Survivors of Torture

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Vignette

Ms. A is a 34-year-old woman with no known psychiatric history who was tortured in Guatemala due to her family's indigenous roots. During her 12-month imprisonment, she was subjected to psychophysical torture. In addition to being placed in isolation, she was raped several times by multiple people and physically beaten, ultimately resulting in a need for medical intervention. During her hospitalization, Ms. A escaped her country of origin. After a long, lonely, distressing journey, she arrived in the USA where she applied for asylum. She was detained for six weeks and was released to the community with an ankle monitor. She was referred to a local community nonprofit organization that works with survivors of torture. With their assistance, Ms. A identified shelter and began to develop a sense of her new community. She was referred to an outpatient medical clinic for evaluation of chronic headaches and insomnia. The nonprofit organization also referred her to psychiatry.

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S. H. Koh et al. (eds.), *Diversity in Action*,
https://doi.org/10.1007/978-3-030-85401-0_2

Prior to her appointment with psychiatry, screening tools including the Hopkins Symptom Checklist and the Harvard Trauma Questionnaire were administered. A 90-min psychiatric intake was scheduled for Ms. A. A Spanish-speaking female interpreter was present and introduced to the patient prior to the appointment. During the appointment, the interpreter sat adjacent to the patient. Limitations of confidentiality were outlined early in the interview. In reviewing Ms. A's history, her life before her primary trauma was discussed; details related to her trauma history were explored only to the degree she felt comfortable. Her short-term and long-term goals were identified. A comprehensive review of symptoms including a detailed sleep history was taken.

Over the course of the first several appointments with the psychiatrist, various components of the patient's history were explored. The provider developed an understanding of how Ms. A's culture defined her sense of self and how her life was shattered by the traumas. As Ms. A became more comfortable with the psychiatrist, she endorsed additional symptoms that included irritability, nightmares, crying episodes, and dyspareunia. Ms. A described intrusive memories, negative cognitions, hypervigilance, and avoidance of public settings due to fears of deportation. She had significant pain associated with sexual activity; this led to anticipatory anxiety and resentment related to intimacy with her husband.

Ms. A was diagnosed with posttraumatic stress disorder (PTSD). She was started on sertraline 25 mg by mouth daily that, over time, was titrated to 100 mg to target mood symptoms associated with PTSD. She was also started on prazosin for management of nightmares. In addition to supportive psychotherapy during each psychiatric visit, she was referred for individual psychotherapy and engaged in 12 weekly sessions of trauma-focused psychotherapy. Eight months into psychiatric treatment, Ms. A's symptoms had fully resolved. Prazosin was slowly tapered and then discontinued. She transitioned to quarterly appointments and eventually gained employment and became pregnant. The frequency of her scheduled visits increased during the peripartum period as a preventative measure. She was continued on sertraline throughout her pregnancy. A letter in support of her asylum application was submitted to her attorney. Eighteen months after arriving in the USA, Ms. A's asylum petition was approved.

Introduction

Torture, derived from the Latin word *torquere*, "to twist," has been a means of corporal punishment and extraction of information as far back as Mesopotamia. The earliest documented description relates to an Egyptian pharaoh in 1300 BC who used torture to collect information regarding enemies during an invasion. Prisoners of war were held captive as slaves, deeming them "fit for torture." In ancient Greece and under Roman law, torture was permitted in slaves and foreigners and prohibited amongst the native free citizens [2]. Slaves were often tortured as a means to obtain incriminating evidence related to their owners. Around 200 AD, torture permissions extended to the lower class citizens as penalties [3].

In the last half-century, there have been multiple international treaties developed that prohibit torture; these include the Universal Declaration of Human Rights, the Geneva Convention, and the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment [1]. Despite recognition as a human rights violation, torture continues to be practiced today. According to Amnesty International, 141 countries reported cases of torture between 2009 and 2013 [4]. Worldwide, two-thirds of all refugees come from Syria, Afghanistan, South Sudan, Myanmar, and Somalia [5]. Human rights advocates argue that even countries who have signed the aforementioned treaties participate in torture, often amidst times of war. In recent years, concern has grown that what US government officials have described as "enhanced interrogation techniques" of prisoners in Guantanamo are in fact acts of torture. Prisoners have been victims to activities such as waterboarding, single cell operation, forcible cell extraction, and second-degree torture (a form of psychological torture in which family members are threatened).

Torture is typically utilized as a means of extracting enemy information during times of war. With the refugee population, torture can also be punishment for certain religious beliefs, political affiliations, and/or sexual orientation. Types of torture vary, and no list is truly comprehensive as methods of torture are invented regularly. Variations in types of torture are often region-specific. Psychological torture is nearly always present and varies in its form. Examples include observing a friend or family member being physically or sexually assaulted or sensory deprivation or overloading (e.g., music torture). The psychological impact this can have on individuals is profound. Many survivors recount that it is the psychological torture that has longer lasting consequences than the physical pain they endure. The fear of threats to loved ones or witnessing family members being tortured haunts some patients for a lifetime. Often, these concerns persist when refugees leave the country in which the torture was committed as they are separated from their contacts and struggle with the unknown state of their loved ones. Feelings of guilt and remorse, coupled with fear, contribute to the development of psychiatric illnesses including PTSD, depression, and anxiety. As court proceedings to obtain refugee/asylee status begin, the retelling of past painful experiences can lead to frequent triggers and experiences of reliving the trauma. The plight of torture survivors warrants

identification and intervention by professionals providing their medical care. Effective care can only begin with awareness.

Definitions

The Torture Victims Relief Act of 1998 defines torture as [6]:

1. an act committed by a public official intended to inflict severe physical or mental pain or suffering (other than pain or suffering incidental to lawful sanctions) upon another person within his custody or physical control;
2. "severe mental pain or suffering" means the prolonged mental harm caused by or resulting from—
   (a) the intentional infliction or threatened infliction of severe physical pain or suffering;
   (b) the administration or application, or threatened administration or application, of mind-altering substances or other procedures calculated to disrupt profoundly the senses or the personality;
   (c) the threat of imminent death; or
   (d) the threat that another person will imminently be subjected to death, severe physical pain or suffering, or the administration or application of mind-altering substances or other procedures calculated to disrupt profoundly the senses or personality.

Refugees and *asylees* are unable or unwilling to reside in their country of nationality due to fear of persecution, war, or violence. Reasons for persecution include race, religion, nationality, and political opinion or social affiliation. Upon departure from their country of origin, refugees do not choose in which country they will reside. After leaving the country of nationality, they enter a neutral country until the United Nations High Commissioner for Refugees (UNHCR) recognizes them as refugees. Upon approval, refugees are flown to the host country, and resettlement is facilitated with subsidiary organizations in conjunction with the federal government. Resettlement agencies aid in the process, which can take up to 2 years.

Asylees are types of refugees. Unlike other refugees, *asylees* apply for humanitarian protection at the port of entry or within 1 year of arriving in the host country. The burden of proof of fear of persecution rests with the asylum seekers. They typically endure long, arduous journeys en route to the host country. Upon arrival and application for asylee status, claims are reviewed over a lengthy waiting period during which basic services are not permitted. Some applicants are deported immediately, while others may be detained for the duration of their legal proceedings. Applicants typically live under the threat of forced repatriation. Once asylee status is granted, applicants can become legal, permanent residents of the host country. Table 2.1 outlines the differences in application process for refugees and asylees.

Of the 22.5 million refugees worldwide, over a third identify as survivors of torture [7]. The majority of refugees come from Syria, Afghanistan, South Sudan,

Table 2.1 Application differences in the USA between refugees and asylees

	Refugee	Asylee
Location at time of application	Permission to enter the USA is granted while outside the country	Application for protection submitted upon arrival to the USA or point of entry
Agency responsible for reviewing application	United Nations High Commissioner for Refugees	Department of Homeland Security; United States Citizenship and Immigration Services
Application assistance	Application assistance with refugee resettlement agency	Burden of proof of persecution fear rests with applicant with limited assistance

Myanmar, and Somalia. For the last several years, the country hosting the most refugees has been Turkey. Since 1975, three million refugees have resettled in the USA. Of these, approximately 1.3 million are survivors of torture [5]. The number of applications which have been accepted in the USA has been decreasing, with the lowest in 2018 at 22,900. In FY 2017, asylum status was granted to 26,568 individuals in the USA, approximately 10% of those who applied [8]. Of these, 60% were approved by the Department of Homeland Security (affirmative asylum) and 40% by the Department of Justice (defensive asylum). Affirmative asylum applications are directly routed to USCIS. If that application is denied, an individual can apply for a defensive asylum application that goes through an immigration judge. The defensive process is much more laborious with a higher likelihood of rejection; 119,303 defensive applications were filed in 2017 of which 10,523 were granted (8%). There were 139,801 affirmative applications in 2017 of which 16,045 were granted (11%). Forty-five percent of those who were granted asylum came from China, El Salvador, or Guatemala. In recent years, the number of applications from people from the Northern Triangle (El Salvador, Guatemala, and Honduras) has steadily increased. The majority of these applicants are minors. The number and type of applicants granted asylum status is affected by political and other factors.

The journey of migration can be prolonged and demanding. Traditionally, a refugee's migration experience is divided into three categories: pre-migration, migration, and post-migration or resettlement. This collectively can be referred to as the "triple trauma paradigm" as each segment of this journey can harbor its own traumas [9]. The *pre-migration* period includes the primary trauma related to fear of persecution that motivates individuals to flee their native country. The *migration* period refers to the travel to the final host country. Often this may include passing through transit countries en route to the destination. This period can be met with uncertainty and unanticipated dangers with limited resources. The *post-migration* period reflects resettlement in a new country amassed with a new culture including social norms and practicalities of daily living. Initial relief of arriving to the host country can quickly be tempered by insecurity. Individuals may experience facets of racism and xenophobia as they transition to living in a new environment. Factors which impact this include prolonged detention periods, insecure immigration status with fear of expatriation, and limitations on work and education opportunities. Detention can be a particularly triggering time during which fear of authorities can

compound environmental similarities to where people were tortured. Similarly when people are released from detention with ankle monitors, they may experience significant distress as there is a constant physical reminder on their bodies of the traumas they have endured. Additional resettlement stressors can include prolonged legal proceedings, limited knowledge of and poor access to services, and insecure unstable housing. Language and cultural barriers can be hard to overcome. Refugees also have varying levels of literacy, from being preliterate to possessing advanced educations. Many leave successful careers only to later face poverty and unemployment in the host country. These types of insecurities make individuals more vulnerable to forms of exploitation such as human trafficking for labor or sex.

When confronted with so many changes, an individual's sense of self may waiver and feelings of grief may surface. Individuals are often socially isolated during the resettlement period. For those that come from cultures that embrace multigenerational households, this solitude can be a harrowing experience. Patients are often separated from their families who may be scattered around the world. Other times, family members may still be in unsafe circumstances in the country of origin. In these scenarios, patients often express feelings of worry, in addition to guilt, for escaping their traumatic environments, while other family members may still be at risk.

Intersection with Healthcare

Physical symptoms tend to be what prompts torture survivors to seek care. Somatic complaints at presentation may include sleep impairment, headache, nausea, and chronic pain. Memory and concentration impairments also arise as a result of traumatic brain injuries. Physical injuries vary based on the type of torture endured, including blunt trauma with subsequent bruising and potential internal injuries, injuries from bodies being placed in stress positions during prolonged suspension and electrical and thermal injury [10]. Sexual trauma, including rape and genital mutilation, can lead to dyspareunia, urinary tract infections, menstrual irregularities, and infertility [11]. Certain physical injuries may not be visible as torturers often employ strategies to minimize evidence. For example, they may place a sheet on the victim's skin during a whipping.

There is also a correlation between physical and mental health illnesses. In an age- and sex-matched study of 1052 refugees in Nepal, those who were tortured (half of the study population) had higher rates of PTSD, depression, and anxiety [12]. These refugees also reported more respiratory and musculoskeletal symptoms. Back pain, disrupted sleep, decreased appetite and libido, and hearing and vision impairments were all reported more often by those who had been tortured [12]. Higher rates of medical conditions have been identified in survivors with comorbid PTSD with depression than with either mental illness alone [13]. Studies use various tools to screen and diagnose depression, anxiety, and PTSD; these include the Hopkins Symptoms Checklist, PTSD Checklist for Civilians, Harvard Trauma Questionnaire, Beck Depression and Anxiety Inventories, and DSM criteria assessed via clinical interview.

Several studies suggest increased rates of PTSD in survivors of torture, though actual prevalence is variable. Depression and anxiety are also common. Mental health diagnoses are likely underreported due to limited access to care and screening of torture survivors. Factors which may predict onset of mental illness include the type and severity of torture endured; post-migration stressors, especially unstable living environments; and length of time to accessing healthcare services. Population sizes in studies range from 30 survivors to over 1200 people; in these studies, rates of mental illness vary between different populations. For example, in one study of 91 Syrian Kurdish refugees, 38% screened positive for symptoms of PTSD [14]. In another study of 278 torture survivors from the Middle East who resettled in the USA, 56.9% screened positive for PTSD, 83.8% for depression, and 81.3% for anxiety. In a study of 131 torture survivors from Africa, 94.7% screened positive for depression and 57.3% for PTSD [15]. In a study of almost 80 survivors from various regions including the Middle East, South Asia, Central Africa, and Southeastern Europe, 78% screened positively for depression and anxiety, and 88% screened positively for PTSD [16]. In a study of 720 survivors in Nepal, under 10% screened positive for PTSD, 27.5% screened positive for depression, and nearly 23% screened positive for anxiety [17]. In one of the larger studies with over 1200 Syrian refugees who resettled in Sweden, 40% were diagnosed with depression, approximately 32% with anxiety, and almost 30% with PTSD [18].

Some studies have looked at mediators and moderators that may predict or protect from certain mental health outcomes. Many report a relationship between severity of torture endured and a diagnosis of PTSD. Those who were tortured for longer periods of time were more likely to be symptomatic. For many, the psychological trauma is more disturbing than the physical pain they weather. Additionally, the stress response can be mediated by a number of factors and demographic characteristics including preexisting mental and medical conditions and an individual's strengths and vulnerabilities, characterological qualities, and resiliency. Those with childhood trauma are more likely to have functional impairments [19]. In one study of survivors who settled in the USA, female sex and older age were predictive factors of later receiving PTSD and depression diagnoses. A similar finding was noted in the study of 720 survivors in Nepal and also found higher rates of anxiety in women and those of Islamic religion [7]. The gender difference with anxiety disorders is consistent with data from the general population [20].

As a form of interpersonal trauma, torture increases the risk of psychological stress. The severity of traumatic experiences coupled with the frequency of traumatic occurrences can reflect the likelihood of developing a mental health disorder. The migration journey and resettlement experiences can further compound psychiatric symptoms. As an example, survivors may fear re-experiencing symptoms while sharing their torture experience during the asylum application process that can include medical and psychological interviews. Sharing vivid memories of what they endured can exacerbate symptoms including nightmares, flashbacks, low mood, and episodes of panic. Once settled, symptoms of stress can also be triggered and further compounded by news, social media, current events, and the political climate as they are reminded of what they survived and from what their friends and

family who are still in the country of origin may continue to suffer. In a study of 134 survivors, those who endured post-migration obstacles were more likely to meet criteria for multiple psychiatric illness than those who did not face as many migration complications [21]. Other studies have shown that torture survivors that experience financial and legal insecurities had higher rates of PTSD [22].

As a result of these known associations, one can observe social predictors of patient outcomes. For example, in a study of Iraqi asylum seekers in the Netherlands, patients who had a longer asylum period were more likely to develop a mental illness than those who recently arrived in the host country. PTSD rates were 10% higher in those whose asylum cases took longer than 2 years versus those who had arrived within the previous 6 months [23]. In another study, survivors who accessed clinical services after 1 year of arrival in the USA were more likely to be diagnosed with depression and PTSD compared to those that accessed services within the first year of resettlement [24]. Symptoms of depression and PTSD improved as immigration status was secured in a study of torture survivors who resettled in New York City [25]. All of these studies are correlational, and it is likely that psychiatric illness and assimilation challenges can affect one another bidirectionally. Experiencing symptoms of depression, anxiety, and PTSD likely further exacerbates assimilation difficulties. As such, it is imperative that social determinants of health and referrals to social and legal services are addressed by the treatment team.

Screening and Assessment

Estimates suggest up to 10% of immigrant patients in urban medical clinics in the USA are survivors of torture [26]. This likely underrepresents the number of patients who present to clinics in which providers are not asking about torture history. Feelings of guilt, shame, and mistrust may limit how much history a survivor of torture volunteers without being asked. Some patients expect medical providers to inquire about trauma, so it may not be disclosed without screening. Implementing screening tools can identify survivors and expedite their access to treatment and social services. One example of a screening tool is the Detection of Torture Survivor Survey (see Table 2.2) that is recommended to be conducted at a patient's second appointment once a doctor-patient relationship has already been established [27].

It may be that the patient's experience with torture is only one component of their trauma history, so it is important to inquire about a patient's life more holistically. A biopsychosocial formulation and treatment plan that encompasses a team-based approach with collaboration between the psychiatrist, therapist, and case manager is ideal. If the patient speaks a different language, all communication should be through a trained interpreter with as close to the patient's preferred dialect as possible. Consents and confidentiality should be highlighted throughout the treatment course and especially in the beginning, prior to establishing strong rapport.

Table 2.2 Detection of torture survivors survey (DOTSS) items from Eisenman (2007) [27]

Introduction: In this clinic we see many patients who have been forced to leave their countries because of violence or threats to the health and safety of patients and their families. I am going to ask you some questions about this:
1. In (your former country), did you ever have problems because of religion, political beliefs, culture, or any other reason?
2. Did you have any problems with persons working for the government, military, police, or any other group?
3. Were you ever a victim of violence in (your former country)?
4. Were you ever a victim of torture in (your former country)?

Adapted from Eisenman [27]

The assessment and subsequent treatment of psychiatric illness in survivors of torture should take a trauma-informed approach. In doing so, a provider recognizes the impact trauma may have on the individual and actively encourages recovery that limits re-traumatization. Paramount to trauma-informed treatment is trust building and psychoeducation. It may be difficult for patients to share details of their lives with anyone, especially someone they recently met. It takes time to develop a trusting doctor-patient relationship, and in the trauma-informed setting, providers should highlight collaboration and the patient's voice and choice, further fostering the patient's underlying resilience. For many torture survivors, engagement with medical care, especially mental health care, is novel. Open-ended questions are recommended, though some patients may need guidance of what to share if they have limited experience engaging in medical care. As an example, they may not correlate their chronic headaches or abdominal pain and disrupted sleep pattern to their emotional state.

Assessments should consider the cultural contributions of a patient's presentation, recognizing that patients may be reluctant to share details of their trauma history with providers. It can be prudent to research the political atmosphere and sociocultural norms of the patient's country of origin if it is known prior to the first appointment. Many torture survivors come from societies that discourage mental health services. As a result, there may be a component of stigma or limited knowledge about mental health that delays a patient's engagement in treatment. Feelings of guilt and shame may also impact a patient's reception to psychiatric diagnoses and care. Some may feel that they deserve to suffer. Reluctance may also be attributed to a fear of legal ramifications subsequent to disclosure so reviewing limits of confidentiality is especially important [28].

One resource that may assist a provider in gaining a better understanding of a patient's cultural background and impact that has on their engagement with mental health is the Cultural Formulation Interview in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) [29]. Through a series of questions, a provider can gain insight into a patient's perspective of the cultural meaning of their symptoms and treatment. Since cultural sensitivity can help inform subsequent treatment planning, using this evidence-based tool can help guide providers while developing the doctor-patient relationship.

Treatment

A patient-centered, strengths-based environment promotes empowerment and the development of a trusting relationship. This, of course, takes time as trust is often shattered when an individual is tortured. It is important for the provider to respect patients' boundaries in how much they share at initial visits. For those patients whose legal proceedings are underway, reviewing the affidavit prior to the intake can be particularly helpful to understand the patient's previous experiences.

When a patient screens positively for a history of torture, providers can share their familiarity and training in the topic to help normalize the patient's experiences. Connecting a patient's torture history to their physical and mental health can help bridge their history to their current presentation. Sometimes describing a cause-and-effect relationship can address some of the stigma issues that concern patients. If possible, refer the patient to appropriate local resources and services that have experience working with the tortured population. Some of these organizations provide more specialized treatment options including psychotherapy and medication management. If a patient reports psychiatric symptoms, treatment plans are typically multipronged with the core components being trauma-informed psychotherapy with concurrent pharmacologic intervention. It is imperative that patients actively participate in treatment planning and that psychoeducation is consistently reviewed. The teach back method is an effective way to ensure patients understand the treatment plan and reinforces an open line of communication.

Psychotherapy Treatments

Evidence-based psychotherapies for PTSD often include structured, time-limited sessions that involve components of exposure and/or changing patterns of cognitions, behaviors, and emotions that lead to difficulties in functioning related to the trauma. PTSD-specific psychotherapy should not occur if patients are currently unstable, suicidal, a danger to self or others, in need of urgent medical attention, or in an unsafe environment. Evidence-based modalities to treat PTSD include trauma-informed cognitive behavioral therapy including prolonged exposure and cognitive processing therapy. There is growing body of evidence that supports the utility of eye movement desensitization and reprocessing therapy and narrative exposures.

Through cognitive restructuring and *in vivo* or imaginal exposures, *cognitive behavioral therapy* (CBT) for PTSD evaluates negative appraisals related to the trauma. *Prolonged exposure*, which is rooted in the emotional processing theory, guides individuals through *in vivo* and imaginal exposures in an effort to recondition their fear response. *Cognitive processing therapy* (CPT) challenges distorted cognitions related to trauma and leads to altering beliefs to accommodate for more adaptive experiences [30]. In *narrative exposure therapy* (NET), patients develop a detailed chronological account of their life experiences while being grounded in the present time. *Eye movement desensitization and reprocessing* (EMDR) helps patients process trauma by focusing on saccadic eye movements while engaging in imaginal exposure to the trauma. Through this process, the traumatic experience is

reformulated, making the memory less distressing. In the limited number of studies comparing these various modalities in refugee and asylum seeking populations, CBT, NET, and EMDR, when conducted in a culturally informed manner, have demonstrated to be efficacious [31, 32].

It is important to note that studies specifically researching trauma in the torture survivor are extremely limited and symptoms of comorbidities such as depression or anxiety may not be addressed by these specific psychotherapies. The National Institute for Clinical Excellence recommends that initial treatments should focus on acute symptomology and the development of adaptive coping skills prior to introducing trauma-informed therapies. Furthermore, awareness of ineffective or harmful treatments is important. For example, psychological debriefing immediately following a traumatic event has shown to be ineffective and may actually increase the likelihood of individuals developing PTSD symptoms [25].

Pharmacologic Treatments

Similar to psychotherapeutic interventions, psychotropic medications have not been extensively studied in the tortured population. Evidence from veteran and civilian trauma is applicable, though it is important to note that mental health cannot be treated in isolation of social, legal, medical, and spiritual needs of these patients. There is currently no evidence to support use of a pharmacological agent to prevent the development of PTSD. It is also necessary to screen for patients' use of traditional culturally appropriate remedies such as supplements or homeopathic therapies.

The Federal Drug Administration (FDA) has approved two selective serotonin reuptake inhibitors (SSRIs), paroxetine and sertraline, for the treatment of PTSD. Additionally, fluoxetine and venlafaxine, serotonin-norepinephrine reuptake inhibitors (SNRIs), have been shown to be effective options. In addition to treating the symptoms of PTSD, SSRIs and SNRIs can also treat mental health comorbidities and suicidal or aggressive behaviors [33]. While these medications are generally well-tolerated, considerations in medication selection should include potential drug-drug interactions (i.e., via CYP P450 2D6 inhibition), side effect profiles/tolerability, comorbidities such as chronic pain, and patient adherence. As an example, if a notable component of the patient's presenting problems include chronic pain, the SNRI duloxetine, which is FDA approved for the management of pain, may be a more appropriate choice than a SSRI. Since most survivors of torture are psychotropic medication naïve, the recommendation is to start at low doses and titrate to effectiveness.

A common symptom associated with torture is nightmares. Clinicians and researchers speculate autonomic nervous system hyperactivity leads to hyperarousal symptoms, agitation, and nightmares. The alpha-adrenergic antagonist prazosin has been shown to be effective for reducing nightmares [34]. Patients should be advised of its FDA off-label use and to monitor for dizziness/lightheadedness, to rise slowly, and to maintain adequate oral hydration. Providers should also monitor for orthostatic hypotension. Doses start at 1 mg at bedtime and should be titrated with provider check-ins to ensure tolerability. Patients typically report either the intensity or

the frequency of the nightmares starts to improve as one gets closer to the optimal dosing. Anecdotally, some patients also report dreams become more vivid in nature prior to improvement. Ultimately the goal is for patients to sleep through the night uninterrupted. Daytime dosing, if tolerated, may be appropriate to target hypervigilance symptoms.

Benzodiazepines are the one class of medications thought to be contraindicated in the treatment of PTSD. Evidence shows that they are ineffective at treating PTSD symptomatology likely due to the differing pathophysiology of PTSD as compared to other anxiety disorders. Because benzodiazepines affect the brain globally, rather than specific structures, their effects can potentiate already hypoactive parts of the brain in the setting of PTSD. They can inhibit cognitive processing and induce emotional numbing that can interfere in the consolidation of memory that assists in the recovery from trauma. Some studies suggest benzodiazepine administration after a traumatic event can increase the likelihood of developing PTSD by promoting avoidance [35]. Discontinuation of this type of medication can lead to withdrawal symptoms that can mimic symptoms of PTSD such as insomnia and irritability [36]. Further, it may negatively impact psychotherapy outcomes by dulling the patient's emotional experiences during exposure exercises and increasing their avoidance of negative emotional states [37]. Figure 2.1 highlights recommended treatment approaches in survivors of torture with PTSD.

Treatment approaches typically target the most distressing symptoms first. For example, for someone with low mood and daily nightmares, focusing on the sleep disturbance can help provide relief as the patient becomes increasingly engaged in treatment. Limited adherence to medications is common in this patient population. It is important for patients to understand the anticipated treatment course including length of time it may take to see any response. For example, patients may self-discontinue an antidepressant after 2 weeks of seeing no benefit. Alternatively, patients may begin to feel better after 3 months on an antidepressant and think that they no

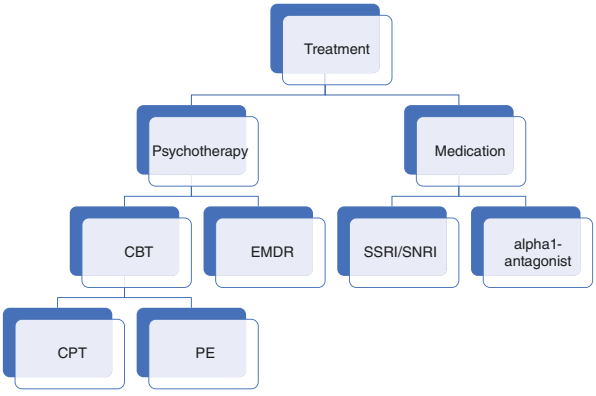

Fig. 2.1 Psychotherapy and medication treatments for PTSD. *CBT* cognitive behavioral therapy (trauma-informed), *CPT* cognitive processing therapy, *PE* prolonged exposure, *EMDR* eye movement desensitization and reprocessing, *SSRI* selective-serotonin reuptake inhibitor, *SNRI* selective-norepinephrine reuptake inhibitor

longer require medication. Frequent follow-up with discussions regarding medication administration are imperative to ensuring adequate adherence, as for many patients, medical literacy may be low. Also, while the psychological wounds are often most distressing, physical symptoms must not be overlooked in survivors of torture. If physical pain persists, it may interfere with resolution of psychological pain as they trigger one another and can exist in a cycle. Collaborating with primary care and referrals for acupuncture, massage, and physical therapy should be considered.

Social and Legal Services

Care coordination with social and legal services can greatly impact patients' progress. Many patients face financial uncertainty; support securing shelter and access to food, clothing, and hygiene products are necessary components in these patients' post-migration journeys. Patients also benefit from assistance to navigate the healthcare system and enroll in health insurance. Additionally, social services can coordinate transportation services so patients can attend their various appointments. They may offer assistance in enrolling patients in English classes, job training, and higher education, which can facilitate a rebuilding of one's sense of self in a new country. Since many torture survivors come from cultures that are based on interdependence, re-establishing a sense of community can be particularly constructive. Often social services introduce patients to fellow immigrants from their country of origin.

One of the primary stressors survivors of torture face are legal challenges. A lack of understanding of the US judicial system coupled with language barriers and financial pressure make it difficult for survivors to secure legal representation for their petition. Even if they are able to access legal services, it can be difficult to engage with them as recounting the details of their torture experiences can be triggering, and any underlying mental health issues such as depression, anxiety, or PTSD can further interfere with their ability to optimally utilize services. For those patients that do have attorneys, coordination between the legal and clinical teams can be instrumental to an asylee's application. In one study of 2400 asylum seekers, 37% were granted asylum without medical documentation. In contrast, of those who had medical documentation supporting their history and symptoms, 90% had their petition approved [38]. Clinically it is important to recognize the impact legal stress has on patients' mental health. It is often difficult for applicants to gather the evidence necessary for their asylum petitions, and the process of application can be quite lengthy. These components of the unknown can increase undue stress on patients and negatively impact the trajectory of their mental health.

Children and Adolescents

Whether a child has directly or indirectly been impacted by torture, the downstream effects can be substantial. Trauma can range from witnessing war zone areas to intergenerational trauma such as residing with parents who struggle in post-torture times. When treating parents, it is important to note how their wellbeing impacts

their children. Youth who have been exposed to torture (directly or indirectly via parents' experiences) can develop PTSD and may present with sleep disturbances, poor concentration, irritability, and avoidant behaviors [39]. Children infrequently volunteer these symptoms, so it is important for caregivers to inquire. Given the limited set of coping skills one has at a young age, children may have more disruptive behavior that is characterized as acting out that can impact school performance. Additional signs can include, but are not limited to, crying episodes, sleep disturbances, developmental regressions (e.g., language and toileting skills), engaging in post-traumatic play, somatic complaints (e.g., headaches, stomachaches), irritability, separation anxiety, and poor school performance [40].

Direct traumas children often encounter are in the migration process, such as exposure to physical violence and shelter and food insecurity. The journey is often emotionally and physically draining. Parents' ability to tend to children's emotional needs during this time may be severely limited as priorities may shift to ensuring basic needs of food and shelter are safely acquired during the journey. In the post-migration period, children may struggle with assimilation. Having left behind friends and family, rebuilding a community is particularly important for children. Because they are more likely to quickly learn the host country's language, children also often serve as the family's interpreter for daily activities. While many will adapt without much difficulty those that show concerning signs (as described above) should be offered prompt intervention.

Pregnancy

For some survivors of torture, sexual activity can be a challenging experience. Dyspareunia is a common symptom that is seldom discussed but can have significant impact on a patient's mental health and relationships. For those with histories of sexual assault, obstetric/gynecologic exams can be particularly triggering. It is important to weigh risks versus benefits in the management of mental health issues when a patient becomes pregnant. In some cases, it may be detrimental to cease previously helpful medications during pregnancy. For example, antenatal in utero exposure to untreated depression is known to be associated with increased rates of prematurity and low birth weight and can have long-term negative outcomes including depression, anxiety, ADHD, and physical illnesses. Postpartum depression occurs more frequently in those who had prepartum depression that discontinued treatment during pregnancy [41]. Certainly each woman must be evaluated individually with a thorough discussion of potential consequences on fetal development so an informed decision can be made.

Conclusion

Well into the twenty-first century, torture continues to plague society. Survivors develop long-term physical and mental health sequelae. Utilization of evidence-based screening tools can help providers identify at risk patients. A resilience-based

and strengths-focused approach to treatment that encompasses a multi-prolonged treatment approach – psychotherapy, pharmacotherapy, and social/legal services – can foster a survivor's recovery.

Summary of High-Yield Points

- As the number of survivors of torture who seek refugee and asylum status continues to grow worldwide, medical providers must recognize that they are at high risk for mental illness.
- Torture survivors can endure traumas throughout their migration experience: pre-migration, migration, and post-migration.
- Predictors of mental illness can include survivors' age, sex, type and severity of torture endured, post-migration obstacles, length of time to legal status resolution, and length of time to accessing healthcare.
- Providers can screen refugee patients for torture histories as many may not self-disclose if not prompted.
- While presenting symptoms are usually somatic in nature, PTSD, depression, and anxiety are common mental health disorders in survivors of torture.
- A trauma-informed approach should guide assessment and treatment that includes trauma-informed psychotherapies and psychotropic medications as well as coordination of care with social and legal services.

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