Psychological torture: definitions, clinical sequelae and treatment principles

Abstract

Psychological torture, in its broadest sense, is the intentional infliction of suffering without resorting to direct physical violence, in what is known as 'no-touch' torture. While several other definitions of psychological torture have been suggested, there is no one precise definition. Given the rapidly evolving current global political climate and the intensification of conflict, war and asylum seeking, the need for better recognition of psychological torture among clinicians, followed by the provision of appropriate treatment support for victims, has become increasingly pertinent. This article raises awareness of the concept of psychological torture among clinicians, through an overview of its debated definitions, the modalities which constitute this form of torture, and its clinical sequelae and treatment approach.

Key words: Fear; Human rights; Pain; Refugees; Survivors; Torture

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Definitions

Psychological torture is understood as the intentional infliction of suffering without resorting to direct physical violence, in what is known as 'no-touch' torture (McCoy, 2006; Ojeda, 2006; Reyes, 2007; Leach, 2016). The UN Convention against Torture was enforced in 1987, prohibiting acts that inflict severe pain or suffering to gain information from captives; however, torture remains a widespread act that is still practised globally (Khamsi, 2007). Despite its ongoing use, the exact definition of psychological torture has been debated widely across the legislature and clinical literature. On one hand, many refer to psychological torture as various non-physical forms of torture. Ojeda (2006) suggests four criteria which must be met for torture to be deemed 'psychological' – suffering, infliction, deliberateness and lack of direct physical violence. However, psychological torture may be interpreted to convey any form of torture that has a residual impact upon the victim's mind (Reyes, 2007).

While the exact definition of psychological torture remains ambiguous, a report by the Physicians for Human Rights (Borchelt, 2005) provided a definition based on the interpretation formulated in the United States Code (Department of Justice, 2004), referring to psychological torture as 'severe mental pain or suffering' caused by the threat of, or actual, administration of 'procedures calculated to disrupt profoundly the senses of personality'. As such, the effects that qualify as torture are clearly defined. If interrogation tactics involve psychological coercion that produces these effects, then such methods constitute psychological torture (Reyes, 2007). Regardless of what the exact definition of psychological torture may be, both physical and psychological torture create physical and mental suffering (Reyes, 2007), making it difficult in practice to separate these concepts.

The term 'ill-treatment' can be used to speak broadly of torture and other methods of abuse prohibited by international law, which include inhumane, cruel, humiliating and degrading treatment, and assault on personal dignity and morals (International Committee of the Red Cross, 2005). However, there is a legal difference between torture and other forms of ill-treatment, related to the severity of pain or suffering imposed (International Committee of the Red Cross, 2005). The aims and subsequent intended effects can further differentiate torture from other forms of ill-treatment. While the act of torture is supported by a specific purpose underlying its practise, for instance to obtain information, other forms of ill-treatment serve no specific purpose other than to inflict significant suffering or pain (International

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Committee of the Red Cross, 2005). Despite these subtle differences, ill-treatment can manifest physically and/or psychologically, which can lead to detrimental effects on both the physical and psychological realms (International Committee of the Red Cross, 2005).

Modalities

Assaults on the mind can be divided broadly into three categories (Leach, 2016). The first category is 'psychological' (Grassian, 1983; Weinstein et al, 1996; Başoğlu et al, 2007; Reyes, 2007), with examples including:

- Isolation, leading to 'insanity'
- Sensory deprivation, including the use of hoods to remove visual stimulation and minimal verbal communication
- Sensory overload
- Sleep deprivation
- Temporal disorientation.

The second category is 'psychophysiological', including environmental manipulation to create noxious thermal stimuli, food and water deprivation, and subjecting individuals to prolonged stress positions (Reyes, 2007). The third category is 'psychosocial', encompassing cultural, ethnic or religious-based humiliation, to forced sexual degradation, nudity and harassment (Başoğlu et al, 2007; Reyes, 2007). Sexual taboos are often exploited by interrogators and may be used against either males or females. However, the impacts on the psyche of women are better understood – for many, the fear of such a form of torture occurring has the same impact as the actual acts themselves (Reyes, 2007). Other examples of psychological torture include denial of personal hygiene, contact with pests or excrement, desperation (whereby victims are subjected to indefinite attention, inducing a sense of futility in their attempt to seek help), exploitation and exposure to phobias, pharmacological manipulation (involving the administration of tranquilisers, hallucinogens or alcohol), and threats of violence or death to the victims or their loved ones (Weinstein et al, 1996; Ojeda, 2006; Reyes, 2007). Mock executions (Başoğlu et al, 2007) and witnessing others being subjected to torture is another method of psychological torture, but these are often exploited as singular, one-off events.

Another important category of methods of psychological torture includes the so-called 'minor' or insignificant methods, which include verbal harassment, petty humiliation and taunting. When considered in isolation, their impact on the mind of the victim may appear insignificant, but when applied collectively over a prolonged period, the cumulative effect of such methods makes them an important component of psychological torture (Reyes, 2007). The experience of torture can be further heightened when different torture stressors are used synergistically with one another (Başoğlu et al, 2007). For example, the distressing effects of physical torture can be augmented by the sense of helplessness induced through blindfolding or hooding, as these remove visual control over the stressors, making them less predictable and controllable (Başoğlu et al, 2007).

Exploitation of phobias is frequently applied during interrogations (Reyes, 2007). Phobias can stem from ideas that go against cultural values – principles that may be observed by a whole population (Reyes, 2007). Alternatively, phobias can target and attack individual personal integrity, morals and/or religious beliefs (Başoğlu et al, 2007). Whether personal or 'collective', the use of phobias maximises psychological suffering, tailoring the inducement of fear and dread to the individual. The use of dogs to induce fear among detainees at Abu Ghraib prison was tailored to the well-known Muslim dread of canines (Mastroianni, 2013). It also exploited the fact that the dog is considered an unclean animal. In other cultures, the fear and revulsion of pigs, for example, has been used to torment victims.

Clinical sequelae

Victims of psychological torture lack any lasting physical damage compared to individuals that have experienced pure physical torture; however, the effects of psychological torture are no less damaging, and both forms of torture can inflict similar levels of pain and mental suffering, leaving their victims with long-term psychological issues (Başoğlu et al, 2007;

Khamsi, 2007). Psychological stressors cannot be easily distinguished from physical torture in terms of their relative psychological impact (Başoğlu et al, 2007). Thus, the effects of psychological torture should not be minimised under the pretext that pain and suffering must be physical to be authentic.

Typical issues experienced by victims of psychological torture include complex post-traumatic stress disorder or 'extreme stress disorder' (Leach, 2016). Others have argued for the existence of a specific 'torture syndrome' characterised by an impairment of cognitive function, particularly memory and concentration, sleep disturbance and nightmares, emotional instability, anxiety and depression (Leach, 2016).

Other psychological effects induced by psychological torture may include:

- Re-experiencing the trauma, as flashbacks, nightmares or stress reactions
- Avoidance of anything recalling the torture experience, known as emotional numbing
- Hyperarousal, including irritability, sleep difficulties, hypervigilance, constant anxiety and difficulties in concentration
- Depressive symptoms
- Depersonalisation, whereby the victim feels detached from their body
- Psychosis or brief psychotic reactions
- Substance and alcohol abuse
- Sexual dysfunction (Weinstein et al, 1996; Reyes, 2007).

Victims may also feel responsible for the torture that is being inflicted on them, inducing feelings of fear, shame, guilt and grief, as well as humiliation (Reyes, 2007). These are common problems that discourage victims from disclosing their personal circumstances (de C Williams and van der Merwe, 2013).

Given the intensity of many profoundly cruel and destructive acts which characterise the practise of psychological torture, it is unsurprising that chronic pain is a common manifestation among survivors (de C Williams and van der Merwe, 2013). Chronic pain has been associated with the development of post-traumatic stress disorder (Tsur et al, 2017), which is particularly concerning as torture survivors have a higher predisposition to develop post-traumatic stress disorder. Thus, pain specialists are likely to encounter torture survivors with persistent pain and psychological issues, commonly in the context of social and financial difficulties (de C Williams and van der Merwe, 2013).

While the consequences of psychological torture are extensive, as illustrated by the plethora of issues that may arise among survivors, the exact psychiatric and neurobiological sequelae vary depending on the individual psychological torture technique used, as different methods disrupt different homeostatic processes that enable one to function normally. For example, sleep plays an integral role in the maintenance of both cognitive and physiological processes, including memory retention and emotional regulation (Vyazovskiy, 2015). The impact of sleep deprivation as a method of psychological torture can thus be characterised by significant cognitive impairments, including deficit in memory, logical reasoning, complex verbal processing and decision making (Durmer and Dinges, 2005). Sleep deprivation is a favoured 'method of interrogation', requiring minimal logistics and skills, and leaving no tangible physical mark on the victim (Reyes, 2007). Prolonged solitary confinement, lasting between 7 and 24 months, can induce anxiety, nervousness, stress, disturbed sleep, difficulties in concentration and elocution, as well as suicidal tendencies, depression and paranoia (Reyes, 2007). Thus, solitary confinement, as stated by the European Committee for the Prevention of Torture, is at least a form of inhumane and degrading treatment if applied for several weeks (Reyes, 2007).

Refugees with a history of torture may have a wide range of psychological and social difficulties that do not easily fit within diagnostic categories (de C Williams and van der Merwe, 2013). The damaging psychological effects associated with psychological torture may be aggravated by the coexistence of physical ailments that are common to refugees, such as serious infections secondary to poor nutritional status (de C Williams and van der Merwe, 2013). Additionally, the normal buffers of social support and financial resources, which are essential for recovery, are frequently lost upon fleeing the home country, and basic communication in English may be a struggle for refugees with a history of torture (de C Williams and van der Merwe, 2013). Thus, symptoms should always be interpreted in light of the patient's current context (de C Williams and van der Merwe, 2013).

Efficacy

While torture increases the likelihood of receiving a confession from the victim, the information obtained is likely to be inaccurate. A 'broken' captive will almost certainly be extremely confused, to an extent where they may be unable to distinguish fact from fantasy and could very well tell their interrogators what they wish to hear in the hope that they will stop torturing them (Costandi, 2016). As such, confessions offered in the stressful environment of an interrogation room are not necessarily reliable, and the likely outcome is that the victim will simply lie or fabricate a story to make their torment end (Costandi, 2016).

It has been suggested that rapport and relationship building techniques are the most effective methods of obtaining a confession, regardless of the interrogation goal (Redlich et al, 2014). This is supported by a study by Goodman-Delahunty et al (2014), in which detainees were 14 times more likely to disclose information early in an interview when practitioners used rapport building compared with when rapport was absent. Furthermore, the more effort that interrogators made to build rapport with the suspect, through techniques such as the demonstration of interest and concern for their wellbeing, the greater the amount of information disclosed by the suspect (Persaud and Bruggen, 2017). Interrogating suspects in a comfortable physical setting also increased disclosure of incriminating information, and it is argued that this may be a result of fostering of trust in the relationship (Persaud and Bruggen, 2017). Therefore, there is evidence that efforts to build rapport result in faster and more accurate disclosure, rendering the practise of psychological torture fruitless and ineffective.

Recognition

Many refugees in the developed world are survivors of torture and present with various health needs without their traumatic experience being disclosed or identified (de C Williams and van der Merwe, 2013). Current circumstances surrounding poverty, uncertainty about asylum, separation from or loss of family members, and difficulties settling in the country of refuge, all contribute to current psychological problems and exacerbate pre-existing ones (de C Williams and van der Merwe, 2013). There is a significant challenge in recognising psychological pain, as it is less readily understood and overtly observable compared to physical pain or injury. As such, under-recognition and under-treatment of torture survivors by general clinicians and specialist healthcare workers is common (de C Williams and van der Merwe, 2013). It is believed that disclosure occurs in only a minority of cases, and rarely during the first clinical consultation (de C Williams and van der Merwe, 2013).

Primary healthcare physicians may be overwhelmed by the vague and complex symptom presentation reported by torture survivors (Weinstein et al, 1996; de C Williams and van der Merwe, 2013), which is often further complicated by symptoms of post-traumatic stress disorder (de C Williams and van der Merwe, 2013). Additionally, the signs of torture can be subtle and overlooked if patients are unable to disclose details surrounding their trauma as a result of their deep distrust of others (Weinstein et al, 1996; de C Williams and van der Merwe, 2013). As such, clinicians are faced with the dilemma of deciding whether it is necessary to pursue a line of questioning if a history of torture is suspected, as this may evoke intrusive memories and flashbacks associated with the trauma, causing considerable distress to the patient, and exacerbating any existing pain (Weinstein et al, 1996; de C Williams and van der Merwe, 2013). However, if there is sufficient evidence from the history and examination to suggest that trauma is the most likely underlying cause of the presenting complaint, the clinician should gently explore the area in a manner that is clear to the patient that they are willing to help, while not re-traumatising the patient (Weinstein et al, 1996).

A compassionate approach is critical when working with torture survivors, and various communication techniques can be used to exude warmth. Examples of such techniques include an explanation of the role as their clinician, thereby reducing anxiety and diminishing any element of surprise particularly during intimate examinations; empowering patients by providing them with a sense of control; acknowledging the difficulty of disclosure; educating patients about their symptoms as well as the available resources and services,

and the use of interpreters where language may pose a barrier (Weinstein et al, 1996). Even if the individual does not feel prepared, or trust the clinician sufficiently to disclose during consultation, the patient has in effect been given the opportunity to disclose and may do so with time and further discussion (Weinstein et al, 1996; de C Williams and van der Merwe, 2013). Fearing the patient's disclosure can be a deterrent to asking important questions, and the patient's account can be very distressing for the clinician, who will need to be prepared to handle it (de C Williams and van der Merwe, 2013).

Treatment principles

In an ongoing therapeutic relationship, a shared knowledge of the details surrounding the trauma will enable the clinician to offer more comprehensive care for the patient. The prospects of recovery can be optimised by using consultative or referral resources provided by mental health professionals trained to work with torture survivors (Weinstein et al, 1996). A multidisciplinary approach to assessment and treatment is recommended, guarding against either disregarding significant psychological distress as inevitable in torture survivors or discounting physical symptoms by attributing them to psychological origin (de C Williams and van der Merwe, 2013).

Cognitive behavioural therapy and narrative exposure therapy seem equally effective in reducing trauma symptoms, and to a lesser extent, depression (de C Williams and van der Merwe, 2013). However, psychological interventions tend to only produce relatively small changes in targeted measures of distress, when compared with standard treatment, and these may fall short of enabling recovery (de C Williams and van der Merwe, 2013). Rehabilitation and reparation are part of the rights of the torture survivor under the United Nations Convention, yet far less attention is paid to health needs on a national or international basis than to legal and civil claims. Collaborative efforts are needed, involving survivors themselves, to better understand the usefulness and limitations of existing assessment tools and treatment methods (de C Williams and van der Merwe, 2013). Despite these shortcomings, it is essential to be aware of any cultural differences in the expression of distress or methods of help seeking, with reference to the personal meaning of torture, when formulating management plans (de C Williams and van der Merwe, 2013). Torture and its sequelae can have multiple meanings and, in the clinical context, the torture survivor's interpretation is the most important (de C Williams and van der Merwe, 2013).

In general, clinicians working with torture survivors need to avoid making legal conclusions about the abuse to which their patients were subjected to as their primary concern. The focus should be to try and understand and treat the damaging effects caused by psychological torture in a holistic manner. Clinicians should be alert in recognising any political, ethnic or religious affairs in a patient's country of origin, should they suspect torture as the aetiology of the presenting signs and symptoms (de C Williams and van der Merwe, 2013).

Conclusions

The issue of psychological torture has become increasingly relevant to the daily practise of medicine because of the increasing levels of global political conflict. The modalities for psychological torture are vast, with clinical sequelae manifesting as a constellation of often challenging signs and symptoms for clinicians. Further work is warranted to establish universally accepted definitions with additional effort required to integrate effective and holistic care within established healthcare systems to support victims of psychological torture.

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Conflicts of interest

The authors declare that there are no conflicts of interest.

Key points

- Psychological torture is understood as the intentional infliction of suffering without resorting to direct physical violence, in what is known as 'no-touch' torture.
- While several definitions of psychological torture have been suggested across both the legislature and the clinical literature, a universally accepted definition has yet to emerge.
- Given the global issues of political conflict, war and asylum seeking, clinicians must develop a heightened awareness of psychological torture to recognise its signs and symptoms, and to understand its implications for victims as well as for clinical practise.

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