

“taking casualties” and “hearts and minds.” When I go outside, I can hear the shouts floating across the water, the young recruits out there sounding off in unison as they go out for their morning run, flat-out gung-ho at 6 a.m. The shouting sounds as if it is coming not just across the marshes but across the decades, and I swear sometimes that I can hear what they are shouting — all that Marine tough-guy talk:

Lock and load!
Ready on the left!
Ready on the right!
Ready on the firing line!

Failure is not an option!

Good to go.

From the Naval Hospital, Beaufort, Parris Island, South Carolina.

GLOBAL HEALTH

Surviving Torture

Richard F. Mollica, M.D.

The shocking, unfiltered images from the Abu Ghraib prison in Iraq have focused the world’s attention on the plight of torture survivors. Physicians in the United States are confronted as never before with the need to identify and treat the physical and psychological sequelae of extreme violence and torture. Yet this is not a new role for medical practitioners. More than 45 countries are currently suffering from the destruction caused by mass violence.¹ The 20th century has been called the “refugee century,” with tens of millions of people violently displaced from their homes. Millions of these people have resettled in the United States, and refugees, asylum seekers, and illegal immigrants now commonly enter our health care institutions.²

Despite routine exposure to the suffering of victims of human brutality, health care professionals tend to shy away from confronting this reality. My colleagues and I have cared for more than 10,000 torture survivors, and in our experience, whether in Bosnia and Herzegovina, Cambodia, East Timor, or the United States, clinicians avoid addressing torture-related symptoms of illness because they are afraid of opening a Pandora’s box: they believe they won’t have the tools or the time to help torture survivors once they’ve elicited their history.

Unfortunately, survivors and clinicians may conspire to create a relationship founded on the avoidance of all discussion of trauma. In one instance, a middle-aged Cambodian woman had had an excellent relationship with her American doctor for nine years, but he had no idea that she had been tortured.

He had had only partial success in controlling her type 2 diabetes. After attending a training session on treating the effects of terrorism after the events of September 11, 2001, the doctor asked the patient for the first time whether she had undergone extreme violence or torture. She revealed that two of her children had died of starvation in Cambodia, her husband had been taken away violently and disappeared, and she had been sexually violated under the Khmer Rouge. More recently, in the United States, her remaining daughter had been nearly fatally stabbed by a gang that burglarized her home. Since September 11, the patient had taken to barricading herself in her house, leaving only to see her doctor.

When the doctor became aware of the patient’s traumatic history, he used a screening tool (available at www.hpvt-cambridge.org/screening) to explore the effects of her traumas, diagnosing major depression. Over time, he was able to treat the depression with medication and counseling, eventually bringing the diabetes under control as well.

Thus, the effective care of torture survivors must begin with awareness. Identifying a patient who has been tortured is not like finding a needle in a haystack. Many characteristics of the patient’s background provide clues that torture may have occurred. It is estimated, for example, that 60 percent of persons who seek asylum in the United States have been tortured, as have many refugees and migrant workers. A history of torture is common in various groups that have resettled here during recent decades — for example, Cambodians and Viet-

name “boat people” and former Vietnamese prisoners of war who arrived in the 1980s, Central Americans who immigrated in the 1980s and 1990s, and recent arrivals from sub-Saharan Africa, the Middle East, and Eastern Europe. Many newcomers enter the United States not only to find economic opportunity, but also to escape violence at home.

When health care practitioners feel sufficiently confident to ask, “Have you experienced extreme violence or torture?” it will be easier to identify and treat the pathological sequelae of such trauma. Patients rarely become emotionally overwhelmed or lose control when questioned about torture. Some torture survivors, especially victims of sexual violence, may have been hiding their history out of shame or fear of stigmatization. Others may come from cultures in which physicians are not expected to be interested in patients’ personal history. Moreover, many survivors do not recognize any relationship between torture and their current medical problems. Posing a direct question may remove these barriers. A simple screening question for possible torture survivors can be used in health care settings. The question emphasizes three key aspects of torture as defined by the United Nations — incarceration, physical or mental suffering, and harm inflicted by organized political agents: “While in captivity, did you ever experience physical or mental suffering, deliberately and systematically inflicted by an agent of a government or of an armed political group (e.g., soldier, policeman, or militant), or any person acting with the government’s approval?”

Once the process of revelation has begun, the best approach to obtaining a complete history of torture is to ask specific rather than open-ended questions. Torturers use techniques designed to cause maximal degradation within a particular cultural context; Amnesty International lists on its Web site (www.amnesty.org) the specific types of torture practiced in various countries. When asked about specific events, patients are usually grateful that the clinician is aware of what they have suffered and is interested in their history.

Knowledge of the types of torture used (see Table) enables clinicians to assess the organ system that may have been damaged,³ identify the possible medical and psychological sequelae, and determine the appropriate treatments. For example, a common form of torture used in Latin America, *falanga*, in which the soles of the feet are beaten with rods,

Table. The Most Common Forms of Torture.*

Beating, kicking, striking with objects
Beating to the head
Threats, humiliation
Being chained or tied to others
Exposure to heat, sun, strong light
Exposure to rain or cold, sustained immersion of body in water
Being placed in a sack, box, or very small space
Near-drowning, repeated submersion of head in water
Suffocation
Overexertion, hard labor
Exposure to unhygienic conditions conducive to infections and other diseases
Blindfolding
Isolation, solitary confinement
Mock execution
Being made to witness others being tortured
Starvation
Sleep deprivation
Suspension from a rod by hands and feet
Rape, mutilation of genitalia
Sexual humiliation
Burning
Beating to the soles of feet with rods
Blows to the ears
Forced standing
Having urine or feces thrown at one or being made to throw urine or feces at other prisoners
Nontherapeutic administration of medicine
Insertion of needles under toenails and fingernails
Being forced to write confessions numerous times
Being shocked repeatedly by an electrical instrument

* From Mollica RF, Caspi-Yavin Y, Lavelle J, et al. The Harvard Trauma Questionnaire (HTQ) manual: Cambodian, Laotian, and Vietnamese versions. *Torture* 1996;Suppl 1: 19-42.

may lead to acute swelling and vascular compromise of the feet and legs, aseptic necrosis of the toes, necrotic ulcers, chronic venous incompetence of the legs, and pain on walking.

Head injuries caused by beatings to the head with fists, clubs, or gun butts represent one of the most common effects of torture, leading to neuropsychological deficits that are rarely identified. Sexual violence is common, and its effects, including cervical dysplasia, human immunodeficiency virus infection and AIDS, and sexual dysfunction, must be identified and treated.

Until very recently, the psychological effects of torture have remained largely invisible⁴ — the combined effect of the difficulty of assessing mental



Abu Ghraib Prison, Iraq, May 2003.

Photograph by Benjamin Lowy, reprinted with permission of Corbis.

symptoms in culturally diverse populations, the unsuccessful search by human rights groups for a unique “torture syndrome,” and the popular belief in medical circles that extreme trauma leads to post-traumatic stress disorder (PTSD). This emphasis on PTSD has obscured the reality that the most common mental illness diagnosed in torture survivors is depression — often a serious and socially debilitating condition associated with serious medical consequences (such as the inadequately controlled diabetes in the Cambodian woman described above).⁵ Clinicians should screen all torture survivors for depression, as well as for generalized anxiety and PTSD. Furthermore, torture survivors rarely suffer from factitious diseases or somatization disorders. Their somatic symptoms are usually culture-specific expressions of emotional distress — often an underlying depression.

In general, persons who have been tortured do not want to be treated primarily as torture survivors. They prefer a holistic approach that addresses their current reality in a culturally sensitive way. Many have begun to recover from torture with the help of spiritual and religious practices, work, and altruistic activities that benefit their family and community. Clinicians should strongly support such self-care

and recommend other healthful practices, such as proper nutrition and exercise, that may enhance the patient’s coping ability and resilience.

Torture and its human and social effects are now in the global public eye. Medical professionals must relinquish their fears and take the lead in healing the wounds inflicted by the most extreme acts of human aggression. Commitment to a process that begins with a simple but courageous act — asking the right question — bespeaks the belief that medicine is a potent antidote to the practices of torturers.

From the Harvard Program in Refugee Trauma, Massachusetts General Hospital and Harvard Medical School, Cambridge, Mass.

1. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World report on violence and health. Geneva: World Health Organization, 2002. (Accessed June 11, 2004, at http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf.)
2. Bramsen I, van der Ploeg HM. Use of medical and mental health care by World War II survivors in the Netherlands. *J Trauma Stress* 1999;12:243-61.
3. Goldfeld AE, Mollica RF, Pesavento BH, Faraone SV. The physical and psychological sequelae of torture: symptomatology and diagnosis. *JAMA* 1988;259:2725-9. [Erratum, *JAMA* 1988;260:478.]
4. Mollica RF. Waging a new kind of war: invisible wounds. *Sci Am* 2000;282:54-7.
5. Cassano P, Fava M. Depression and public health: an overview. *J Psychosom Res* 2002;53:849-57.