Original Research

Survivors of torture in a general medical setting: how often have patients been tortured, and how often is it missed?

ABSTRACT ● **Objectives** To measure the frequency of people reporting torture among patients in a medical outpatient clinic and to determine primary care physicians' awareness of their patients' exposure to torture. ● **Design** Cross-sectional survey followed by selected in-depth interviews of participants reporting a history of torture. Medical record review and interview of torture survivors' primary care physicians. ● **Setting** The internal medicine clinic of a large, urban medical center. ● **Participants** A convenience sample of 121 adult patients who were not born in the United States and who were attending the adult ambulatory care clinic. ● **Interventions** All participants were interviewed using the Detection of Torture Survivors Survey, a validated instrument that asks about exposure to torture according to the World Medical Association definition of torture. Participants who reported a history of torture were interviewed in depth to confirm that they had been tortured. We reviewed the medical records of participants who reported a history of torture and interviewed their primary care physicians. ● **Main outcome measures** Self-reported history of torture. The awareness of primary care physicians of this history. ● **Results** Eight of 121 participants (6.6% [95% confidence interval: 3.1%-13.1%]) reported a history of torture. None of the survivors of torture had been identified as such by their primary care physician. ● **Conclusions** Physicians of patients who have not been born in the United States and who attend urban general medical clinics frequently are unaware that their patients are survivors of torture. Primary care physicians can be the locus of intervention in the care of torture survivors. The first step is for physicians to recognize the possibility of torture survivors among their patients.

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Survivors of torture often seek treatment of the chronic physical and psychological consequences of torture in specialized treatment and rehabilitation centers. But access to these centers is limited by their unavailability in most cities, cultural beliefs about illness and distress, and language and financial barriers. Instead, torture survivors may present to physicians' offices, community health centers, or medical centers seeking care for their health problems. For instance, one case report described three survivors of torture who presented to an ambulatory care clinic in internal medicine for health problems that were related to torture. These problems included anxiety, depression, infected wounds, a ruptured tympanic membrane, a fractured rib, and musculoskeletal pains.[1]

Such a report is not surprising because torture is associated with chronic medical and psychological problems. In one study, US prisoners of war who had been tortured had higher incidences of chronic peripheral nerve, joint, and back disorders than a matched group of US prisoners of war who had not been tortured.[2] Other controlled studies of refugee populations who have been tortured found higher rates of anxiety and depression symptoms.[3-5] Five percent to 35% of the world's refugees are estimated to have been tortured,[6(p85)] and 400,000 survivors of torture live in the United States.[7] Physicians who care for immigrant patients may be particularly likely to deal with the health problems of survivors of torture. Five percent to 10% of patients who present to urban medical clinics who were born outside the United States are estimated to be survivors of torture.[8]

To test the hypothesis that survivors of torture will be found among a general medical outpatient population, we surveyed patients attending a medical clinic at an urban municipal medical center to determine how frequently patients reported a history of torture. Furthermore, we hypothesized that primary care physicians are not aware that their patients have been tortured.

PARTICIPANTS AND METHODS

Institutional review board approval was secured in June 1996. The study was performed from June through August 1996. Eligible patients were aged 18 years or older and were born in a country outside the United States and its territories. Patients born in this country and in US territories (Puerto Rico and Guam) were excluded because of their low prevalence of torture.

A nonconsecutive convenience sample of patients was drawn from patients attending the internal medicine ambulatory care clinic of a large, urban, municipal medical center in New York City. This clinic registered 9,547 visits among 2,700 unique patients during the study period. Two trained research assistants enrolled participants at 75% of clinic sessions during the study period. First, they examined the clinic registration and identified all eligible patients. About 50% of the registered patients were eli-

gible. Second, they approached those patients who were in the clinic waiting room. The large number of patients in this clinic at this medical center made it logistically impossible to reach most persons in a timely manner. About 15% of patients were approached (selected only on the basis of availability). Third, the research assistant asked the patient to participate in a study about "the health care needs of foreign-born patients." No reimbursement or incentives were offered for participation in the study. One of the research assistants was bilingual in Spanish. Hospital translators were used for participants who spoke French, Bengali, Russian, Polish, or Chinese (Mandarin and Cantonese dialects). To encourage participation and disclosure and to ensure safety, all participants were interviewed in a private office without friends or family.

The research assistants verbally administered the interview using the Detection of Torture Survivors Survey. The survey instrument has been validated against a standardized instrument and blinded, clinical interview for screening culturally heterogeneous clinical populations for exposure to torture.[9] The primary outcome was a self-reported history of torture, as determined by the survey. The Detection of Torture Survivors Survey uses the definition of torture of the World Medical Association's Declaration of Tokyo: "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."[10] All survivors of torture were asked whether the physicians who were treating them knew about their reported history of torture. Also, the investigators reviewed participants' medical records and interviewed the patients' primary care physicians to determine whether the physicians either had made notes on or knew about their patients' reported history of torture. The participants' presenting complaints and their treatments were not systematically recorded.

Participants whose histories of torture fit the criteria in the Detection of Torture Survivors Survey were interviewed by clinicians who were expert in the evaluation of torture survivors. The expert interviewers came from the medical and psychology staff of the Bellevue–New York University Program for Survivors of Torture. Clinical assessment was chosen because research indicates that clinical interviews have good diagnostic accuracy for defining exposure to torture.[11] The clinical assessment included taking a detailed history of medical and psychiatric problems and of trauma. The history of trauma was correlated with what is known about the conditions in the country where the trauma was said to have taken place. To further verify each participant's reported exposure to torture would require a full physical examination and possibly ancillary testing.[8] Such an examination can be both time-consuming and retraumatizing for a survivor.[12] We did not try to obtain complete forensic verification of the reported torture because we decided it was unethical.

Summary points

- Over 6% of foreign-born primary care patients report a history of torture
- Physicians fail to identify the history of torture even when patients believe it has affected their health
- Torture survivors may not volunteer their torture history due to feelings of guilt, shame, or generalized mistrust of others
- Because of differing cultural beliefs about illness and distress, torture survivors may not relate their chronic health problems to torture experienced many years ago
- Outpatient medical providers who serve an immigrant population should consider torture and related traumas as a cause of health problems
- Outpatient medical providers can elicit a history of torture in the context of a safe environment, trusting relationship, and empathic interview

We carried out a univariate analysis that included means, standard deviations (SDs), and 95% confidence intervals (CIs). Bivariate analyses for differences in means were computed by the Student t test. Differences in proportions were computed using a χ^2 test.

RESULTS

Of 124 patients who fit our criteria and were invited to participate in the study, 121 (98.0%) agreed to do so. Sixty-eight (56.2%) were male. The mean (±SD) age of the study group was 45.0 ± 14.4 years. The mean time they had lived in the United States was 12.2 years.

Of the 121 participants, 8 (6.6% [95% CI: 3.1%-13.1%]) reported a history of torture. Survivors of torture did not differ from people who did not report torture, by age (40.1 ± 12.7 years for torture survivors vs 44.9 ± 14.4 years for patients who had not been tortured; $P = 0.18$) or sex (male: 75% for torture survivors vs 55% for patients who had not been tortured; $P = 0.14$), but they had lived in the United States fewer years (7.4 ± 3.8 years for torture survivors vs 14.0 ± 0.7 for patients who had not been tortured; $P < 0.001$). The eight participants who reported a history of torture came from Bangladesh (n = 4), El Salvador (n = 2), Ivory Coast (n = 1), and Romania (n = 1). None of the participants who reported a history of torture to the investigators had ever reported this history to their primary care physician, according to the participant, physician, and a review of the participant's medical record. Participants who reported a history of torture had a mean of 3.0 visits with their primary care physician (range: 1.0-6.0). The types of torture reported included beatings with sticks and fists, prolonged beating on the

soles of the feet (*falanga*), rape, repeated verbal threats to life, and being forced to watch the torture of others.

DISCUSSION

About 1 of 15 patients born outside the United States who participated in this study reported a history of torture. Although one case report described three torture survivors who presented to an outpatient medical clinic,[1] we know of no published study estimating the frequency of torture survivors in such settings. Our results provide evidence that survivors of torture are being seen in physicians' offices and that primary care physicians should learn to identify which of their immigrant patients have been exposed to torture.[13-16] Although this study did not attempt to fully determine which demographic and clinical characteristics were associated with a reported history of torture, physicians should inquire about a history of torture in patients born outside of the United States whenever the differential diagnosis includes trauma-related illnesses, such as depression, anxiety, posttraumatic stress disorder, musculoskeletal complaints, and chronic headaches.

The primary care physicians in this study were unaware of their patients' reported history of torture. One explanation for this is that the physicians had simply not been educated to consider the possibility that their patients had been tortured. Also, physicians may unknowingly erect barriers to a survivor's story because they feel helpless, guilty, or overidentify with the patient. They thereby avoid any investigation of traumatic material or may even deny that torture exists. If physicians do not ask, patients may not tell. The emotional responses to torture commonly experienced by survivors—such as feelings of guilt, shame, or a generalized suspiciousness and mistrust of others—may prevent them from volunteering this information. Last, the survivors may not relate their health problems to torture experienced many years ago.

Eliciting a history of torture can help physicians to diagnose, treat, and refer patients appropriately. Without this knowledge, physicians may not fully meet their patients' needs. For instance, one participant, whose physician had diagnosed his condition as irritable bowel syndrome, believed that his chronic abdominal pain was due to persistent emotional suffering from torture. Eliciting a history of torture may be traumatic for survivors, so physicians should know how to reduce the risk of retraumatizing their patients by asking about torture. To make these skills even more useful, physicians should know how and when to refer survivors for appropriate health and social services, including to specialized treatment centers, where these are available. A growing body of literature describes the health needs of survivors and how general internists may effectively participate in their care.[8,12-15]

Our measured outcome was based on self-reported data. Previous reports have reviewed the accuracy of participants' reports of torture and trauma (82% sensitivity, 92% specificity).[17,18] It may be impossible to verify that torture has taken place if more objective sources of verification, such as prison records or medical reports from the country of the trauma, either do not exist or are not available. Because we did not attempt to determine the clinical characteristics associated with a reported history of torture, we did not systematically assess the medical problems and presenting symptoms of the study sample. Furthermore, since we used a convenience sample of patients, we cannot determine the prevalence of people reporting a history of torture among the population of adult patients born outside the United States who attended this medical clinic. Nevertheless, considering the large immigrant and refugee populations living in urban areas, it is not surprising that survivors of torture are presenting to urban medical clinics. Immigrants and refugees widely use outpatient medical clinics,[19] and they often have somatic manifestations of psychological disorders.[20] Outpatient medical providers can be the locus of intervention in the care of survivors of torture. The first step is for physicians to recognize the possibility that some of their patients may have problems that are related to torture.

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