kolk, B.A. The Complexity of Adaptation to Trauma. Self Regulation, Stimulus Discrimination, and Characterological Development. In: Van der Kolk, B.A., McFarlane, Weisaeth, L. (Editors). *Traumatic Stress. The Overwhelming Experience on Mind, Body, and Society*. New York: The Guilford Press 1996. (pp.182-213).

¹⁶ Sutker, P.B., Winstead, D.K., Galina, Z.H., Allain, A.N. Cognitive deficits and psychopathology among former prisoners of war and combat veterans of the Korean conflict. *Am J Psychiatry* 1991; 148: 67-72.

¹⁷ Port, C.L., Engdahl, B., Frazier, P. A longitudinal and retrospective study of PTSD among older prisoners of war. *Am J Psychiatry* 2001; 158:1474-9.

¹⁸ Petersen, H.D., Abildgaard, U., Daugaard, G., Jess, P., Marcussen, H., Wallach, M. Psychological and physical long-term effects of torture. A follow-up examination of 22 Greek persons exposed to torture 1967-1974. *Scand J Soc Med* 1985; 13, 89-93.

G. Detention

38. Harsh detention conditions and solitary confinement can have consequences for mental health. Eitinger described the psychiatric symptoms of the concentration camp syndrome after examining 100 survivors, 15 – 20 years after their arrest: Increased fatigue, impairment of memory, dysphoria, emotional instability, impairment of sleep, feeling of insufficiency, loss of initiative, nervousness, restlessness, irritability, vertigo, vegetative lability, headache.¹⁹
39. A study of 81 former political prisoners suggested that a feeling of mental defeat, a feeling of alienation from others, and perceived permanent change in personality or life aspiration are related to PTSD.²⁰
40. A study investigated the long term effects of political imprisonment in the former German Democratic Republic and compared 146 former political prisoners, imprisoned for an average of 38 months, with 75 controls matched for age and sex²¹. 30% had PTSD currently, and there was a lifetime prevalence for PTSD of 60%. Anxiety disorders such as claustrophobia and social phobia were more common than affective disorders, and the level of dissociation was higher in the prisoner group. Of the PTSD symptoms, intrusive recollections and hyperarousal were more common than avoidance and numbing symptoms.
41. Detention of asylum seekers, who have previously been tortured, has serious consequences for their mental health. The findings of a recent study indicated that the psychological health of detained asylum seekers is extremely poor and worsens the longer asylum seekers remain in detention. Detention appeared to be a substantial contributing factor to this psychological distress. Rates of anxiety, depression and PTSD symptoms were extremely high among detained asylum seekers. Clinically significant symptoms of depression were present in 86% of detainees, anxiety was present in 77%, and PTSD in 50%. Further, study doctors documented that these levels of psychological distress worsened as the length of detention increased.²²

¹⁹ Leo Eitinger. Pathology of the Concentration Camp Syndrome. Archives of General Psychiatry. Vol 5, Oct., 1961. p.371-379

²⁰ A. Ehlers, A Maercker, A Boos. Posttraumatic stress disorder following political imprisonment: the role of mental defeat, alienation, and perceived permanent change. J Abnorm Psychol. 2000 Feb;109(1):45-55

²¹ Maercker A, Schutzwohl M. Long-term effects of political imprisonment: a group comparison study. Soc Psychiatr Epidemiol. 1997 Nov;32(8):435-442.

²² From Persecution to Prison: The Health Consequences of Detention for Asylum Seekers. June 2003, Physicians for Human Rights and the Bellevue/NYU Program for Survivors of Torture. Boston and New York City. Available on http://www.phrusa.org/campaigns/asylum_network/detention_execSummary/. The authors compared this modern reception to the welcoming words by Emma Lazarus inscribed on the Statue of Liberty:

“Give me your tired, your poor, your huddled masses
yearning to breathe free the wretched refuse of your teeming shore.
Send these, the homeless, tempest-tossed to me,
I lift my lamp beside the golden door...”

H. Protective factors

42. There seems to be a higher rate of PTSD among tortured non-activists than in those politically active. A study compared 55 tortured political activists and 34 torture survivors with no history of political activity, commitment to a political cause or expectations of arrest and torture and were thus presumed to be less “psychologically prepared” for torture. Non-activists were subjected to relatively less severe forms of torture but had significantly higher prevalence of current PTSD (58% vs. 18%) and current depression (24% vs. 4%) and higher levels of psychopathology on most measures²³.
43. Prior knowledge of and preparedness for torture, strong commitment to a cause, immunization against traumatic stress as a result of repeated exposure, and strong social supports appear to have protective value against PTSD in survivors of torture.²⁴ On the other hand, survivors who have stronger feelings of injustice arising from the impunity enjoyed by the perpetrators of human rights violations, have more severe psychological problems subsequent to torture. Both loss of control and fear of further persecution are critical to the survivor’s reaction to the impunity of the perpetrators. Torture has long-term psychological effects independent of those related to uprooting, refugee status, and other traumatic life events in a politically repressive environment.

I. What to observe and what to ask to detect PTSD

44. The difficulties experienced after trauma are categorized into three clusters of symptoms: re-experiencing, avoidance and hyper-arousal. Vivid images, sounds or other sensations reminiscent of the trauma can interrupt or dominate the victim’s thoughts. They can feel like the event is happening again. Flashbacks can present while awake or appear as nightmares, and when severe, they can be difficult to distinguish from hallucinations. The victim can re-experience the trauma in various ways. Intrusive thoughts are common, especially just after the trauma. Recurring memories of the event can be difficult to shake. These experiences are often accompanied by fear, tension or anxiety, in the form of heart palpitations, rapid breathing or excessive sweating. Understandably, the survivor tries to avoid thoughts and places that remind of the traumatic incident. Sometimes this avoidance is not completely voluntary. Memories can be difficult to recall, and often parts of the event cannot be recalled. This blackout can be distressing for the victim, as can the chaotic bits of recollections of the event. Emotional numbness is common, but not until a few weeks after the trauma. Interest in significant activities can be markedly diminished. The victim feels detached or distant from others, feels alone or alienated. There is a sense of foreshortened future, which leads to a lack of preparedness and consideration of future possibilities. Sleep is disturbed and there are other symptoms of arousal, such as irritability and outbursts of anger. A common complaint after a few months is difficulty concentrating and memory

²³ Basoglu M, Mineka S, Paker M, Aker T, Livanou M, Gok S. Psychological preparedness for trauma as a protective factor in survivors of torture. *Psychol Med.* 1997 Nov;27(6):1421-33.

²⁴ Basoglu M, Paker M, Paker O, Ozmen E, Marks I, Incesu C, Sahin D, Sarimurat N. Psychological effects of torture: a comparison of tortured with nontortured political activists in Turkey. *Am J Psychiatry.* 1994 Jan;151(1):76-81.

feels diminished. The victim becomes vigilant and on guard for signs of danger (which may be necessary, however), and has an exaggerated startle response.^{25,26}

45. PTSD actually causes the victim to be silent about the specifics of the trauma, not merely because of a conscious decision, but rather because of a psychological or neuropsychological process, evidenced by neuro-anatomical changes seen in these patients, as a result of the trauma. These processes may disturb cognitive and intellectual abilities such as memory, concentration and thought.
46. When the three different types of trauma symptoms are present and are severe, posttraumatic stress disorder is diagnosed. PTSD is a debilitating and chronic disease. It can result from a sudden risk of death or a threat to ones own or others' health or integrity.²⁷ The disorder can lead to impairment and there is a high rate of suicide attempts. PTSD is often associated with depression, anxiety, alcohol and substance abuse, and somatic disease. A high number of somatic complaints should raise suspicion of trauma.

J. Course and prognosis

47. Knowledge about the time frame of the development of symptoms can be helpful when evaluating the evidence of torture. Intrusive thoughts and emotional instability appear in many victims immediately after the traumatic event. Typically, sleep disturbance sets in days later, with irritability, concentration difficulties and memory disturbance. Weeks or months later, emotional numbing becomes prominent, with hypervigilance, reactivity and avoidance. Pain can be a major symptom throughout the course, sometimes after a delay of a few days, but the diffuse musculoskeletal pain and somatoform syndromes usually appear late, often after several months of more specific somatic symptoms and localized pain. Immediately after serious, violent assault, a majority of victims meet the diagnostic criteria of PTSD, but in the course of the next weeks, about half improve, without treatment. PTSD is still an indicator of prognosis, as those with PTSD several days after the incident, have a more chronic course, while those with only some post-traumatic symptoms, and not full-blown PTSD, have a more favourable outcome. To further complicate matters, PTSD symptoms are typically fluctuating in nature. Since all victims do not develop all symptoms, these guidelines on the course of symptoms are not absolute.

K. Treatment

48. It should be borne in mind that PTSD is a potentially treatable disorder, and that also other torture victims can benefit from therapy for psychological consequences of trauma. Because PTSD causes considerable suffering and often has a chronic course if untreated, it is important to ensure that treatment is available, especially for vulnerable populations.

²⁵ Istanbul Protocol. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. New York and Geneva: United Nations 2001.

²⁶ Goldfeld, A.E., Mollica, R.F., Pesavento, B.H., and Faraone, S.V. (1988) The Physical and Psychological Sequelae of Torture. *JAMA* 259:2725-9.

²⁷ Diagnostic and Statistical Manual, 4th edition (DSM-IV).

However, a culture of impunity for perpetrators of torture can cause psychological problems and impede the healing process in victims.²⁸

49. A good therapeutic relationship is necessary for progress and recovery. An environment based on trust facilitates the dialog that is an essential part of therapy. A detention situation may therefore hamper therapy and impede recovery, but does not totally prevent treatment.
50. Pharmacotherapy has been shown to have a substantial impact on the symptoms of PTSD and the other mental health consequences of torture described above. Therefore it is important to examine the availability of psychoactive medicines, especially the SSRI antidepressants. Some neuroleptics are efficient for nightmares and flashbacks.
51. Psychosocial treatments are well established and effective in many different PTSD populations²⁹. Most psychosocial (cognitive-behavioural) approaches make use of exposure and/or anxiety management training. Psychosocial treatment has been shown to have a low relapse rate, but requires the access to trained practitioners. As with medication, not all patients achieve full remission in the short term with psychotherapy³⁰.
52. Testimony therapy is a brief method for working with survivors of trauma that was originally developed for victims of state-sponsored violence. First described in Chile³¹, and further developed by Agger³², the survivor and therapist establish a working alliance that makes it possible for the trauma to be told and documented. Together they then look for appropriate ways to make their story known to others. Studies show that this method reduces PTSD symptoms, the severity of reexperiencing, avoidance, hyperarousal and depression, and improves functioning³³. The construction of a narrative, with cognitive reappraisal, emotional exposure, closure by signing the document and sharing it with others, seems to be beneficial to the victim³⁴.

L. Evidence

53. When can psychological symptoms be regarded as evidence of torture? As with physical symptoms and signs, a change in mental health only becomes evidence in the context of other information; assessment of the allegations of torture and of the interviewed persons, the victim, other detainees and staff, the consistency of the allegations, in addition to an evaluation of the settings and other facts found. Information from multiple corroborating sources lends more credibility to the evidence, which is further supported by

²⁸ Basoglu, M., Jaranson, J.M., Mollica, R., and Kastrup, M. Torture and Mental Health. A Research Overview. In: Gerrity, E., Keane, T.M., and Tuma, F. *The Mental Health Consequences of Torture*. New York: Kluwer Academic/Plenum Publishers, 2001. (p. 35-62).

²⁹ Foa, E.B., Keane, T.M., Friedman, M.J. *Effective treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies*. New York: Guilford Press, 2000.

³⁰ See footnote 2.

³¹ Cienfuegos AJ, Monelli C. The testimony of political repression as a therapeutic instrument. *American Journal of Orthopsychiatry* 1983; 53, 43-51.

³² Agger I, Jensen S: Testimony as ritual and evidence in psychotherapy for political refugees. *J Trauma Stress* 1990; 3:115-130.

³³ Weine SM, et al. Testimony psychotherapy in Bosnian refugees: a pilot study. *Am J Psychiatry* 1998; 155:1720-1726.
20. van Dijk JA, Schoutrop MJ, Spinhoven P. Testimony therapy: treatment method for traumatized victims of organized violence. *Am J Psychother.* 2003;57(3):361-73.

similar cases found at the same site. The most important determining factor in the assessment is the integration of all the information in the interview.

54. Interview techniques based on respect and empathy may help in determining the consistency of allegations. Attentive listening is more important than asking the right questions when assessing allegations. The medical evidence observed in this way by the delegation or documented in the medical records, can support allegations made, even though there are no physical findings.
55. Thus, medical evidence can be consistent with allegations of torture, even though the medical evidence consists exclusively of psychological or psychiatric symptoms and signs.

III. Appendix

Diagnostic Classification (adapted from the Istanbul Protocol)

56. While the chief complaints and most prominent findings among torture survivors are widely diverse and relate to the individual's unique life experiences and his or her unique cultural, social and political context, it is wise for evaluators to become familiar with the most commonly diagnosed disorders among trauma and torture survivors. Also, it is not uncommon for more than one mental disorder to be present, as there is considerable co-morbidity among trauma-related mental disorders. Various manifestations of anxiety and depression are the most common symptoms resulting from torture. Not infrequently the symptomatology described above will be classified within the categories of anxiety and mood disorders.

1. Depressive disorders

57. Depressive states are almost ubiquitous among survivors of torture. In the context of evaluating the consequences of torture, it is problematic to assume that PTSD and major depressive disorder are two separate disease entities with clearly distinguishable etiologies. Depressive disorders can be present with or without psychotic, catatonic, melancholic or atypical features. In order to make a diagnosis of Major Depressive Episode³⁵ five or more of the following symptoms must be present during the same two week period and represent a change from previous functioning (at least one of the symptoms must be depressed mood or loss of interest or pleasure):

- 1) depressed mood,
- 2) markedly diminished interest or pleasure in all or almost all activities,
- 3) weight loss or decreased or increased appetite,
- 4) insomnia or hypersomnia,
- 5) psychomotor agitation or retardation,
- 6) fatigue or loss of energy,
- 7) feelings of worthlessness or excessive or inappropriate guilt,
- 8) diminished ability to think or concentrate, and
- 9) recurrent thoughts of death or suicide.

58. To make this diagnosis the symptoms must cause significant distress or impaired social or occupational functioning, not be due to a physiological disorder, and not be accounted for by another disorder.

³⁵ According to DSM-IV, the American Psychiatric Association's Diagnostic and Statistical Manual, 4th edition.

2. Posttraumatic stress disorder

59. The diagnosis most commonly associated with the psychological consequences of torture is posttraumatic stress disorder (PTSD). The association between torture and this diagnosis has become very strong in the minds of health providers, immigration courts and the informed lay public. This has created the mistaken and simplistic impression that PTSD is the main psychological consequence of torture.
60. The definition of PTSD³⁶ relies heavily on the presence of memory disturbances in relation to the trauma such as intrusive memories, nightmares, and/or the inability to recall important aspects of the trauma. The individual may not be able to recall with precision, specific details of the torture events but will be able to recall the major themes of the torture experiences. For example, the victim may be able to recall being raped on several occasions but not be able to give the exact dates, locations, and details of the setting or perpetrators. Under such circumstances, the inability to recall precise details supports, rather than discounts, the credibility of a survivor's story. Major themes in the story also will be consistent upon re-interviewing. For some victims, these lacunae can cause considerable distress.
61. PTSD can be acute, chronic or delayed³⁷. According to diagnostic criteria, the symptoms must be present for more than one month and the disturbance must cause significant distress or impairment in functioning. In order to make the diagnosis of PTSD, the individual must have been exposed to a traumatic event that involved life-threatening experiences for him/herself or others and produced intense fear, helplessness or horror.

The event is **re-experienced** persistently in one or more of the following ways:

- 1) intrusive distressing recollections of the event,
- 2) recurrent distressing dreams of the event,
- 3) acting or feeling as if the event were happening again including hallucinations, flashbacks, and illusions,
- 4) intense psychological distress at exposure to reminders of the event, and
- 5) physiological reactivity when exposed to cues that resemble or symbolize aspects of the event.

The individual persistently demonstrates **avoidance** of stimuli associated with the traumatic event and/or shows general **numbing** of responsiveness as indicated by at least three of the following:

- 1) efforts to avoid thoughts, feelings or conversations associated with the trauma,
- 2) efforts to avoid activities, places or people that remind him/her of the trauma,
- 3) inability to recall an important aspect of the event,
- 4) diminished interest in significant activities,
- 5) detachment or estrangement from others,
- 6) restricted affect, and
- 7) foreshortened sense of future.

Also necessary to make the diagnosis of PTSD is the persistence of symptoms of **increased arousal** that were not present before the trauma as indicated by at least two of the following:

³⁶ According to DSM-IV.

³⁷ See footnote 18.

- 1) difficulty falling or staying asleep,
- 2) irritability or angry outbursts,
- 3) difficulty concentrating,
- 4) hypervigilance, and
- 5) exaggerated startle response.

Symptoms of PTSD can be chronic or fluctuate over extended periods of time. During some intervals, symptoms of hyperarousal and irritability dominate the clinical picture, at these times the survivor will usually also report increased intrusive memories, nightmares and flashbacks. At other times the survivor may appear relatively asymptomatic or emotionally constricted and withdrawn. One must keep in mind that not meeting diagnostic criteria of PTSD does not mean that torture was not inflicted. In a certain proportion of cases, PTSD may follow a chronic course over many years, with eventual transition to an enduring personality change³⁸.

3. Enduring personality change

62. After catastrophic or prolonged extreme stress, disorders of adult personality may develop in persons with no previous personality disorder. The types of extreme stress that can change the personality include concentration camp experiences, disasters, prolonged captivity with an imminent possibility of being killed, exposure to life-threatening situations such as being a victim of terrorism, and torture. The diagnosis of an enduring change in personality should only be made when there is evidence of a definite, significant and persistent change in the individual's pattern of perceiving, relating, or thinking about the environment and him/herself, associated with inflexible and maladaptive behaviours not present before the traumatic experience³⁹. The diagnosis excludes changes that are a manifestation of another mental disorder or a residual symptom of any antecedent mental disorder, as well as personality and behavioural changes due to brain disease, dysfunction or damage.
63. To make the diagnosis of Enduring Personality Change after Catastrophic Experience⁴⁰, the changes in personality must be present for at least two years following exposure to catastrophic stress. The diagnostic manual specifies that the stress must be so extreme that "it is not necessary to consider personal vulnerability in order to explain its profound effect of the personality." This personality change is characterized by a hostile or distrustful attitude towards the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of "being on edge" as if constantly threatened, and estrangement.

³⁸ According to ICD-10, WHO's International Classification of Diseases, 10th edition.

³⁹ According to ICD-10.

⁴⁰ According to ICD-10

4. Substance abuse

64. Clinicians have observed that alcohol and drug abuse often develop secondarily in torture survivors as a way of suppressing traumatic memories, regulating unpleasant effects, and managing anxiety. Although co-morbidity of PTSD with other disorders is common, systematic research has seldom studied the abuse of substances by torture survivors. The literature on populations that suffer from PTSD may include torture survivors such as refugees, prisoners of war, and veterans of armed conflicts and may provide some insight. Studies of these groups reveal: 1) substance abuse prevalence varies by ethnic or cultural group, 2) former prisoners of war with PTSD were at increased risk for substance abuse, and 3) combat veterans have high rates of co-morbidity of PTSD and substance abuse. In summary, there is considerable evidence from other populations at risk for PTSD that substance abuse is a potential co-morbid diagnosis for torture survivors.

5. Other diagnoses

There are other diagnoses to be considered in addition to PTSD, major depressive disorder and enduring personality change. The other possible diagnoses include but are not limited to:

- a) Generalized anxiety disorder: featuring excessive anxiety and worry about a variety of different events or activities, motor tension and increased autonomic activity.
- b) Panic disorder: recurrent and unexpected attacks of intense fear or discomfort including four symptoms such as sweating, choking, trembling, rapid heart rate, dizziness, nausea, chills or hot flashes. Panic disorder following torture by suffocation may be associated predominantly with respiratory symptoms⁴¹.
- c) Acute stress disorder: this disorder features essentially the same symptoms as PTSD but is diagnosed within one month of exposure to the traumatic event.
- d) Somatoform disorders: featuring physical symptoms that cannot be accounted for by a medical condition.
- e) Bipolar disorder: featuring manic or hypomanic episodes with elevated, expansive or irritable mood, grandiosity, decreased need for sleep, flight of ideas, psychomotor agitation and associated psychotic phenomena.
- f) Disorders due to a general medical condition: often in the form of brain impairment with resultant fluctuations or deficits in level of consciousness, orientation, attention, concentration, memory and executive functioning.
- g) Phobias: such as social phobia and agoraphobia.
- h) Psychosis. Psychotic symptoms can be debilitating and may prevent meaningful communication. It may be difficult to establish whether a psychotic disorder preceded the torture, but it should be borne in mind that a psychiatric patient can develop post-traumatic stress syndrome. Illusions may take the form of pseudo-hallucinations and may border on true psychotic states. False perceptions and hallucinations that occur on falling asleep or on waking are common among the general population and do not denote psychosis. It is not uncommon for torture victims to report occasionally hearing screams, his or her name being called, or seeing shadows, but not have florid signs or symptoms of psychosis. Flashbacks, that do not distort reality testing, should be distinguished from hallucinations.

⁴¹ Buower, C., Stein, D. Panic disorder followed by suffocation is associated with predominantly respiratory symptoms. *Psychological Medicine*. 1999; 29 (1): 233-236.

- i) Individuals with a past history of bipolar disorder, recurrent major depression with psychotic features, schizophrenia and schizoaffective disorder may experience an episode of that disorder.
- j) Neurological and neuropsychological impairment. There is a significant overlap with the symptomatology arising from PTSD and major depressive disorder. Fluctuations or deficits in level of consciousness, orientation, attention, concentration, memory and executive functioning may result from functional disturbances as well as organic causes. Neuropsychological assessment may be necessary to determine an organic cause. The most common neurological symptoms are headaches, vertigo, and dizziness and there may be a history of loss of consciousness⁴². Severe confinement conditions may cause permanent organic damage. Weight losses over 35% during confinement predicted long-term compromise in cognitive performance in former prisoners of war compared to veteran controls.⁴³

⁴² Moreno, A., Grodin, M.A. Torture and its neurological sequelae. *Spinal Cord* 2002; 40, 213-233.

⁴³ Sutker, P.B., Galina, Z.H., West, J.A. Trauma induced weight loss and cognitive deficits among former prisoners of war. *Journal of Consulting and Clinical Psychology*. 1990; 58 (3), 323-8.