

## MENTAL CONSEQUENCES OF TORTURE

### The Method of Rehabilitation at a Rehabilitation Centre at Copenhagen

MARIANNE KASTRUP  
INGE LUNDE  
JORGEN ORTMANN  
INGE KEMP GENEFKE

#### Introduction

Investigations of former KZ-prisoners report of extensive physical and psychological sequences. Some studies have focused on the somatic consequences of hunger dystrophy (Herman and Thygesen 1954, Thygesen et al 1970) and the KZ-syndrome is seen as an organic damage also affecting the brain (Nielsen 1986). Others (e.g. Chodoff 1982) stress that the massive emotional and physical trauma may be seen as the cause behind the sequelae. In studies of other consequences of the Second World War, such as the War Sailor Syndrome (Askewold 1980), similar findings were reported.

Systematic analysis of the physical and psychological sequelae of torture began in 1973 when Amnesty International appealed to the medical profession to participate in such investigations. The first medical group in Amnesty International was founded in Denmark in 1974 and had as a main objective through systematic investigations to give evidence whether or not torture had taken place in a given case. One result of these investigations was the demonstration of both immediate and long-term effects of torture (Kjaersgaard and Genefke 1977, Rasmussen et al 1977). The consequence of these findings was that the question of treatment and rehabilitation was raised. An international rehabilitation group was founded in 1978, and in 1980 it was decided to ask the Danish members of the group to establish the first center for

the treatment of torture victims. Amnesty International stated that treatment was outside the aim of the organisation. The result was the establishment of the private and independent institution the International Rehabilitation and Research Centre for Torture Victims in Copenhagen, Denmark, in 1982. In the following years this institution was built up and in 1984 the official opening took place.

#### Mental sequelae to torture

Torture has been practiced and is still being practiced in a number of countries all over the world. The objective has been to punish people, to get confession or to obtain information. These objectives will of course still exist, but at present the main objective is to break down the individual.

Persons, having been submitted to this attempt specifically to break down their identity, present a number of physical and mental sequelae. Among the most frequent are pain and trouble caused by muscles, joints and bones, many present psychosomatic complaints as chronic diffuse headache, tensions, dyspeptic symptoms or fear of having a heart disease. Many experience the psychological sequelae as the most painful, lack of concentration and memory loss are among the most frequent together with sleep disturbances, frequent nightmares, anxiety evoked by sensory, auditory or visual signals. Depression is another common feature, and loss of self esteem and a feeling of guilt are often linked together.

and furthermore, a great proportion shows symptoms of fatigue, emotional instability, social withdrawal, change in identity and sexual disturbances.

### *Principles of treatment*

The treatment of torture victims started in 1980 at a University Hospital in Copenhagen (Regshospitalet) and over the following years a model was developed for the treatment of the victims (Lunde et al 1986). Treatment is based upon the following principles:

1. Any procedure reminding the patient of the torture, he has been exposed to should be avoided as far as possible.
2. Simultaneous start of both physical and mental treatment with physiotherapy as an important element of the physical treatment.
3. The physical and the psychological treatment run in parallel with each other.
4. Treatment should not only include the individual victim, but should be offered to the entire family.
5. The social conditions should always be included as a factor, and a personal social service should be a part of the treatment.

### *Treatment at the RCT today*

The International Rehabilitation and Research Centre today has two villages at its disposal and nearly all treatment takes place as an out-patient treatment. When poor physical and/or mental condition indicates admission to hospital we have to our disposal two beds in the department of Neurology at Rigshospitalet.

#### *A. Referral to the RCT*

Everybody can refer to the RCT, but being accepted for treatment, it is necessary

to be a refugee in Denmark. After referral an interview takes place according to directions laid down in a precoded schedule. Information is obtained about imprisonment, torture, state of health and social conditions, and if it is concluded that the person investigated is in fact a torture victim and in need for treatment, the client goes through a standard examination programme.

#### *B. Examination Programme*

The standard examination programme comprises a detailed psychotherapeutic assessment, a clinical examination, examination by a social worker, by rheumatologist, assessing the need for physiotherapy, dental examination, and furthermore the spouse and the children, if any, are offered examination and treatment. All examinations are based upon precoded standardized schedules.

#### *C. Treatment programme*

The treatment includes psychotherapy, physiotherapy, general somatic treatment and social counselling, and in addition treatment of spouse and children.

A more detailed description of the total treatment programme is given elsewhere (Lunde et al 1986) and in this paper emphasis is placed on the psychotherapeutic treatment.

The psycho-therapeutic treatment is centrally placed, and usually started with 2 times 2 hours per week. In the session the patient is asked to describe all details about the torture she/he has been subjected to, and she/he tries to understand the objectives of the torture, and to abreact accumulated more or less suppressed feelings of anger, grief and fury. Through an analysis of some of the most traumatic experiences the client is brought in closer contact with more or less repressed emotions, and this may result in a relief to the victim. Here it is characteristic that the most serious traumas are frequently not remembered until the

therapy has been going on for some time. We try to make the patient recognise that the guilt experienced should be placed with the torturers, and that torture situations can be seen as situations of impossible choices because, no matter what answer the victim gave to the torturers' questions, it meant threat, imprisonment or torture to other people. Talking about this is painful and arouses strong resistance which means that many victims try to avoid talking about such subjects in details. However, it is necessary in the therapy to try break this resistance. In order to do that patience is necessary, and a pre-requisite is the establishment of a confident emotional contact with the patient.

In the therapy it is important to remember that the clients are not psychiatric patients, but persons who have been subjected to a deliberate and systematic destruction.

A number of therapeutic methods are used including drawings, role-playing, interpretations of nightmares and dreams, home recording on tapes of what the victim experiences at certain situations. Our methods undergo a continual development as we have to allow ourselves to be influenced by different cultures and the many and varied consequences of torture. As already mentioned the psycho-therapeutic sessions take place twice weekly, after 2-3 months they are reduced to one session weekly. Treatment may last in total up to one year. The goal of the therapy is to place the experiences of the torture in a wider context as a part of the life of the victims, and to rebuild their identity and help the victims' work for the future.

#### *Preliminary Results*

After the Centre had existed for two years an evaluation took place of the 57 clients terminating their treatment during that period (30.10.1982 to 30.11.1984). Of the 57 clients 38 were torture victims, 5

spouses of victims, and 14 children. The clients came from 9 different nations, and in table 1 the different kinds of torture, they

Table 1

Methods of Torture Used to 38 Torture Victims	
Methods of torture	n = 38
Beating	92%
Electrical torture	68%
"Other physical torture"	55%
Other psychological torture	45%
Sexual abuse	42%
Head-trauma	37%
Asphyxia	34%
Threats of execution	34%
Moch-Executions	26%
Starvation	26%
Isolation more than 2 week	26%
Blindfolding	21%
Torture in presence of others	21%
Climatic torture	21%
Falange	21%
Sleep deprivation	18%

had exposed to are shown. One of the victims had exclusively been exposed to psychic torture, 8 exclusively to physical torture, whereas the remaining 29 had been exposed to a combination of both.

A high prevalence of physical and psychological symptoms were present.

Table 2

Neuropsychological Symptoms of 38 Torture Victims	
Impaired memory or concentration	66%
Headache	63%
Night mares	63%
Sleep disturbances	60%
Depression	60%
Anxiety	42%
Emotional instability	26%
Fatigue	23%
Sexual disturbances	21%

In 25 cases both physical and psychological symptoms were found, in 10 exclusively physical changes, and in 2 exclusively psychological sequelae. One case only expressed social difficulties. This means that - in other words - we deal with a group of persons with a high symptom load and an urgent need for treatment.

The evaluation showed that the clients had had benefit from the treatment as about 90% improved substantially or completely.

Since 1985 a prospective analysis of all clients starting treatment has been going on. The main purpose of this project is through systematic data-collection to describe the health conditions of the torture victims at their first examination, to recall all examinations and treatment and to make an evaluation and assessment of the effects of the treatment given. Results are not yet available.

### Discussion

According to the definition of the World Medical Assembly (The declaration of Tokyo 1975) torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons, acting alone or on the orders of any authority to force another person to yield information, to make a confession, or for any other reason.

Torture today is an essential part of certain regimes' attempts to break down the basic values, beliefs and loyalties of the political prisoners. They are customarily tortured long after useful information has been obtained (Goldstein & Bresling 1986). It is increasingly recognised that the main objectives of torture is to break down the personal and collective identity, understood as the feeling of the personal and social entity, historical continuity and personal life and collective life in pleasure and work, in family life and in language and ideas to be given to the next generation. Previous investigations (e.g. of KZ-camp survivors, Bettelheim 1966, Eitinger 1981) have shown that an active engagement provides you with a better possibility to preserve your identity despite the torture, and that a firm religious or political conviction improves your chances of survival.

Torture is a trauma threatening the existence of the victim, a threat far beyond which any person normally can defend oneself against by reproducing previous experiences. Different points of view have been forwarded regarding the sequelae of torture and its nosological classification. In recent years DSM III has tried to overcome the problem by defining a post-traumatic stress disorder that owes the response to a psychologically traumatic event of man made or natural origin. Some stressors (e.g. torture) frequently produce the disorder, others do only occasionally (APA 1980). Whereas some researchers (Allodi and Cowgill 1982) believe in a "torture syndrome" representing a clinical entity. This opinion is not shared by the majority of researchers working in the field.

Despite the different opinions regarding classification it is generally agreed that the physical and psychological sequelae to torture result in serious problems and difficulties in adaptation for the victims who frequently also suffer from their state as refugees. Their problems cannot be solved satisfactorily within the frame work of the existing health service but need an expertise for their particular problems.

The experiences from the Danish model for rehabilitation where retrospective estimations of treatment have as mentioned shown that about 90% have improved substantially or recovered completely indicate that we have succeeded in improving the mental health conditions and the total situations of the victims treated. However, it is too early to predict about the results on a long time basis, but results obtained hitherto are encouraging and indicate that long lasting symptoms may be reversible if proper treatment is installed.

### References

- ALLODI, F. & COWGILL, G. (1982). Ethical and psychiatric aspects of torture: A Canad-

- ian study, *Canadian Journal of Psychiatry*, 27, 98-102.
- American Psychiatric Association. (1980), *Diagnostic and Statistical Manual of Mental Disorders - 3rd edition*.
- ASKEWOLD, F. (1980), The War Sailor Syndrome, *Danish Medical Bulletin*, 27, 220-223.
- BETTELHEIM, B. (1966), Individual and mass behaviour in extreme situations. In Maccoby et al (eds), *Readings in Social Psychology* Newyork, Mathmen & Co.
- CHODOFF, P. (1981), Survivors of the Nazi Holocaust, *Children Today*, September-October 2-5.
- EITINGER, L. (1981), Denial in Concentration Camps, *North. Psyk. Tss*: 35, 148-56.
- GOLDSTEIN, RH. & BRESLING, P. (1986), Technicians of Torture. *The Sciences*, N.Y. *Academy of Sciences*, March/April.
- HERMAN, K. & THYGESEN, P. (1954), KZ-Syndrom, *Ugeskr Læger* 116: 825-36.
- KJAERSGÅRD Aar & GENEFKKE, I. K. (1977), Tortur i Uruguay og Argentina, *Ugeskr Læger*: 139, 1059-9.
- LUNDE, I., BOYSEN, G. & ORTMANN, J. (1986), Rehabilitation of Torture Victims: Treatment and Research.
- NIELSEN, H. (1986), Dødelighed og invaliditet blandt danske modstandsfolk deporteret til nazistiske koncentrationslejre, *FAIDL*, København.
- RASMUSSEN, OV., DAM AM, & NIELSEN, I. L. (1977), Tortur, *Ugeskr, Læger*: 139, 1049-53.
- The DECLARATION OF TOKYO (1975), adopted by the 29th World Medical Assembly. (1984), *Ethical Codes And Declarations Relevant To The Medical Profession*. London: Amnesty International Publication, 9.
- THYGESEN, P., HERMAN, K. & WILLANGER, R. (1970), Concentration Camp Survivors in Denmark.