

Caring for Refugee and Asylee Torture Survivors in Primary Care

Nicole Chow Ahrenholz, MD; Mahri Haider, MD, MPH; and Anjali Niyogi, MD, MPH

Dr. Ahrenholz is a clinical assistant professor and Dr. Haider is a clinical instructor in the Division of General Internal Medicine at the University of Washington. Dr. Niyogi is a clinical assistant professor in the Department of Internal Medicine and Pediatrics at Tulane University School of Medicine.

Case: *An 81-year-old Vietnamese man had been followed for several years for right leg pain, numbness, and weakness that were exacerbated by hunger and insomnia. Labs, imaging, and subspecialty referrals to orthopedics, neurology, and rehabilitation medicine were unrevealing. Eventually he disclosed that he was imprisoned in Vietnam for 22 years, with solitary confinement in tight spaces, starvation, and beatings. At night, guards pulled the shackles around his ankles back and forth to deprive him of sleep. The patient attributed his chronic leg symptoms to his experience of torture in Vietnam.*

Despite international declarations and conventions prohibiting torture, it remains a frequent practice around the world and is an experience shared by many refugees. Torture is defined by Article 1 of the United Nations Convention against Torture as:¹

Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain and suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions.

As of 2000, it was estimated that approximately 400,000 torture survivors lived in the United States, and the number is almost certainly much

higher now.² In 2014, the United States resettled almost 70,000 new refugees from around the world—the majority from countries where torture is known to be practiced.³ Prevalence of torture varies widely by the population studied. Surveys at primary care clinics indicate that 6% to 11% of foreign-born participants have a history of torture; 0% of these were identified by their primary care physician.^{4,5} A meta-analysis of 42,626 refugees and other conflict-affected groups showed an overall prevalence of 21%.⁶ As US physicians see greater numbers of refugees, they will need familiarity with taking a torture history and understanding the sequelae of torture and their implications for medical care.

Refugees and Asylum Seekers

A refugee is defined as a person fleeing persecution, which includes abuse, ill treatment, ill usage, maltreatment, oppression, and torture because of race, religion, nationality, political opinion, or membership in a particular social group. As of 2013, an estimated 51.2 million people were forcibly displaced from their homes due to conflict, persecution, and abuses.⁷ Of these, 1.1 million were seeking asylum. The United States is the second leading industrialized country accepting asylum seekers, with 85,000 applications

filed in 2013 and more than 300,000 cases pending.⁷

In contrast to refugees, asylum seekers are those individuals who flee their country of origin and apply for refugee status once arriving in the host country. While refugees are immediately entitled to all resources available to permanent residents, asylum seekers may not have legal status. They are often placed in detention centers and are ineligible for federal benefits while they await a ruling on their claims. As such, they do not qualify for health insurance and may be ineligible to apply for employment.

Asylum seekers face many barriers in seeking medical treatment. In addition to language and cultural differences, they frequently experience economic hardships and the fear of deportation. Furthermore, many survivors are reluctant to disclose their history of torture due to shame or guilt. To attain asylum, a person must prove a well-founded fear or history of persecution. In the United States, only one third of applicants are granted asylum. Medical forensic evidence increases this likelihood three-fold (30% vs. 85%).⁸ Formal training in conducting medical and psychological evaluations along with preparing affidavits is available through Physicians for Human Rights.

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Medical Care

A past experience of torture, even when remote, can affect medical care. The following factors should be taken into consideration during the initial clinical evaluation:^{9,10}

1. *Taking a torture history.*¹¹ Relevant history questions are shown in Table 1.
2. *Physical sequelae.* US physicians who care for refugees will encounter the long-term physical sequelae of torture, which vary by the type and severity of torture performed (Table 2). Beatings and blunt trauma can result in poorly healed fractures and traumatic brain injury, with effects on memory, executive function, and mood. Falanga, or beating the soles of the feet, can cause subcutaneous fibrosis, resulting in chronic pain and gait abnormalities. Survivors of electrical torture may have characteristic burns or neuropathy.

While some survivors of torture have scars or visible deformities, others lack visible evidence of torture but still suffer from chronic debilitating pain. Knowledge of a patient's history of torture can sometimes help explain atypical pain complaints, as described in the case on page 4.

3. *Psychological sequelae.* The psychological effects of torture can be more debilitating than the physical sequelae. Mental health disorders occur frequently in survivors of torture, with 81% having clinically significant anxiety, 85% clinically significant depression, and 46% symptoms

of post-traumatic stress disorder (PTSD). Often a patient's psychiatric symptoms can wax and wane depending on other medical or life stressors:

A 65-year-old Cambodian gentleman with a history of diabetes and chronic kidney disease began to experience nightmares and poor sleep when he was told he needed dialysis. He revealed that he was having frequent nightmares about when he lived in a labor camp under the Khmer Rouge. He viewed his dependence on dialysis as a type of confinement, where his freedom was once again being limited. With attention to the narrative behind his symptoms, he was able to get effective treatment for his PTSD and eventually was willing to start dialysis.

4. *Retraumatization by the medical setting.* Many patients who have been subjected to torture are reluctant to discuss their experience, and clinicians may fear retraumatizing patients by inquiring about their past. However, not knowing a patient's history of torture has the potential for even greater retraumatization. The medical setting can bring back painful memories, as torture often has medical overtones (e.g. performing procedures, administration of drugs including psychoactive compounds, and physician participation in the act of torture). Lying still in a loud MRI scanner can evoke claustrophobia and panic in a person who has been subjected to forced postures or

imprisonment in confined spaces. Being connected to ECG leads or EMG needles can provoke flashbacks of electrical torture. Many of the routine practices that occur in the clinical setting can trigger memories of past torture:

A 53-year-old Cambodian woman with diabetes had a meeting with a nutritionist to discuss diet and weight loss that triggered memories of food deprivation and watching her children die of starvation during the Khmer Rouge.

A 32-year-old Chinese woman presented to clinic requesting removal of her intra-uterine device (IUD). Upon further questioning, she revealed that when she was in China and pregnant with her second child, she was forced to undergo an abortion and placement of an IUD in accord with the One Child Policy. Knowledge of her past torture allowed the physician to anticipate the retraumatization that might occur during an IUD removal and take the time to adequately prepare the patient.

5. *Nonadherence.* Closely tied to the issue of retraumatization is the problem of nonadherence. The act of torture robs a person of control and renders him/her powerless. For many torture survivors, encounters with the US health care system create many of the same feelings of powerlessness, which can lead to lack of follow through with appointments, labs, studies, or referrals.

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A 73-year-old Oromo man was seen for recurrent episodes of cerumen impaction in his right ear but repeatedly failed to present to nurse appointments for irrigation. He later revealed a history of torture including “telefono” (i.e. repeated striking of his ears) that occurred around 40 years ago in Ethiopia when he was advocating for political rights of the Oromo population. He reported fearfulness about ongoing damage to his ears and lack of control during irrigation or manual disimpaction. Once his history of torture was known, his physician was able to negotiate management strategies that allowed the patient more control over his care, such as applying his own eardrops at home.

Summary

Torture unfortunately remains prevalent in many parts of the world and is an experience shared by thousands of immigrants and refugees. Awareness of a patient’s torture history can allow physicians to understand the background of certain physical and psychological symptoms, anticipate and prevent re-traumatization, troubleshoot barriers to adherence, and further a path to healing.

Suggested Reading

<http://www.healtorture.org/>
<https://www.healthright.org/>

References

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Table 1. Taking a Torture History

What made you leave your home country?
In your home country, did you ever have problems because of religion, political beliefs, culture, or any other reason?
Did you have any problems with persons working for the government, military, police, or any other group?
Were you ever a victim of violence in your home country?
How did you get this scar?

(Adapted from Walker PF, Barnett ED. *Immigrant Medicine*, Table 48.2, reprinted with permission)

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Table 2. Common Methods of Torture

Physical Methods	Psychological Methods
<ul style="list-style-type: none"> • Blunt trauma (e.g. beatings all over; “falanga”, beating the soles of the feet; “telefono”, striking the ears) • Penetrating trauma (e.g. cutting, amputations) • Crushing trauma • Positional torture (e.g. suspension, confinement in small spaces, fixation by ropes or chains) • Shaking • Asphyxiation • Chemical torture • Burns (e.g. electrical, acid, cigarettes) • Pharmacologic or microbiologic torture (e.g. forced ingestion of medications, inoculation of pathogens such as HIV) • Sexual torture 	<ul style="list-style-type: none"> • Humiliation (e.g. mocking, sexual humiliation, forced breaking of religious taboos) • Threats • Mock executions • Deprivation... of light and sound of food and drink of access to toilet facilities of sleep of company of access to medicine and medical care • Witnessing or perpetrating the torture of others

(Adapted from Walker PF, Barnett ED. *Immigrant Medicine*, Table 50.2, reprinted with permission)

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