

## Guest editorial

# The survivors of torture: what health and social care professionals should know

Mary Dawood RN MSc BSc (Hons)

Nurse Consultant Emergency Nursing, St Mary's Hospital Paddington, London, UK

There can never be any justification for torture. It creates an escalation of violence in the internal affairs of states. It spreads like a contagious disease from country to country. It has a lasting effect on the mental and physical health of the victim and brutalises the torturer. (Amnesty International, 1973)

The UK is a signatory to the United Nations Convention Against Torture and other Cruel or Inhuman or Degrading Treatment or Punishment (1984). This convention requires the signatory states to legislate against torture in their countries and to investigate and prosecute any such activity. Despite such widespread agreement on human rights, Amnesty International estimates that torture and human rights abuses are currently practised in 132 countries (Amnesty International, 2005). This is a very conservative estimate, and the figure is thought to be much higher, but the shameful and clandestine nature of torture means the real figure will never be known. It is no surprise then that the majority of asylum seekers originate from countries with documented records of human rights abuses and torture. In the UK, estimates of the proportion of asylum seekers who have been tortured vary between 5% and 30%, depending on the definition of torture used and the country of origin (Burnett, 2002). While the devastating physical, psychological and social effects of torture are well recognised and have been documented by human rights organisations, identifying the sufferers when they first present is not always straightforward. Professional education in health and social care has not traditionally taught students to recognise torture survivors, and for good reason because it was not seen as necessary. Torture has traditionally been regarded as a rare and horrifying relic of the past, but sadly this is not the case. Torture is a contemporary phenomenon that invades and disturbs our consciousness with increasing regularity.

Torture is a very effective weapon irrespective of the perpetrator's motives. In the past it was used to force confessions from people, but in recent times it has been used as a weapon to repress individuals and to destroy societies. A large majority of those tortured die

of their injuries or remain in custody. The minority that we encounter in our practices are the survivors who have endured an annihilating experience and have somehow found the fortitude and determination to survive and escape. These people are worthy of our deepest respect, not only because of their strength of character but because they represent the triumph of the human spirit over adversity and evil. Regrettably, uninformed and negative media reporting on asylum issues means that respect is something these vulnerable people are rarely accorded – a situation that in so many ways diminishes the humanity of everyone in society. To recognise and be able to care effectively for torture survivors, it is vital to have some insight into their experiences and to acknowledge and validate the huge personal cost of their escape to a safe country.

The main aim of the torturer is to destroy and dismantle, publicly humiliating the person as a warning to the whole community. Contrary to the common perception of making people talk, torture often silences both the victim and the community. This silencing effect can endure long after the event, a feature which greatly impedes any hope of recovery, as survivors are often incapable of articulating their anguish. Consequently, torture survivors may present to care facilities with a variety of vague symptoms such as headache, insomnia, back pain or leg pain, which are chronic and often somatic in nature. It can be very difficult for clinicians to decipher the cause of these complaints, but it pays to be patient and sensitive because gentle probing may uncover the grim reality of torture, revealing a broken mind and body that needs skilled help.

In addition to being silenced by terror, some torture survivors are tormented by a deep sense of shame and embarrassment at what has happened to them, as though the torture was somehow their fault. For example, survivors of sexual torture, such as rape or sexual assault, fear being ostracised or somehow being blamed or shunned by their own communities, and so tell no one. They try to get on with life, sharing their shameful secret with only one person, their torturer. Such a secret is inevitably destructive, particularly of

future intimate relationships unless expert therapeutic intervention can be found. Other consequences of sexual torture may include sexually transmitted diseases, or HIV infection as well as unwanted pregnancies, resulting in ambivalent attitudes to the developing foetus.

Many survivors of torture suffer from post-traumatic stress disorder (PTSD) where they are plagued by flashbacks which can be triggered by something seemingly innocuous like a smell or a picture, reminding them vividly of their ordeal. Such flashbacks intrude indiscriminately into ordinary daily living, causing severe distress which to the onlooker may seem extreme. Before trying to calm and reassure someone in such distress it may be useful to remember the man who spent every night waiting to be tortured outside a cell where he had to listen to his friend being tortured. Twenty years later he is unable to sit in a hospital waiting room without having a panic attack. While this may seem like an irrational response, it should be borne in mind that in some countries doctors and nurses have tortured or been complicit in torture. Understandably, torture survivors may be suspicious and terrified of healthcare workers, responding in a negative and sometimes aggressive way when they need care; a dismissive reaction to such a response serves only to further alienate and demoralise. What is required is acknowledgement of the individual's distress, empathy, and patience in establishing meaningful dialogue.

Professionals caring for survivors of torture need to be mindful that language can be a significant barrier to communication. Even those with a reasonable grasp of English may struggle to express themselves or to convey the true horror of their experiences when distressed. The Medical Foundation for the Care of Victims of Torture recommends the use of specially trained interpreters, and strongly discourages the use of family or friends, however convenient or expedient that may seem. There are two reasons for this. First, recounting the experience may result in exposing secrets that the torture survivor feels are shameful and which should, therefore, be concealed from family members who might react negatively. Second, interpreters may also suffer trauma at having to relay the torture survivor's story, or may belong to the community responsible for what has happened.

In western societies the torture of children is still regarded as utterly despicable and depraved. Moral opprobrium, however, is weak and has little or no effect on countries which sanction and practise torture. In reality children are often deliberately targeted and either tortured in front of their parents or made to witness the torture of their parents. As the most

treasured possessions of the enemy adults, they are also the future, and so the terrorisation of children and the destruction of their potential is a most powerful and paralysing force aimed at the whole victim community (Forrest, 1996).

How children subjected to such atrocities recover and reconstruct their lives may depend on their age and ability to rationalise their appalling experiences. Undoubtedly many are damaged irreparably, not only by the trauma experienced in their own country but by their experiences of escape and exile. It is therefore heartening to read current research in this issue into the experiences and feelings of young refugees who came to this country as unaccompanied minors (Sutton *et al*, 2006). This paper looks at how a sample of young people has actively constructed their experiences of trauma and embarked on a process of positive changes and feelings of post-traumatic growth in the face of adversity. The paper highlights the important role of multiple sources of social support and the need for professionals to create an environment where the person feels safe and able to tell their terrible stories.

Inherent in that environment are respect, kindness and understanding afforded by professionals to torture survivors as essential prerequisites redressing some of the terrible wrongs perpetrated against our fellow beings.

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## ADDRESS FOR CORRESPONDENCE

Mary Dawood, Nurse Consultant Emergency Nursing, Emergency Department, St Mary's Hospital, Praed Street, London W2 1NY, UK. Tel: +44 (0)207 886 6859; fax: +44 (0)207 886 1211; email: [Mary.Dawood@St-Marys.nhs.uk](mailto:Mary.Dawood@St-Marys.nhs.uk)