



This book is part of the book series of the European Academy of Rehabilitation Medicine, whose motto and aims are:

The Motto is

*“Societas vir origo ac finis
– Man is both the source and goal of the society”*

The Aims are to:

- Improve all aspects of the rehabilitation of people with disabilities;
- Be a reference point in the scientific, educational and humanitarian aspects of Rehabilitation Medicine;
- Engage in moral and ethical debate, particularly in relation to the practice of Rehabilitation Medicine;
- Exchange information, define the field of rehabilitation and bring precision to terminology;
- Ensure that education in rehabilitation is part of the undergraduate medical curriculum;
- Support and help improve research in rehabilitation;
- Introduce and promote the concept of rehabilitation among people with disabilities, the general public, as well as medical and professional group, while being sensitive to differing socio- cultural issues found across Europe



RCT Field Manual on Rehabilitation

RCT Field Manual on Rehabilitation



RCT

Rehabilitation and Research Centre for Torture Victims
Version 1:1, Copenhagen 2007

RCT Field Manual on Rehabilitation



RCT
Rehabilitation and Research Centre for Torture Victims
Version 1:1, Copenhagen 2007

RCT Field Manual on Rehabilitation

Version 1:1

Edited by:
Bengt H. Sjölund

Contributing authors:

Uwe Harlacher
Gunilla Brodda Jansen
Marianne Kastrup
Ane-Grethe Madsen
Edith Montgomery
Karen Prip
Bengt H. Sjölund

© The Rehabilitation and Research Centre for Torture Victims (RCT), 2007
PO Box 2107 , DK-1014 Copenhagen K, Denmark
Phone: (+45) 33 76 06 00
E-mail: rct@rct.dk
www.rct.dk

This publication may be freely copied and quoted
(provided that the source is clearly stated) and is
available in pdf-form on www.rct.dk.

ISBN – 13: 978-87-90878-17-7

Care has been taken to confirm the accuracy of the information presented and to describe generally accepted practices. However, the authors, editor and publisher are not responsible for errors or omissions or for any consequences from application of the information in this book and make no warranty, expressed or implied, with respect to the currency, completeness, or accuracy of the contents of the publication. Application of this information in a particular situation remains the responsibility of the practitioner.

The authors, editor and publisher have exerted every effort to ensure that drug selection and dosage set forth in this text are in accordance with current recommendations and practice at the time of publication. However, in view of ongoing research, changes in government regulations, and the constant flow of information relating to drug therapy and drug reactions, the reader is urged to check the package insert for each drug for any change in indications and dosage and for added warnings and precautions.

FOREWORD

The RCT Manual for the Rehabilitation of Torture and Organised Violence Survivors is addressed to health workers, particularly those who have no professional training and work in countries with limited resources. It constitutes a valuable tool and guide in the therapy not only for victims of Torture and Organised Violence, but also those of other psychosocial traumas as well. It represents more than two decades of the RCT's professional experiences, centred on torture survivors and refugees, and is also the result of active and open exchange via workshops and the RCT's joint, interactive work in Latin America, Africa and Asia.

This manual has been developed by the RCT professional and technical team under the direction of Professor Bengt Sjölund for use by personnel who are not professionally trained in therapy, especially in countries with limited resources. It has an interdisciplinary and integrated approach and contains physical, physiological, pharmacological, psychological, social, psychiatric and therapeutic aspects, not only from an academic outlook, but also taking into account complementary or alternative medicine and respect for cultural, religious and spiritual aspects.

We believe that it can be profitably read and studied individually and collectively in communities by promoters and health multipliers. It constitutes a source of experience and knowledge for both students and teachers of nursing, medicine, physiotherapy and psychology programs, as well as social workers and health promoters. The manual offers the possibility of being continuously enriched through validating what the manual shows by work and interaction between the RCT and specialized centres, and the work in communities and fraternal centres themselves.

Our congratulations to Professor Bengt Sjölund and the collaborative team who made the development of this manual possible.

Juan Almeyda MD
CPTRT Executive Director
Honduras

CONTENTS

1. INTRODUCTION	11
2. PROBLEMS	14
2.1 BODY FUNCTIONS	14
Abdominal pain.....	14
Anger	16
Anxiety.....	16
Arm pain	22
Back pain.....	24
Bleeding from orifice	26
Breathing difficulties	28
Burning sensation	30
Chest pain	31
Cognitive problems	33
Coldness	37
Constipation	39
Coughing.....	41
Depersonalisation	44
Depression	46
Diarrhoea	50
Disfiguration.....	51
Disorders of Extreme Stress Not Otherwise Specified (DESNOS).....	53
Dissociation	55
Dizziness	58
Facial Pain.....	60
Flashback.....	61
Foot pain	62
Guilt feelings	64
Hand Pain	67
Headache.....	69
Hearing difficulties	72

Heart palpitation.....	73
Hyper-vigilance.....	75
Incontinence.....	77
Indigestion.....	79
Intrusive memories.....	81
Leg pain.....	82
Loss of appetite.....	84
Loss of energy.....	86
Loss of interest.....	86
Menstruation problems.....	88
Micturition.....	90
Muscle, joint and bone pain.....	90
Muscle weakness.....	92
Nausea.....	95
Neck pain.....	96
Numbness.....	99
Over alertness.....	100
Pain, Acute.....	102
Pain, chronic.....	105
Pain, neuropathic.....	108
Pain, psychogenic.....	111
Paranoia.....	112
Paresis.....	114
Pelvic pain.....	115
Persistent thoughts.....	117
Phantom pain.....	117
Posttraumatic Stress Disorder (PTSD).....	119
Posture and balance problems.....	121
Reproduction difficulties.....	123
Sense of a limited future.....	125
Sexual problems.....	127
Shame.....	130
Shoulder pain.....	133
Skin infections.....	136

Sleeping difficulties.....	138
Somatisation	144
Somatisation - children	145
Substance abuse (craving)	147
Sweating	149
Swelling.....	151
Tics.....	153
Tinnitus	154
Tiredness	156
Ulcer of skin	158
Urge to urinate	160
Urinating difficulties.....	160
Vision difficulties	162
Vomiting	164
Weight loss.....	165
Whole body pain.....	167
2.2. ACTIVITIES AND PARTICIPATION	169
Aggressive outbursts	169
Alienation.....	172
Antisocial behaviour.....	172
Avoidance behaviour	173
Bed wetting.....	176
Bereavement.....	179
Community life, participation in	182
Coping and preoccupation with pain	183
Disability	187
Dressing problems.....	190
Eating problems.....	191
Exclusion from participation in social and political activities	193
Family life, participation in.....	193
Friendship breakdown	194
Gainful activities	194
Identity problems.....	195
Intimate relations	199

Isolation.....	199
Lifting and carrying objects.....	201
Maintaining a dwelling.....	202
Mistrust.....	204
Nightmare	205
Night terror.....	209
Obsessive-compulsive activities	211
Parenting	213
Performing household work.....	214
Redress	215
Regressive symptoms	216
Relational problems.....	218
Risk-taking behaviour	218
Self-efficacy problems.....	220
Self-harm	225
Self-mutilation	228
Taking care of others	229
Toileting problems	230
Traumatic play.....	232
Using transport	233
Walking problems.....	235
Washing problems.....	237
Worrying about symptoms.....	238
2.3. CONTEXT	241
Armed conflict	241
Basic needs not satisfied.....	244
Breakdown of infrastructure.....	247
Domestic Violence	248
Education.....	254
Family breakdown	255
Family disappearance	256
Family separation.....	257
Forced displacement, including refugees.....	257
Health services	260

Job - acquiring, keeping and terminating one	262
Local community breakdown	262
Organised violence	265
Population at risk.....	265
Post conflict society	265
Practising religion and spirituality	265
Relating to environment and nature.....	266
Re-traumatisation.....	266
Rule of law problems and re-traumatisation	266
Sexual violence	268
Stress.....	272
Torture and Organised Violence.....	277
Values and attitudes.....	281
Violations of human rights	282
2.4. SELECTED REFERENCES	285
3. THERAPIES	293
Assessment of torture survivors.....	293
Care for caregivers.....	303
Cognitive-Behavioural Therapy (CBT)	308
Community Approach	310
Complementary and Alternative Medicine (CAM)	314
Counselling	317
Exposure Therapy	324
Information and psycho-education	333
Interventions with traumatised children.....	338
Local physical therapy (joint mobilization, stretching, heat/cold)	346
Pain management.....	348
Problem solving	351
Psycho-education.....	354
Psychotherapy	355
Public Health Approach	356
Rehabilitation and Physical Medicine.....	362
Stress management.....	367
Testimony therapy.....	385

Whole body physical therapies (relaxation and body awareness exercises) 389
Working with interpreters 395

**4. ANNEX I: INTERNATIONAL CLASSIFICATION OF
FUNCTIONING AND DISABILITY (ICF)..... 397**

5. INDEX 416

I. INTRODUCTION

The RCT Field Manual on Rehabilitation is intended to meet the need for sound, evidence-based and/or consensus-based advice in attempts to rehabilitate survivors of torture or organised violence, in regions with limited physical and human resources and lacking specialized medical care. The present manual is not a textbook of traumatology; rather it is specifically directed towards the rehabilitation of survivors of torture, from 3 months after the trauma and onwards (i.e. when soft tissue injury has usually healed). This compilation is an attempt to provide practical recommendations for health workers at different skill levels, who are in difficult situations with little or no specialized professional help available.

We are also very much aware that the general knowledge and cultural traditions in a local community are extremely important for the satisfactory outcome of rehabilitation efforts. Therefore, the manual is by no means an attempt to impose a Western model of health care without acknowledging local customs and practices. Rather, it is important to emphasize the need to understand the beliefs of the culture in which rehabilitation is being offered and to use strategies for overcoming non-compliance and resistance that is secondary to a different cultural perspective. Only by acknowledging and integrating local concepts of health, disease and healing can rehabilitation, group cohesiveness and empowerment be successfully promoted. We therefore recommend that our advice should be combined with such contextual inputs.

The manual is unique in its organization and emphasis. It is *problem-oriented*, not professionally oriented, since the survivor presents with one or several problems and does not usually have access to multi-professional healthcare. It uses the globally developed concepts of the *International Classification of Functioning & Disability* (ICF; WHO, 2001) rather than diagnoses from

Western medicine. This serves to emphasize the *rehabilitation approach*, which is focussed on a person's ability to be active and to participate, rather than on disease or on remaining injury. The problems are listed in three sections according to the ICF domains (see Annex 1): *Impairments* (in physical structure or function); *Limitations/restrictions in Activities & Participation* and *Context*. Each entry word defines a problem that a torture survivor may experience and the advice given is presented at *three levels*: (1) for a healthcare assistant (or layman); (2) for a healthcare professional (usually a nurse or a practising physician); and (3) for a physician with the relevant specialization. A separate section details commonly employed *therapies* in TOV survivor rehabilitation, followed by selected references. **Bold characters** mean that the word is an entry word in this manual.

Contributions to this manual have been written by a highly motivated team of professionals from our organization, each of whom has extensive training and experience in rehabilitation:

Uwe Harlacher, Clinical Psychologist, PhD, Psychotherapist in Behavioural Therapy,

Gunilla Brodda Jansen, MD, PhD, Specialist in Rehabilitation Medicine and Pain Management,

Marianne Kastrup, MD, PhD, Specialist in Psychiatry, Consultant in Transcultural Psychiatry,

Ane-Grethe Madsen, RN, MSc I H, Health Programme Manager,

Edith Montgomery, Child Psychologist, PhD, Director of RCT Research,

Karen Prip, P.T., M.Sc, Senior Physiotherapist,

Bengt H Sjölund, MD, DMSc, Professor of Rehabilitation at the University of Southern Denmark: Specialist in Rehabilitation Medicine, Pain Management and Neurosurgery.

We would like to express our sincere thanks to our assistant, Katrine Gotfredsen, and to our research secretary, Janni Hansen, for expert technical editing, to Mrs Pat Shrimpton, MSc, for scrutinising the English text and to Head of Documentation, Sven Eric Baun, RCT, for editing and finding the references.

This first edition of the manual, version 1:1, has been reviewed by two health professionals with extensive but different contextual experiences from the South, Professor Juan Almendares, MD, Head of the Centre for the Prevention, Rehabilitation and Treatment of Torture Survivors and their Families, Tegucigalpa, Honduras, and Jone Schanche Olsen, MD, psychiatrist, previously health programme manager at RCT, now consultant in Stavanger, Norway. We thank them both for their important and constructive criticism.

In addition, many experienced people among RCT's global partners have kindly contributed valuable comments on the manuscript: Vimla Pillay, Director, and Sarah Crawford Browne, Head of Service Delivery, Trauma Centre for Survivors of Violence and Torture, Cape Town, South Africa; Loreine B. de la Cruz, Director, Balay Rehabilitation Centre, the Philippines; Akramul Haque, MD, Deputy Executive Director, BRCT, Dhaka, Bangladesh; Sister Mabel Rodrigo, Home for Victims of Torture, Kandy, Sri Lanka; and also by Peter Polatin, MD, psychiatrist and health programme manager at RCT, Copenhagen, Kristina Sjölund, MD, PhD, gastroenterologist, Lund University, Sweden and Mats Möller, MD, general surgeon, Stockholm, Sweden.

It is our hope that the present manual will be a tool that can be employed globally to advantage in the efforts to relieve the suffering caused by Torture and Organised Violence. It will be made available free of charge via the internet and will be regularly updated. We are painfully aware that the present text is only a first attempt and we invite comments and suggestions for improvements and modifications to the text, to be sent to: rct@rct.dk.

Copenhagen in December, 2007

Bengt H Sjölund
Editor
Director General, RCT

2. PROBLEMS

2.1 BODY FUNCTIONS

Abdominal pain

HEALTHCARE ASSISTANT

Key Signs

Abdominal pain is often acute, has no obvious physical cause, and passes quickly. Acute intensive abdominal pain that does not pass within hours, should always be brought to the attention of a healthcare professional, especially if it is accompanied by **Vomiting**, fever, or intensive cramps. Apart from very acute diagnoses, abdominal pain can stem from sanitary problems during imprisonment (infection) or trauma (beating of the stomach). Many torture survivors suffer from stomach ache in combination with acid regurgitation, due to dyspepsia, or even gastric duodenal ulcers.

Stress, anxiety and fear may also cause abdominal pain in adults and children (**Anxiety, Stress management**). The pain then has a more diffuse localisation, often increasing when the patient is more tense or nervous. In these cases, the pain may also be associated with defecation problems, such as diarrhoea or constipation. This form of abdominal pain can last for many years and is often part of a **Whole body pain** syndrome.

Action

- Understand pain location and intensity.
- Drugs such as morphine can cause **Constipation**.
- Aspirin in large doses may cause inflammation in the stomach and even gastric ulcers.
- Excessive coffee drinking and spices can cause abdominal pain.

- General activity can reduce abdominal pain, walking and moving about.
- Letting the person rub his or hers stomach lightly might reduce symptoms in case of constipation and bloating.
- **Diarrhoea** may cause dehydration. Instruct the person to drink plenty of water and to use a stopping diet.

Note

If fever or acute new and more severe symptoms than indicated above appear, or if you cannot understand the origin of the pain or if the intensity is severe, see a healthcare professional.

HEALTHCARE PROFESSIONAL

Characteristics

Diagnose cause of abdominal pain by excluding treatable diagnoses. See to it that non-medical precautions are being followed.

First therapy

Treat infection.

Treat dyspepsia with antacids.

Psycho-education can be used to give information about the connection between abdominal pain and psychological distress.

Advice should be given on a healthy diet and drinking to support normal digestion and minimise symptoms.

Second therapy

Paracetamol 500 mg x 4-6.

Note

If there is severe trauma to the abdomen refer to a specialist, normally a general surgeon.

HEALTHCARE SPECIALIST

Assessment

Diagnose cause of severe abdominal pain.

Proposed measures

Propose specific treatment if possible thereafter.

Anger

See **Aggressive outbursts**.

Anxiety

HEALTHCARE ASSISTANT

Key signs

Anxiety is a normal reaction that can be described as a prominent urge to avoid or flee from what are perceived as dangerous situations. Anxiety is seen very frequently in survivors of torture due to the prolonged, intense stress they have experienced.

The physiological component of an anxiety-reaction is, broadly speaking, similar to an intense “fight-flight-response” (compare **Stress**). As a result of different learning-mechanisms (especially so-called classical conditioning), anxiety can also be elicited by objects and situations that are not dangerous in reality. Torture survivors frequently suffer from many causes of anxiety, elicited by objects that have previously been linked to their torture-related experiences, e.g. anxiety about darkness and narrow rooms, based on having previously been imprisoned in darkness and in narrow cells. These learning principles are often systematically used by perpetrators to “programme” future anxiety on the part of the victims. For example, music, e.g. the national anthem, is played during torture which later triggers anxiety

when listening to that music. The type of anxiety described above is called “phobic” anxiety; another type of anxiety – “panic type” that torture survivors often suffer from, is based on the perception that bodily symptoms are dangerous. The interpretation of increased **Heart palpitation** (often caused by stress) as a sign of an imminent heart attack may induce anxiety (and further stress and symptoms).

Anxiety elicited by objects and situations that are not dangerous is divided into specific types of diagnoses, described as anxiety disorders in psychiatric diagnostic systems.

Anxiety disorders are seen very frequently in survivors of torture as a result of the prolonged, repeated and intense normal anxiety and stress that they have experienced.

With children:

In smaller children frequent symptoms are clinging behaviour, fear of the dark, fear of going to sleep, fear of strangers, fear of being alone and irrational fears such as of certain animals or specific situations. In older children anxiety can result in concentration problems. Anxiety can also show itself in physical symptoms such as stomach ache or **Headache**.

Action

- Remain calm.
- Illustrate how to stop quick and shallow breathing (use a paper-bag to breathe in and out for 1 min).
- Relaxation techniques, controlled breathing (see **Whole body physical therapies**).
- Distraction (e.g. listening to music, the radio).
- Encourage physical exercise.
- Advise the person to avoid too many stimulants, e.g. caffeine.
- Avoid sleep deprivation.
- Provide **Psycho-education** that explains how symptoms may have originated.

If you have experience in and/or the possibility of getting supervision for conducting **Exposure therapy** (see this entry), use that treatment for phobic-type anxiety.

With children:

Small children should patiently be comforted and calmed down and they should not be left alone. Fears of certain objects or situations normally occur in many children at certain stages of development and disappear with maturation. New situations might have to be introduced gradually. They need time and stability to overcome their fears. At school they should be helped and not pressed or punished. They should be encouraged when they perform well so that they gradually come to experience self-mastery.

Note

Consider possible self-medication and risk of **Substance abuse**.

In acute case, if symptoms are continuous and worsening, consult with level two.

If no improvement after one month, refer to next level. Consider the presence of other mental disorders.

Consider concomitant physical illness.

Consider recent psychosocially stressful events.

With children:

Refer to next level if symptoms persevere and are so intense that the child's development is at risk, e.g. if anxiety prevents a child from exploring his/her surroundings or participating in age-relevant activities. Consider history of child abuse.

HEALTHCARE PROFESSIONAL

Characteristics

Consider anxiety types.

Anxiety is part of a number of mental disorders, e.g. generalised anxiety, panic disorder, social phobia, depressive episode, **PTSD**.

With Children:

All children show symptoms of anxiety at different ages and stages of development. It is important to distinguish between normal anxiety and pathological anxiety that needs to be treated. If symptoms are persistent and severe and interfere with daily life, the child's development may be at risk and action must be taken.

First therapy

Panic type

- Panic characterized by recurrent attacks of severe anxiety that are not restricted to particular situations.
- Attacks are usually unpredictable and include **Chest pain**, palpitations, choking sensations and **Dizziness**. They are also followed by fear of dying, losing control or going mad. A panic attack is often followed by fear of having another attack.
- Explain the panic cycle: Physical symptoms, e.g. palpitation-catastrophic interpretation, e.g. heart attack, dying, becoming crazy – induces **Stress** – increases palpitation or other physical symptoms. This vicious circle results in a full-blown panic attack.

Phobic type

- The anxiety is automatically triggered by specific external situations such as people in uniforms or cars that have been used by perpetrators but may also be triggered by somatic perceptions, such as palpitations or feeling faint. The anxiety is usually independent of rational reasoning, people are conscious that objectively the situation is not dangerous but secondary fear of dying, losing control, or going mad may occur. Mere imagination of phobic situations may provoke an anxiety attack. Automatically-triggered anxiety cannot be reasoned away merely by explaining that the situation is not threatening. It is important not to flee in order to avoid the situation but that the person confronts anxiety-provoking stimuli in stages, remaining in each stage until anxiety fades away or diminishes spontaneously (compare **Exposure therapy**).

Separate from or in combination with exposure therapy use the following:

- Maybe an illustration for educational purposes.
- A calming explanation.
- Reduce stress due to erroneous beliefs held by the person and his environment.
- Encourage the person to ask questions together with the family and answer, with a calm professional attitude.
- Give basic knowledge about how anxiety and physical symptoms are related.
- Try to explain the non-life-threatening nature of the attacks to the person and the family.
- Give advice and supervise level one.

With children:

See **Interventions with traumatised children.**

Second therapy

Assist the person/family to carry out exposure therapy. This is done through a gradual increase in the contact with the situation/object causing the anxiety and remaining at each level until the anxiety disappears (see **Psychotherapy**).

Check appropriate use of any medication.

Appropriate medication (Selective Serotonin Reuptake Inhibitors, e.g. fluoxetine for panic attacks).

Relaxation techniques.

Note

Consider possible **Substance abuse.**

Children:

If symptoms persist refer to next level.

HEALTHCARE SPECIALIST

Assessment

Use of structured interview (See **Assessment of torture survivors**) e.g. SCID or assess severity of anxiety with Hamilton Anxiety scale.
Differential diagnosis are various anxiety disorders or as part of another mental disorder.

With children:

Anxiety disorders are among the most common psychiatric disorders in children. They are often associated with impairment of school, social and personal functioning. Frequent diagnostic categories are:

Separation anxiety

Obsessive-compulsive disorders

Post-traumatic Stress Disorder (PTSD)

Use a structured diagnostic interview for children such as DISC or K-SADS_PL (see **Assessment of torture survivors**).

Proposed measures

- Appropriate medication (Selective Serotonin Reuptake Inhibitor (e.g. fluoxetine) for panic attacks).
- **CBT** (see specific entry).
- Advise and supervise level 2.

With children:

- CBT in an individual, group or family format (for children from about 6 years of age).
- Family therapy.

Arm pain

HEALTHCARE ASSISTANT

Key signs

Pain in the arm often originates from the neck or the shoulder. In prison and detention centres the prisoners are often tied up with tight ropes round the arms. The tightness may cause lasting damage to the nerves and to the blood supply in the arms. Fractures of the upper or lower arm may have healed improperly and thus constitute a risk of malfunctioning and compensatory movements. Tension in the neck muscles, the muscles in the shoulder girdle and arm often add to the reduction of movements in the joints and contribute to pain in the arm. Deep cuts and/or gunshots may have damaged nerves and muscles. Weakness and muscle stiffness and local or diffuse pain may be the consequence.

Action

- Ask for history and ability to carry out daily activities.
- Massage often provides immediate pain relief (see **Whole body physical therapies**). Train members of the family to give massage once a day. The muscles in the neck, shoulder girdle and in the upper and lower arm should be massaged. Massage can be given with the person lying down or sitting down. Ensure that the person is in a comfortable position.
- After massage instruct the person to move his/her neck (see **Neck pain**), shoulder (see **Shoulder pain**), elbow and hand (see **Hand pain**). Moving the joints often reduces pain and helps the person to gradually become involved in activities in family life and in the community.
- If there are bruises and swollen areas use the RICE principle: *Rest* in the acute phase, depending on the severity of injury; apply *Ice* (or cold water) to painful areas to minimize **Swelling** and reduce pain; apply *Compression* (with elastic bandage) on swollen area to minimize swelling; *Elevate* injured limb until swelling has subsided.

- Give paracetamol (500 mg, two tablets 2-6 times daily) or aspirin (500 mg 4 times daily). Ask first if the person can tolerate and/or has previous experience with these drugs.
- Pain medication for a short period may relieve pain and enhance functioning of the arm.

Note

The source of arm pain is often difficult to detect. Neck, shoulder and arm pain are often closely linked. Keeping up with daily activities and participating in family life will often reduce sensations of pain and increase the functioning of the arm.

In rare instances, sudden or new pain in the little-finger side of the left arm in connection with chest pressure may indicate heart infarction and the person should, if possible, be sent to a health professional for evaluation.

HEALTHCARE PROFESSIONAL

Characteristics

See above.

Selected muscle groups may be weak because of muscle and nerve damage. Assess pain, muscle function and strength in shoulder, elbow and hand.

First therapy

Range of motion exercises for neck, shoulder, elbow and hand.

Give exercises to strengthen the muscles groups.

Psycho-education.

Second therapy

Standard pain medication.

Assess for and treat **Pain, neuropathic.**

Note

Refer to orthopaedic specialist if no effect.

HEALTHCARE SPECIALIST

Localise possible sources of arm pain.

Back pain

HEALTHCARE ASSISTANT

Key signs

Back pain is strongly associated with various types of torture (beatings, forced, sustained, stressful positions, cramped confinement, suspension by the arms or legs, sexual torture and mental torture). Pain in the back may be located regionally in the back or expand to the buttocks and further down the legs. Back pain is one of the most common forms of pain complained of and is accompanied by stiffness and tenderness.

Action

- Ask for trauma history and pain history.
- If the back pain is regional and/or occurs in conjunction with buttock and thigh pain and varies with time and physical activities advise the person to keep physically active (see **Whole body physical therapies**).

Note

If pain in the leg is worse than in the back, is constant and very severe and does not vary with time and physical activities and radiates to the foot refer the case to a healthcare professional.

HEALTHCARE PROFESSIONAL

Characteristics

Diagnostic triage:

1) Ordinary backache:

- Lumbosacral region, buttocks, and thighs.

- Pain is mechanical in nature
 - varies with physical activity and time.

2) *Nerve root pain:*

- Unilateral **Leg pain** is worse than back pain.
- Pain usually radiates to foot or toes.
- **Numbness** or paresthesia in the same areas.
- Nerve irritation signs
 - reduced straight-leg raising; this movement reproduces leg pain.
- Motor, sensory, or reflex change
 - limited to one nerve root.

3) *Serious spinal pathology:*

Red Flags (indicate need for more thorough examination):

- Significant trauma.
- Constant, progressive, non-mechanical pain.
- Thoracic pain.
- Non-mechanical pain.
- Previous medical history.
 - carcinoma,
 - systemic steroids,
 - drug abuse, HIV.
- Systemically unwell.
- **Weight loss.**
- Lumbar flexion <5 cm.
- Laboratory signs of inflammation.
- Widespread neurological signs.
- Structural deformity.

First therapy

Assess nerve root pain.

Assess for red flags.

Give pain medication (paracetamol 500 mg, two tablets 2-6 times daily) or aspirin (500 mg 4 times daily). Ask first if the person can tolerate and/or has previous experience with these drugs.

Second therapy

Refer to orthopaedic surgeon in case of red-flag symptoms, if possible.

HEALTHCARE SPECIALIST

Assess for treatable pathology.

Bleeding from orifice

HEALTHCARE ASSISTANT

Key signs

Long after torture, there may be temporary bleeding from body orifices. This can be due to small, residual parts of foreign bodies introduced into an orifice, e.g. the anus, by a perpetrator, such as in sexual torture. Alternatively, chronic mucosal inflammation due to ingested contaminated water or to ingested chemical agents may give rise to shedding of superficial cell layers and to intermittent and infrequent mucosal bleeding from the nose or from the bronchi. Ulcers in the gastrointestinal canal may be stress-related and can occasionally cause severe bleeding.

Action

If minor but constant, send to next level within weeks.

Note

Severe bleeding from the mouth or from the anus is an emergency and may be life threatening. Go to next level immediately.

HEALTHCARE PROFESSIONAL

Characteristics

Bleeding from orifices may occur as a late result of forcefully introducing foreign bodies through such an orifice, through a tearing of mucosal lining or from mucosal inflammation, e.g. due to the ingestion of contaminated water or chemical agents. It may also be a sign of longstanding **Stress**, such as after torture, and ultimately, of radiation sickness.

Perform appropriate diagnostic checks including inspection and palpation.

First therapy

Remove foreign bodies and other irritating agents. If necessary, refer to next level.

Second therapy

If stress-related, **Counselling** must be considered. If bleeding is from the gingiva, mouth or teeth hygiene must be considered.

Note.

Determine haemoglobin/hematocrite to assess severity of blood loss, if possible. Hematuria may be due to kidney malfunction after blows to the trunk.

HEALTHCARE SPECIALIST

Assessment

Clarify origin and cause of the bleeding.

Proposed measures

According to findings.

Breathing difficulties

HEALTHCARE ASSISTANT

Key signs

Shortness of breath is a feeling that one cannot get enough air or one's chest may feel tight. Sometimes the feeling is worse when physically active or when lying down. There may be other symptoms such as a cough, **Chest pain** or fever.

Shortness of breath can be caused by psychological problems such as anxiety and panic attacks after being subjected to periods of intense **Stress** such as torture and threats. It may also be caused by a number of diseases, such as asthma or other lung diseases, including emphysema, caused by smoking or by heart failure, which causes fluid to collect in the lungs.

Action

Psychological problems such as **Anxiety** and panic attacks should be relieved by **Counselling**.

If shortness of breath is combined with a cough and/or fever, the person may have a chest infection or pneumonia. If cause is known, treat accordingly.

Try to make the person stop smoking.

Note

If symptom is new and cause is not known, refer to next level within days.

HEALTHCARE PROFESSIONAL

Characteristics

Shortness of breath can be caused by psychological problems such as **Anxiety** and panic attacks. It may also be caused by a number of diseases,

such as asthma, pneumonia or other lung diseases, including emphysema, caused by smoking or by heart failure, which causes fluid to collect in the lungs.

Find the cause of the breathing problem by interviewing the patient and the family and making a physical exam. The doctor also may order some tests such as a chest x-ray or an electrocardiogram and perform appropriate diagnostic checks.

First therapy

Psychological problems should be relieved by **Counselling**.

Second therapy

Treat chest infection or pneumonia with antibiotics. Less common causes of breathing problems are lung cancer, a blood clot in the lungs, air leakage around the lungs or scarring of the lung tissue.

Note.

Fluid balance must be considered.

Progressive shortness of breath is a warning sign.

HEALTHCARE SPECIALIST

Assessment

Infectious disorder assessments.

Proposed measures

According to findings.

Burning sensation

HEALTHCARE ASSISTANT

Key signs

A feeling of burning or of heat, usually in an extremity or part thereof. If felt over the whole or most of the body, the cause is usually psychological and signals inner mental tension that may be due to a previous life-changing event, such as having undergone torture, and now reflected in the body.

If felt regionally or locally, the cause may be either psychological or due to physical injury of a nerve, of the spinal cord or of the brain. Muscle weakness is then often, but not always, present. Hanging, strapping or confining the person under torture may be the cause.

Action

Clarify the patient's history by careful questioning and treat accordingly: If psychological, give **Counselling**. If physical, prescribe treatment regimen consisting of massage or firm touch.

Note

If psychological, the problem usually resolves spontaneously.

HEALTHCARE PROFESSIONAL

Characteristics

Feeling of burning or of heat, usually in an extremity or part thereof. If felt over the whole or most of the body, the cause is usually psychological and signals inner mental tension that may be due to a previous life-changing event, such as torture.

If felt regionally or locally, the cause may be either psychological or due to physical injury of a nerve, of the spinal cord or of the brain. Muscle

weakness is then often, but not always, present. Hanging, strapping or confining the person under torture may result in nerve injuries and be the cause of these symptoms.

First therapy

Clarify the patient's history by careful questioning and treat accordingly:

If psychological, give **Counselling**.

If physical, prescribe treatment regimen consisting of warmth or firm touch. Note that nerve injuries may take months or years to heal.

Second therapy

See **Pain, neuropathic**.

Note

Numbness that has a psychological cause usually resolves spontaneously.

HEALTHCARE SPECIALIST

Assessment

Psychiatric and neurological or PRM assessments.

Proposed measures

According to findings.

Chest pain

HEALTHCARE ASSISTANT

Key signs

There are many causes of chest pains. Some causes are life-threatening and require immediate medical attention, the most common is a heart attack.

This may also be the case for a torture survivor and should always be suspected if the chest pain is sudden, very intense and appears without a

cause. The main cause of chest pain, not due to heart disease (angina pectoris or heart attack), is pain originating in the muscles and skeleton of the chest, from gastritis or from anxiety. But there are other causes of chest pain in the case of the torture survivor, for instance muscle pain affecting not only neck and low-back muscles, but also muscles in the chest region. Another cause is **Stress**, both acute and chronic, which can very often be part of a pain syndrome involving chest pain.

Action

- If the onset of the chest pain is sudden and intense, perhaps radiating to the left arm, see a healthcare professional immediately.
- In other cases with more longstanding pain, try to identify the cause including psychological factors such as **Anxiety**, fear of physical injury, sleeping problems.
- Reduce stressful factors.
- If pain is reduced by food intake, gastritis may be suspected.
- If there is a musculoskeletal cause (pain on palpation of chest), use paracetamol or aspirin.

Note

Always consult a healthcare professional in the case of chest pain.

HEALTHCARE PROFESSIONAL

Characteristics

Exclude somatic causes of chest pain. Chest pain is a common part of the pain syndrome in torture survivors.

First therapy

Assess pain intensity with a nonverbal scale (by simply asking the person or using a visual analogue scale or a face scale).

Diagnose treatable causes of chest pain such as angina.

Treat depression and **Anxiety** accordingly.

Treat pain accordingly. Start with paracetamol, (500 mg, two tablets 2-6 times daily) or aspirin (500 mg 4 times daily). Ask first if the person can tolerate and/or has previous experience with these drugs.

Treat gastritis with antacids.

Note

If angina or heart attack is suspected, see a healthcare specialist.

HEALTHCARE SPECIALIST

Assessment

Diagnose specific somatic or mental disease causing chest pain, such as angina, heart attack, etc.

Proposed measures

Propose specific treatment, if possible, thereafter.

Cognitive problems

HEALTHCARE ASSISTANT

Key signs

Cognitive problems mostly occur in the form of memory malfunction and inability to concentrate. Memory problems are e.g. difficulties remembering recently received, written (e.g. newspaper articles) or oral information (e.g. the content of the news heard on radio or television). An example of concentration problems is the inability to perform even simple mental tasks, e.g. easy mathematical tasks because of lack of ability to focus. The difficulties are experienced as unusual by the people themselves, i.e. under normal conditions they are able to remember and concentrate. Temporary cognitive problems may stem from many different causes. With torture survivors, cognitive problems will often be a side-effect of one or other

condition caused by torture, such as **Dizziness, Tiredness, Pain, Anxiety,** and **Depression.**

Children

Children who have experienced violent events often have problems with concentration and attention. When trying to concentrate on school work memories of the events will come to their minds and interrupt them. This will interfere with their learning, and is not due to lack of abilities.

Action

Give the following information about cognitive problems to reduce the **Stress** caused by the person's (and family's) erroneous concerns:

- Explain that cognitive problems are normal, given the person's current problems with pain, sleep, anxiety, etc.
- Explain that there is no direct treatment for the problem but that the underlying problems have to be addressed.

Give information about how the problems can be dealt with:

- Behaviour that is often repeated and thus becomes more or less "automatic" is less affected by memory disturbance. Accordingly, the person should establish fixed routines for everyday key-activities, e.g. always put the keys in the same place when coming home.
- Different aids, such as diaries etc., can be used to assist memory.
- In order to assist the person and the family in developing strategies for better coping with cognitive problems, **Problem solving** can be taught.

With children:

- Try to minimize any disruption in schooling.
- Let the teachers know about the situation of the child.
- Reward even small improvements.
- Help the parents to acknowledge the importance of school and **Education** and support the child e.g. by giving him/her the time and peace to do homework.

- Do not punish the child.
- See **Interventions with traumatised children**.

Note

If the problems do not vary with the intensity of the underlying causes (e.g. pain intensity, sleep disorder, mood suppression) and especially if they worsen over time – refer to next level.

HEALTHCARE PROFESSIONAL

Characteristics

Cognitive functioning is the ability to take in new information to the brain/memory and to retrieve stored information from the memory. This is an energy-consuming process that can be disturbed by many factors.

Cognitive problems can occur due to structural damage to brain tissue, e.g. after violence to the head, or to dysfunction without tissue damage.

Somatic and psychological problems that torture survivors often have, e.g.

Dizziness, Tiredness, Pain, Anxiety and Depression, can all contribute to cognitive problems. People (and their families) are often, erroneously, concerned about brain-damage (or related threats such as concern about developing mental disease or dementia), which induces further

Stress/anxiety resulting in further cognitive symptoms.

With Children:

Problems with attention and concentration are frequent in traumatized children. The recurring memories of traumatic events preoccupy the child and distract him/her from performing other tasks such as school work.

First therapy – further psycho-education

Provide further psycho-education for the person and family. A daily registration of the intensity of cognitive problems (by the person and/or someone else who is close) can be used to illustrate that these fluctuate markedly and co-vary with underlying factors such as sleep, pain or anxiety intensity.

This pattern can be contrasted to information that is provided about the course of symptoms due to traumatic (low fluctuation and slow improvement) or progressive (low fluctuation, slowly worsening) cerebral tissue damage. Simple diagrams can be drawn to illustrate the differences.

Second therapy

Try to optimize treatment (medication and/or other interventions) of the body functions (see above) underlying the cognitive problems.

Third therapy

Provide an assessment of cerebral dysfunction, using e.g. the Mini-Mental State test. A reasonable test result can be used to further calm the person down. Avoid allowing a positive result to be taken as evidence of a cerebral damage – explain that the test shows dysfunction but not its cause and that repeated testing would be expected to reflect fluctuation in results, which would not be expected if there was damage to cerebral tissue.

Other possible interventions

Identify central problems in daily life arising from cognitive problems and assist the person to find better ways of coping and **Problem solving**. Use some examples of problem solving together with the person/family and gradually reduce the support you give. Encourage the person/family to use the same tools on their own. It may be advisable to initiate this intervention but to delegate it to level 1 and to give supervision.

With Children:

Counsel teachers to understand the child's situation and to avoid punishing him/her.

Family **Counselling**.

Stress management techniques.

Note

If the possibility of actual cerebral damage cannot be excluded, the person should be referred to next level.

HEALTHCARE SPECIALIST

Assessment

Typically people are concerned about cerebral pathology. Apart from an examination to establish cerebral causes, an assessment aims to diminish the person's (family's) **Stress** resulting from erroneous reasoning. A diagnostic assessment/exclusion of cerebral pathology is in this sense to be seen as a type of simultaneous psychotherapeutic intervention.

If there are signs of cerebral-tissue damage, initiate an examination using the diagnostic tools that are accessible.

With children

Take a detailed history and eliminate other sources of the problems, such as physical illness or dyslexia.

Proposed measures

Treatment according to findings.

Coldness

HEALTHCARE ASSISTANT

Key signs

Feeling cold, either generally or feeling coldness in a specific body part.

Fever bouts may be accompanied by sudden feelings of cold or freezing. If the feelings of coldness are localized, note whether skin is actually cold and pale in that body part.

Action

- If there is a feeling of coldness in one body part, the blood flow should be examined by noting skin temperature and peripheral pulses. If these are normal, the reason is usually innocent. The sensory (cold) nerve could be over-active due to nerve injury from overstretching (such as

after Palestinian or other forms of hanging), of forced body positions or of repeated beating.

- If the skin is cold but there are pulses in the body part, the reason may be over-activity in the independent (autonomic) nervous system, which is usually relieved by carefully warming the body part.

Note

If there is sudden coldness *and* sudden severe pain in an extremity, usually a leg, an occlusion of an artery must be suspected, either due to the formation of a blood clot or to arteriosclerosis. Such situations are emergencies and the person should be sent to the next level immediately. With recurring bouts of fever and freezing, consider deep-seated infection (bacteria may have entered the blood stream). Send the person to the next level within days.

Feeling cold, malaise and being pale may be due to a sudden loss of blood volume through bleeding either externally from wounds or internally from orifices - this may take hours to become noticeable. Such situations are emergencies and the person should be sent to the next level immediately.

HEALTHCARE PROFESSIONAL

Characteristics

Coldness can be due to systemic or local causes, arising from problems originating in the blood circulation, in infection or in the nervous system. Perform appropriate diagnostic checks: Arterial pulses? Skin temperature? A feeling of coldness as a long-term consequence of torture is usually due to injury of peripheral nerves.

First therapy

Examine for sensory loss or exacerbation. Information about minor nerve injury and reassurance are important in relieving **Anxiety** about chronic sensory disturbances.

Second therapy

Treat according to other findings.

Note

Feeling of coldness from nerve injury may subside slowly. Refer to next level only if there is a circulatory or infection problem.

HEALTHCARE SPECIALIST

Assessment

Surgical, infectious disorder assessments.

Proposed measures

According to findings.

Constipation

HEALTHCARE ASSISTANT

Key signs

Trouble with bowel movements. The stools may be very hard, making them so difficult to pass that one has to strain or one may feel the need to have another bowel movement immediately after having had one. Not everyone has bowel movements once a day. A normal range is generally 3 times a day to twice a week.

A number of things can affect stool formation leading to constipation. Serious problems may be anal fissures or scars due to trauma from torture, e g from a broken bottle. However, more often, constipation can be due to not drinking enough fluids, not being active enough, not eating enough fibre, taking certain drugs, not emptying the bowel when one has the urge to have a bowel movement or even regularly using laxatives.

Action

- To prevent constipation, the person should be advised not to resist the urge to have a bowel movement; if possible to set aside time to have a bowel movement (e.g. after a meal); to eat more fibre, to drink plenty of fluids - at least 8 glasses a day - and to move around more.
- Foods rich in fibre are unrefined breakfast cereals, whole wheat and rye flours, grainy breads, fresh or dried fruits and vegetables.
- **Stress management** and relaxation techniques are sometimes helpful.

Note

Refer to next level if mechanical obstacles are suspected, if constipation is new and unusual for the person, if he/she has had constipation for three weeks or more, if there is **Abdominal pain** combined with **Vomiting** and a distended abdomen or if blood has been observed in the stools.

HEALTHCARE PROFESSIONAL

Characteristics

Trouble with bowel movements may be due to not drinking enough fluids, not being active enough, not eating enough fibre, taking certain drugs, not emptying the bowel when one has the urge to have a bowel movement or overusing laxatives. The differential diagnosis is (partial) occlusion by a structural deformation, that may occur after some forms of sexual assault (e.g. with a sharp object), or by a tumour.

Perform appropriate diagnostic checks.

First therapy

Treat according to findings.

Second therapy

For bowel advice, see above. Laxatives should usually be avoided. Apart from bulk-forming and osmotic laxatives, they are not intended for long-term use. These work naturally to add bulk and water to the stools so that

they can pass more easily through the intestines. Bulk-forming laxatives can be used every day. They include oat bran, psyllium and methylcellulose.

Note.

Specialist examination may be necessary.

Progressive or colic pain is a warning sign of a life-threatening obstruction.

HEALTHCARE SPECIALIST

Assessment

Surgical assessment.

Proposed measures

According to findings.

Coughing

HEALTHCARE ASSISTANT

Key signs

If a cough lasts for more than 3 weeks, it may be chronic. The following are questions the answers to which will help decide whether the person should be referred to the next level about the cough:

- Is thick yellow or green phlegm coughed up?
- Is blood coughed up?
- Is there any wheezing (making a whistling sound when breathing in)?
- Is the person's temperature higher than 38 degrees Celsius?
- Is there **Weight loss**?
- Does the person have heavy sweats in bed at night?

If the answer is "no" to these questions, the cough may be due to one of the causes below:

Action

Aspiration sequelæ

Persistent cough could be due to iterated aspiration of polluted water in connection with 'submarino', a torture method where the victim's head is repeatedly held under water (often dirty) and he/she is semi-drowned. This gives rise to chronic bronchial infections.

Temporary relief may be achieved from inhalation of clean water vapour. A health professional should usually be consulted.

Smoking

Smoking can cause a cough that does not go away. If the person smokes, he/she needs to stop.

Allergies

Allergies can generate a cough because mucus runs down the throat from the back of the nose. The person should try to avoid the things that cause the allergic reaction, such as dust, smoke, furry animals, mold, freshly cut grass, certain plants and chemical fumes.

Asthma

Coughing can be a sign of asthma. In some people with mild asthma, a cough is the only symptom. Try using some asthma medicine to see if the cough goes away.

Other causes

Some medicines can cause a chronic cough, such as medication for high blood pressure.

Tuberculosis is another relevant cause of chronic coughing and the person should be seen by a healthcare professional.

Acid from the stomach may come back up into the person's throat. This is called "acid reflux." It can cause heartburn or coughing. Acid reflux occurs more commonly in the horizontal position. Therefore, try raising the head of the bed about 10 cm. It might help to avoid eating or drinking for two hours before going to sleep.

Note

Do not stop taking a prescribed medicine unless told to do so by the doctor.

HEALTHCARE PROFESSIONAL

Characteristics

Acute coughing is usually a sign of respiratory infection or of cardiac insufficiency.

Causes of chronic coughing include aspiration sequela due to iterated aspiration of polluted water in connection with 'submarino' or similar torture methods. Here the victim's head is repeatedly held under usually dirty water and he/she is semi-drowned. This gives rise to a chronic bronchial infection. The following may also be present: Effects after a post-nasal drip; gastroesophageal reflux disease; cough from asthma; drugs; a foreign body; post-viral bronchial hyperresponsiveness; and habitual cough.

Cigarette smokers often have what is referred to as a Smoker's Cough. This takes the form of a loud, hacking cough and often results in the expiration of phlegm.

Perform appropriate diagnostic checks (pulmonary auscultation, pulmonary X-ray if possible).

Note possible side effects of medicines and the possibility of changing to other drugs.

First therapy

Treat bronchitis with a broad spectrum antibiotic.

Second therapy

Treat according to other findings. An antihistamine-decongestant combination may help allergies and coughing.

Note.

In severe cases, prolonged coughing can cause fatigue fractures of lower ribs or costochondritis, an inflammation of the connective tissue between the breastbone and the ribs. Chronic complications are common. In certain cases, prolonged coughing can even lead to abdominal or pelvic hernias.

HEALTHCARE SPECIALIST

Assessment

Infectious disorder or internal medical assessment.

Proposed measures

According to findings.

Depersonalisation

HEALTHCARE ASSISTANT

Key signs

The person may complain of that he/she, or his/her surroundings have changed. The change may relate to the quality of the surroundings, which may seem unreal or remote. The person may feel alienated, altered and with no contact with himself/herself. People who have experienced severe traumatic events may show signs of depersonalisation.

Action

Refer to next level.

Note

Depersonalisation may be a symptom of severe psychiatric illness but is then usually episodic.

HEALTHCARE PROFESSIONAL

Characteristics

The feeling of depersonalisation may be accompanied by a feeling of de-realisation where the environment and other people may also seem unreal, even dead. The severity of the feeling may range from a vague feeling of a kind of change to a clear feeling of living in an unreal world.

First therapy

Interview the person and relatives about other mental symptoms, such as hearing voices, paranoia (see **Paranoia**) disordered thoughts.

Second therapy

If assessed as psychotic, the person should be given antipsychotic medication.

Note

Both symptoms may be seen in cases of schizophrenia or severe depression.

Depersonalisation may also be seen in some types of epilepsy.

If the person is found to be severely ill, refer to next level.

HEALTHCARE SPECIALIST

Assessment

Use a structured interview (SCID or SCAN) to evaluate underlying mental illness, typical schizophrenia or depression.

Proposed measure

If mental illness is diagnosed, treat according to findings.

Depression

HEALTHCARE ASSISTANT

Key signs

People with depressive problems may frequently complain of various vague physical symptoms, lack of strength, aches and vague pains. Such symptoms may be more prominent than the psychological aspects, particularly in cases where the person may be unfamiliar with putting feelings into words which is common in certain cultures.

Other key signs are a sad appearance, stiff facial expression, tendency to cry, signs of lack of energy, lack of appetite, **Weight loss**, difficulty in sleeping, **Isolation** from others, reduced concentration, reduced self-esteem, **Guilt feelings**, pessimistic view of the future, **Loss of interest** or pleasure in normal activities. People who have experienced **TOV** frequently complain of depressive problems, often in combination with such symptoms as sleep problems, flash-backs and **Cognitive problems**.

Children

Depressive symptoms in children will often co-occur with behavioural problems, problems in school, physical symptoms and **Anxiety** symptoms. Some children and adolescents will think of committing suicide and some will also try to do so.

Action

- Ask the person about extreme life events in the near past, e.g. exposure to **Organised violence**, losses or illnesses.
- Take a history from the person's relatives about his/her symptoms.
- Check whether the person is alone or is living with relatives.
- Advise about regular physical exercise and how it can alleviate depressive symptoms.

- Psycho-educate the relatives regarding risk of **Self-harm**; explain that the person cannot by force of will just “pull himself together”, that the person needs sufficient food and rest.
- Refer to a healthcare professional if the person stops eating or drinking, lies passively in bed or expresses sincere ideas about committing suicide.

With children:

- Try to discover why the child is depressed. He/she might be mourning the loss of an important family member, or reacting to separation from family or friends. He/she might also be reacting to a difficult situation in the home if one or both parents have mental problems.
- Allow the child to share the sad feelings and help the parents to be patient and comforting.
- Allow time for normal grief after the death of a family member and be open to the child’s wish to talk about that person.
- Encourage the child to participate in activities, e.g. in school, and make sure the teacher is aware of the child’s situation.

Note

Always consider the risk of self-harm or suicide, ask about any history of such things.

HEALTHCARE PROFESSIONAL

Characteristics

Depressive symptoms may take many forms. Characteristics are lowered mood, tendency to cry, inhibition (retardation) regarding speech and thought, self-reproach, expressions of guilt or worthlessness, difficulty making decisions, suicidal ideas or suicide attempts (see above).

Depression may be disguised as increased agitation or restless attitude where the person moves around with no apparent purpose, or sometimes show signs of irritability.

At the same time one may see social withdrawal, significant distress and impairment of social and occupational functioning.

Worrying about having a serious illness is also common.

Children

In children and adolescents depression often co-occurs with other emotional and behavioural symptoms. It can be related to traumatic events or to a stressful family situation.

First therapy

Take a detailed history focusing on previous similar episodes, family history, history of **Self-harm**, recent life events, losses, etc.

Take the person's history from relatives to get an impression of how depression influences functioning.

Ensure the person's safety.

Advise that regular physical exercise may alleviate symptoms.

Give advice or supervision to level 1.

Inform relatives about safety, and of the risk of self-harm.

Second therapy

Prescribe an antidepressant drug in a gradually increasing dosage over weeks, such as a Selective Serotonin Reuptake Inhibitor (e.g. fluoxetine up to 20 to max 60 mg daily) or if that drug is not available Tricyclic

Antidepressants (e.g. imipramin up to max 150 mg daily).

With children

- Family **Counselling**.
- Inform parents and teachers about the child's situation and about how to provide a safe and secure life situation at home and at school.
- See **Interventions with traumatised children**.

Note

Some may develop **Substance abuse** as a means of self-medication.

Depressive symptoms may be a sign of severe physical illness, e.g. cancer, which must be ruled out.

Depressive symptoms may be part of a **PTSD**.

If there is no improvement after a month, consult with next level.

With children

Refer to a specialist if symptoms persist or if the child has recurring thoughts or makes attempts at suicide.

HEALTHCARE SPECIALIST

Assessment

Use a structured interview (See **Assessment of torture survivors**; e.g. SCAN, SCID) to establish the existence of depression and rating scales (Beck's Depressive Inventory, or Hamilton's depression scale) to evaluate the severity of depression.

Make a differential diagnosis of possible severe physical illness.

Check medications for possible interaction.

With children use a structured interview (e.g. DISC or K-SADS-PL).

Proposed measures

- If Selective Serotonin Reuptake Inhibitor or Tricyclic Antidepressant (TCA) have no effect, check dosage, possibly change medication. If depression is severe, TCA may be more effective.
- If the person also complains of **Anxiety**, add short-term sedative treatment.
- CBT (see **CBT**).
- Activation through regular physical exercise and creative therapies.

With children:

- Improvement of the child's general life conditions.
- Supportive therapy for the child.
- Family therapy.

Diarrhoea

HEALTHCARE ASSISTANT

Key signs

Watery stools, frequent defecations, urge to defecate. A very common cause is gut or stomach infection or food poisoning. The condition usually includes mild to moderate bowel cramps, malaise, **Nausea** and sometimes **Vomiting** or fever.

This problem may also be of psychological origin, for example resulting from intense **Anxiety** or **Stress**.

Action

- Often of short duration (less than 24 hrs), drink fluids.
- If there are severe bowel cramps or pain, contact next level immediately (risk of intestinal obstruction requiring surgery).
- If stools are greyish or greasy, there are probably gallbladder or pancreas problems. Go to next level within a few days.
- If of psychological origin, **Counselling** is recommended.

Note

If problems persist, it is usually bacterial or parasitic diarrhoea. Go to next levels within a few days or weeks.

HEALTHCARE PROFESSIONAL

Characteristics

Loose or watery stools, frequent defecations, urge to defecate. Causes of persistent problems as shown above but further causes could be malabsorption, side effects of drugs or inflammatory bowel disease. Fecal impaction due to chronic **Constipation** may also result in watery diarrhoea or bloody stools.

Perform appropriate diagnostic checks.

First therapy

Treat according to findings.

Second therapy

Treat according to findings.

Note

Fluid balance must be considered.

Progressive or colic pain may be a warning sign of a life-threatening obstruction.

HEALTHCARE SPECIALIST

Assessment

Surgical or infectious disorder assessments.

Proposed measures

According to findings.

Disfiguration

HEALTHCARE ASSISTANT

Key signs

Part(s) of the body may have been amputated (e g hands, outer ears, tongue, testicles) or crushed and left to heal. Scarring due to the slow healing of infected wounds may impede normal joint movements or affect normal body positions. Incomplete or non- aligned healing of bone fractures may cause disfiguration of extremities, hands, feet or fingers.

Action

Systematic exercise of that/those joints with an impeded range of movements (ROM) may be helpful. If the person cannot perform the

intended movements himself, another person may cautiously exercise the extremity by slowly extending passive movements several times a day for several weeks.

Note

People with major soft-tissue deformities or scarring should be referred for surgical assessment

HEALTHCARE PROFESSIONAL

Characteristics

See above.

First therapy

ROM exercises.

Second therapy

People with major soft tissue deformities should be referred to surgical/orthopaedic assessment of possibilities for reconstruction, or to get even a simple prosthesis.

HEALTHCARE SPECIALIST

Assessment

Surgical or orthopaedic assessments.

Proposed measures

According to findings. Prosthetic aids may be of paramount importance for everyday activities.

Disorders of Extreme Stress Not Otherwise Specified (DESNOS)

HEALTHCARE PROFESSIONAL

Characteristics

In the field of rehabilitation of torture survivors, the psychiatric diagnostic category “**PTSD**” (see this entry) is widely used to describe the typical major problems that such people suffer from. “PTSD” covers a great range of problems caused by exposure to very different traumatic events. Both the degree of negative impact of traumatic events and the degree of suffering in a given person may differ greatly. For example, a person with relatively mild and specific symptoms after a single minor motor-vehicle accident may apply for the diagnosis PTSD in the same way as a torture survivor with experiences of multiple extreme traumas and very intense and widespread symptoms. Many researchers and clinicians in the field hold the opinion that “PTSD” is not a suitable or adequate diagnostic category for people suffering from intense symptoms after extreme traumas, as many torture survivors do. Alternative categories such as “torture syndrome” and the like have been proposed. There is a proposal that the concept “Disorder after Extreme Stress Not Otherwise Specified” (DESNOS) should be included in the next version of the influential and widely used American psychiatric diagnostic system, DSM (Diagnostic and Statistical Manual of Mental Diseases (current version DSM-IV)). Most torture survivors with a current diagnosis of “PTSD” would probably be diagnosed with “DESNOS” in the next version of the DSM if this category were to be included. The suggested criteria for “DESNOS” are cited below.

According to the DSM-IV PTSD taskforce, including experts in psychiatry/psychology, the diagnosis of DESNOS requires alterations in six areas of functioning: (1) regulation of affect and impulses; (2) attention or consciousness; (3) self-perception; (4) relations with others; (5) **Somatisation**; and (6) systems of meaning. (Numbers in parentheses

indicate number of subscale items required for endorsement of subscale. Only one item required for endorsement of all other subscales with no numbers in parentheses).

I. Alteration in Regulation of Affect and Impulses

(A and 1 of B–F required):

- A. Affect Regulation
- B. Modulation of Anger
- C. Self-Destructive
- D. Preoccupation with suicide
- E. Difficulty Modulating Sexual Involvement
- F. Excessive Risk-taking

II. Alterations in Attention or Consciousness

(A or B required):

- A. Amnesia
- B. Transient Dissociative Episodes and Depersonalisation

III. Alterations in Self-Perception

(Two of A–F required):

- A. Ineffectiveness
- B. Permanent Damage
- C. Guilt and Responsibility
- D. Shame
- E. Nobody Can Understand
- F. Minimizing

IV. Alterations in Relations With Others

(One of A–C required):

- A. Inability to Trust
- B. Re-victimization
- C. Victimizing Others

V. Somatisation

(Two of A–E required):

- A. Digestive System
- B. Chronic Pain
- C. Cardiopulmonary Symptoms
- D. Conversion Symptoms
- E. Sexual Symptoms

VI. Alterations in Systems of Meaning

(A or B required):

- A. Despair and Hopelessness
- B. Loss of Previously Sustaining Beliefs

Action

See problem-specific entries and therapies.

Dissociation

HEALTHCARE ASSISTANT

Key signs

Dissociation is characterized by the person being “absent from the here and now”, i.e. the person is more or less out of contact with the present surroundings.

Mild forms of dissociation occur normally in many healthy individuals, e.g. immediately after dreaming when it can be difficult to decide whether one is in the “real” world or still in the “dream-reality”. In general, a high level of **Stress** increases the probability of dissociative experiences.

Dissociative experiences in the form of acting and feeling as if a traumatic event, e.g. torture, is actually happening again, is relatively often frequent in torture survivors. This experience, labelled flashback, is the most common dissociative symptom in post-traumatic stress disorder (PTSD). Though

awake, the affected person experiences extreme dissociative flashback episodes, that can be compared to experiencing Nightmares, about the torture episodes. Feelings, observations, perceptions and actions are fully experienced, as if the torture is actually ongoing.

Action

- Inform the person (but not during an episode) and his family that experiencing dissociative **Flashback** as such, is not dangerous and is not a sign of developing a serious disease, e.g. becoming insane.
- The episodes normally stop spontaneously in the course of a couple of minutes. Other people present during an episode should keep calm. Apart from preventing harm that could be caused by the actions of the person affected, no specific interventions are needed. Shouting at and touching the person in a harsh way has to be avoided because of the risk of provoking feelings of aversion and violent behaviour (as the person e.g. can think they are being attacked by the “torturer”).
- In most cases, different interventions can be tried to bring the person “back to reality”, e.g. talking to the person softly, seeking eye contact, directing the person’s attention to objects in the present situation, etc. Offering gentle body contact (first asking the person for permission), e.g. offering a hand, may be suitable. The advisability of using physical contact is, however, controversial.
- The primary, indirect treatment of flashbacks is to treat the underlying **PTSD**.

Note

If it is not possible to initiate/perform treatment of the underlying PTSD problem or if there are other prominent symptoms similar to dissociation that could be caused by other underlying problems, e. g. persistent loss of reality due to psychotic disease or **Substance abuse** – refer to next level.

Characteristics

In psychology and psychiatry, dissociation is described as a state in which certain functions of the psyche (even of the body), that are normally experienced as integrated with the rest of the functions, are now separated. For this reason, dissociation is sometimes referred to as "splitting" or **Alienation** of parts of the mind. Alienation can, in addition to its similarity to dissociation, also refer to an experience of being set apart from one's social surroundings (compare difficulties in **Family life, participation in**).

Dissociation can affect various functions such as thoughts, emotions, sensations, memories and even body-movements. Depending on which function(s) is(are) affected, special forms of dissociation are described as types of psychiatric disturbances (amnesia, fugue, identity disorder, **Depersonalisation** and conversion disorder). These special forms of dissociation might to some extent be relevant in cases of torture survivors. In addition to being symptoms of PTSD, these disturbances can also occur independently or as symptoms of other somatic or psychiatric diseases; a differential diagnosis should be performed by a specialist.

First therapy

Same guidelines as above but, informed by more detailed medical knowledge, it is possible to make advice more specific and relevant. Initiate **PTSD**-treatment if necessary.

Second therapy

If there are doubts about whether dissociative symptoms are due to PTSD – or to PTSD alone - assist level 1 by ruling out alternative explanations that might need different treatment, e.g. psychotic disorder, somatic disease or substance use. Initiate treatment for these alternative or additional problems if possible.

Note

Refer to next level if reasons for the adequate dissociative symptoms differ from PTSD, cannot be excluded or if the competences and resources for adequate treatment are not available.

HEALTHCARE SPECIALIST

Assessment

Rule out any hitherto unidentified/untreated somatic or other circumstances that are contributing to dissociative symptoms.

Proposed measures

According to findings.

Dizziness

HEALTHCARE ASSISTANT

Key signs

Feeling of unsteadiness. Could be due to: Drop in blood pressure after a sudden shift in body position in bedridden or even in normal (young) people; overmedication; irregular heart beat; mental pressure or confusion.

Action

- Try to clarify which of the above is the cause through asking.
- After long-term bed rest, train the person to get into an upright position gradually over a week for gradually extended periods.
- Try to relieve mental pressure through **Counselling**.
- Adhere to prescribed doses of medicine and contact the prescribing doctor.

Note

If confusion or irregular heart beats are present, seek next level.

HEALTHCARE PROFESSIONAL

Characteristics

Dizziness is usually due to a nervous system malfunction, directly or indirectly. Its simplest form is orthostatic hypotension after extended bed rest or vagal overactivity in the young. Signs of circulatory instability (irregular heart beats, blood pressure drop) should be checked. Another reason for it can be lack of normal movements of the neck or lack of coordination practice. Mental pressure or stress may also cause dizziness, as can confusion due to overmedication, brain injury or brain disease.

First therapy

According to assessment:

- Practise sitting and standing.
- Eliminate overmedication.
- Treat circulatory instability.
- Give **Counselling** for mental pressure & **Stress**.
- Perform eye-hand (neck) coordination exercises, where the hands are tracked by the eyes during simple repetitive arm/hand movements.

Second therapy

Refer cases of brain injury to next level.

Note

Usually an innocent condition, but could be an indication of an imminent **Flashback**.

HEALTHCARE SPECIALIST

Assessment

Internal medicine consultation.

Proposed measures

According to findings.

Facial Pain

HEALTHCARE ASSISTANT

Key signs

Pain in the face or jaws, either constantly or intermittently. The pain can be caused by trauma directly to the face, or be due to muscle tension, infection in the face, mouth (teeth) or ears. Facial pain can also be caused by pain from adjacent areas, such as muscles in the neck.

Action

- Inspect the person thoroughly. Look for signs of trauma to the head and for fever.
- Inspect the nose, mouth, ears, status of teeth; ask about complaints of **Hearing difficulties**.
- If there is any suspicion of trauma, make sure the person is seen by a health professional for treatment and diagnosis.
- Facial pain can be associated with tension type **Headache**.
- For pain relief use paracetamol (500 - 1000 mg 2-4 times daily) or aspirin (500 mg 2-4 times daily).

Note

If there is suspicion of trauma or infection, see a healthcare professional.

HEALTHCARE PROFESSIONAL

Characteristic

Facial pain may be caused by trauma, but if it is chronic consider a muscular cause and treat as headache due to muscle tension. Exclude fractures in face.

Try to examine for **Pain, neuropathic**, especially if the pain is very intense and intermittent; trigeminal neuralgia is possible. The person then

complains of intermittent pain triggered by touching the face or muscle activity, for instance when eating.

First therapy

Inspect mouth and assess health condition of teeth.

Treat infection.

See **Headache** for therapy to counteract muscle tension.

Second therapy

If the cause is trigeminal neuralgia (intermittent lightning pain; no sensory signs), use carbamazepine, initially 100 mgx2, increasing dosage up to 800 mg/day if pain is severe. Explain the side effects of carbamazepine (**Tiredness**, balance problems) to the person.

Note

Fractures to the face should, if possible, be treated by a specialist.

HEALTHCARE SPECIALIST

Assessment

Diagnose specific head and face injury.

Proposed measures

Propose specific treatment if possible thereafter.

Flashback

See **Dissociation**.

Foot pain

HEALTHCARE ASSISTANT

Key signs

Beatings, burns, cuts, cuffs, tight ropes around the ankles may cause intense pain in the feet which may persist long after the injury was sustained.

Falanga (beating the soles of the feet) is a common torture method.

Fractures, infections after wounds and foreign bodies (glass, bullets, etc.) can also cause foot pain.

Typical late symptoms after falanga are various forms of pain in the feet.

The late after-effects after falanga are

- Deep, dull cramping pain in the feet, which intensifies when carrying weights and with muscle activity.
- Burning, stinging pains in the soles which appear spontaneously or are stimulus evoked.
- The pain is often accompanied by sensory disturbances such as tingling, pins and needles and **Numbness**.
- Feelings of **Tiredness** and heaviness in lower legs and thighs, pain in the knee and ankle joints.
- **Burning sensation** in the feet at night.
- Muscle cramps.
- Feet are perceived as alternating between being very hot or cold and having a tendency to sweat more.
- The pain may spread from the feet up the lower legs.
- Often the victim is only able to walk short distances.

Action

Provide information and advice concerning pain-relieving self-help actions such as:

- Foot hygiene.
- Wear shoes or sandals with soft flexible, shock-absorbing soles.

- Put feet in cold water, if there is a burning feeling.
- Mobilise the toes and ankle joints.
- Massage the feet and lower legs.
- Stretch calf muscles.
- Increase walking distance (see **Leg pain** and **Walking problems**).
- See **Whole body physical therapies**.

Note

The symptoms in the feet may diminish with daily self-care. However, if pain has become chronic, this is often a sign that **Pain, neuropathic** has developed.

HEALTHCARE PROFESSIONAL

Characteristics

Scars, reduced mobility in the joint and tight, tense muscles may prevent normal foot function and thus impair walking. This may appear, for example, as a deviation from a normal gait pattern. A compensatory gait pattern with a short stride, avoidance of setting down the heel and abnormal toe steps may develop.

First therapy

Learning to find one's own physical limits and deal with physical limitation. Find optimum physical capacity. Institute graded physical training. Graded training modalities are undertaken slowly, respecting the individual's ability and pain threshold.

Second therapy

Adjust walking distances and speed to a reasonable pace. Paracetamol 1000 mg 2-4 times a day, aspirin 500 mg 3 times a day or medication against a component of **Pain, neuropathic** as needed.

Note

Increasing physical activity in general may reduce the pain in the feet.

HEALTHCARE SPECIALIST

Assessment

Orthopaedic and/or **Pain management** assessment.

Proposed measures

Aids such as special shoes, inlays, and bandages. Advanced pharmacotherapy (gabapentin, pregabalin).

Guilt feelings

HEALTHCARE ASSISTANT

Key signs

Guilt feelings are common in people who have been exposed to **Torture and Organised violence**. Guilt about having survived while others died, guilt about not having helped others enough to avoid their destiny, or guilt about having been forced to participate in acts of violence or even torture. Guilt feelings may be particularly pronounced if the person has been subjected to **Sexual violence** and been forced to perform or witness sexual practices that are unacceptable or considered immoral in the present society. This guilt feeling is not universal, and is seen less in cultures where there is a belief that destiny determines what happens and more common in those where the individual is urged to have control over his/her own life.

Action

- Ask about previous trauma and recent life stressors.
- Get a history about this from relatives and about any signs of depressed mood.
- Show an understanding attitude; listen to his/her story.
- If the person has a history of torture, explain that he/she had no influence over what happened to others, that his survival was not linked to the death of others.

Note

Refer to next level if the guilt feeling is severe and continues over weeks.

In some cases it would be helpful if the patient could write by hand freely; some aspects of his life (you do not need to ask him/her directly to write something about their guilt feeling), without grammar corrections and interruptions (as in stream of consciousness writing). The ideal situation is that he/she writes more than two pages. So that the patient will feel more confident, you tell him/her that this writing is confidential, that you will read it in front of them and give back their writing. This procedure works well when the person prefers to express his/her feelings in writing rather than verbally. You can then analyze the narrative content and ask questions.

Another way to discover the guilt feelings of the person is to ask him/her to draw a picture that represents their feelings (they do not need to draw a human picture - it could be an object or any imaginary representation of their feelings).

If the person cannot write because of illiteracy, tell him/her to relate one story the person learned from the family or the community. After the story is told, ask how he/she fits into the story. If the person does not want to talk, you can tell some story and then you can ask how he or she fits into the story. Drawing can be useful even for an illiterate person. This procedure is a complementary method of obtaining more information in addition to the traditional interviews. From clinical experience, this procedure is useful particularly when the patient denies his/her situation. (Another more controversial way is to share one's personal experiences with the victim; this may open the channels of communications more easily.)

Alternative therapies

- Music

If a person likes to sing (even if the person is not a singer), you can suggest singing when he/she is alone or with others.

- Poetry

It may be helpful in certain cases also that the person writes or reads poetry written by himself/herself or others.

HEALTHCARE PROFESSIONAL

Characteristics

Signs of guilt may also be part of a depressive condition. Here the guilt is frequently excessive, the person may be making statements about having caused accidents, illnesses in others, etc., but with no evidence that this is true.

First therapy

- Take the history of the person.
- Interview the person to see if there are signs of depression. If so, treat it (see **Depression**).
- Show an understanding attitude, listen to his/her story.
- If the person has a history of torture, explain that he/she had no influence over what happened to others, that his/her survival was not linked to the death of others.
- Explain that inducing guilt feeling in survivors is a technique often used by torturers and that those to blame are the torturers, not the survivors, who were facing impossible situations.

Second therapy

See **Counselling**.

Refer to next level if the guilt reaches a level of severity where the person assumes the blame for war situations, or other things that are far beyond any realistic responsibility.

Note

People with very severe guilt feelings may run the risk of attempting suicide (see **Self-harm**).

HEALTHCARE SPECIALIST

Assessment

Use a structured interview (see **Assessment of torture survivors**; SCID or SCAN) to evaluate the presence of mental illness.

Proposed measure

Treat possible mental illness (see **Depression**) according to findings.

Hand Pain

HEALTHCARE ASSISTANT

Key signs

To be able to use one's hands is almost a prerequisite for individuals to be able to support themselves and their families. Mutilations and methods of torture aimed at destroying hand function can be a disaster. Hand torture may consist of suspension by the thumb, extracting nails, crushing fingers or fracturing hands and fingers; burns from cigarettes or other objects may leave permanent visible signs and constantly remind the person of the torture. Tight handcuffs, wires or ropes round the wrist may leave pressure injuries in the underlying tissues. The results may be nerve injury, restricted blood supply and loss of sensory and motor function. The ultimate action is amputating one or both hands (see **Disfiguration**).

Action

- Visit the home and observe and assess difficulties in handling objects and carrying out different activities of daily living (eating, dressing, toileting, preparing food, etc.).
- Help the person to find solutions for better working conditions in the home and, e.g., with work tools.
- Instruct the person to move all the joints in the hand: "Make a fist and spread the fingers out" several times a day. Start in the morning when the fingers and hand may feel stiff and painful.

- Instruct the person to increase muscle strength: Keep a small rubber ball in the hand and squeeze it. Keep the ball in the hand as long as you can during the day and squeeze frequently. If the person gets a pain in the forearm he/she may have been too vigorous.

Note

See **Shoulder pain, Arm pain.**

HEALTHCARE PROFESSIONAL

Characteristics

Tight bands around the wrist may cause narrowing of the carpal tunnel. This may in turn cause compression of the median nerve and restriction of motor function, as well as sensation along the median nerve distribution of the hand. Compression of the carpal tunnel can stem from a variety of factors, such as **Swelling** secondary to Colles' fracture of the distal end of the radius, or anything causing swelling secondary to other general trauma affecting the wrist. To confirm a diagnosis of carpal tunnel syndrome, you can elicit or reproduce pain in the distribution of the median nerve by tapping the wrist over the volar carpal ligament (Tinel sign) or by maximal volar flexion of the wrist.

First therapy

Instructions about stretching and massage the volar ligaments of the hand. The movements of the small joints of the carpus are often restricted. Instructions about self-management of movements of the wrist joints.

Second therapy

The hand's sensory nerve supply comes from 3 levels in the cervical spine (C6: thumb and index finger: C7: index, third and fourth finger dorsal side, C8: third, fourth and fifth finger volar side). Sensory loss in any of these areas may relate to neuromuscular skeletal problems in the neck.

See **Pain, chronic, Neck pain, Shoulder pain, Arm pain.**

Note

If neurological signs are present go to level 3 for orthopaedic/neurological assessment.

HEALTHCARE SPECIALIST

Assessment

Test for signs of entrapment or compression neuropathies.

Proposed measures

Surgical decompression may be necessary depending on functional loss and on intolerable pain.

Headache

HEALTHCARE ASSISTANT

Key signs

Headache can be anything from a symptom of distress, to tension or to a severe condition after trauma to the head or infection. It can be localized to one part of the head or face, or it can be experienced as a diffuse pain through the whole of the head depending of the cause. Poor vision can also cause headaches, as well as overuse of painkillers and alcohol.

Headache is often intensified during psychological stressful events and is frequently part of a chronic pain syndrome.

School-age children might experience headaches in a stressful life situation, see **Somatisation**.

Action

- Be sure to inspect the person thoroughly: Look for signs of trauma to the head, fever, neck stiffness and signs of dehydration.
- Find out if the headache started before or at the time of the torture.

- Drug treatment: Paracetamol 500 mg twice daily, acetylsalicylic acid, (aspirin) 500 mg twice daily.
- Reduction in alcohol and coffee intake and cigarette smoking.
- Teach the person relaxation techniques (see **Whole body physical therapies**) together with light physical activity.
- Traditional or complementary treatments such as music therapy and various teas (camomile and valerian) can be tried, as well as relaxation techniques (see **Whole body physical therapies**).
- Reduce use of analgesics if they are being overused. Medication-induced headache can occur if the person has been using paracetamol or aspirin on a regular basis for more than three months.
- Avoid direct strong sunlight.
- If there are signs of dehydration, see to it that the person gets enough water to drink.
- Acupuncture can be used for tension headache and for migraine.

Note

If headache is accompanied by fever, **Vomiting** or increasing unilateral weakness, see a healthcare professional within hours.

If headache is due to effects of torture, without a head trauma, see a healthcare professional for medical investigation and further treatment.

HEALTHCARE PROFESSIONAL

Characteristics

Studies show that, as many as 90% of torture survivors report headaches. Diagnose headache and plausible genesis (trauma-induced, direct or indirect, migraine, tension, medication-induced). Examine neurological status and vision and take a headache history about the period prior to the torture trauma. Examine neck muscles and teeth.

Diagnose **Pain, Neuropathic** component.

First therapy

Examine headache localization, severity, intensity, frequency, and triggering factors.

Teach relaxation techniques.

Treat comorbidity causing the headache, e.g. chronic infections such as sinusitis.

Diagnose and treat **Depression, Anxiety** (also in children – see **Interventions with traumatised children**).

Second therapy

Use a headache diary. Get the person to write down when headaches appear.

Amitriptyline 10-75 mg/day in slowly increasing dosages over several weeks.

Relaxation techniques.

Note

Mentally affected people should be referred to a healthcare specialist in neurology (risk of increased intracranial pressure).

HEALTHCARE SPECIALIST

Assessment

Diagnose specific head injury or neurological disease.

Proposed measures

Propose specific treatment, if possible, thereafter.

Hearing difficulties

HEALTHCARE ASSISTANT

Key signs

Difficulty or inability to detect spoken words or to react even to loud sounds, e.g. hands clapping.

Action

Ask whether the problem came after trauma to the ears (e.g. blows with the flat of the hand) or after exposure to extreme sounds. The ear drums may be fragmented but they will usually heal spontaneously within weeks.

Note

Avoid exposing ear orifices to water, e.g. by diving. Send to next level if blood or fluid comes from the orifice, if there is no improvement within one month or if there are signs of infection (fever, local pain, pus).

HEALTHCARE PROFESSIONAL

Characteristics

Difficulty or inability to detect spoken words or to react even to loud sounds, e.g. hands clapping. Ask whether the problem came after trauma to the ears (e.g. blows with the flat of the hand) or after exposure to extreme sounds. Inspect the tympanic membranes – they might be fragmented. They usually heal spontaneously. Alternatively, there could be blood (from skull-base fracture) or fluid (decomposed blood or remains of infection) in the middle ear, preventing normal movements of tympanic membranes.

First therapy

Nose drops may help.

Second therapy

Prevent infection (treat with antibiotics) if necessary and avoid exposure of the middle ear to water.

Note

Skull-base fractures carry the risk of cerebrospinal fluid (clear) leaking and of infection.

HEALTHCARE SPECIALIST

Assessment

Otological examination, skull radiography.

Proposed measures

According to findings.

Heart palpitation

HEALTHCARE ASSISTANT

Key signs

Heartbeats that are hard and fast are called palpitations. It is normal to hear or feel one's heart "pounding" as it beats faster while exercising or engaging in other physical activities. But with palpitations, the person may feel the heart beating fast while just sitting still or moving slowly. People who suffer intense **Anxiety** or are prone to panic attacks may feel their heart pounding when they are afraid of something. Such anxiety or fear can be a consequence of having experienced intense **Stress**, such as torture.

Action

Give information about the innocuous nature of heart palpitations and occasional and irregular heartbeats.

Certain medicines, herbal supplements and illegal street drugs can make the heart beat faster. Caffeine (found in coffee, tea and soda), alcohol and tobacco can also cause palpitations. Avoid drugs and palpitation-related foods.

Note

Sometimes the break in the heart's normal rhythm can be a serious problem, such as with an irregular heartbeat or arrhythmia. Some medical conditions can also cause palpitations.

If the problem persists, refer to next level.

HEALTHCARE PROFESSIONAL

Characteristics

Heartbeats that are hard and fast are called palpitations.

Causes can be heart-related and people with an irregular heartbeat or arrhythmia may also have palpitations. Most often, palpitations and irregular heartbeats are harmless. However, sometimes the break in the heart's normal rhythm can be a serious problem for heart functioning and output of the heart.

There are many causes not related to the condition of the heart, such as:

- Intense anxiety or panic attacks that may be a consequence of having experienced intense **Stress**, such as torture.
- Certain medicines, herbal supplements and illegal street drugs. Medicines that can cause palpitations include asthma inhalers and decongestants. Caffeine (found in coffee, tea and soda), alcohol and tobacco can also cause palpitations.
- Medical conditions, such as thyroid disease and anaemia.

Perform appropriate diagnostic checks.

First therapy

If related to panic attacks or **Anxiety**, initiate **Counselling**.

Second therapy

Eliminate relevant food components and drugs. Treat arrhythmias, if necessary by referral to next level.

Note

The cause of the palpitations cannot be found in about 1/7 of all people who have palpitations. Palpitations in these people are usually not harmful.

Additional therapy

Stress management, Whole body physical therapies, breathing exercises, music therapy.

HEALTHCARE SPECIALIST

Assessment

Internal medicine/cardiology assessment.

Proposed measures

According to findings.

Hyper-vigilance

HEALTHCARE ASSISTANT

Key signs

Hyper-vigilance or **Over alertness** is a state of enhanced or increased activity of the senses regarding specific information; it is a common symptom of anxiety. It occurs both as a normal reaction after distressing experiences (e.g. a car-driver paying increased attention to traffic risks after being involved in an accident) and as a symptom of anxiety and other,

stress-related disorders. Hyper-vigilance can occur either unintentionally; a person anxious to spiders (spider-phobic) for example, automatically “scans” for spiders when entering a room, or as a result of conscious effort. For example, a person who is worried about suffering from a serious disease will carefully observe and register any conspicuous physical sensations (and thereby detect sensations that otherwise would not have been registered - which further nurtures the worry that he/she could really have a disease).

Action

Since hyper-vigilance is often a symptom of underlying disorders, the natural treatment is to address the underlying problems; i.e. if there is hyper-vigilance regarding body-symptoms due to panic disorder, treat the panic disorder. Hyper-vigilance is not normally a direct, main target in the treatment of **Anxiety** disorders. It is rather used to demonstrate to a person with anxiety that the experience of physical symptoms depends on the attention that is focussed on them. For example different experiences can be achieved by directing the attention to something else (e.g. quietly observing) and away from the body (e.g. by performing a counting task such as multiplication of numbers).

Note

Hyper-vigilance could be a sign of an undiscovered psychiatric disorder (e.g. **Paranoia**, hallucinations) or of a disorder that cannot be treated at level 1 – in such cases refer to next level.

HEALTHCARE PROFESSIONAL

Characteristics

Hyper-vigilance is a common symptom of various types of somatic anxiety and a strong masking factor for it. It may also occur, however, as a symptom of real disease and psychiatric disorder, other than anxiety disorders, e.g. psychoses.

First therapy

Exclude somatic and psychiatric diseases other than those normally connected with hyper-vigilance as potential causes.

Provide/initiate treatment of **Anxiety** (and other stress-related) disorders underlying hyper-vigilance.

Note

Refer to next level if differential diagnosis or treatment cannot be performed.

HEALTHCARE SPECIALIST

Assessment

Conduct differential psychiatric diagnosis of underlying causes of hyper-vigilance.

Incontinence

HEALTHCARE ASSISTANT

Key signs

Urinary leakage from a person unable to stop urinary flow at will. It can be intermittent, sometimes with an urge, and related to **Stress**, to physical activity or to coughing, or be continuous. Usually, voluntary voiding is possible but may be impaired or absent. Blows or other injury to the lower body or to the spine, common in **Torture and Organised violence**, may cause the condition as may sexual assault.

Action

Go to next level to have cause diagnosed.

If problems are minor, train pelvic muscles by doing daily exercises:

- Ask the person to try to locate the muscles slowing his/her urinary flow.

- Instruct him/her to contract these muscles and count to 5 or 10, then to relax for another count to 10.
- Do this exercise 10–20 times, 3 times a day.

Note

Incontinence may occur spontaneously in middle-aged and elderly women, especially after multiple childbirths.

HEALTHCARE PROFESSIONAL

Characteristics

Involuntary urinary leakage has structural or functional causes. A history including questions about sexual assault should be taken and the genitals should be examined for structural abnormalities, such as fistula formation between the bladder and vagina. An impaired nervous control of the bladder may occur with spinal-cord or pelvic injury without structural changes, but is usually combined with other neurological symptoms, such as faecal incontinence, **Paresis** of the leg(s) and sensory loss.

Perform appropriate diagnostic checks.

First therapy

Treat according to findings. For pelvic training, see above.

Second therapy

Referral to a specialist in obstetrics & gynaecology or to a surgeon may be necessary to correct structural abnormalities such as fistula closure.

Note.

If the person is unable to void voluntarily, the bladder will empty only through overflow and there is a risk of potentially serious infection and kidney damage. Clean (but not sterile) intermittent catheterisation is by far the simplest and safest procedure for emptying the bladder manually.

HEALTHCARE SPECIALIST

Assessment

Surgical assessment.

Proposed measures

Reconstruction, if possible.

Indigestion

HEALTHCARE ASSISTANT

Key signs

Indigestion, or heartburn, is a burning feeling in the lower chest, accompanied by a sour or bitter taste in the throat and mouth. It usually occurs after eating a big meal or while lying down. The feeling can last for a few minutes or up to a few hours. It is caused by a reflux of acid into the oesophagus or by too much acid in the stomach.

Action

Many things can make heartburn worse. Heartburn is most common after overeating, when bending over or when lying down. **Stress**, such as in conjunction with threats or torture, but also pregnancy or clothing that is so tight it puts pressure on the stomach, can make this condition worse. Cigarette smoking, coffee and other drinks that contain caffeine, alcohol, citrus fruits tomato products, onions, fatty or spicy foods and aspirin may also generate heartburn. Thus, advice should be given about limiting the external contributors to this condition. Eating small meals is important, as is avoiding intake of food just before going to sleep.

Note

Indigestion can be mistaken for ischemic heart disease or ischemic heart attack, but in those cases the pain and pressure over the lower thorax is usually more severe with heart problems.

HEALTHCARE PROFESSIONAL

Characteristics

Indigestion, or heartburn, is a burning feeling in the lower chest, accompanied by a sour or bitter taste in the throat and mouth. To enter the stomach, the food must pass through the opening between the oesophagus and stomach. Usually, this opening closes as soon as food passes through. But if it does not close, acid from the stomach can get through the opening and back into the oesophagus. This is called reflux. Stomach acid can irritate the oesophagus and cause heartburn.

Indigestion can be mistaken for ischemic heart disease or ischemic heart attack, but in those cases the pain and pressure over the lower thorax is usually more severe.

Perform appropriate diagnostic checks.

First therapy

Eliminate irritating factors (see above).

Second therapy

Relieve stress (see **Stress management**).

Note.

Do not have a heavy dinner or eat heavy food at late hours at night.

Do not lie down or go to sleep immediately after dinner.

Take the proper time and pleasant moments during and after eating.

Reduce the stress previous to, during and after eating.

Refer to next level only if gastric ulcer is suspected.

HEALTHCARE SPECIALIST

Assessment

Surgical assessment.

Proposed measures

According to findings.

Intrusive memories

HEALTHCARE PROFESSIONAL

Key signs

An intrusive memory is an involuntarily triggered, recurrent and distressing recollection of a traumatic event. It is a common symptom in **PTSD** disorder and thus common in many torture survivors. Intrusive memories mirror parts of the traumatic event and can include images, thoughts or perceptions. Intrusive memories mainly consist of relatively brief fragments of the traumatic experience in the form of images, sounds, smells, tastes or physical sensations, e.g. pain. They are not usually linked to the most distressing parts of the traumatic events but to situations immediately prior to these and might be a type of “warning-signal”.

Like dissociative flashbacks (compare **Dissociation**), intrusive memories are different from ordinary memories from the past, in that they are experienced with a feeling of a current threat and immediacy (i.e. a feeling of it happening here and now). Compared to flashbacks, however, intrusive memories are less dramatic and people do not lose all their awareness of their current surroundings. Intrusive memories can be interpreted as being a milder form of dissociative flashbacks (see **Dissociation** for treatment guidelines).

Leg pain

HEALTHCARE ASSISTANT

Key signs

Pain in the leg often originates from the lower back region or the structures of the leg. Various types of torture methods (beatings, forced positions in sustained stressful positions, tight ropes around various parts of the legs, deep cuts, burns and gunshots, etc.) may result in chronic pain after badly healed fractures, impaired muscle or nerve function and joint function of the hip, knee and foot. An altered walking pattern and difficulty in standing and walking may reduce the person's ability to work and carry out daily activities.

Action

- Ask for a history and about ability to work and carry out daily activities.
- Assess problems together with the spouse and give advice how to make daily activities easier.
- Assess the person's ability to
 - *squat*: Ask the person to get into and out of the seated or crouched posture on their buttocks with knees closely drawn up; or to sit on their heels, which may be necessary in toilets that are at floor level; or to change body position from squatting to any other position such as standing up.
 - *kneel*: Ask the person to get into and out of a position where the body is supported by the knees with the legs bent, such as during praying; or to change body position from kneeling to any other position, such as standing up.
 - *sit*: Ask the person to get into and out of a seated position and change body positions from sitting down to any other position, such as standing up or lying down, sitting with bent legs or cross legged; getting into a sitting position with feet supported or unsupported.

These activities require good mobility in the hips, knees and ankle joints and call for good muscle strength in the legs, coordination and balance of the whole body.

In maintaining the squatting, kneeling or cross-legged positions the hip and knee muscles will be stretched. Stretching the leg muscles may give pain relief, increase leg function and improve walking ability.

- Walking and standing ability should be increased slowly, by increasing walking time, walking speed and walking distance.

Note

The person should participate as much as possible in family and community life and practise the above activities every day (see **Back pain**).

HEALTHCARE PROFESSIONAL

Characteristics

One of the most common mistakes is to assume that all leg pain is sciatica, and must be due to a prolapsed disk pressing on a nerve. Most leg pain is not nerve root pain, and has nothing to do with prolapsed discs. 70% of people with back pain have some radiation of pain to the legs. This referred pain relates to the fascia, muscles, ligaments, periosteum, facet joints, disk or epidural structures.

First therapy

Assess body alignment in standing and sitting (see **Back pain**).

Assess range of motion in the spine, hips, knees and feet.

Assess muscle strength in the legs and feet.

Assess pain (see **Pain, acute, Pain, chronic, Back Pain and Muscle, joint and bone pain**).

Assess **Walking problems**.

Second therapy

Give instructions about dynamic movement of the spine, especially extension movements.

Pain medication (see **Pain, chronic**).

Relaxation techniques (see **Whole body physical therapies**).

Note

If leg impairments and pain are severe, assess for nerve injury due to constriction or to forced positions (see **Pain, neuropathic**).

HEALTHCARE SPECIALIST

Assessment

Assess impairments, pain and activity limitations.

Proposed measures

According to findings.

Loss of appetite

HEALTHCARE ASSISTANT

Key signs

No desire to eat. With diminishing calorie intake (under eating), there is weight loss after a few weeks. If no food at all is ingested, the **Weight loss** can amount to 2-3 kg/week.

The reasons can be mental, notably due to **Stress, Anxiety, Depression** or grief, or physical, due to underlying disease such as infections (hepatitis/jaundice, tuberculosis, fever), heart conditions, thyroid deficiency, alcoholism, high calcium blood levels, stomach ulcer, liver or kidney failure, swallowing difficulties or cancer. Certain medications may also produce loss of appetite, notably amphetamines, erythromycin and digoxin.

Action

Temporary loss of appetite is not a problem and usually resolves within days. If it does not, underlying causes must be sought for through referral to next level.

Note

Intoxication is another relevant cause. Gender issues like family violence, rape, incest and child abuse or drug abuse could be related to loss of appetite.

HEALTHCARE PROFESSIONAL

Characteristics

Permanent loss of appetite in torture victims usually has a psychological background. Relevant physical causes including medication (cf. above) should be eliminated through standard diagnostic procedures.

First therapy

Counselling.

Second therapy

Appetising meals.

Note

Diagnosis of physical causes may need specialist advice. Ongoing **Weight loss** is a warning sign.

HEALTHCARE SPECIALIST

Assessment

Psychiatric and internal medicine assessments.

Proposed measures

According to findings.

Loss of energy

See **Tiredness**.

Loss of interest

HEALTHCARE ASSISTANT

Key signs

Loss of interest is a common occurrence, and is not in itself an abnormal behaviour requiring any intervention. Loss of interest may vary over time and be related to symptoms of **Tiredness** and lack of energy. It may thus be a symptom of many physical as well as mental illnesses.

The symptom may subside over time or when the problem that causes it is solved or has vanished (see **Problem solving**).

The loss of interest may also be seen as an aspect of social **Isolation** and withdrawal.

People who have been exposed to trauma may also experience a loss of interest in activities that they used to be interested in.

The person may show other signs, such as depression (see **Depression**).

In children, loss of interest in activities the child used to engage in with pleasure can be a stress reaction.

Action

Inform parents of children's **Stress** reactions. Do not force the child.

Note

If there are no other symptoms, the problem is usually transient.

HEALTHCARE PROFESSIONAL

Characteristics

Children

In children, loss of interest can be a transient stress reaction, but it can also be seen in children who have been exposed to longstanding and severe stress. In that case, the child will also often have other symptoms.

First therapy

Counselling of parents.

Second therapy

With children:

Stress management.

HEALTHCARE SPECIALIST

Assessment

Use structured interview (see **Assessment of torture survivors**; SCID or SCAN) to evaluate underlying mental illness.

With children:

Take a detailed history in order to understand when and how the symptoms started. Assess for **PTSD** and **Depression**.

Proposed measure

Treat possible mental illness (**Depression** or **Anxiety**) according to findings.

With children see **Interventions with traumatised children**.

Menstruation problems

HEALTHCARE ASSISTANT

Key signs

Menstruation is a woman's monthly bleeding. Menstruation is a complicated process involving different hormones, the woman's reproductive organs and the brain. The menstrual cycle is a term used to describe the sequence of events that occur within a woman's body as it prepares for the possibility of pregnancy each month. Girls can begin menstruating as early as 8 or as late as 16 years of age. Menstruation lasts for four to seven days after which there is a pause of about 23 days until the next period. The second part of these 23 days (from release of egg to onset of bleeding) lasts about 14 days. Women continue having periods until menopause, which occurs around the age of 51 years.

Women can have various kinds of problems with their menstruation, including **Abdominal pain**, skipped periods and heavy bleeding. Causes of absence of menstruation (amenorrhea) include pregnancy, breastfeeding, hormonal therapy, improper use of drugs for the prevention of pregnancy, stress (such as that arising from having been subject to torture) and extreme weight loss, e.g. resulting from starvation.

Action

- Exclude natural causes of amenorrhea.
- Treat **Weight loss**.
- **Counselling** may be necessary to alleviate the chronic **Stress** from being exposed to torture.

Note

If the problems persist, go to next level within months.

HEALTHCARE PROFESSIONAL

Characteristics

Amenorrhoea is the absence of a menstrual period. This term is used to describe the absence of a period in young women who have not started menstruating by aged 16, or the absence of a period in women who normally have regular periods. Causes of amenorrhoea include pregnancy, breastfeeding, **Stress** (such as that arising from being subjected to torture) and extreme **Weight loss** caused by serious illness, by starvation or excessive exercising. Problems with hormones or with the reproductive organs may be involved. In torture victims with chronic stress there is often a combination of limited menstruation (oligomenorrhoea) and **Abdominal pain**.

Dysmenorrhoea denotes painful periods, including severe menstrual cramps. In younger women, there is often no known disease or condition associated with the pain. Sometimes a disease, such as uterine fibroids or endometriosis, causes the pain.

Abnormal bleeding includes very heavy bleeding or unusually long periods, periods too close together, and bleeding between periods. In adolescents and women approaching menopause, hormone-imbalance problems often cause irregular cycles.

Perform appropriate diagnostic checks.

First therapy

Simple painkillers such as ibuprofen can help.

Second therapy

Refer to next level.

Note

If due to chronic stress after torture, **Counselling** is often needed.

HEALTHCARE SPECIALIST

Assessment

Gynaecological and/or psychiatric assessments.

Proposed measures

According to findings.

Micturition

HEALTHCARE ASSISTANT

Key signs

Voluntary control of voiding urine.

See **Incontinence**.

Muscle, joint and bone pain

HEALTHCARE ASSISTANT

Key signs

Muscle pain is common and is often a reaction combined with other pain conditions. Both physical and psychological tension may evoke muscle pain. Pain in one part of the body may evoke muscle pain in other parts of the body and may be regional or widespread. Scars after cuts and burns may also cause problems with muscle or joint function.

The pain associated with muscle damage is typically described as an aching and cramping pain. Muscle pain is often difficult to localize to one specific muscle. It is a frequent cause of pain after torture and is known for its tendency to become chronic.

Pain in the bones and joints is often described as deep, grinding, stabbing, gnawing and aching and is often related to movement. This may make sufferers afraid to move because they fear that movement will injure their joints. The contrary, however, is true. Movements and regular compression in the joints are essential for the healthy functioning of joints.

Action

- Ask for a history and about the ability to work and carry out daily activities.
- Assess problems together with the spouse and give advice about how to make daily activities easier.
- Assess the person's ability to cope with daily living.

Note

If the muscle damage is visible (bruises, wounds or **Swelling**) or if the joints are swollen and hot, contact a healthcare professional. If not, the person should participate as much as possible in family and community life (See **Coping and preoccupation with pain**).

HEALTHCARE PROFESSIONAL

Characteristics

People should make purposeful *mental efforts* to reduce pain and to manage daily activities as they did before, in order to cope with muscle and joint pain. What they *do* depends on how and what they think about their pain symptoms. Their behaviour expresses and communicates the perceived severity of pain and physical impairment. The more severe the experienced physical disorder is, the more illness behaviour he or she may display.

First therapy

Assess and treat bruises, wounds or **Swelling** and inflammation.

Assess illness behaviour.

Assess whether pain is regional or widespread.

Assess whether the condition has influenced posture, range of movement in the spine, the extremities, muscle strength and body function.

Assess consequences of pain regarding family and social behaviours.

Second therapy

Counselling.

Medication: Paracetamol 500 mg two tablets 4 times a day maximum, aspirin 500 mg 3-4 times a day.

Note

If pathology is diagnosed send to orthopaedic surgeon or rheumatologist.

HEALTHCARE SPECIALIST

Assessment

Assess for systemic pathology.

Proposed measures

According to findings.

Muscle weakness

HEALTHCARE ASSISTANT

Key signs

Lameness or weakness of muscles in spite of maximum voluntary activation, but usually without pain, is found in a conscious person. It could affect movements around a single joint, of an arm or a leg, of both legs, and most severely, of legs, trunk and arms. If it occurs suddenly or within hours after a blow or other trauma to the head or spine, an injury to the brain or spinal cord should be suspected. A blow, a knife stab or a bullet may produce similar injury. If an extremity is hit, the local nerves and/or

the blood vessels may also be injured and produce local or regional muscle weakness.

Nerve injuries are common after torture, not only due to blows but to overstretching by hanging, after compression by strapping the arms behind the back or by pressure on nerves caused by confining people to unnatural body positions for extended periods of time.

If weakness occurs spontaneously within hours, it is likely due to a blood clot in a brain vessel or a haemorrhage in the brain. If it develops slowly over weeks and months, a disease of the nervous system may be the cause.

Action

- For spinal injury, monitor urinary output (1-2 litres/day) and prevent pressure sores by changing position of the paretic parts every 3 hours.
- In the case of lameness, carefully move the extremity through the whole range of movement every morning and evening to maintain mobility of joints. Nerve injury, if not from a penetrating object, may heal spontaneously over months or may even take years.
- In the case of muscular weakness, start regular progressive exercises, 3-5 times 3 times a day by
 - performing muscle contraction against resistance,
 - lifting the extremity,
 - moving around.

Note

An undetected fracture might lie behind the weakness but is usually painful if movement is attempted.

Seek next level if there are urinary problems, if there is a recent penetrating injury or if fracture of the spine is suspected.

HEALTHCARE PROFESSIONAL

Characteristics

Lameness or muscle weakness in relation to torture traumas is usually due to injuries to the nervous system, either through penetrating agents (bullet, knife, spear), through blows from blunt instruments or through overstretching or compressing peripheral nerves. Check for signs of nerve injury: Muscle weakness in muscles innervated from the same nerve and or sensory loss in the skin from that nerve (use a pin prick!).

First therapy

Check for and treat undetected fractures. Ensure urinary flow through clean, intermittent catheterisation. Try to establish site of injury and inform the person about the chances of spontaneous recovery in peripheral lesions.

Second therapy

Prevent joint stiffening by regular movement. Start regular muscular exercises according to above.

Note

If available, a specialist rehabilitation centre or orthopaedic surgeon should be consulted in severe cases.

HEALTHCARE SPECIALIST

Assessment

Appropriate PRM (Physical & Rehabilitation Medicine) or orthopaedic consultation.

Proposed measures

According to findings. This may involve financing a hospital stay of 1–3 months as well as simple technical aids to help mobility and self-support.

Nausea

HEALTHCARE ASSISTANT

Key signs

A sense of malaise combined with an urge to vomit. This may be accompanied by general weakness, a sense of fainting (and a decrease in blood pressure), a feeling of cold and **Sweating**. It is not only seen in conjunction with abdominal problems such as stomach or gut infection, gut obstruction or liver disease but also with general infections, heart disease and kidney disease, and importantly, with major trauma or other disturbances of body functions, including mental pressure.

Action

- Often of short duration and due to mild stomach or gut infection.
Drink fluids.
- If mild and recurrent, try
 - eating small meals throughout the day so that one is never too full or too hungry.
 - avoiding rich, fatty foods and foods with stronger unpleasant smells.
 - eating more carbohydrates (plain baked potato, white rice, bread).
 - wearing "acupressure" wrist bands, which are used to prevent sea sickness.
 - drinking ginger tea may give temporary relief.

If persistent, go to next level within days for diagnosis.

Note

If severe bowel cramps or pain are present, contact next level immediately (risk of intestinal obstruction requiring surgery).

HEALTHCARE PROFESSIONAL

Characteristics

A sense of malaise combined with an urge to vomit. This may be accompanied by general weakness, a sense of fainting (and a decrease in blood pressure), a feeling of cold and **Sweating**. It is not only seen in conjunction with abdominal problems such as stomach or gut infection, intestinal obstruction or liver disease but also with general infections, heart disease and kidney disease, and with major trauma or other disturbances of body function, including mental pressure.

Perform appropriate diagnostic checks.

First therapy

Nausea related to mental pressure should be treated with **Counselling**.

Note

Fluid balance must be considered.

Progressive or colic pain is a warning sign of a life-threatening obstruction.

HEALTHCARE SPECIALIST

Assessment

Surgical, infectious disorder assessments.

Proposed measures

According to findings.

Neck pain

HEALTHCARE ASSISTANT

Beatings to the head, pushes and falls, shaking, enforced awkward positioning, suspension by the arms in an upright position and suspension with the hands tied behind the back may cause pain in the neck, reduced

mobility in the neck joints and tension and taut muscles in the neck and shoulder girdle. Tension in the neck and shoulder muscle may contribute to tension headache. Dizziness can be accompanied by neck pain.

Action

- Ask what trauma caused the neck pain and for how long this pain was present.
- Observe neck movements and give instructions about how to increase neck movements by forward/backward and sideway bending and rotation.
- Instruct a family member how to massage the neck muscles, shoulder girdle and the back.
- Relax muscles by gently stretching the neck muscles while the person breathes in and out simultaneously.
- Hot water baths may reduce muscle tension. Camomile baths are sometimes advocated.
- When lying down, a towel wrapped around the neck may feel comforting and relax the muscles.

Note

If the neck is completely stiff and no movements are possible and the person complains of intense pain, **Dizziness** and **Headache** an underlying disease may be present. Refer to next level.

HEALTHCARE PROFESSIONAL

Characteristics

If the person complains of dizziness, see **Dizziness**.

Persistent neck pain may be due to sustained muscular tension, tightness and reduced mobility in the neck and shoulders. Hard physical labour, working conditions and compensating posture and movement patterns may add to this condition. Assessment of the cervical spine including bony palpation, soft tissue palpation, range of motion and neurological examination should be performed.

First therapy

Design a simple exercise program which should include a recommendation about awareness of the importance of changing posture regularly and improving physical activity.

Ask about working conditions, analyse feasible changes and help to implement those changes.

Find the optimal aerobic capacity level to enable the person to reach a desired level of physical ability.

Temporary medication: Paracetamol 500 mg 2-4 times daily, or aspirin 500 mg 2-4 times daily.

Second therapy

Introduce a relaxation technique suited to the particular person. See **Stress management**.

Note

Follow-up sessions ensure the person's compliance with treatment and reveal any reduction pain in the neck. Additional advice should be added to previous recommendations according to the development of the condition.

HEALTHCARE SPECIALIST

Assessment

Orthopaedic or neurological specialist should be consulted.

Proposed measures

According to findings.

Numbness

HEALTHCARE ASSISTANT

Key signs

Feeling of sensory loss.

If felt over the whole or most of the body, the cause is usually psychological and signals an inner mental tension that may be due to a previous life-changing event, such as being subjected to torture.

If felt regionally or locally, the cause may be either psychological or be due to physical injury of a nerve, of the spinal cord or of the brain. Muscle weakness is then often, but not always, present. Suspension, strapping or confining the person under torture may be the cause.

Action

Clarify the person's history by careful questioning and treat accordingly:

If psychological: Give **Counselling**.

If physical: Provide a treatment regimen as under **Muscle weakness**. Note the need to avoid pressure sores by regularly changing the positions of the body.

Note

If psychological, the problem usually resolves spontaneously.

HEALTHCARE PROFESSIONAL

Characteristics

Feeling of sensory loss.

If felt over the whole or most of the body, the cause is usually psychological and signals an inner mental tension that may be due to a previous traumatic event, the effects of which are now reflected in the body.

If felt regionally or locally, the cause may be either psychological or be due to physical injury of a nerve, of the spinal cord or of the brain. Muscle weakness is then often, but not always, present. Suspension, strapping or confining the person under torture may be the cause.

First therapy

Clarify the person's history by careful questioning and treat accordingly:

If psychological: Give **Counselling**.

If physical: Provide a treatment regimen as under **Muscle weakness**. Note that nerve injuries may take months or years to heal.

Second therapy

Specialist treatment is usually necessary with spinal-cord injury or severe brain injury.

Note

Numbness that has a psychological cause usually resolves spontaneously.

HEALTHCARE SPECIALIST

Assessment

Psychiatric and PRM assessments.

Over alertness

See also **Hyper-vigilance**.

HEALTHCARE ASSISTANT

Key signs

Children often react with symptoms of over alertness if something is bothering them. Usually the symptoms are transient. In children who are traumatized, symptoms can be more injurious and severe. Over alertness

presents as restlessness, poor concentration, jumpiness, irritability and the child getting easily upset and angry.

Action

Find out what is bothering the child and talk to him/her about it. Inform the parents of the nature of the problems and help them to establish a safe and supportive environment for the child. Never punish the child for having symptoms but remain calm. See also **Interventions with traumatised children.**

Note

If problems are severe and injurious refer to next level.

HEALTHCARE PROFESSIONAL

Characteristics

Symptoms of over alertness are frequent in traumatized children. The child might be very restless, unable to settle down, jumping from one activity to the next. He/she cannot concentrate on a given task, which will have a negative influence on school work. The child can be irritable and easily become upset and angry. He/she is easily aroused and has a strong startle response. These symptoms often get the child in trouble in school and within the family.

First therapy

Family **Counselling** focused on identification and understanding of the problem. If the child has had traumatic experiences, he/she needs support from parents and teachers in a safe environment. See **Interventions with traumatized children.**

Second therapy

Group or individual activities that help the child to attain body and affect regulation, see **Stress management.**

Note

If the child does not respond to interventions and the symptoms are part of a larger symptom complex, this could indicate more severe problems. Refer to next level.

HEALTHCARE SPECIALIST

Assessment

Assess for more complicated mental problems such as **PTSD, Depression** or **ADHD**. Use a structured interview for children (see **Assessment of torture survivors**; e.g. DISC or K-SADS-PL) and take a thorough history in order to identify what caused the problems.

Proposed measures

Treat according to findings. **CBT** and family therapy will often be the treatment of choice.

Pain, Acute

HEALTHCARE ASSISTANT

Acute pain is a normal reaction on the part of the body after injury and differs in intensity over time. Acute pain is the body's alarm signal to the brain that there is actual or potential damage in the body. After the onset of acute pain, the body starts preparing itself for repair of the injury. Common causes of acute pain are inflammation in joint or intestine, a broken bone, or acute muscle pain, blunt trauma or **Headaches**.

The intensity of pain that a person experiences is not always related to the severity of the injury. In stressful situations, such as during torture, pain may be absent at the time of injury, and appear later.

Action

- Reduce the acute pain as effectively as possible with medication, such as paracetamol, 500 mg, 2 tablets 2-4 times daily, or aspirin, 500 mg, 1-2 tablets 3-4 times daily (ask first if the person can tolerate and/or has previous experience with these drugs).
- Let the person find a restful position; sometimes movement is preferred.
- Reduce the stressful situation as much as possible.
- Use the RICE principle: Rest in the acute phase, depending on severity of trauma. Apply Ice (or cold water) to painful areas to minimize **Swelling**. Apply Compression to swollen area to minimize swelling (with elastic bandage). Elevate injured limb until swelling has subsided.

Note

The cause of acute pain needs to be diagnosed, and a reasonable cause must be found. The cause must be treated, if possible. Remember that pain is a subjective experience; listen to the person's story.

If the pain is severe, refer to healthcare professional within days.

HEALTHCARE PROFESSIONAL

Characteristics

Acute pain is often accompanied by autonomic reactions such as **Sweating**, palpitations, increased blood pressure, all signs of flight mechanisms. Acute pain is often accompanied by **Anxiety** and can be accompanied by fear.

Chronic pain can be interrupted by episodes of acute pain, such as **Headache** or acute low-**Back pain**.

Make sure that the cause of the pain is assessed.

First therapy

Assess history and onset of pain.

Assess pain intensity using a verbal scale; no pain, moderate pain, severe pain or intolerable pain.

Use NSAIDs (Non-Steroidal Anti-Inflammatory Drugs) or paracetamol regularly in adequate doses.

Assess structural damage and cause of pain. Check vital signs of infection and stabilize fractures etc.

Make sure the person is as relaxed as possible, and that he/she receives as much relief from the pain as possible to minimize the risk of developing chronic pain.

Second therapy

If the pain is severe, opiates can be used for a shorter period of time (morphine 5-10 mg, if available, by mouth, 4–6 times a day); be sure to document real pain relief in contrast to sedation. (Unfortunately, in some countries morphine is not available or is strictly regulated).

Therapy has to be suited to the cause of the pain, pain location (local or widespread), pain intensity and time pattern (constant or intermittent).

Note

Acute pain is by definition a pain state that may last up to 12 weeks. When using medication beware of compliance problems. Spend a lot of time educating the person about how and when to use even simple medication.

HEALTHCARE SPECIALIST

Assessment

Relevant assessment of organ functions should be carried out.

Test sensibility to touch, temperature, and pinprick in and adjacent to the painful area (see **Pain, neuropathic**).

Assess pain-reducing factors, medication, and affective components.

Proposed measures

Those required by findings in the assessments above.

In the later phase of acute pain, consider affective components. If necessary treat **Anxiety, Depression**.

Pain, chronic

HEALTHCARE ASSISTANT

Key signs

Chronic pain is pain that lasts for more than three months, frequently without any visual signs of injury. Many torture survivors suffer from chronic pain several years after their torture experience. The most common locations for pain are the head, neck and back or whole-body pain. Chronic pain often increases in intensity and location if the person suffers from **Depression**, poor sleep or **Anxiety**.

Chronic pain is often felt in a larger area than in the acute phase. This may be due to long-term changes in the nervous system, which becomes more sensitive to the sensation of pain over time, as well as to the meaning of the pain condition for that individual. It is therefore important to find a suitable strategy for each person.

Action

- Activate the person; involve him/her in their own treatment.
- Inform him/her that medication alone will probably not help this pain problem. If the person continues with paracetamol and/or aspirin their effects should be evaluated with a health care professional.
- If there is a disturbed sensation close to the painful area and an injury to the nervous system is suspected, it is important to try medication for so-called **Pain, neuropathic** and the person should be referred to level 2.
- Often regular pain medications are not very useful for states of chronic pain. These drugs can be used instead for treatment in conjunction with being more active, which will otherwise cause an increase in pain.

- It is important for the person to understand that, in comparison to the acute pain, chronic pain is not equal to harm and bodily damage. Let the person try out activities that are possible for them in their own environment, to find out his or her preferences.
- Different methods of relaxation can be learned (see **Whole body physical therapies, Stress management**).
- Reduce catastrophising (negative) thoughts concerning the pain by helping the person back to activity; group activities can be used.

Note

If the person seems depressed, send to level 2 to discuss whether antidepressant medication is necessary.

HEALTHCARE PROFESSIONAL

Characteristics

There are often no or few signs of apparent tissue damage on the body (leg, neck, back) in the person with chronic pain. The cause of the pain is more often to be found in sensitisation of the nervous system, and neurobiological changes in the spinal cord and brain due to longstanding pain signals. It is important to correctly diagnose and if possible treat a **Pain, neuropathic** component, which can induce and maintain chronic pain.

Because of intense pain sensations, the person may have adopted an inactive behavioural pattern because of fear of increasing the experience of pain and fear of causing further harm to the body.

First therapy

Assess history and onset of pain.

Assess present activity limitations to use as therapy outcome measures.

Use NSAIDS (500 mg tablets 2-4 times a day) or paracetamol (500 mg 2-4 times a day), but evaluate the effect, since these drugs are not always

effective. For a short period of time, passive treatments such as massage and acupuncture are indicated.

Psycho-education and counselling about **Pain management (Coping and preoccupation with pain, Counselling, Psycho-education, Stress management)** are often helpful in reducing activity limitations.

Second therapy

Assess for a possible neuropathic pain component (see **Pain, neuropathic**) by making a bedside test of sensitivity to light touch, temperature (hot, cold), pinprick and try to determine whether there is damage to peripheral nerves (e.g. after suspension by the arms, or after being handcuffed), or neuropathy after the beating of the soles of the feet with sticks or batons. Such pain can often be treated with small, gradually increasing doses of amitriptylin (5–50 mg/day, given in the evening).

If the pain is severe, opioids can be used for a shorter period of time (morphine 5-10 mg 4-6 times a day). Extreme care should be taken to avoid addiction (sudden dose increase, “lost medication”); be sure that real pain relief can be documented within three months rather than mere sedation. Consider treating **Depression** and **Sleeping difficulties**.

Note

When using medication over a longer period of time, beware of the compliance problem: Spend a lot of time instructing the person when and how to use medication.

HEALTHCARE SPECIALIST

Assessment

If available, consult a specialist in PRM to arrange for multi-professional assessment and rehabilitation of those patients severely disabled by their chronic pain.

Proposed measures

Consider affective components. If necessary, treat **Anxiety** and **Depression** along with pain-relieving and activity-increasing measures. **CBT** is often effective.

Pain, neuropathic

HEALTHCARE ASSISTANT

Key signs

Neuropathic pain is caused by an injury to the nervous system, the nerves, the spinal cord or the brain. It can be caused by infection, toxic substances, illness and trauma. Trauma, such as stab wounds and gunshots, falanga (beating on the foot soles), suspension by the arms, and blunt trauma to the head that causes bleeding in the brain, could all cause pain of neuropathic origin. Forced postures may cause nerve injury and neuropathic pain in the arms.

The person complains of pain (often spontaneous), but also of other sensations such as:

- Loss of sensitivity to touch or temperature.
- Cramps.
- “Strange” sensations such as spontaneous tingling, heat, cold in the affected area.
- Oversensitivity to touch or cooling, in or close to the painful area.
- Discomfort from wearing loose fitting clothes or shoes.

Action

Ask the person about specific traumas (see above).

Regular pain medication has little or no effect on neuropathic pain. Simple advice is to instruct the person about wearing tight, as well as soft, clothing. Sometimes bandaging the arm or leg might help. Heat or cold can help

some people but need to be tested carefully, as in some people they will elicit pain. The extremity will often be less painful when not used a lot. Sometimes rubbing the skin will reduce the pain or discomfort.

Note

Neuropathic pain is under-diagnosed in people with pain after trauma. If it is suspected that this is the case, the person should be referred to a healthcare professional.

HEALTHCARE PROFESSIONAL

Characteristics

Neuropathic pain is caused by a primary lesion of or a dysfunction in the nervous system. Clinically, neuropathic pain is characterised by the lack of apparent signs of tissue damage but there is usually a history of probable nerve injury. Neuropathic pain varies in intensity, but typically, there is disturbed skin sensation in or adjacent to the area in pain. This may be a loss of sensation but also an increasing pain intensity with repeated skin stimulation and an after-sensation of persistent pain once stimulation has ceased. There may also be signs of hyperactivity of the sympathetic nervous system; e.g. increased **Sweating**, change in skin temperature and colour. The pain may be local - in a scar, hand, arm, foot - radiating from a nerve lesion or involve the lower part of the body (after a spinal cord injury). After a stroke in the brain, neuropathic pain can involve one whole side of the body.

In one study, as many as 81% of torture survivors exposed to beating of the soles of the feet had symptoms of peripheral neuropathy, and 64% suffered from partial plexus damage after being suspended by the arms in a forced posture, so-called Palestinian hanging.

The pain is often spontaneous, but can be experienced in many ways, not only as a **Burning sensation**, which is common, but also as aching,

cramping, and shooting. Phantom limb pain is also a form of neuropathic pain (see **Phantom pain**).

First therapy

Localize the pain and find a plausible explanation (type of trauma). Make a bedside neurological examination; look for sensory disturbances in the area of pain, involving sensitivity to touch, temperature, pinprick and muscle function. Using a cotton swab try to test whether the sensation of touch is normal. Lightly stroke the swab in the affected area, then repeat on the other side (arm, foot, leg) for comparison. Note if there is a difference between sides. Note if there is a loss of touch sensation or discomfort or even pain when stroking the skin on the affected side; if so, neuropathic pain should be suspected.

Consider starting amitriptylin, initially 10 mg in the evening, increasing the dosage individually, to around 75-100 mg/day. Side effects of the drug are often dry mouth, stomach ache and sleepiness. Common side effects are dry mouth and in higher doses, blurred vision and sleepiness, and in males, **Micturition** difficulties. This medication should be avoided in recent heart problems. The side effects can be minimized by increasing the dosage very slowly, 10-25 mg every 3rd-4th day and giving the dose in the evening two hours before bedtime.

Second therapy

Strong opioids (morphine) can have some beneficial effect in extreme cases, but has proved difficult to tolerate for a long period of time. Neuropathic pain is a chronic pain and co-morbidities such as **Depression**, **Anxiety** and sleeping disturbances are common.

Note

For severe neuropathic pain a specialist (neurologist, orthopaedic surgeon, neurosurgeon) should be consulted, if possible.

HEALTHCARE SPECIALIST

Assessment

Diagnose specific nerve, spinal cord or brain damage.

Proposed measures

Propose specific treatment, amitriptylin as first choice and gabapentin as second choice. Electro-stimulation is another option.

Pain, psychogenic

HEALTHCARE ASSISTANT

Key signs

Psychogenic pain can only be diagnosed when all physical explanations (including psychological reaction due to pain) have been ruled out. **Stress**, tension and **Depression** due to, or in combination with, pain are not sufficient for a diagnosis of having a psychogenic pain.

Action

Pain is often bilateral, in diffuse locations and with no precipitating cause. If seen in a person who shows signs of psychosis (has hallucinations or is confused), send to level 2.

Note

Psychogenic pain should be diagnosed by a health professional.

HEALTHCARE PROFESSIONAL

Characteristics

Psychogenic pain is diagnosed if pain is present in conjunction with a severe psychiatric disorder such as schizophrenia and when other pain

states have been ruled out. It is not pain associated with **Anxiety** disorders or **Depression**.

First therapy

Treat psychiatric disease with medication.
Analgesic drugs have little or no effect

Note

If the psychiatric disorder does not stabilize or improve, refer to a psychiatrist.

HEALTHCARE SPECIALIST

Assessment

Diagnose specific psychogenic pain in association with psychiatric disease.

Proposed measures

Propose specific treatment thereafter.

Paranoia

HEALTHCARE ASSISTANT

Key signs

People suffering from paranoia show signs of **Mistrust** and suspicion towards others. Paranoia is not a frequent condition in torture survivors but may be seen in a few cases.

They may have a firm belief that others may harm or deceive them, even if there is no obvious reason for this. They will often expend a great deal of energy trying to fight for their rights. They are reluctant to confide in others and are in some cases openly hostile or react with **Anger** when someone shows a lack of belief in them. The person's beliefs and fears often will not be shared with others but will be of private character.

When hearing the history one may feel that the person has been subjected to various adverse events, e.g. losing a court case, that has triggered the present situation.

Mistrust may be seen in people who have been persecuted or been victims of **Organised violence**, since such experiences may have led to a general lack of trust in others.

Action

- Take a history of previous traumatic experiences.
- Avoid getting into discussions with the person about his ideas and do not agree with his private logic, e.g. by encouraging him to pursue his case further.

Note

If the person is openly convinced of his ideas and seems to suffer because of this, or becomes openly hostile, refer the person to level 2.

HEALTHCARE PROFESSIONAL

Characteristics

The paranoid symptoms are not consistent with the cultural beliefs of the person, but are specific to the person, who cannot be convinced of the lack of reality in the situation. On the contrary he may become more convinced the more he is told the opposite.

People exhibiting mistrust have not lost their sense of reality. In contrast to the openly paranoid, they generally do not have a belief that also pervades other parts of their life, but have more of a general mistrust towards others.

First therapy

Interview and gain an overview of the severity of the person's beliefs.

Remain calm and friendly but avoid getting involved in the person's private logic.

Try to obtain the point of view of the family regarding the person's belief.

Give advice or supervision to level 1.

Second therapy

If the paranoid symptom is severe and the person is suffering, try a small dose of anti-psychotics (e.g. a few mg Haloperidol or a few mg Risperidone) to alleviate the suffering.

In the case of **Mistrust**, antipsychotic medication is normally not indicated, but if the mistrust is part of a **PTSD**-condition, this should be addressed.

See **Counselling**.

Note

If there is no effect from treatment after a couple of months or the person becomes openly aggressive, refer to next level. Side effects include drowsiness and rigidity.

HEALTHCARE SPECIALIST

Assessment

Use structured interview to evaluate presence of mental illness. Note: It is important to be very careful using structured interviews with paranoid patients and torture survivors; in certain cases it is not advisable.

Proposed measures

Check the use of anti-psychotics – problems of compliance, dosage, etc. It may be necessary to provide expert input in legal cases.

Paresis

See **Muscle weakness**.

Pelvic pain

HEALTHCARE ASSISTANT

Key signs

Pain may originate from the lower abdomen. In women the pain may originate from intestines, uterus, the vagina, and the urinary bladder. In men pelvic pain can originate from the prostate, penis and testicles, as well as from intestines and bladder. When meeting a torture survivor who complains of pelvic pain it is necessary to examine them for trauma to the genitals (cigarette burns, electricity and blunt trauma, insertion of foreign objects into the vagina or anus); having been a rape victim must also be considered.

The pain can be caused by the trauma to soft tissue or damage to nerves in the area. Acute pelvic pain can be caused by urinary infection (see **Micturition**). The symptoms range from a low intensity, dull sensation to a sharp cramp-like pain.

Chronic or neuropathic pain with no obvious cause may occur as a consequence of long-lasting disease in the internal organs. Women's pelvic pain may be constant or dependent on stimulation, for instance during intercourse.

Action

- If pain is acute, consult a healthcare professional.
- Inspect external genitals and groin for trauma, hernia (a painful **Swelling** in the groin) or infection.
- If the healthcare assistant is competent to carry out **Counselling**, use this technique for women who have been raped.
- Use paracetamol (500-1000 mg 2-4 times a day), or aspirin (500 mg tablets 2-4 times a day) and evaluate the effect after three weeks.

Note

Seek advice from a healthcare professional in case of acute pain. Always consider sexual abuse if a torture survivor complains of pelvic pain.

HEALTHCARE PROFESSIONAL

Characteristics

Diagnose cause of pain and consider sexual abuse.
Pelvic pain can be part of a whole-body pain syndrome.

First therapy

Anamnesis and inspection of genitals – to ascertain the presence of structural defects is important.
Treat infection with antibiotics.
If there is suspicion of rape in the recent past, do a pregnancy test.

Second therapy

See **Sexual violence**.
Amitriptyline 10-20 mg can be used if there is a suspicion of a **Pain, neuropathic** component.
If the person is depressed or anxious, treat accordingly (see **Anxiety** and **Depression**).

Note

Refer to a specialist if surgery is needed.

HEALTHCARE SPECIALIST

Assessment

Diagnose structural problem.

Proposed measures

Reconstructive surgery thereafter, if possible.

Persistent thoughts

See **Intrusive memories**.

Phantom pain

HEALTHCARE ASSISTANT

Key signs

Phantom limb pain is a sensation of pain experienced in parts of the body that no longer exist (or that are completely numb due to major nerve injury). The limb continues to be felt as a “phantom” because of spontaneous activity from the injured nerves and is painful, some of the time in most people and most of the time in others. Many amputees report factors that increase phantom pain (urination, emotional upset, cold weather) or provide temporal relief (massage, warming).

The person may feel deliberate or involuntary movements of the limb that no longer exists. The “phantom” may also be perceived as distorted in size and location.

Action

- Inform the person about the reason for the pain and that it is NOT a sign of ongoing physical injury.
- Treat local ulcers around the stump area
- If the person is using a prosthesis, make sure it is fitted as tightly as possible to the stump; this will reduce the intensity of phantom pain.
- Bandaging of the stump can reduce symptoms

Note

Discuss with healthcare professionals. Medication as for **Pain, neuropathic**, can be used.

HEALTHCARE PROFESSIONAL

Characteristics

More than half of amputees experience some form of phantom pain years after the amputation. The more laceration there is in connection with the amputation, the more risk of developing a phantom pain. Phantom pain is caused by the misinformation sent to the brain by severed nerves originating in the foot, leg or arm, signalling that the extremity still exists and hurts.

First therapy

If the stump is infected, careful revision of the wound should be performed. Antibiotics may be indicated.

For pain relief, Amitriptyline 10 (-150) mg in slowly increasing dose should be tried, starting at 10 mg and increasing every week. It is important to follow up after four weeks. Common side effects are dry mouth and in higher doses, blurred vision, and in males, **Micturition** difficulties. This medication should be avoided in recent heart problems.

Second therapy

Opioids (Morphine 5-10 mg 4-6 times a day). Side effects include obstipation and drowsiness.

Karbamazepine (200 mg 2-4 times daily) if there is shooting pain. Over dosage may cause coordination problems.

Local anaesthetics: Lidocain injected locally in the stump can reduce phantom pain for short periods of time, i.e. during revision and cleaning of infected ulcers.

Note

Medication often has limited effect. In addition, the side effects may be difficult to tolerate. Recent research indicates that asynchronous tactile stimulation (tapping) of adjacent areas may reduce phantom pain.

If very painful, consult specialist.

HEALTHCARE SPECIALIST

Assessment

By specialist in neurology or orthopaedic surgery.

Proposed measures

See **Pain, neuropathic**.

Posttraumatic Stress Disorder (PTSD)

HEALTHCARE PROFESSIONAL

Characteristics

In DSM-IV, the diagnostic criteria for Posttraumatic Stress Disorder (309.81) are:

- A. The person has been exposed to a traumatic event in which both of the following were present:
- (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
 - (2) The person's response involved intense fear, helplessness or horror.
Note: In children, this may be expressed instead by disorganised or agitated behavior.
- B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
- (1) Recurrent and intrusive, distressing recollections of the event, including images, thoughts and/or perceptions.
Note: In young children, repetitive play may occur in which these or other aspects of the trauma are expressed.
 - (2) Recurrent, distressing dreams of the event.
Note: In young children, there may be frightening dreams without any recognizable content.

- (3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and/or dissociative flashback episodes, including those that occur on awakening or when intoxicated).

Note: In young children, trauma-specific re-enactment may occur.

- (4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- (5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

- (1) Efforts to avoid thoughts, feelings and/or conversations associated with the trauma.
- (2) Efforts to avoid activities, places and/or people that arouse recollections of the trauma.
- (3) Inability to recall an important aspect of the trauma.
- (4) Markedly diminished interest or participation in significant activities.
- (5) Feeling of detachment or estrangement from others.
- (6) Restricted range of affect (e.g. inability to have loving feelings).
- (7) Sense of a foreshortened future (e.g. does not expect to have a career, marriage, children or a normal life span).

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by at least two of the following:

- (1) Difficulty falling or staying asleep.
- (2) Irritability or outbursts of anger.
- (3) Difficulty concentrating.
- (4) Hyper vigilance.
- (5) Exaggerated startle response.

E. Duration of the disturbance (symptoms in criteria B, C, and D) is more than one (1) month.

F. The disturbance causes clinically significant distress and/or impairment in social, occupational and/or other important areas of functioning.

Acute: Duration of symptoms is less than three (3) months.

Chronic: Duration of symptoms is more than three (3) months.

Delayed Onset: Onset of symptoms is at least six (6) months after the incident.

Action

See problem-specific entries and therapies: **CBT, Counselling, Exposure therapy, Stress management** and EMDR.

Note:

There are other psychosocial traumas that differ from PTSD. See also **DESNOS**. In addition, it should be mentioned that there are complementary views on this impairment held by some therapists.

Posture and balance problems

HEALTHCARE ASSISTANT

Key signs

Cannot or finds it difficult to maintain body posture, keeps falling.

Action

Try to gently promote an increase in upright, daily, physical activity:

- Practise sitting up for increasingly longer periods.
- Practise standing for short periods.
- Try walking with support from another person.
- Try walking with a stick.
- Try walking independently.
- Avoid walking in difficult terrain in the dark.

Note

If there has been a blow to the head or neck, local pain and movement problems, seek next level immediately.

The person should be awake, alert and able to follow instructions. If there is no rapid improvement, seek next level within a few weeks.

HEALTHCARE PROFESSIONAL

Characteristics

The person may be unsteady on his/her feet due to general weakness, to muscular weakness in lower legs and/or trunk, to signs of spinal injury, to balance-organ or brain injury. Examine for history and signs of each of these conditions.

In particular, injury to one balance organ could be due to skull-base fracture from an intense blow to lower posterior part of skull or to general head trauma. Nystagmus is then usually present in one or several gaze directions.

First therapy

Train appropriate primary function (e.g. muscular strength) or allow short rest with adequate nutrition to regain adequate general strength. Then train as above (see “Action”).

Second therapy

Balance-organ problems and light to moderate brain injury are usually compensated for spontaneously over weeks or months. Severe brain injuries have lifelong sequelæ. Note that proprioceptive injury may cause balance problems in spite of adequate muscular strength but is compensated for by adequate vision (avoid walking at dusk or in darkness in difficult terrain).

Note

A virus infection may produce temporary balance problems. People with spinal injury should be monitored for urinary function and for pressure sores and should be referred to a specialist (see **Muscle weakness**).

HEALTHCARE SPECIALIST

Assessment

Neurological examination.

Proposed measures

According to findings. The long-term aspect should be taken care of.

Reproduction difficulties

HEALTHCARE ASSISTANT

Key signs

A normal couple with a regular sex life will usually achieve pregnancy within one year. Reproduction difficulties, i.e. finding it difficult or being unable to conceive a child, may have physical as well as psychological causes. It is generally acknowledged that **Stress**, especially traumatic stress, may be one important factor, for both females and for males. Thus, this problem can be secondary to having suffered torture.

Action

See **Menstruation problems**, **Sexual problems**.

Note

It is important to learn more about one's body and how it works.
If reproduction difficulties persist in spite of education, seek next level.

HEALTHCARE PROFESSIONAL

Characteristics

A normal couple with a regular sex life will usually achieve pregnancy within one year. Reproduction difficulties, i.e. finding it difficult or being

unable to conceive a child, may have physical as well as psychological causes.

Perform appropriate diagnostic checks. Be certain to explore the occurrence of traumatic events.

See **Menstruation problems**, **Sexual problems**.

First therapy

Treat according to findings. Note evaluation of men and women. Couple approach is recommended in counselling, diagnosis and treatment.

Second therapy

Counselling for previous traumatic experiences may be necessary if the person is able to re-engage in **Intimate relations**.

Note

If the problem persists in spite of education and counselling, seek next level.

HEALTHCARE SPECIALIST

Assessment

Gynaecological/urological and/or psychiatric assessments.

Proposed measures

According to findings.

Sense of a limited future

HEALTHCARE ASSISTANT

Key signs

A sense of having a limited future is usually described as a common, but not essential, symptom of **PTSD**. It is described as a “sense of foreshortened future” (e.g. “I do not expect to have a career, marriage, children or a normal life span”). The same or similar experience may also occur in **Depression** and since torture-survivors often develop PTSD and/or depression, it may be expected to be a relatively common symptom in such cases. No specific treatment guidelines are given but treatment should address the underlying disturbance.

Children

The sense of having a severely limited future is one of the signs of trauma in children. They might think that their lives will end before they reach maturity and thus, they are not able to imagine a future.

Action

Children with this reaction usually exhibit other emotional or behavioural symptoms as well. Any action needs to address all of these problems. Providing a safe and supportive environment is important, e.g. by advising parents on how to deal with a traumatized child or by making sure that teachers or other adults support the child when parents are unable to do so. See also **Interventions with traumatised children**.

Note

Refer to next level if the symptoms do not ease within three months or if they are severe and restrict the life of the child.

HEALTHCARE PROFESSIONAL

Characteristics

The sense of having a severely limited future will often be one of several trauma reactions, particularly in school-aged children and adolescents. Other symptoms that often co-occur with this are compulsory, repeated behaviours; nightmares; reduced interest in activities the child used to engage in with pleasure; fears and lack of confidence in self and others.

First therapy

Individual or group activities first aimed at teaching the child to attain body and affect regulation and secondly to process the traumatic events. See also **Interventions with traumatised children**.

Second therapy

Family **Counselling**.

Note

Refer to the next level if the symptoms are persistent, putting the child's development at risk.

HEALTHCARE SPECIALIST

Assessment

Use a structured interview in the assessment (see **Assessment of torture survivors**, e.g. DISC or K-SADS-PL). The child might be suffering from **PTSD** or **Depression**. Also be aware of the possibility of child abuse or neglect.

Proposed measures

CBT in individual, group or parental/family format.
Family therapy.

Sexual problems

HEALTHCARE ASSISTANT

Key signs

Arousal disorder is the inability or difficulty of engaging in sexual activity due to not feeling a sexual response or being unable to stay sexually aroused, whereas *orgasm* represents the feeling of reaching a sexual climax. Many women do not have an orgasm during intercourse.

Previous sexual abuse, such as in torture (rape or forceful insertion of objects into the vagina or rectum) or of other traumatizing events (such as sexual child abuse or incest previous to torture) can seriously affect the ability to have sex. Simply being tired or caring for young children may make one feel less sexual desire, as well as being bored with a long-standing sexual routine.

Lubrication difficulty is when, upon arousal, the normal vaginal lubricating fluid is scant or absent. This liquid reduces friction during intercourse and protects the delicate tissues. Causes of lubrication difficulties can be fatigue, problems in the relationship with the sexual partner or previous abuse, such as in torture (rape or forceful insertion of objects into the vagina or rectum) or other traumatizing events, but also reduced hormonal levels (e.g. after the menopause) or alcohol and tobacco use and some drugs. In addition, feeling nervous about sex because of a bad experience or being stressed or depressed, may lead to this symptom.

Erectile Dysfunction or impotence is when a man cannot get a sufficient erection to have sex or cannot keep an erection long enough to finish intercourse. Erectile dysfunction can occur at any age, but it is more common in older men. Most men will experience erection problems at one or another time. Persistent erectile dysfunction is estimated to affect about 10% of all men.

There are two main causes of erectile dysfunction: Physical and psychological.

Physical causes:

- Alcohol, tobacco and other drug abuse.
- Fatigue.
- Sexual or other abuse, such as in torture (rape or forceful insertion of objects into the rectum; squeezing or traction of the testicles).
- Brain or spinal-cord injury.
- Liver or kidney failure; prostate or bladder surgery.
- Endocrine (testicular) problems.
- Some medicines, e.g. beta-blocking agents.
- Systemic disease, such as diabetes, high blood pressure or atherosclerosis.

Psychological causes:

- Feeling nervous about sex, perhaps because of a bad experience such as being a victim of sexual abuse or because of a previous episode of impotence.
- Feeling stressed or anxious, including stress from work or family situations.
- Feeling depressed.
- Lowered self-esteem or having problems in the relationship with the sexual partner.

Action

- Feeling relaxed, secure and respected are all important components in being able to engage in meaningful sexual activities, as is a satisfactory relationship with one's sexual partner. Improving the relationship by creating a sincere dialogue may help the sex life. Fantasizing or changing the usual routine may increase sexual desire.
- It may be important to let foreplay go on longer, until the female is truly ready. Sexual activity other than intercourse, such as massage, oral sex or masturbation may increase arousal.

- An open discussion between the partners about what they each like and dislike and asking for the partner's help may improve matters. Mutual respect concerning each other's comforts and discomforts is important.

Counselling on previous traumatic experiences may be necessary for reengagement in **Intimate relations**. It is also important to learn more about one's body and how it works.

Note

If there is an erection when masturbating but not with a partner, or one wakes up with an erection, or has erections during the night, then usually the dysfunction has psychological causes.

HEALTHCARE PROFESSIONAL

Characteristics

Perform appropriate diagnostic checks to exclude physical causes or drug side effects (beta-blocking agents, anti depressants). Explore history for sexual abuse, for other abuse and as regards **Relational problems**.

First therapy

Treat according to findings. Give information and advice on **Intimate relations**. It is often necessary to involve the partner in the treatment.

Second therapy

Tell the couple to abstain from sex but allow intimate interaction and caressing of a gradually increasing intensity over four weeks. Then again allow intercourse.

One may try a medicine to help with erectile dysfunction. However, if a man has erectile dysfunction as a result of emotional conflict, providing him with a drug that produces an erection is not going to resolve that conflict; in fact, it might even make it worse.

Note.

Psychotherapy may be necessary.

HEALTHCARE SPECIALIST

Assessment

Psychiatric assessment.

Proposed measures

Specialized therapy according to findings.

Shame

HEALTHCARE ASSISTANT

Key signs

Feelings of shame are common in people, who have been exposed to **Torture and Organised violence**. In particular, women who have been exposed to sexual assaults and rape may express such feelings. The woman may be afraid to reveal anything of her violation to her family or friends for fear that they may reproach or even punish her.

Anxiety and **Isolation** may thus accompany the feeling of shame. The feeling of shame may be particularly common in cultures where the sexuality of women is strictly controlled.

Note

In some cultural contexts it is also frequent to see male sexual abuse during torture and also sexual abuse, discrimination and torture due to a person being homosexual.

Action

- Ask about previous trauma, any kinds of sexual assault, sharing experiences with others, including the partner or immediate family.

- Show an understanding attitude, listen to the story, do not blame the woman for what happened to her but share her story and be sympathetic.
- If the person has a history of torture, explain that she had no influence over what happened to her, but that sexual violation is commonly used by torturers as a sign of their superiority.
- Try to elicit whether the family or others in her environment may be able to support her.

Note

Women who have been raped may hide pregnancy.
They may also have ideas of **Self-harm**.

HEALTHCARE PROFESSIONAL

Characteristics

Sexually violated women report feelings of fear, shame and guilt.

Feelings of shame may prevent women from reporting **Sexual violence**, even when it is safe to do so, due to fear of their husbands or families. Many also express symptoms of **Anxiety**, powerlessness and loss of concentration.

Somatic complaints are common, including symptoms concerning the reproductive system. Such behaviours may represent pathology attached to the traumatic experiences or may be normal, situation-specific responses to current stresses.

In some cultures the family may feel they share the “shame” of the raped woman and that they, in hiding her history, believe that they are protecting her. As a result she may be prevented from seeking help. The same situation applies in the case of a man who has been subjected to sexual abuse, or if there is homosexuality. In both cases the family believes that they are protecting the victims by hiding their histories. In some social

contexts, the family is prejudiced and discriminatory and blames the victims for the situation, based on the fact that they are homosexuals.

Society may find that the suffering of a victim of rape or violence requires some intervention, even from a moral point of view. In western society the woman will not normally be seen to be complicit in the violence and can expect sympathy from her social network. Patriarchal/traditional societies, on the other hand, may not see the sexually assaulted woman as a "victim" deserving sympathy. In very traditional societies she may even run the risk of being socially excluded from the community. All this may further increase the feeling of shame.

First therapy

- Take the history of the person, and analyse the context: cultural, religious values and behaviour with respect to homosexuality, gender issues and sexual education.
- Interview the person to see if there are signs of depression. If so treat this (see **Depression**).
- Show an understanding attitude, listen to their story.
- Do not blame the person or in any way signal that he/she was an accomplice in his/her own situation.
- If the person has a history of torture, explain that he/she had no influence over what happened to others, that his/her survival was not linked to the death of others.
- Explain that inducing shame may be one method used by torturers and that those to blame are the torturers, not the survivors who were facing impossible situations.

Second therapy

Establish groups of victims who have had the same experiences so that they can share their stories and work on ways to find coping strategies. See **Counselling**.

Refer to next level if the shame reaches a level of severity where the person sees himself/herself as unworthy, not deserving to live, or other things that are far beyond any realistic sense.

Note

People with very severe feelings of shame may run the risk of attempting suicide (see **Self-harm**).

HEALTHCARE SPECIALIST

Assessment

Use structured interview (see **Assessment of torture survivors: SCID or SCAN**) to evaluate the presence of underlying mental illness.

Proposed measure

Treat possible mental illness (see **Depression**) according to findings.

Shoulder pain

HEALTHCARE ASSISTANT

Key signs

Frequently used torture methods that affect the shoulder are: Suspension with upright arms, suspension with arms behind the back and forced stressful body positions. These methods may cause injuries to joints, muscles, nerves and blood vessels accompanied by long-lasting pain in the shoulders, arms and hands.

Typical complaints are:

- A feeling of heaviness and weakness in the arms and hands.
- The shoulders may feel loose (without actual looseness).
- Pain in the shoulders and arms from lifting, carrying and reaching out for objects.
- Ability to move the shoulders in different directions is limited.

- Pain may be localised to the shoulder joint but is often difficult to localise. The pain may be described as diffuse in the arms and shoulder region.
- A variety of pain sensations may be present: e.g. shooting, burning, cutting, deep pain in the bones of the arms. Different cultures may have different expressions for pain sensations but the underlying cause is the same. The sensations may come spontaneously (without any notice) or with physical activity. Sometimes there are signs of accompanying sensory disturbances like pins and needles and **Numbness**. (See **Pain, chronic** and **Pain, neuropathic**).

Action

- Because of fear of pain, the person may have avoided movements of the shoulder joints for a long time. The consequences are restricted, painful movements of the shoulder joint and tight and painful muscles.
 - Ask for previous history.
 - Assess the person's shoulder function while simultaneously performing the movements yourself when giving the instruction:
 - Reach behind your head and touch the upper edge of the opposite shoulder ("Scratch test").
 - Reach in front of your head and touch the upper part of your opposite shoulder.
 - Reach behind your back and touch the lowest point of your opposite shoulder blade.
 - Clasp both hands at the back of your neck.
 - Mark on a wall how far the person can reach up with their arms. The marks should be higher within weeks of training.
- Instruct the person to do these exercises several times every day.
- Apply crushed ice in a towel to the shoulder for pain relief
 - Instruct a family member in how to massage the shoulder girdle.
 - Use relaxation techniques (see **Stress management**).
 - Medication: Paracetamol 500 mg 2-4 times daily or aspirin 500 mg 2-4 times daily.

Note

A few simple relevant instructions and advice will increase the person's compliance. The simple movements, mentioned above, are the shoulder-joint movements needed to carry out activities of daily living (dressing, eating and house work). Pain reduction and increased range of movement should be assessed by follow ups. Refer to next level if the condition gets worse.

HEALTHCARE PROFESSIONAL

Characteristics

See above.

- Assess for Complex Regional Pain Syndrome (See **Pain, neuropathic**).
- Shoulder pain may originate from the cervical spine (C4, C5). Assess for cervical disc lesion: Muscle strength, sensory disturbances and reflexes. (See **Neck pain**).

First therapy

Immobilise with a towel or soft collar around the neck at night for max 2 weeks. The person should remain active with no prolonged bed rest. Continue with movements of the shoulder. Correct slouched posture to upright body posture when sitting and standing.

Second therapy

Relaxation (se **Stress management**).

Medication: Paracetamol 500-1000 mg 2-4 times daily or aspirin 500 mg 2-4 times daily or see **Pain, neuropathic**.

Note

Follow-up sessions support the person's compliance and pain reduction. It is important to remember that you are treating the person and not only the shoulder. A holistic approach is always necessary.

HEALTHCARE SPECIALIST

Assessment

Orthopaedic surgeon: CRPS - Complex Regional Pain Syndrome; Cervical disc lesion.

Proposed measures

Advice on Complex Regional Pain Syndrome.
According to findings for cervical disc lesions.

Skin infections

HEALTHCARE ASSISTANT

Key signs

The most important roles of the skin are to protect underlying organs against mild to moderate trauma and to maintain the internal environment, notably providing fluid balance and freedom from infections. The late effects of having suffered mechanical or other trauma, e.g. beating of soft tissue, but also having been subject to electrical currents or to heated objects may include persistent, often infected, ulcers of the skin.

Action

The wound should be cleaned by rinsing with clean water, initially, if necessary, with a mild antiseptic agent. Open wounds heal from underneath and should be given only a simple dressing, without creams or ointments or, if possible, be left without any dressings, for at least parts of the day. If persistent, go to next level within a few weeks for treatment.

Note

An accompanying high fever and malaise may indicate that sepsis (bacteria in the blood stream) is imminent or present. Professional healthcare should then be sought immediately.

HEALTHCARE PROFESSIONAL

Characteristics

Any form of trauma, be it mechanical, thermal, electrical or chemical, may cause skin infection. Traumatic eczema from scratching or a minor skin irritation may also lie behind this condition, as may (minor) foreign bodies in the wound(s).

Action

Inspect the wound closely for signs of infection, of dead tissue and of even minor foreign bodies.

First therapy

Thoroughly rinse the wound and remove dead tissue and possible foreign bodies. Use light dressing without ointments or creams or, if possible, treat openly, if major contamination can be avoided.

Second therapy

Antibiotics for limited periods.

Note.

Secondary healing is often necessary.

In developing countries it is very common for women to have chronic skin ulcers in the legs, either unilaterally or bilaterally, related to varicose veins, multiple pregnancies and poor conditions of life.

HEALTHCARE SPECIALIST

Assessment

Surgical, infectious disorder assessments.

Proposed measures

According to findings.

Sleeping difficulties

HEALTHCARE ASSISTANT

Key signs

All humans relate to a consistent day-night (diurnal) cycle, usually with about 2/3 spent in the awake/active state during daylight and 1/3 resting/asleep during the night. In fact, the brain has a built-in diurnal centre controlling this cycle and its total length may vary considerably between individuals, unless corrected by recurrent exposure to daylight, when the normal active state begins.

People with sleeping difficulties, e.g. due to anxiety or to chronic pain, cannot go to sleep or tend to wake up repeatedly during the night. When they are finally exhausted just before dawn, they usually fall asleep until well into the morning or even midday. This sleeping pattern may soon be established, resulting in loss of social interaction and of work time.

There are many possible reasons for sleep disturbances; stress-related or psychological problems underlie most cases (refer to next level if there are obvious signs of underlying physical diseases). Many forms of sleep disturbances occur but difficulties falling asleep and fragmented sleep are the most prominent.

Action

Advise the person as follows:

- Try to re-establish a regular daily routine by waking up with the rest of the family.
- Avoid naps during the day.
- Arrange calm evening routines and sleeping quarters, if possible.
- Give information about sleep to reduce **Stress** arising from the person's erroneous beliefs about sleep:

Sleep deprivation is never fatal (except as an ongoing torture technique). When the need for sleep becomes too great, the body enforces sleep to get sufficient for survival.

- Sleep duration varies among individuals (4–11 hours is normal with a median of around 7 hours) and depends on age. Moderately (around 2 hours) reduced sleep duration can be fully compensated for by improved quality of sleep.
- There are no fixed times for optimal quality of sleep. Most people can freely choose the time for sleep. Some people sleep best by going to bed and getting up early; for others it is vice-versa. These types should accept their biological proneness and organize their everyday-life accordingly.
- If the sleep disturbances are caused by bad dreams: Explain that everyone dreams but not everyone remembers their dreams. In periods of high stress, and when there are many problems, the bad dreams are often about these things and are more easily remembered. If the stress disappears and the problems are solved (see **Problem solving**), the situation returns to normal. Anxiety disorders regularly result in nightmares related to the anxiety. The primary treatment here is the underlying disorder (see **Anxiety**) but direct treatment for the nightmares can also be tried out (see **Nightmare**).

Give advice to improve “sleep hygiene”:

- Maintain a regular sleep pattern (getting up and going to bed at regular times).
- Optimize sleep conditions: Avoid disturbances (noise, light, extreme temperatures, etc.); create a stable environment (changes result in more easily in awakening during certain sleep phases); do not use stimulating substances (caffeine, etc.) just before bedtime.
- Do not use the bed/sleeping place for disturbing activities – only for sleeping and sex.

Give the person this additional advice if sleep-onset problems persist:

- If the cause is thinking about problems: Write down your worries and postpone the worrying by defining a fixed “worry-time” the following day when you will comprehensively go through the list.
- Decide on a fixed time for getting up, even if you have not slept. No naps are allowed during the daytime. Do not go to the sleeping place before you feel tired. If you are not asleep after ca. 20 min., leave the sleeping place and engage in a quiet activity; return to sleep when tired. Repeat if necessary.

Give the person this additional advice if problems with fragmented sleep persist:

- Decide on a fixed time for getting up. If your normal average sleeping time is e.g. 6 hours, go to your sleeping place 6 hours prior to the ‘getting-up’ time.
- If stable sleep occurs but you still feel tired at ‘getting-up’ time, continue to use the same sleeping time for an additional 4 nights and then after that go to sleep 20 minutes earlier. Repeat as long as a stable pattern remains.
- If stable sleep does not occur after 4 nights by the first attempt of going to bed at fixed times: Go to bed 20 minutes later to reduce your sleeping time. Repeat until stable sleep is achieved. After that try to go to sleep earlier stepwise – as described above.

Additional possible interventions

Encourage the use of “folk remedies” such as calming beverages (e.g. camomile tea) to aid the onset of sleep.

Some types of relaxation methods can be useful in promoting sleep and falling asleep again after interruption.

“Paradoxical” intentions, i.e. willing yourself to try to stay awake (e.g. by keeping your eyes open as long as possible) has the effect of promoting sleep for some people (but the contrary effect for others).

Note

If sleep problems persist, consider that they may be secondary to other problems, e.g. **Depression** and/or **Anxiety** disorder, and try to address these. Consider referral to level 2 – especially if the sleep problems could be caused by problems with pain or diseases that you cannot treat and/or if the problems deviate markedly from the key signs described above.

HEALTHCARE PROFESSIONAL

Characteristics

The major physiological mechanisms (other factors being e.g. exposure for light and intake of food) directing sleep are the circadian, also called the day-night or diurnal, rhythm which is an “inner biological clock” and “sleep pressure” - measured by the concentration of a biochemical in the brain.

The concentration increases with the time the individual is awake.

There are many potential somatic and psychiatric reasons for secondary sleep disturbances that should be assessed, chronic pain being one of the most common. People often find it difficult to fall asleep due to pain, or their sleep is fragmented because of increasing pain intensity during sleep or insufficient “sleep pressure” that after some sleep can no longer match a constant pain level.

Some people, e.g. during a period of intense pain, have developed a distorted circadian rhythm - being unable to sleep at night but only during the daytime.

First therapy

Optimization of medication: Assess whether the person receives and uses analgesics and/or other medication properly. The dosage and timing of tricyclic antidepressants prior to sleep may have to be adjusted.

Acetylsalicylic-acid or paracetamol could be given in a slow-release form for a more constant pain relief during sleep.

Optimization of medication for other problems e.g. **Anxiety** and **Depression**.

Consider whether it is a case of **Substance abuse**.

Second therapy

Preventive awakening and planned portioning of sleep:

If too prolonged sleeping/immobilization increases pain intensity and awakens the person too early (as assessed by clinical interview and/or diary), give advice about performing preventive awakening: Ask to be woken up ca. 30 minutes before the expected time of awakening due to increased pain. Perform physical activities of the same kind that help prevent increased pain during daytime. Return to sleep and repeat if necessary. Alternatively, instruct the person to drink a lot of water prior to going to sleep in order to use the urge to urinate as a preventive “awakener”.

If the person shows a consistent pattern of waking up after some sleep because the remaining “sleep pressure” is no longer able to balance constant pain, try the following: Organize daily life so that the sleeping time needed is distributed over two or more shorter sessions with longer periods of being awake in between. The time for being awake, prior to sleep, has to be sufficient to “collect” enough “sleep pressure” for the person to stay asleep for the desired period. In order to achieve a regular pattern, suitable time periods have to be tested and these should be maintained in a stable manner.

Third therapy

Advice for correcting distorted circadian rhythm:

Some causes of chronic sleep disorders are the result of a mismatch between the body’s internal clock and the external 24-hour schedule. These sleep-timing problems are called “circadian rhythm sleep disorders” because circadian describes the body’s daily sleep/wake hormone regulation (“circadian” is Latin for “about a day”). The circadian rhythm for most people is at ca. 25 hours, i.e. with regular times for sleep each night; the physiological sleep optimum is plus one hour.

Keeping to the same time for falling asleep re-adjusts the rhythm each day (“the inner clock is daily re-adjusted by one hour”). Under “free running” conditions, e.g. due to irregular sleep patterns because of intense pain or for other reasons, the circadian rhythm is successively moved forward in time and the sleep optimum may stabilize in the middle of the day. In order to re-adjust the rhythm stepwise to a sleep-onset optimum that is more compatible with social demands, a forward strategy is effective:

Example: A person starts with a usual sleep onset at noon (12.00) but an onset at midnight (00.00) is desired. Postponing the daily sleep onset by 1 hour (from 12.00 to 13.00, 13.00 to 14.00, etc.) is biologically the most effective method as it follows the natural daily drift of the circadian rhythm; it would take 12 days to reach the desired aim in this example.

The circadian rhythm also implies that for (most) people with intermittent sleep-onset problems, the instruction to go to sleep later than usual (= closer to sleep-optimum) is advisable, whereas the instruction to go to sleep earlier than usual (= more distant from sleep optimum) is not.

Since exposure to daylight contributes to re-establishing a normal day-night rhythm, it is advisable to instruct the person to avoid being in a dark environment during the day. If available, the person could also be exposed for artificial bright light (2500-10000 lux intensity).

Note

If sleep problems persist, consider that they may be secondary to other, somatic and/or psychiatric problems, and try treating these. Refer to next level; especially if there is lack of specific medication for problems identified or symptoms/problem patterns indicate underlying hitherto hidden problems.

HEALTHCARE SPECIALIST

Assessment

Potential underlying somatic and/or psychiatric causes for the sleep disorder should be ruled out.

Apart from common possible diseases, also problems related to sleep, such as sleep apnea, should be considered.

Proposed measures

Possible prescription of medications that addresses sleep-disturbing symptoms, such as analgesics, should be considered. Following up on effect, adjustment of dosage and timing and control of the person's compliance are important issues in this case.

Specific medications that directly address sleep problems are:

- Tricyclic antidepressants ca. 2 hours prior to sleep (e. g. amitriptylin 10 – 25 mg; there are great inter-individual differences).
- Anti-allergy medicine (Difenhydramin).
- Benzodiazepines should be avoided or only be used for strictly limited time periods.

Somatisation

HEALTHCARE PROFESSIONAL

Key signs

Somatisation is a psychiatric concept describing various physical complaints for which there is no (or no satisfactory) medical explanation. The symptoms are not produced at free will and psychological problems are assumed to be a major cause for the symptoms (medical conditions may be a partial, contributory cause). Somatoform diagnoses should not be given if the physical experienced symptoms are due to other psychiatric problems (e.g. **Anxiety** and **Depression**) which are often associated with many physical symptoms.

Since torture survivors have often been exposed to extreme physical violence (and there are considerable medical causes for tissue damage as a reason for the development of body symptoms such as pain), and since psychiatric problems such as anxiety and depression are prominent, a somatoform psychiatric diagnosis is usually of minor relevance for these people. For that reason, treatment guidelines are not given. In single cases, it might be possible that somatoform disorders are undetected because they are mistaken for post-torture symptoms; in such cases the problems could be expected (at least at minor intensity) to already have occurred prior to the torture experience. A differential diagnosis should be made, and possible treatment initiated only on level 3.

Much less clearly defined than in the psychiatric sense, the concept of “somatisation” has been used to describe some form of physical expression (voluntarily or not) of underlying psychological problems or conflicts. Since there is no reasonable consensus around this understanding of “somatisation”, the concept for adults is not further discussed here.

On the other hand, “somatisation” is frequently used in the field of clinical work with children, since children very frequently express psychosocial **Stress** in terms of body sensations. With children in mind, the concept is described below and treatment guidelines are given.

Somatisation - children

HEALTHCARE ASSISTANT

Key signs

Here, somatisation is understood as emotional problems manifested in physical symptoms, e.g. stomach ache or **Headache**. In children such symptoms are very frequent, particularly in stressful situations.

Action

- Inform parents of the connection between physical symptoms and emotional problems.
- Do not focus too much on the pain, so that the complaint does not become a way of getting attention.
- Help the child to talk about his/her worries.

Note

If symptoms are intense or long-lasting always refer to next level in order to eliminate physical illness.

HEALTHCARE PROFESSIONAL

Characteristics

In children emotional difficulties are often revealed in somatic symptoms such as pain. If there is no medical cause, there are often signs of **Anxiety** or depression.

First therapy

Stress management.

Second therapy

Family counselling (see **Interventions with traumatised children**).

Note

If uncertain of the origin of the symptoms, or if the symptoms persist or are part of a larger symptom complex and the child is not responding to first and second therapy, refer to next level.

HEALTHCARE SPECIALIST

Assessment

It is important to eliminate physical illness as the source of the problems.

Proposed measures

Family **Counselling**.

Substance abuse (craving)

HEALTHCARE ASSISTANT

Key signs

Substance abuse is commonly seen in traumatized people. Alcohol or drugs are used as a way to avoid **Anxiety** and reduce **Stress**. Substance abuse can lead to violence, and violence can lead to substance abuse.

The choice of substance is related to the cultural background of the person, as use of alcohol is unacceptable in some cultures, khat, or cannabis in some and drugs (e.g. amphetamine, opiates) in most.

Older children and adolescents might also use alcohol or drugs to reduce stress and to help them cope with a difficult life situation.

Action

- Take a detailed history of the substance abuse and of trauma.
- Be aware that substance abuse sometimes leads to **Aggressive outbursts** that can affect the family in a very negative way.
- Use psycho-educational effort to help the person understand what he/she is trying to accomplish through the abuse, and convince him/her that there are better ways of dealing with trauma.
- In the case of children or adolescents, try to relieve the stressful situation and teach the youth other ways of coping, e.g. using **Stress Management** skills.

Note

If the abuse continues, refer to next level.

HEALTHCARE PROFESSIONAL

Characteristics

There is a clear association between a history of violent assaults and substance abuse. The relationship is reciprocal, so that violence can lead to substance abuse and substance abuse can lead to violence, among both men and women. Intervention is necessary for both conditions at the same time. Substance abuse among older children and adolescents is often a sign of a stressful life situation. However, curiosity and group pressure can add to the problem. Social and cultural norms are important for how much and from which age the child or adolescent starts using alcohol or drugs. Substance abuse can result in **Cognitive problems** and impact negatively on academic and social life.

First therapy

Psycho-education.

Group **Counselling.**

Second therapy

Individual counselling.

Note

If the person has other severe mental or behavioural problems refer for assessment at the next level.

HEALTHCARE SPECIALIST

Assessment

Substance abuse can be related to severe mental problems that need treatment. Substance abuse is often a co-morbid condition with **PTSD**. Take a detailed history including the social life circumstances of the person.

Proposed measures

Treat according to findings.

Note:

There are additional problems with substance abuse. Some consumers are obliged to become victims of organised crime in addition to having the problem of drug abuse, and they may be the object of violence, panic and intimidation by the drug promoters.

Sweating

HEALTHCARE ASSISTANT

Key signs

Sweating plays an important role in the body because it helps maintain body temperature by cooling it down. Sweating (also called perspiration) is the production and evaporation of a watery fluid, consisting mainly of sodium chloride (the main constituent of "table salt") in solution that is excreted by the 3 million sweat glands in the skin.

Sweating is controlled by the autonomic (independent) nervous system and may be activated by emotions, by nervousness, by suffering or by hormonal changes in the body. It can also be a sign of fever or, if night sweating, of tuberculosis.

Action

- Sweating due to emotional causes poses no physical danger.
Counselling related to suffering and previous traumatic experiences may be necessary.
- If extensive and due to fever, drink fluids.
- Signs of dehydration can include:
 - dry or sticky mouth, eyes that look sunken into the head, dry and cool skin.
 - lack of urine for 12 hours (or only a very small amount of dark yellow urine).
 - lethargy, irritability, fatigue or **Dizziness**.

If there is severe fever or other signs of disease, contact next level within days.

Note

Sometimes children lose abnormally large amounts of water and salts through fever (more water evaporates from the body when body temperature is increased), **Diarrhoea**, **Vomiting** or long periods with excessive sweating.

HEALTHCARE PROFESSIONAL

Characteristics

See above.

Perform appropriate diagnostic checks to discriminate between physical and psychological origins.

First therapy

Treat according to findings.

Second therapy

With psychological causes, **Counselling** is often necessary.

Note.

Fluid balance must be considered.

HEALTHCARE SPECIALIST

Assessment

Infectious disorder assessments.

Proposed measures

According to findings.

Swelling

HEALTHCARE ASSISTANT

Key signs

Swelling is the enlargement of organs caused by accumulation of excess fluid in tissues, called oedema. It can occur throughout the body (generalized), or only some parts or a single organ are affected (localized). It is considered one of the five characteristics of inflammation.

Parts of the body may swell in response to injury, infection or disease, or because of an underlying lump. Swelling can also occur if fluid does not circulate well (especially swelling of the ankles). Generalized swelling or massive oedema is a common sign in severely ill people.

Action

- Examine for insect bites and for allergic reactions that usually produce temporary swelling.
- Ask about previous beating of or trauma to part of an extremity and examine for scars that may hinder fluids from leaving that body part.

Note

If problems persist, check for previous traumas and for heart problems and refer to next level within weeks.

HEALTHCARE PROFESSIONAL

Characteristics

Possible causes of localized swelling:

Injury

Infection

Skin swelling, e.g. from skin trauma or infection, contact dermatitis, eczema, hives or other allergic reaction or insect bite

Dependent oedema

Lymphatic obstruction

Venous thrombosis

Causes of generalized swelling

Protein deficiency

Malnutrition, Beri-beri

Premenstrual syndrome, pregnancy, preeclampsia

Congestive heart failure

Lymph oedema/obstruction

Cirrhosis of the liver/chronic hepatitis

Filariasis

Perform appropriate diagnostic checks to exclude malnutrition, infections and pregnancy.

First therapy

Treat according to findings.

Second therapy

Small daily dosis of diuretics may be helpful.

Note.

Fluid balance must be considered.

HEALTHCARE SPECIALIST

Assessment

Surgical, infectious disorder assessments.

Tics

HEALTHCARE ASSISTANT

Key signs

Tics are 'nervous' contractions in muscles and disturbing sounds, such as clearing the throat, that the person cannot control. Tics are frequent in children during the early school years. Tics can also be seen in adults. Tics often have a biological background, but they can be intensified during **Stress**.

Action

- Use **Psycho-education** to help the person understand the symptom.
- In the case of children, help parents to ignore the symptom and support the child if in a difficult situation.

Note

Tics often disappear by themselves within a year.

HEALTHCARE PROFESSIONAL

Characteristics

Tics are involuntary, rapid, repeated contractions in larger or minor muscle groups, e.g. blinking the eyes. A special form is sound tics or vocal tics, i.e. producing sudden sounds or words without a purpose. Tics are difficult to control. Most tics have a biological and genetic background, but they can be intensified during **Stress**.

First therapy

Stress management.

In case of children, give information to parents and school about the nature of the problem.

Second therapy

Relaxation exercises.

Note

Refer to next level if symptoms are intense and the person has simultaneous emotional or behavioural problems.

HEALTHCARE SPECIALIST

Assessment

Neurological and psychiatric/child psychiatric assessment.
Assess for Tourette's syndrome.

Proposed measures

Behavioural techniques.

Tinnitus

HEALTHCARE ASSISTANT

Key signs

Perception of whining or buzzing sound, that does not arise from an external source. It can be constant or intermittent. It is often concomitant with reduced hearing function. A simple reason could be an occluding body in the ear orifice, such as cerumen, or fragmentation of the eardrum as a result of a torture-related blow. A chronic infection of the middle ear, changes in the inner ear related to sound exposure, or changes in the brain or balance organ due to torture-related head trauma may also cause the condition. Moreover, overdosing on pain-relieving medicines (aspirin) may produce tinnitus.

Action

- Cautiously inspect and rinse the ear orifices.

- Try to eliminate external causes.
- Protect from excessive sound exposure.
- Control overmedication.

Note

To eliminate other causes, send to next level.

HEALTHCARE PROFESSIONAL

Characteristics

Perception of whining or buzzing sound, that does not arise from an external source. It can be constant or intermittent. It is often concomitant with reduced hearing function. A simple reason could be an occluding body in the ear orifice, such as cerumen, or fragmentation of the eardrum resulting from trauma to the outer ear, such as a torture-related blow. A chronic infection of the middle ear, changes in the inner ear related to exposure to sound or changes in the brain or balance organ due to torture-related head trauma may also cause the condition. Overdosing on pain-relieving medicines (salicylic acid) may also be responsible.

Assessment

Take a history and inspect ear orifices and eardrums for problems.

First therapy

According to findings.

Second therapy

Using a hearing aid, if available, may lower tinnitus.

Note

Torture – related tinnitus may be susceptible to **Psychotherapy**.
Counselling and **Stress management** are also advisable.

HEALTHCARE SPECIALIST

Assessment

Otological and psychological assessments.

Proposed measures

According to findings. Tinnitus is sometimes associated with **Stress**, **Anxiety** or **Depression**. **Cognitive behavioural therapy** reduces the emotional reaction to tinnitus.

Tiredness

HEALTHCARE ASSISTANT

Key signs

Tiredness is a symptom that may have many causes, both psychological and physical.

Tiredness is not a symptom specific to people exposed to torture but may be a symptom associated with other conditions frequently found in torture survivors. The most common reasons are **Stress**, depressive problems, and exhaustion with lack of sleep, physical illnesses or convalescence from physical illnesses. The key sign is lack of energy to perform usual tasks. Often the person does not feel any improvement after a rest or sleep. Other key signs may be **Loss of interest** or pleasure in usual activities and social withdrawal.

The tiredness may be accompanied by depressive problems and various physical symptoms.

Action

- Take a history from the person, including life events in recent past, losses, recent physical illnesses or symptoms of physical illnesses.
- Take history from the person's relatives.
- Advise about regular physical exercise may help reduce symptoms.

- Consider the daily tasks of the person, as some may be reduced or carried out by others.
- Avoid alcohol intake.
- Try to keep normal, daily rhythm with regular sleep.

HEALTHCARE PROFESSIONAL

Characteristics

Tiredness may be an initial sign of a severe illness or a depressive episode. It is characteristic that the person, despite feeling tired, is unable to find rest.

Assessment

Take a detailed history focusing on somatic problems, depressive symptoms, daily tasks, recent life events, losses, etc.

Conduct a physical examination.

Take a history from relatives.

First therapy

Give advice or supervision to level 1.

Second therapy

Short-term use of sedatives may be needed.

Note

Some may develop **Substance abuse** as a means of self-medication.

If no improvement after a month, consult with next level.

See assessment for physical illnesses.

HEALTHCARE SPECIALIST

Assessment

Use structured interview and rating scales to evaluate presence of mental illness.

Make differential diagnosis of severe somatic illness.

Check medication types – interaction.

Proposed measures

According to the underlying cause of the symptom.

Ulcer of skin

HEALTHCARE ASSISTANT

Key signs

The most important roles of the skin are to protect underlying organs against mild to moderate trauma and to maintain the internal environment, notably providing fluid balance and freedom from infections. Late effects of having suffered mechanical or other trauma, e.g. beating of soft tissue, but also having been subject to electrical currents or to heated objects may include persistent, often infected, ulcers of the skin.

Action

- Wound cleaning should be performed by rinsing with clean water, initially, if necessary, with a mild antiseptic agent.
- Open wounds heal from underneath and should have only a simple dressing without creams or ointments, or, if possible be left without any dressings, for at least parts of the day.
- If persistent, go to the next level within a few weeks for treatment.

Note

An accompanying high fever and malaise may indicate that sepsis (bacteria in the blood stream) is imminent or present. Professional healthcare should then be sought immediately.

HEALTHCARE PROFESSIONAL

Characteristics

Any form of trauma, be it mechanical, thermal, electrical or chemical, may cause **Skin infections**. Traumatized eczema from scratching or minor skin irritation may also lie behind this condition, as may (minor) foreign bodies in the wound(s).

Inspect the wound closely for signs of infection, dead tissue and even minor foreign bodies.

First therapy

Thoroughly rinse the wound and remove dead tissue and possible foreign bodies. Use light dressing without ointments or creams or, if possible, treat openly, if major contamination can be avoided.

Second therapy

Antibiotics for limited periods.

HEALTHCARE SPECIALIST

Assessment

Surgical, infectious disorder assessments.

Proposed measures

According to findings.

Urge to urinate

HEALTHCARE ASSISTANT

Key signs

A strong feeling of having to urinate, often in conjunction with only passing a little urine or not being able to urinate at all.

The most common cause is urinary infection. Injury to the pelvic organs may be present but the condition may also be **Stress**-related.

See **Incontinence**.

Urinating difficulties

HEALTHCARE ASSISTANT

Key signs

Urinary problems may be due to local injury to the kidneys in the upper lateral parts of the abdomen, to the urinary tracts, to the urinary bladder in the midline of the pelvic cavity or to the genital area, both in men and women. It can also result from injury to the spinal cord or to the pelvic nerves controlling the emptying of the bladder. Such lack of control may also result from injury to the anterior part of the brain (the frontal lobes).

Action

See **Incontinence**.

Note

The most common cause of urinary problems is urinary infection with frequency, **Urge to urinate**, painful urination, lower stomach ache and sometimes fever. Go to the next level for diagnosis and treatment.

HEALTHCARE PROFESSIONAL

Characteristics

Urinary problems may be due to infection or have structural or functional causes. A history including questions about sexual assault should be taken and the genitals should be examined for structural abnormalities, such as fistula formation between the bladder and vagina. An impaired nervous control of the bladder may occur with spinal cord or pelvic injury without structural changes, but is usually combined with other neurological symptoms, such as faecal incontinence, **Paresis** of the leg(s) and sensory loss.

Perform appropriate diagnostic checks.

First therapy

Treat according to findings. For pelvic training, see **Incontinence**.

Second therapy

Referral to a gynaecological specialist or to a surgeon may be necessary to correct structural abnormalities.

Note.

If the person is unable to void voluntarily, the bladder will empty only by overflow and there is a risk of potentially serious infection and kidney damage. Clean intermittent catheterisation four times a day is to be recommended.

HEALTHCARE SPECIALIST

Assessment

Surgical or gynaecological assessment.

Proposed measures

According to findings.

Vision difficulties

HEALTHCARE ASSISTANT

Key signs

Unable to see (blindness) or to read with one or both eyes. If sudden new blindness occurs in both eyes, the blood supply to the brain may be affected. If there is slowly progressing vision difficulty in both eyes, clouding of the lens (cataract), diabetes or deep infection may be the reason.

Problems in one eye can be caused by any of the above or that a foreign small body has entered the eye, e.g. after an explosion, or also that, after a blow (e.g. during torture) to the eye bulb, there is a detachment of the light-sensitive tissue (the retina) from the inner wall of the eye, sometimes with heavy bleeding blurring the light rays.

Action

Refer to a specialist.

Note

If there are signs of infection (red eye) or a history of foreign body, act quickly!

HEALTHCARE PROFESSIONAL

Characteristics

History can be positive (infection, blow or foreign body) or negative (spontaneous vision difficulties). If one conjunctiva is reddish, there is excessive tear formation, corneal damage or even an entrance opening, local injury (and/or infection) is the cause.

It is important to differentiate 'red eye' situations due to glaucoma (increased ocular pressure) or allergy

If progress is sudden and without external cause for one or both eyes, a cerebrovascular cause is likely. General condition (stroke or hæmorrhage with more dramatic symptoms) is decisive.

If progress is slow and there is an obvious external cause, a lens cataract or a diabetic retinopathy is likely.

Environmental conditions such as air and water contaminations by dust, heavy metals from mining industry, toxic residues, and pesticides are common causes of eye problems in developing countries.

First therapy

Medication with eye ointment (Oculentum) Sulpha or Chloroamfenikol 3 times a day for three days.

Rest for one day and then mobilization. Other symptoms may become more prominent.

Inspect pupillary opening for shades of grey. Test for urinary sugar and other signs of diabetes. Treat accordingly.

Note

If thrombosis is certain, prophylaxis with salicylic acid (100 mg/day) is relevantly long term.

Rare side effects of Chloramphenicol include bone marrow depression and it is not recommended in pregnant and lactation; Sulpha may cause allergic reactions.

HEALTHCARE SPECIALIST

Assessment

Ophthalmiatric assessment.

Proposed measures

According to findings.

Vomiting

HEALTHCARE ASSISTANT

Key signs

Throwing up stomach content in short bursts, usually preceded by intense **Nausea** and malaise.

Action

- Often lasts only a short time (minutes to hours); drink fluids afterwards.
- If there are severe bowel cramps or **Abdominal pain**, contact the next level immediately (risk of intestinal obstruction requiring surgery).

Note

If problems persist, there is usually a more severe underlying cause. Go to the next levels within a few days.

HEALTHCARE PROFESSIONAL

Characteristics

Common reasons for vomiting are gastroenteritis or stomach, gallbladder or liver disease but the reason may also be bowel obstruction. The latter is usually combined with intermittent and progressive colic pains or cramps and inability to pass gas rectally.

Assessment

Take a history. Perform appropriate diagnostic checks.

First therapy

Treat according to findings.

Second therapy

Fluid balance must be considered.

Note

Progressive or colic pain is a warning sign of a life-threatening obstruction. An unusual but important reason for vomiting is increased intracranial pressure due to blood collection, occurring after head injury, sometimes even up to weeks later. Here there may or may not be preceding **Nausea** or neurological signs, including somnolence. The risk of rapid progression (including loss of conscience, cessation of brain functions and death) is imminent and specialists should be consulted immediately.

HEALTHCARE SPECIALIST

Assessment

Surgical, infectious, neurological disorder assessments.

Proposed measures

According to findings.

Weight loss

HEALTHCARE ASSISTANT

Key signs

Difficult living conditions in captivity with cramped and dark quarters for victims of TOV, suffering from extreme temperature variations with insufficient clothing, from grossly insufficient diet, **Isolation**, fatigue and often longstanding infections may contribute to considerable weight loss of up to 10–20 kg in adults in a short time. The amount of weight loss has even been recognized as an indicator of the severity of the trauma after torture.

Action

- Since appetite and feelings of hunger are often persistently small, it is important to eat regularly again, if possible every third hour, and never to skip a meal.
- It is recommended that the number of calories in the food should be increased by gradually enlarging the size of the portions and by adding a few grams of extra fat per day, e.g. from oil or from nuts.
- Moderate physical activity may stimulate the appetite.

Note

If problems persist, consult the next levels within months.

HEALTHCARE PROFESSIONAL

Characteristics

The amount of weight loss in survivors of TOV has been recognized as an indicator of the severity of the trauma after torture. Perform appropriate diagnostic checks to exclude serious systemic disorders.

First therapy

For dietary advice, see above.

Second therapy

Treat according to findings.

HEALTHCARE SPECIALIST

Assessment

Internal medical assessments.

Proposed measures

According to findings.

Whole body pain

HEALTHCARE ASSISTANT

Key signs

The person may say that he/she has pain all over the body. There are differences between and within cultural groups and within groups in the manner in which the experience of body pain is expressed verbally and with behaviour. These cultural expressions should be acknowledged and taken seriously.

Action

See **Stress management, Pain, chronic, Coping and preoccupation with pain.**

HEALTHCARE PROFESSIONAL

Characteristics

Because of diversity in the way pain is expressed both between and within cultures, it is important for the clinician not to make stereotypical judgments about pain. How can we assess or measure a person's pain accurately when his or her cultural background affects the way he or she responds to and expresses pain and even affects the words used to describe pain? Kleinman has developed a set of questions which may be used to elicit the person's beliefs and attitudes about pain:

- What words would you use to describe your pain?
- Where do you think this pain came from?
- Why do you think it happened when it did? Why do you think it has lasted this long?
- Do you think this pain will go away? If it goes away, what will make that happen?
- What are the main problems your pain causes you?

- Have you gone to any other healer for this pain? With what remedies did they try to help you? Are you still using what they recommended? Do you still see this person?
- Who, if anyone, in your family or community knows about your pain and its treatment? What do they know? What do you want them to know?
- How do your family and friends react to your pain? What do they think about it?

First therapy

See **Worrying about symptoms, Stress management, Whole body physical therapies, Pain, chronic and Coping and preoccupation with pain.**

Second therapy

Counselling and Psycho-education about pain.

Note

Adjust pain medication and refer to next level if pain is severe and extremely therapy-resistant for a long period of time.

HEALTHCARE SPECIALIST

Assessment

By rheumatological or pain-management specialist.

2.2. ACTIVITIES AND PARTICIPATION

Aggressive outbursts

HEALTHCARE ASSISTANT

Key signs

Aggressive outbursts are seen in many contexts. In areas of conflicts and war it may be a frequent behaviour seen both in those with a history of trauma and in the children of such people. The aggression may be directed towards the immediate family (as in **Domestic violence**) or directed towards others.

The behaviour may be part of the person's ordinary behaviour pattern or it may be apparent only in certain situations, e.g. after the intake of alcohol or other drugs.

If the aggression is due to previous trauma it may be triggered by certain key situations that the person has experienced, which may seem of minor importance to others.

Children:

Aggressive behaviour in children can be a reaction to traumatic events. It can also be a result of the child copying violence in the environment.

Action

- Obtain an overview from the person and those around him/her about the situations in which aggression occurs.
- Take a history of any **Substance abuse**, particularly alcohol.
- Take a history of any trauma in the person's history or that of the immediate family.
- **Psycho-education:** Explain the connection between the history of torture and behavioural problems.

- Do not advise the person to give in to the aggressive impulses as a way of eliminating these outbursts.
- Encourage distractions to keep the mind off irritating stimuli.
- Try to convince the person to avoid stimulants, including alcohol.
- Try role play, where you teach the person alternative ways to acting where aggression is less prominent.

If seen in children

Counsel parents on how to deal with the aggressive child:

- Permissiveness will increase aggressive behaviour.
- Do not hit or shout at the child but stay firm and calm.
- You might have to remove the child from the situation which elicited the aggressive behaviour, e.g. by declaring 'time out'.
- Withdraw attention when the child behaves aggressively and reward desirable behaviour.

Note

If the aggressive behaviour is directed towards minors it is advisable to report the case to the appropriate authorities in the local community so that they can intervene.

If seen in children:

Refer to next level if the problems are persistent or if the parents react with harsh punishment.

HEALTHCARE PROFESSIONAL

Characteristics

Aggressive outbursts may be a sign of a post-traumatic condition. In such cases the aggressive behaviour is new to the person and is frequently experienced as foreign and sometimes frightening.

This may be in contrast to those who exhibit such behaviour due to a personality disorder, where the behaviour has typically been noticed since early adulthood.

Children

Traumatized children can react with aggressive acting-out behaviour, particularly if they have grown up in an environment where multiple, chronic and prolonged traumatic events occurred. Aggressive behaviour can also be a result of modelling, particularly among older children, i.e. they have observed **Organised violence** in their surroundings over long periods of time.

First therapy

Assess and quantify any **Substance abuse**.

Provide information about the relation between violence and abuse.

Recommend a complete stop of alcohol or drug intake.

Give advice or supervision to previous level.

For children:

Family counselling.

Supervision of teachers.

Second therapy

If the aggressive outburst is part of a **PTSD**-condition this should be treated (see **Counselling**).

Stress management techniques, e.g. in a group setting, can be taught to adults as well as children (see **Stress management**).

Note

Some may develop substance abuse as a means of self-medication

For children:

Refer to next level if the aggressive behaviour isolates the child from school or other activities. Consider history of child abuse.

HEALTHCARE SPECIALIST

Assessment

Use structured interview (see **Assessment of torture survivors**; e.g. SCID or SCAN or in case of children DISC or K-SADS_PL) to elicit presence of mental illness.

Children might suffer from Attention Deficit Hyperactivity Disorder.

Proposed measures

- Use of short cognitive programs on anger management.
- In certain cases the prescription of small doses of anti-psychotics may be beneficial.
- There is some empirical evidence for the use of Selective Serotonin Reuptake Inhibitors.
- Provide expert input in legal cases.

For children:

- Family therapy.
- Group work with school-aged children and adolescents.

Alienation

See **Dissociation**.

Antisocial behaviour

See **Aggressive outbursts**.

Avoidance behaviour

HEALTHCARE ASSISTANT

Key signs

Avoidance behaviour is characterized by a person maximizing immediate well-being by avoiding a precipitating factor (e.g. immediate anxiety in situations where it is required to meet people) with the probable consequence of minimizing future well-being (e.g. social participation in the long run). In that sense avoidance results in immediate positive consequences but negative consequences in the long run (e.g. Self-harming behaviour reduces intense anxiety immediately but causes pain and tissue damage that remains). The general principle of avoidance treatment corresponds to that for treatment of (phobic) anxiety.

Avoidance behaviour can be

- a) adaptive (successful adjustment) or
- b) maladaptive (unsuccessful adjustment).

One example concerning pain: Walking intensifies the pain and is therefore avoided; the person then becomes immobile.

- a) If there is a recent fracture, walking would postpone healing.
- b) If there is no injury, avoidance of walking prevents pain intensifying immediately but results in a weakening of muscles and other tissue, thus increasing pain and weakness in the long run.

One example concerning anxiety (**PTSD**): Avoidance of social gatherings due to the risk of contact with people in uniform after having been tortured by soldiers.

- a) A risk of being maltreated by those in uniform (soldiers, police) is still present.
- b) Since there is no longer a risk of maltreatment (or a risk only from a certain type of uniformed persons), the avoidance is exaggerated and leads to minimizing social participation in general.

Action

If the avoidance is maladaptive:

- Explain the negative consequences of avoidance in the long run to the person and his family:
 - *Example concerning pain:* Malfunctioning and more pain/weakness in the long run.
 - *Example concerning anxiety:* Exaggerated avoidance and **Anxiety** will persist, reduces quality of life and limits activities and participation.

- Assist the person to change his/her behaviour:
 - *Example concerning pain:* Help the person to stop staying immobile in small steps (e.g. stand up, walk for a short distance, then successively longer distances, etc.); instruct the person's family to encourage the performance of each step.
 - *Example concerning anxiety:* Encourage the person to confront people in uniform in small steps; e.g. observing a police station from a distance and later from subsequently shorter distances. Instruct the person to remain in each situation until the anxiety has declined to a comfortable level and then to take the next step. At the beginning of the training, the trainer should be present and assist/encourage the person in the procedure. Instructions should also be given to the person's family to provide encouragement in the same way.

Note

If it is difficult to assess whether the avoidance is adaptive or not, if it is complex, refer to healthcare professional at next level.

HEALTHCARE PROFESSIONAL

Characteristics

Since human behaviour tends, in many circumstances, to be controlled more by short-term and much less by long-term consequences, maladaptive avoidance behaviour is observable in many everyday-life situations and is associated with many psychiatric problems, e.g. **Anxiety** and **Substance abuse**. With substance-abuse disorder, e.g. one avoidance behaviour might be the use of a substance in order to avoid abstinence symptoms (positive effect immediately) with negative effects in the long run.

Avoidance behaviour is prominent in almost all cases of PTSD and is often present in people suffering from chronic pain. Whether the avoidance is adequate or not is sometimes difficult to assess, e.g. whether or not worries about being persecuted (compare **Paranoia**) are still realistic or whether avoidance of physical activity could be explained by still undetected tissue-damage or malfunction. Because of the specific preconditions in various contexts and treatments of different disorders with which avoidance behaviour is associated, the treatment differs in detail. Only a general guideline can be given which needs to be adapted to the specific context.

First therapy

The same guidelines as above but based on more detailed medical knowledge about the patient which allows the therapist to fine-tune direct advice and purposeful training.

Second therapy

The provision of aids (e.g. crutches that could be used as an intermediate step between total immobility and walking without aids) may be useful. Treatment of other aspects of disorders of which avoidance is a part of, e.g. anti-depressive medication for **PTSD** or analgesics for pain may also be helpful.

Note

Refer to next level if it is thought that additional medical expertise would be able to optimize the application of the guidelines and/or when it is advisable with respect to assessment and treatment of diseases, symptoms and disorders.

HEALTHCARE SPECIALIST

Assessment

Rule out whether there are hitherto unidentified/untreated somatic or other circumstances that are contributing to the avoidance behaviour.

Proposed measures

According to findings.

The guidelines described above can be used for additional and refined **Psycho-education** about avoidance behaviour.

Bed wetting

HEALTHCARE ASSISTANT

Key signs

Children: The child starts to pass water in the bed at night after having been dry for a period.

Adults: Adults suffering from acute as well as post-traumatic stress reaction can start to wet the bed or lose his/her control over passing water in the daytime. It is important as a healthcare person to remember to ask about any problems with urinating when meeting a torture survivor, since the person might not be willing to talk about such problems voluntarily.

Action

Children:

- Try to find the reason. The child might be upset because of traumatic events. He/she might also react to changes in the family situation, e.g. loss of or separation from a parent or because of **Anxiety** or fears. Never scold or punish the child.

Adults:

- Try to find the reason. If the person has any history of trauma to the genitals or kidney region or reports blood or malodorous urine, consult a healthcare professional.

Note

Children cannot be expected to be dry at night before the age of approximately 5 years. Refer to next level if the problem co-occurs with other symptoms.

HEALTHCARE PROFESSIONAL

Characteristics

The child starts to wet his/her bed at night after having been dry for a period.

If the child is more than 5-7 years old and has never been dry at night, the problem might be caused by a somatic condition that needs medical attention.

First therapy

Inform and counsel the parents. Let the child talk about upsetting events. If persistent, monitor dry nights in order to find the reason for the bedwetting.

Exclude infection, trauma or other somatic cause of bedwetting. Treat if present.

Reduce intake of water, tea or coffee just before bedtime.

For both children (from 6-7 years of age) and adults use desmopressin nasal spray, 20 microgram, before bedtime

Another alternative is to use an alarm, triggered by nocturnal urine leaks, if such equipment is available for biweekly periods.

Refer to next level for a detailed history of somatic cause such as trauma to the genitals or kidneys.

Second therapy

Family **Counselling**.

See also **Interventions with traumatized children**.

Note

Refer to next level if the problem persists and is part of a larger symptom complex.

HEALTHCARE SPECIALIST

Assessment

Take a detailed history in order to establish whether the nocturnal enuresis is primary or secondary.

Proposed measures

According to findings. In the case of secondary enuresis the symptom might be part of a larger symptom complex, e.g. **PTSD**. CBT is often suitable.

Bereavement

HEALTHCARE ASSISTANT

Key signs

Bereavement or grief is a normal, complex emotional reaction to loss; usually the death of family members or others close to the person. Even other types of loss, e.g. relations, work, home, health, etc. can trigger bereavement.

The reaction is characterized by low mood and painful feelings. In many cultures crying often occurs when the person is reminded of the loss, but there are great response variations in the face of loss. Religious, cultural, societal and familial traditions and rituals have a great influence on how bereavement is experienced and handled. Bereavement is usually a transient process where the expected length of time it lasts varies among individuals and cultures. Since bereavement is a normal part of life, most people are able to manage it within their normal social network, without external social or healthcare support.

In some situations, however, bereavement can be aggravated and/or prolonged or even become chronic, e.g. when the loss also includes losing the supporting social network and/or if the person applies unsuitable strategies for handling grief; bereavement can also result in, or interact with, other emotional problems, e.g. with depression. In these cases, external social and healthcare support may be necessary to help the person to work through the bereavement. Some torture-survivors may belong to this group.

Action

1. Assess whether the intensity and duration of the bereavement is acceptable in relation to the kind and degree of loss and the cultural context (would comparable people react in a similar way?).
2. Assess whether there is a lack of a supportive social network that could assist the person in working through the bereavement. If not, try to find

- a substitute for this support, e.g. by promoting contact with a relevant religious social system and/or groups of people in similar situations.
3. Assess whether the person is applying an exaggerated avoidance strategy, i.e. avoids negative feelings by avoiding recollections (e.g. by distracting or using substances), objects (e.g. pictures) or places (e.g. rooms, graves) that reminds him/her of the loss. If this is the case, apply the treatment principles described in the **Avoidance behaviour** section.
 4. Assess whether the bereavement is combined with other emotional problems, e.g. **Depression** and/or **Anxiety** disorders. If this is the case, provide treatment according to the guidelines of these disorders.

Note

If it is difficult to assess whether bereavement is normal in the given social context and/or whether there are other problems that interact with it - refer to healthcare professional.

HEALTHCARE PROFESSIONAL

Characteristics

There have been theories about universal stages in bereavement processes but, due to great individual and cultural differences, these have been shown to be widely invalid.

There are potential obstacles to torture-survivors engaging in a normal process of bereavement, e.g. intense anxiety due to **PTSD** or intense pain that results in avoidance of social situations that would normally promote a working-through process. The first line of treatment may be seen as assisting the person to overcome these obstacles and to get in contact with the social structures that normally assist in the bereavement processes. One complication could also be that the losses experienced, in combination with other problems, not only result in a normal crisis but in a depressed state that is not amenable to normal crisis handling in the given social context but requires supportive anti-depressive treatment. Excessive avoidance

behaviour towards situations that arouse memories of the loss is another potential obstacle to the normal working-through of bereavement.

First therapy

Same guidelines as above but supported by more detailed medical knowledge that can guide direct advice in a more fine-tuned manner and allow more purposeful handling of the problem. The main goal should be to assist the person and his social network to engage in the working-through process that is normal for the given cultural and social context. If an informal, supportive social network is lacking, one should try to provide a substitute by promoting contacts with organised support (e.g. via religious organisations or self-help groups).

Second therapy

If excessive and/or prolonged bereavement is due to excessive avoidance, follow the guidelines in the **Avoidance behaviour** section.

Third therapy

If the problem interacts with other problems, e.g. **Anxiety, Pain, chronic** or **Depression** – initiate treatment of these problems, perhaps in combination with first and second therapy guidelines. As a rule of thumb to be used for the differential diagnosis of normal bereavement and depression - lowered mood in the first case normally goes “in waves” and is triggered by reminders about the loss, whereas lowered mood due to depression is more constant and independent of external triggers.

Note

Refer to next level if it is thought that additional medical expertise might optimize the application of the guidelines and/or when it is advisable with respect to assessment and treatment of diseases, symptoms and disorders.

HEALTHCARE SPECIALIST

Assessment

Rule out any so far unidentified/untreated somatic or other circumstances contributing to excessive and/or prolonged bereavement.

Proposed measures

According to findings.

The guidelines described above can be used for additional and refined **Psycho-education** and advice for dealing with bereavement.

Community life, participation in

Key signs

When a person is involved in a traumatic experience such as torture, it is likely to affect his/her surrounding community, and people in the community might themselves experience post-traumatic stress responses. Often the community members do not know how to express their sympathy, and become awkward towards the survivor. The torture survivor is often very sensitive to any changes in behaviour from other community members.

Mistrust may be a major issue that becomes an underlying problem in many relationships. People may have little tolerance of one another and quickly jump to conclusions that may include negative attitudes towards victims of torture, which further increase the risk of exclusion from participation in community life. The survivor may even be stigmatised as “criminal” due to lack of knowledge or because people might be afraid to socialise with the survivors of torture.

Action

- *Psychosocial interventions* targeting the community and specific **Groups at risk** to prevent development of mental health disorders; e.g. elderly

people, victims of torture, female victims, poor people living in rural areas with little or no **Education**, disabled people.

- *Social support* and encouragement of volunteer action and *self-help groups* for empowerment and sharing.
- Community participation and activities that facilitate the inclusion in social networks of people from the community are strongly recommended. These networks may include interest groups such as women's groups, or human rights activists groups, a political group or a religious community.
- Involvement of the community leaders/religious leaders and/or other key persons in the community in the problems of the torture survivors, to improve support and acceptance of the torture survivors.
- Establish awareness meetings in the community to overcome problems of negative attitudes and improve understanding of the problem among the community members.
- Consider (group) creative therapies such as dancing, painting, poetry, theatre, creative writing.
- Consider exercises (in groups) such as yoga, Tai Chi, Chi Gong, jogging, walking, etc.

Coping and preoccupation with pain

HEALTHCARE ASSISTANT

Key signs

Coping with pain is the way in which we deal with pain problems. It refers to both the mental efforts we make to manage or reduce pain and to behaviours with the same purpose. What people do depends very much on what they think about their symptoms and whether they fear an underlying illness. Coping with pain can be subdivided into a) efforts aimed at alleviating the pain, typically by diminishing the underlying causes (coping focused on **Problem solving**) and b) efforts aimed at better enduring the

negative consequences of pain (coping focused on emotions). The first way of dealing with pain can be characterized as “repairing efforts” (in order to get rid of the pain) and the second as “enduring efforts” (referred to as “learning to manage the pain”).

Since acute pain is normally due to some kind of tissue damage with a potential to heal, “repairing efforts”, e.g. seeking a medical diagnosis and treatment that is expected to promote healing, is often sufficient. The same principle applied to chronic pain, however, is not at all or less adequate since there is, by definition, no ongoing tissue damage with a potential for further healing. “Enduring efforts” are usually more successful with chronic pain.

Amelioration of chronic pain symptoms by e.g. medication or physical treatment methods may be sufficient and meaningful, but in most cases the goal of total freedom from chronic pain is not realistic. Having chronic pain usually implies that, despite optimal treatment, pain symptoms and functional restrictions persist to some extent and have to be dealt with.

Since most people associate a pain experience with underlying acute tissue damage, it is understandable that people apply “repairing efforts” even if their pain is of the chronic type. This can result in a meaningless, time-consuming and frustrating “search for a cure” in the hope of finally meeting a doctor/healer who “detects the underlying damage or disease” and implements a healing. The fruitless search for repair is also a negative experience for the person since it postpones the beginning of an adaptation process to the chronic pain problem, using the more effective “enduring efforts”. To help people with chronic pain to replace focusing on “repairing efforts” by focusing on “enduring efforts” is for many reasons an important issue.

Focusing on “repairing efforts” normally implies paying great attention to the experience of the pain, which easily can result in the development of a preoccupation with pain. Such preoccupation with pain can be defined as a

form of exaggerated attention to pain signals. Experiencing pain induces per se some degree of attention since (acute) pain normally serves as an important signal triggering behaviour that prevents (further) tissue damage, e.g. cooling a body part after a burn.

The risk of developing a preoccupation with pain is very similar to **Hyper-vigilance** in general (see this entry) and can be expected particularly if the person is anxious that the pain signals may be due to a serious disease or damage. If a person still experiences pain after the objective healing of the tissue damage that initially induced the pain, it can be very difficult for an uninformed person to understand that the continuing pain consists of “false alarms”, unless a trustworthy explanation about chronic-pain mechanisms is provided.

Explaining that there are “false-alarm pain signals” may in some cases be misunderstood to imply that a mental disease is the cause (“if it is not in the body, it must be in the mind”), which does not diminish, but rather further fosters, concerns about and preoccupation with pain. The delivery of a sound explanation for chronic pain that integrates both physical “false-alarm signalling” and the role of psychological and behavioural factors – in contrast to pure mental diseases (that may produce a different type of pain) - is a central treatment principle for preoccupation with pain. Direct pain treatment is another important way to counteract the problem; see other relevant entries about pain treatment.

Action

- Explain to the person and his/her social environment the difference between acute and chronic pain with respect to prognosis, treatment and adequate coping.
- Address the possible misunderstanding that the pain might be understood as a symptom of a (developing) mental disease. The use of simple drawings can assist explanations and illustrative examples, e.g. **Phantom pain** as a pain signal experienced from body parts that no longer exist, can be helpful.

- Give examples showing that “enduring efforts” do not imply “capitulation” to the pain but are a means to improve the quality of life on the basis of acceptance of symptoms that cannot be get rid of, comparable to the situation for sufferers of chronic diseases such as diabetes or malaria.
- Explain that “enduring efforts” means that the person has to become his own expert on his pain, finding ways to live a life despite pain and finding ways to keep the pain experience on an acceptable level. Give examples of “enduring efforts”, e.g. the use of pain-ameliorating treatments as medication, physical methods (e.g. warmth/cold), learning new abilities such as relaxation techniques, optimal pacing (not too little/not too much physical activity), looking for work that is less pain-intensifying, etc.

Note

Acute pain has to be excluded (refer to next level if in doubt).

Even the best given explanations might not be accepted by the person and/or his family because the level of medical authority that the information-giver represents, is perceived as insufficient (an experience that even a medical specialist might have if he/she does not have the “correct” expertise in the eyes of the person) – refer to next level in such cases.

HEALTHCARE PROFESSIONAL

Characteristics

Delivering an alternative explanation for the person preoccupied with the idea that their pain is caused by an undiscovered ongoing disease/damage might be difficult for someone at level 1, due to the limited medical knowledge that they can use in giving correct information, or simply because they lack sufficient medical authority.

First therapy

Exclude somatic and psychiatric diseases that could be alternative explanations for the experiencing of pain. Otherwise, follow the same

guideline as above but informed by more detailed medical knowledge. Use your authority as a healthcare professional.

Note

If necessary, refer to next level if it is judged that additional medical knowledge or authority will optimize the delivery of information to counteract preoccupation with pain.

HEALTHCARE SPECIALIST

Assessment

Conduct differential diagnosis of underlying causes (type of pain) for preoccupation with pain.

Proposed measures

Give correct information about chronic-pain processes. Use your medical experience and authority.

Disability

HEALTHCARE ASSISTANT

Key signs

A disability is seen as a functional limitation relative to the usual standard experienced by an individual or their group. The term is often used to refer to individual organ function such as physical, sensory, cognitive or intellectual impairment.

However, a person's disability is the result of an ongoing interaction between health conditions (diseases, disorders, injuries, trauma consequences) and contextual (environmental and personal) factors. In reality, disability denotes the situation where there is substantial limitation

concerning one or more major activities of life or of participation therein. Obviously, this can be caused by torture, physical as well as mental.

Action

Rehabilitation is the key notion to support a person with disabilities:

- Help the person to focus on his or her resources.
- Find ways to increase daily skills in spite of impairments, both through alternative solving of practical problems in daily activities and through simple aids (taking notes in memory problems; using physical extensions/splints/crutches in lameness; reading through magnifying glass in **Vision difficulties**, etc). See reference Werner, D. 2003, for good examples!
- If medication is needed due to disturbing symptoms, e.g. muscle cramps, pain, epilepsy, consult a healthcare professional.

Note

It is not only physical impairments that are important, but **Depression**, sleep disturbances, memory problems and chronic pain as well as environmental and personal factors may all cause disability.

HEALTHCARE PROFESSIONAL

Characteristics

In 2001 the World Health Organization published the International Classification of Functioning, Disability and Health, ICF (see **Annex**). The aim was to establish a common language for describing health and health-related states with regard to body function and structure, activities and participation in relation to context (environmental factors such as family, work, attitudes and society).

WHO defines disability as

‘an umbrella for impairments, activity limitations and participation restrictions and means the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors’.

First therapy

If a person is in need of medication against mental or physical health problems related to disability, treat **Pain, Depression, Anxiety** and **Sleeping difficulties** accordingly.

Second therapy

Assess the need for **Counselling, Psycho-education** and coping strategies.

Assess the need for technical aid appliances.

Teach the person, together with a healthcare assistant, how to live and cope with problems of disability through learning new strategies (see this chapter and chapter 3, “**Therapies**”).

If many people suffer from the same disability, consider group treatment and rehabilitation, if possible.

With multiple disabilities, it may be necessary to refer to rehabilitation specialists, if available.

HEALTHCARE SPECIALIST

Assessment

Assess specific impairments, activity limitations and participation restrictions in the actual context.

Proposed measures

Propose specific treatment and rehabilitation strategies thereafter, if possible. Direct or indirect supervision of local health professionals may be the only realistic measure to provide.

Dressing problems

HEALTHCARE ASSISTANT

Key signs

Dressing is a coordinated action in the putting on and taking off clothes and footwear. Beatings to the whole body, being tied up in a sustained, awkward position, suspension by the arms, mutilation of hands and fingers are all common torture methods. Pain, weakness and reduced mobility in the back, the arms and hands are consequences which may not be easily overcome. The victim must then ask the spouse or other family members for help when getting dressed. It may be shameful and humiliating to be dependent on other people, especially for performing tasks which may be regarded as simple. Dressing is, however, often demanding and requires many coordinated skills and movements of the body. If the victim is depressed or tired he/she may not wish to get dressed (see **Depression, Tiredness**).

Action

- Ask for history and ability to get dressed.
- Encourage family members to help the person to get dressed. Show respect and patience. Gradually, the person should be able to handle dressing problems alone.

Note

If the person is incapable of getting dressed by himself/herself and is totally dependent on others, refer to healthcare professional.

HEALTHCARE PROFESSIONAL

Characteristics

See above.

First therapy

Assess structural, neurological and cognitive impairments.

Give pain medication.

Treat **Depression**.

Provide simple technical aids and teach strategies.

Second therapy

Counselling, Psycho-education and ergonomic guidance.

Note

Refer to a healthcare specialist if a neurological disease is suspected.

Eating problems

HEALTHCARE ASSISTANT

Key signs

Children's appetites vary widely and periods when the child refuses to eat very much are normal. During traumatic life circumstances many children are unable to eat normally.

Action

- Advise parents to be calm and not force the child to eat.
- Help parents to provide meals in a calm and secure atmosphere.
- See also **Interventions with traumatised children**.

Note

If the child's height and weight do not progress normally or the child has other physical symptoms, it is necessary to examine the child to eliminate somatic illness. Adolescents who lose weight in an uncontrollable manner also need closer examination.

HEALTHCARE PROFESSIONAL

Characteristics

Eating problems in children are often symptomatic of emotional unbalance and **Stress**, but somatic illness needs to be eliminated as an underlying cause. In some children refusal to eat can develop into a power struggle with parents. Eating problems in adolescence can develop into actual eating disorders if not attended to.

First therapy

Family **Counselling**.

Second therapy

Group counselling with older children and adolescents.

Note

If the child loses weight over a period of time, refer to next level.

HEALTHCARE SPECIALIST

Assessment

Eating problems can be part of **PTSD**, but diagnoses of Anorexia Nervosa and Food Avoidance Emotional Disorder must also be considered. Prepubertal onset of Anorexia Nervosa is rare. A family pattern of disturbed communication and interaction, major life events such as separation and loss of family members, disruptions of family homeostasis, new environmental demands and attachment difficulties have all been identified as causative contributory factors in eating disorders. Also be aware that starvation and malnutrition alter a number of physiological parameters and can cause the syndrome to be self-perpetuating.

Proposed measures

According to findings.

Exclusion from participation in social and political activities

See Community life, participation in.

Family life, participation in

Key signs

Many survivors of trauma and torture report difficulties with their relationships following the trauma. The person's responses to trauma including fear, **Mistrust**, irritability, withdrawal or **Shame** will naturally have an impact on relationships with family and friends. The survivor becomes very sensitive towards other people. They may also not tell their loved ones what happened, for fear of upsetting them unnecessarily.

Children can also experience difficulties in the family following their own or their parents' traumatic experiences. Some children have had to take great responsibility for the family during e.g. the father's imprisonment, and have been forced into a too early adulthood. If the father returns and is marked by his experiences, roles in the family can become unclear and confusing for the children.

Action

- **Psycho-education** including information about reactions to torture so that the spouse and children understand why the torture survivor isolates himself/herself and withdraws from participating in the family.
- The survivor is encouraged to talk about the problems.
- The whole family or the couple might need **Counselling** on how to communicate more openly and improve their skills in solving their problems.
- The presence of a social network, including a nuclear or extended family, is a protective factor that improves resilience.

Friendship breakdown

See **Family life, participation in** and **Community life, participation in**.

Gainful activities

HEALTHCARE ASSISTANT

Key signs

After a trauma such as torture, the person is often in a state of acute or chronic distress, where **PTSD** is often diagnosed for the chronic state. For the torture survivor inactivity due to **Depression, Anxiety, Pain** or low self-esteem can cause problems in managing daily routines.

Action

- Help the person activate himself/herself in simple daily routines and give advice on structuring the content of each day.
- Introduce **Counselling** to alleviate anxiety.
- Reduce alcohol or sedatives which will interfere with activities.
- If the person seems depressed, see a healthcare professional for medication.

Note

Find gainful activity on an individual basis but remember the role of the attitudes of the family and employers and the support of the immediate family.

HEALTHCARE PROFESSIONAL

Characteristics

Inactivity and a sense of hopelessness can be major problems for people after a traumatic experience. Combined with low self-esteem this may cause problems with gainful activities.

First therapy

Diagnose treatable causes of inactivity.

Treat **Depression, Pain** and **Anxiety** accordingly.

Support the patient in focussing on his/her abilities rather than the opposite.

Second therapy

Identify cognitive and contextual barriers.

Facilitate development and strengthening of self-esteem through practical information about rights and empowerment.

Give **Psycho-education**.

Start work with undemanding, short tasks and make stepwise increases.

Note

Reinforcement through periodic checks and encouragement is very helpful.

HEALTHCARE SPECIALIST

Assessment

Diagnose specific somatic or mental disease standing in the way of finding gainful activity. Arrange for multi-professional assessment if possible.

Proposed measures

Propose specific treatment thereafter, if possible.

Identity problems

HEALTHCARE ASSISTANT

Key signs

The feeling of identity is the picture of oneself as constant in relation to other people, to what is important in life and according to central convictions such as religious and political orientation. In practice, however,

there is an ongoing change in one's view of the self and of the world due to the never-ending stream of new impressions and experiences. Normally this changing process of identity is slow, occurs gradually in minor steps and is usually not recognized as a change; it can also be seen as ongoing, effortless learning.

Sudden and drastic changes in living conditions, such as separations, unemployment or loss of social context due to enforced migration, make demands on the feeling of identity and enforce, to a greater or lesser degree, a redefinition of identity within a short space of time. This type of change often necessitates effortful, intentional learning in order to adapt to the new situation. Correspondingly, sudden somatic changes can be seen in maturation processes, e.g. puberty, or with drastic changes in health due to accidents, diseases, etc. Problems in adapting to dramatically new situations can result in experiencing identity problems occurring as conflicts between previously held images of oneself to which new circumstances do not correspond.

One example is a previously physically very active person, e.g. a professional soccer player who, after torture, is unable to continue with his profession (implying multiple losses such as income, social network, reputation etc.). Another example is a politically active person who, prior to having been tortured, believed that the rumours that torture occurred in his/her own country, were just propaganda from hostile foreign countries (implying a conflict between previous convictions and experience).

Children

During late childhood and adolescence young people need to develop a sense of their own identity, i.e. a picture of who they are in relation to other people, what is important for them in life and what they wish for in the future. Growing up in violent life circumstances can affect this development. It may be difficult to find one's own place in life when the surroundings are unstable and changing all the time. Sometimes older children and adolescents are given too many and too heavy adult

responsibilities during times of **Organised violence** and this can also hamper the young person's chance of developing his/her own identity.

Action

- Help the person to put words to the identity problem.
- Make it possible for the person to discuss/share the problems with other people in a similar situation (thereby normalising the problems and promoting mutual assistance).
- In many cases practical problems, pain or mental-health problems are major obstacles to a natural recovery as regards identity problems. Accordingly, assist the person to solve practical problems and treat somatic and/or mental problems by sending to next level.

In children

- Help the family to support the young person and to give him/her space and the chance to find his/her own place in life.
- Support participation in school and educational activities and help parents to do the same.

Note

Refer to next level if the person cannot be assisted as described or does not respond to the treatment delivered.

Identity problems can sometimes lead the child or young person to identify with criminal or otherwise deviant groups and to take part in risky endeavours. If this is the case refer to next level.

HEALTHCARE PROFESSIONAL

Characteristics

In cognitive psychology, the principle of gradually integrating information is called "assimilation" which is defined as the integration of new information into an existing cognitive structure by which this structure is changed minimally. A corresponding, gradual change of identity can be

seen as a result of normal aging, which in this area is primarily recognized as affecting the picture of oneself in relation to physical ability and changes due to memory, perception, taste, etc. Drastically different, new life situations require effortful, intentional learning in order to adapt to the new situation. In psychology, this process is called “accommodation”, defined as the integration of new information into an existing cognitive structure by which this structure undergoes a major change.

Children

Identity confusion and forced entrance into adult life may be consequences of growing up in violent life circumstances. Traumatic experiences may cause **Alienation** such that the young person feels removed from his/her surroundings, both intimate family contexts and more abstract contexts such as society, culture and religion. The sense of security, gained through association with people who care, is fundamental to identity development, but this security is shaken during **Organised violence**. Consequently, the young person will experience doubts, both about others and of himself/herself, and this will influence his/her identity. Sometimes these problems result in identification with deviant groups and risk-taking or self-harming behaviour.

First therapy

If self-help as described above is not sufficient it might be useful to assist groups or individual people through **Counselling**, assisting mutual support in the group/family and giving explanations about identity problems and suggestions for overcoming them.

Second therapy

If there are obstacles to overcoming the problems in the form of pain or mental-health problems – treat these according to guidelines.

In children

Initiate group counselling aimed at strengthening mutual support and sharing among the young people in a secure and safe environment. Help

the young people to share their feelings and concerns and work with them to resolve problems at home. Act as a role model for them. Use lots of physical and creative activities. See also **Stress management**.

Family counselling may be necessary in order to establish a realistic and reasonable place for the young person in the family and support for his/her development into adulthood.

Note

In cases that do not respond to intervention, refer to next level.

HEALTHCARE SPECIALIST

Assessment

Conduct differential diagnosis of psychopathology. Also be aware of the possibility of child abuse.

Proposed measures

Treat according to findings.

Intimate relations

See **Family life, participation in** and **Sexual problems**.

Isolation

HEALTHCARE PROFESSIONAL

Key signs

Isolation is commonly defined as the avoidance of social contacts which can occur for many different reasons as a part of normal life or as a result of suffering from various psychiatric disturbances, e.g. some types of personality disorder, social phobia, **Depression** or psychotic diseases. Even

PTSD is often associated with isolation and, since this disorder is common in torture survivors, isolation will often be seen in these persons.

In some contexts, a “feeling of detachment or estrangement from others” is described as a common, but not required, symptom of PTSD. Social isolation is thus to be expected as a behavioural response if this symptom is present. As isolation is a potential symptom of PTSD and/or other post-torture psychiatric problems such as depression, no specific treatment guidelines are given but treatment should address the underlying disturbance.

In some cases, post-torture problems may mask a tendency to social isolation even prior to the trauma, e.g. due to social phobia, and treatment of these problems should also be considered in order to improve the person’s quality of life.

Note

Torture survivors or other people who have been persecuted or threatened with death are forced to be isolated by necessity and it may be very helpful to follow general therapeutic suggestions:

Meditation

Yoga

Breathing exercises

Stationary running

Tai chi

Art therapy

Lifting and carrying objects

HEALTHCARE ASSISTANT

Key signs

Lifting and carrying objects refers to the person's ability to raise an object in order to move it from a lower to a higher level. Lifting and carrying objects is an important part of the activities of everyday life. Some activities require fine coordination of small muscle groups and no particular force (lifting and carrying a glass of water). Other activities require more dynamic and strenuous force (lifting and carrying a child). Beatings, suspension by the arms, tight ropes around the muscles of the arm, being tied up in awkward positions for long periods of time and tight handcuffs are all torture methods which compromise the back and arm/hand function.

Action

- Ask for history and about the ability to lift and carry objects.
- Assess problems together with the spouse and try to find solutions to ease lifting or carrying problems, for instance by using tools or aids.
- Assess the person's ability to do the following activities:
Lift and carry
 - a drinking glass in the hands,
 - a child in the arms,
 - a bucket of water,
 - other specified objects.

Note

The above lift-and-carry activities are meant as examples. Lift-and-carry activities should be related to the person's daily life and relevant context.

HEALTHCARE PROFESSIONAL

Characteristics

See above.

First therapy

Identify impairments and barriers preventing lifting and carrying activities.

Second therapy

Counselling according to findings.

Note

The ability to carry out physical activities is also dependent on a person's mental state. Fear of pain and belief that physical activities will be harmful are often the main barriers to taking part in daily activities.

Maintaining a dwelling

HEALTHCARE ASSISTANT

Key signs

Acquiring and maintaining a dwelling and furnishings refer to finding, keeping and taking care of one's own dwelling, its exterior, interior and contents, such as paying rent or constructing a hut, repairing fixtures and furniture, and using the tools required for repair work. Because of various mental and physical difficulties, torture victims may not be capable of performing all these tasks, which may have been easy for them before torture. The consequences may be a slow fall into ruin with additional family consequences.

Action

- Help the person to activate himself/herself in simple daily routines and facilitate return to **Gainful activities**.
- Mobilize family support.
- Reduce alcohol or sedatives which will interfere with daily activities.
- If the person seems depressed, see a healthcare professional for medication.

Note

See **Gainful activities**.

HEALTHCARE PROFESSIONAL

Characteristics

Inactivity and hopelessness can be a problem for people after a traumatic experience. This can be part of somatic or mental **Disability** causing problems in maintaining proper housing for the person and his family.

First therapy

Diagnose treatable causes of inactivity.

Treat **Depression** or **Anxiety** accordingly.

Treat pain accordingly.

Support the patient in focussing on his/her abilities rather than the opposite.

Second therapy

As in many aspects of activities and participation, a practical reintroduction, training and encouragement from family members or friends is of paramount importance.

HEALTHCARE SPECIALIST

Assessment

Diagnose specific somatic or mental disease causing problems in finding a gainful activity.

Proposed measures

Propose specific treatment thereafter, if possible.

Mistrust

HEALTHCARE ASSISTANT

Key signs

People who show mistrust are characterized by their lack of trust in others and often by a generally suspicious attitude even towards healthcare staff. Mistrust may be a natural reaction and has proved useful in situations of persecution.

The condition is frequently seen in people who have been persecuted or subjected to **Organised violence**, resulting in their losing trust in fellow human beings, and it is accompanied by problems of **Isolation** and **Loss of interest** (see also **Paranoia**).

Action

- Take a history exploring whether the person has habitually shown a lack of trust or whether it appeared after persecution or torture.
- Search for traumatic events in the past.
- Behave very transparently and avoid any action that may aggravate the suspiciousness (such as passing on information without the patient's consent).
- If overtly suspicious, try to confront the patient with reality and do not confirm his/her ideas.
- If the person loses his sense of reality, refer to healthcare professional.

HEALTHCARE PROFESSIONAL

Characteristics

Mistrust, frequently as part of a post-traumatic stress disorder; explore whether there are other signs of this disorder.

First therapy

If mistrust is part of a **PTSD**-condition, treat this with a SSRI or TCA (Selective Serotonin Reuptake Inhibitor or Tricyclic Antidepressant).

Second Therapy

If the mistrust has become so severe that the person is no longer in touch with reality and has become openly paranoid, antipsychotic medication may be necessary for a period (see **Paranoia**).

HEALTHCARE SPECIALIST

Use structured interview (with caution if paranoia) to evaluate presence of mental illness.

Proposed measures

Check the use of anti-psychotics – problems of compliance, dosage, etc. People showing mistrust are characterized by their lack of trust in others and often by a generally suspicious attitude.

The condition is frequently seen in those who have been persecuted or subjected to **Organised violence** resulting in their losing trust in fellow human beings (see **Paranoia**).

Nightmare

HEALTHCARE ASSISTANT

Key signs

Dreams with extremely negative content, especially with recurrent, identical or similar content, are described as nightmares. Nightmares can be caused by anxiety or stress. Nightmares due to underlying anxiety disorders usually have a content closely corresponding to the concrete anxiety, whereas nightmares related to acute stress usually have more changeable contents.

Children

Nightmares are frightening dreams, where the child may shout out and possibly wake up very afraid. All children get nightmares occasionally. In traumatized children anxiety can be manifested in frequent nightmares.

Action

- Give information to reduce stress due to the person's (and his/her family's) erroneous concerns about nightmares:
 - Explain that nightmares are a natural phenomenon under certain circumstances, e.g. due to suffering from **Anxiety** or currently high **Stress**, but are not a sign of developing a mental or other disease.
 - Explain that reducing the underlying problems (such as stress or anxiety) can be expected to reduce the occurrence and intensity of nightmares, i.e. having nightmares is to some extent directly treatable.
 - Children who remember their dream need to be allowed to talk about it and be comforted by the parent.

If the nightmares are due to an underlying anxiety disorder, the main action to be taken is the treatment of this underlying disorder (refer to next level).

- For nightmares unconnected to identifiable, underlying, mental disturbances, the following method has been used successfully:
 - Write down (or draw/paint) your nightmare in detail.
 - Change the content of your nightmare from one point that you freely choose. Write down (draw/paint) the whole new version of the nightmare in detail.
 - Read (look at) the new version of the nightmare at least once a day under relaxed conditions and imagine the content as vividly as possible. Continue until the nightmare has disappeared.
 - If there is more than one nightmare: Work only with one at a time. If new nightmares occur, apply the same procedure.

Note

If there is no effect and/or nightmares seem to be linked to unidentified underlying problems or could be a side effect of medication – refer to next level.

Characteristics

Nightmares can occur without the dreamer suffering from any somatic or psychiatric diagnosis or even elevated **Stress** level. Most nightmares are, however, associated with elevated stress levels and underlying disturbances, especially anxiety disorders (see **Anxiety**), or PTSD. Nightmares can also occur as a side effect of medication, e.g. anti-depressives. It is thus important to rule out medication or other possible causes, e.g. other types of currently elevated stress or side effects of medication.

Children

Nightmares can be a symptom of anxiety in traumatized children, often in combination with other emotional symptoms.

First therapy

Provide further assistance in treatment of the underlying disorder – probably **Anxiety**, especially **PTSD**, in order to optimize the indirect treatment of nightmares.

Second Therapy

If the method of direct treatment described above (level 1) has previously been used: Assess whether the method was used properly (including the person's understanding and compliance; e.g. the person has not given a full account of the nightmare, excluding the most traumatic parts of the content). Maybe the approach should be adjusted and modified, e.g. the chosen nightmare is too traumatic and a less traumatic one should be chosen to begin with.

Third therapy – other treatment options

In late sleep phases, the proportion of Rapid Eye Movement (REM) sleep increases and the vividness of dreams is usually more pronounced. If the person's nightmares predominantly appear during later sleep phases, attempt to alter the sleep pattern by dividing the sleep into two (or if necessary more) phases in a similar manner as described under **Sleeping**

difficulties, addressing the problem of awakening due to pain because of lack of sleep pressure.

Managing the problems after experiencing a nightmare maybe an option; **Stress management** and behavioural advice (e.g. cooling down, physical activity) could be used.

In children

Help the parents to act in a comforting way, providing security and safety for the child. The child should never be punished for having emotional symptoms.

See **Interventions with traumatised children**.

Note

If there is no effect and/or nightmares seem to be linked to unidentified underlying problems or could be a side effect of medication – refer to next level.

Search for child abuse, incest, rape, sexual abuse of women, for television programs on terror, for radio and TV news on violence (such as police or military brutality in the communities) in the country or in other nations.

HEALTHCARE SPECIALIST

Assessment

Conduct differential diagnosis of underlying **Anxiety** disorders and/or other psychiatric problems. In children, use a structured interview (see **Assessment of torture survivors**; e.g. DISC or K-SADS-PL).

Exclude other potential underlying causes for nightmares, e.g. side effects of medication.

Proposed measures

Treatment according to findings.

Implement new or optimize ongoing medication.

Note that anti-depressive medication during implementation and reduction can have nightmares as a side-effect and that these may occasionally also occur during stable treatment.

Night terror

HEALTHCARE ASSISTANT

Key signs

Night terror usually affects children and in most cases disappears spontaneously during adolescence. It is often mistaken for a **Nightmare** as the affected person often seems to be extremely horrified during an episode. But in contrast to nightmares, there is no memory about an episode after awakening. During an episode the affected person has open eyes, talks and moves (e.g. sits up), and thus gives the impression of being awake, which is not the case.

Action

- In order to handle episodes of night terror:
 - Inform the parents (or the person if he/she is an adult) and the child about the innocent nature of the problem.
 - Make clear that verbal statements that could be experienced as embarrassing for the parents are the result of uncontrolled spontaneous activity in the nervous system and are not related to the child's real attitudes and feelings.
 - Instruct parents not to: a) wake the child, b) try to calm the child down, c) touch the child. These actions will be experienced as highly adverse by the child during an episode of night terror.
 - Instruct parents just to observe and wait out an episode (typically they last no longer than around 15 minutes) and to prevent the child from harming itself by its movements.

- In order to prevent the occurrence of night terror:
 - Instruct the parents to register the time between onset of sleep and the onset of an episode.
 - If there is a good estimation of the time lapse (the observation time needed depends on the frequency of episodes), instruct the parents to awaken the child about 15 minutes prior to the expected onset of an episode.
 - Let the child sleep again after some minutes; no special measures are to/should be taken apart from waking the child.

Note

Episodes can recur in relation to elevated **Stress**, e.g. infectious diseases; repeat the prevention procedure in these cases. If the handling of night terror has not improved and/or the prevention strategy does not work after some weeks – refer to next level.

HEALTHCARE PROFESSIONAL

Characteristics

Night terror is tied to a different sleep state (short time after the deepest Non-Rapid Eye Movement sleep) than nightmares (predominantly occurring during REM sleep). The problem is not directly caused by (traumatic) **Stress** but is an innocent symptom linked to maturation of the nervous system. Stress (including somatic problems such as infections) can trigger episodes and/or result in episodes recurring.

To eliminate the possibility of the problem being nightmares and not night terror, ask in-depth questions about whether there are any memories about the episodes. Complete, or almost complete, amnesia is expected in the case of night terror.

First therapy

The same instructions and preventive procedure as described above. Failure may be due to information not being properly given/understood; assess whether this might be the case. Instructions concerning the preventive

strategy may have to be adjusted, e.g. shorter/longer time of awakening before expected time of onset of episode.

Note

If no improvement is observable despite proper implementation of instructions, especially if there are signs of unidentified underlying factors such as diseases, psychiatric problems, etc., consider referral to next level.

HEALTHCARE SPECIALIST

Assessment

Examine whether there could be underlying factors originating in unidentified medical conditions and/or side effects of medication.

If available, a documentation of the sleep pattern in a sleep laboratory can give useful information that may help to optimize instructions, e.g. about the exact time to wake up in order to prevent episodes.

Proposed measures

Depending on findings.

Obsessive-compulsive activities

HEALTHCARE ASSISTANT

Key signs

Obsessions are distressing, intrusive thoughts and compulsions are the related actions in the form of tasks or rituals that are repeated again and again. In children they are part of normal development, as long as they can be stopped and do not interfere negatively with the life of the child. If the thoughts (obsessions) and acts (compulsions) cannot be stopped, even if they are experienced as unnecessary and silly by the person, they may be a sign of **Anxiety** or other emotional problems. Obsessions are also seen in

traumatized people, e.g. in the case of a rape victim who washes herself again and again.

Action

- Use **Psycho-education** to make the person aware of the nature of the problem.
- In the case of children, inform the parents about the nature of the problem and that the activities are involuntary and therefore the child should be supported and not scolded or punished.

Note

If the situation continues and seems to be problematic because it interferes with normal life, refer to next level.

HEALTHCARE PROFESSIONAL

Characteristics

Obsessions are thoughts that occur unintentionally and against the person's will and compulsions are acts that cannot be stopped, even if they are experienced by the person as unnecessary and silly. Both adults and children will experience anxiety when trying to break a compulsive pattern. A child might try to involve the parents in the compulsions, e.g. by asking them the same question again and again or demanding that the food is served in a certain order or things placed in a certain way. The child might experience guilt because of the demand made on the parents.

Obsessive-compulsive activities may be related to trauma.

First therapy

CBT, for children preferably in a family format (see **Counselling** and **Psychotherapy/CBT**).

See also **Anxiety** and **Avoidance behaviour**.

Second therapy

In the case of children, family counselling should focus on the nature of the problem and its relation to other problems. See also **Interventions with traumatised children**.

Medication with Selective Serotonin Reuptake Inhibitors may also be tried.

Note

When symptoms are severe and impacting negatively on the life and development of the person, refer to next level.

HEALTHCARE SPECIALIST

Assessment

Obsessive-compulsive activities can be part of other emotional and behavioural problems, e.g. **Anxiety**, **Depression** or **PTSD** that need to be treated. Make a thorough assessment using a standard interview format such as SCID (adults) or DISC (children).

Parenting

Key signs

Parenting is the process of raising and educating a child from birth to adulthood. Sometimes when parents are traumatized, it interferes with their ability to provide good parenting for their children. They can become preoccupied with their own problems so that they are not able to be available and emotionally accessible to their children and to offer protection and safety in stressful life conditions. This can be an important source of secondary **Stress** for the child in a situation of **Organised violence**.

Action

- Help the parents to deal with their own problems, see **Counselling**.

- Inform the parents about the reactions of children to traumatic experiences; see **Psycho-education** and **Interventions with traumatised children**.
- Help the parents to overcome social problems associated with their situation as traumatized by **Torture and Organised Violence**; see **Community life, participation in**.
- Involve the broader family network; there might be other family members who are able and willing to provide parenting for a period.

Note

If parents seem to be unable to care for their children despite help, it might be necessary to find other ways of ensuring that the basic needs of the children are met.

Performing household work

HEALTHCARE ASSISTANT

Key signs

Managing a household by cleaning the house, washing clothes, storing food and disposing of garbage requires overview and resources. Planning, organizing, cooking and serving meals for oneself and others and finding edible food and getting together ingredients for preparing the meal sometimes require complex methods of preparation (peeling, slicing, mixing, kneading, stirring).

In many cultures these activities are usually undertaken by women. If the woman is unable to take care of the household, the survival of the family is in jeopardy.

Action

- Ask for a history and ability to perform household work.
- Make a home visit and identify problems.
- Help the family to solve problems in their own context.

Note

It will be necessary to advise the men and other members of the family to help the women in performing these activities as a part of the therapy and also as an education on gender issues.

HEALTHCARE PROFESSIONAL

Characteristics

See above.

First therapy

Visit the family to supervise progress in **Problem solving** in context.

Second therapy

Consider appropriate treatment of relevant impairments. Support the patient in focussing on his/her abilities rather than the opposite.

Note

Contact a health specialist if severe disease or illnesses are identified.

Redress

HEALTHCARE ASSISTANT

Key signs

The object of redress is to “obtain reparation for the victims of torture and, when appropriate, their families, anywhere in the world. To make accountable all those who perpetrate, aid and abet acts of torture”. Strategies are to provide legal advice and assist torture survivors to gain access to courts and thus to redress for their suffering.

Action

- Redress is the process of reparation for torture survivors using social and jurisdictional reconstruction. It is a complex problem which needs the interaction of many actors.
- Redress is a matter that should be referred to the community level, not always involving medical professionals.

Note

Redress is an attempt to increase awareness of the use of torture and measures to provide legal action.

HEALTHCARE PROFESSIONAL

Characteristics

See above.

First therapy

Assessment of whether documentation of physical or psychological signs of torture is needed.

Note

The Istanbul Protocol should be adhered to for documentation. Legal expertise may be needed for court proceedings.

Regressive symptoms

HEALTHCARE ASSISTANT

Key signs

Regressive symptoms are reactions or behaviours that belong to an earlier period of development in the child's life. This could be a school-age child who starts wetting his/her bed again at night, a child who could play alone before, but now cannot let his/her mother out of sight or a child who starts

using baby language after having spoken properly for a period. Such reactions are frequent after traumatic experiences.

Action

Do not punish the child. See **Interventions with traumatised children**.

Note

Usually the regressive symptoms disappear once the child feels safe.

HEALTHCARE PROFESSIONAL

Characteristics

Regressive symptoms are reactions or behaviours that belong to an earlier period of development in the child's life. They occur when the child feels insecure, e.g. in a stressful life situation or when parents or carers are not available to fulfil the needs of the child. They can also occur as a result of the child's own traumatic experiences.

First therapy

Inform parents about why these symptoms occur and help them to provide safety and support for the child without punishment.

Second therapy

Family **Counselling**.

Note

Refer to next level if symptoms are persistent or interfere with the child's development.

HEALTHCARE SPECIALIST

Assessment

Take a detailed history and eliminate other possible sources of the problem such as physical illness or child abuse.

Proposed measures

According to findings.

Relational problems

See **Family life, participation in.**

Risk-taking behaviour

HEALTHCARE ASSISTANT

Key signs

Traumatized people, particularly older children and adolescents, sometimes engage in behaviour that involves risk to their lives as a reaction to traumatic experiences. This is a way of coping with feelings of **Anger** and **Depression**. This could take the form of drinking, using drugs, engaging in unprotected sexual activities, participating in dangerous behaviour in the traffic, refusing to go to school and joining violent youth gangs.

Action

Children and adolescents:

- Counsel parents to be firm with their children in opposing risk-taking behaviour. Even if the child rejects parental interference, parents need to take their responsibility as guardians in this situation. Older children and adolescents need to know that someone cares about them and is in control in difficult situations.
- Help parents to provide a structured home environment with clear rules about acceptable behaviour.
- Encourage the children to talk about their feelings, counsel them about the consequences of risk-taking behaviour and help them stay in school.
- Counsel teachers about the causes of risk-taking behaviour and encourage them to keep the child in the school.

Adults:

- Use **Psycho-education** to make the person aware of his/her self-destructive behaviour and how it is related to trauma. Give **Counselling** relevant to the specific type of risk-taking behaviour.

Note

If the behaviour continues and poses a threat to the person's health, refer to next level.

HEALTHCARE PROFESSIONAL

Characteristics

Risk-taking behaviour among traumatized people can be seen as a way of coping with feelings of **Anger** and **Depression** in a seemingly hopeless life situation. This is often the case during prolonged violent life circumstances. Such behaviour often poses a threat to the person's health, and takes the form, for example of, **Substance abuse**, unprotected sex and reckless driving.

First therapy

Family **Counselling**

Support for school teachers to deal with risk-taking children in the classroom.

Second therapy

Group counselling focussing on the particular type of risk-taking behaviour.

Note

In very serious cases refer to next level.

HEALTHCARE SPECIALIST

Assessment

A thorough assessment is necessary in order to identify the underlying causes of the risk-taking behaviour, e.g. **Depression** or ADHD.

Proposed measures

According to findings.

Self-efficacy problems

HEALTHCARE ASSISTANT

Key signs

Self-efficacy is defined as a person's perceived ability to solve their own specific problems. A person with self-efficacy believes in the possibility of influencing his/her own life situation. In relation to the objective ability to solve problems (see **Problem solving**), self-efficacy can be exaggeratedly low or high.

Low self-efficacy: The person might avoid engaging in the solving of a specific problem (compare **Avoidance behaviour**). The person's failure to solve the problem is explained by him/herself as being due to his/her personal incompetence or low abilities. If the person succeeds in solving/addressing the specific problem, this will often be explained by the person as being due to external factors (such as luck, the task being unusually easy, etc.)

High self-efficacy: The person engages repetitively in unsuccessful attempts at problem solving, since he/she does not possess adequate knowledge to address the problem. Failing to solve the problem, the person explains this as being due to external factors (such as bad luck, the problem being unusually difficult, etc.). Occasional success will be explained by the person's personal competences and high abilities.

Children

Traumatized young people may lose belief in self and others and thereby also in their own ability to influence their lives. They might then live unhealthy lives, engaging in risky acts and maybe identifying with deviant groups.

Action

- Give corrective information explaining the characteristics of low/high, adequate/inadequate self-efficacy.

In children

- Inform the young person and his/her parents about health hazards and how they can protect themselves against them, e.g. HIV. Help them to identify their options and take action where possible. See **Problem solving**.

Note

If the person's family does not accept corrective information, if it is difficult to find a suitable form and amount of physical activities, if the problem is embedded in a complex of other problems, e.g. **Anxiety**, **Depression**, that are difficult to address, or if the problems result in severe risks, refer to next level.

HEALTHCARE PROFESSIONAL

Characteristics

The degree of self-efficacy for a given problem depends on the person's previous experiences (own and/or based on the observation of other, similar, people) with similar problems, on social persuasions and on the person's interpretation of the physiological symptoms that accompany the problem (e.g. stress symptoms that may be interpreted in a catastrophic way, see **Stress**). Too low (occasionally even too high) self-efficacy can be expected to become a problem for torture survivors since they may be confronted with new problems, e.g. **Pain, chronic** and **Anxiety** for which they lack previous experience and advice for suitable coping strategies from

the social environment; additionally, the experienced symptoms may be prone to an erroneous, catastrophic interpretation.

Most people see physical symptoms as caused by an ongoing organic disease. Accordingly, it is natural, and in the case of acute diseases often acceptable, that the self-efficacy for handling these symptoms is low. Hence, it is assumed that suitable treatment can only be provided by medical experts. Many of the post-torture problems, however, such as chronic pain or anxiety-induced symptoms, do not have the character of acute diseases but are rather dysfunctions that cannot be fully treated by passively receiving a medical treatment, but instead demand that the sufferer becomes an educated, active person who takes responsibility in order to achieve adequate treatment and handling of the problems. To support the post-torture person in developing this perspective is the meaning behind increasing his self-efficacy.

Low self-efficacy can also be a symptom of depression and accordingly, anti-depressive treatment has a high priority in these cases. If the person receives medical treatment, it should be given in a way that promotes self-efficacy, e.g. by introducing some freedom in instructions about medication, by giving responsibility to the person by instructing him to find out exactly what the optimal time is for taking a certain medicine.

Children

Young, traumatized people will often experience doubts both of others and of themselves and this might cause them to believe that they cannot influence their lives in any way. They might identify with deviant groups, engage in risky behaviour, and neglect their own health, i.e. by using too much alcohol or drugs or having unprotected sex.

First therapy

The treatment of exaggerated low or high self-efficacy is illustrated by using the example of coping with chronic pain.

Assess whether there is too low or too high self-efficacy:

- *Too low self-efficacy*: The person feels that he/she is a helpless victim of the pain, unable to influence the pain by their own behaviour. They may be convinced they are suffering from an ongoing but undetected acute injury to the body and accordingly, they seek diagnostic help and treatment from experts. The “patient role” results in putting all responsibility onto the diagnosing and treating experts. Typically, the person avoids behaviours that he/she expects to potentially worsen the imagined underlying damage (e.g. not moving the head preventing further worsening of an imagined instability in the neck). The expected result is an intensifying of the problem, since measures that the person could take to reduce the pain are not taken and/or immobilization is practiced, which is known to have a pain-intensifying effect in the long term.
- *Too high self-efficacy*: The person is erroneously convinced (e.g. based on previous experience from acute pain states) that the pain problem can be “trained away” and/or that provocation of pain by physical exercises has a healing effect in the long run (“bad things chase bad things away”). Alternatively, the person expects excessive rest to alleviate the pain problem, which can result in the same activity-avoiding behaviour as described above, but based on a different cause (e.g. the conviction that not moving the head will allow an imagined instability in the neck to heal). The expected result in both cases is negative as it is known that not only immobilization but also that unsuitable/exaggerated or pain-provoking exercises have an intensifying effect on chronic pain.

Give corrective information (involve family/social environment if possible in order to use social pressure in suitable direction).

- *Too low self-efficacy*: Explain the harmless character of chronic pain. Explain that immobilization exacerbates the problem and that, well-paced movement and physical activity has a beneficial effect on pain intensity. Explain that the person, by trying, can detect many factors that influence pain and that the person himself can control, e.g. the use

of heat and cold, distraction, finding the right amount of physical exercises, etc.

- *Too high self-efficacy*: Explain that the problem cannot be “trained away” nor “rested away” but in addition to other measures, it should be handled by a suitable level of physical activity. Explain that the provocation of pain does not have a habituation effect but risks further increasing pain intensity.

Use a stepwise strategy for altering activity-avoiding behaviour as described under **Avoidance behaviour**.

In children

Inform the young person of how he/she can influence his/her own health situation. Try to identify the underlying problems by listening to the young person’s story and problems and counsel him/her accordingly. Forming support groups of young people might also be helpful. See **Problem solving** and **Stress management**.

Family **Counselling**. Parents need to be made aware of the situation of the young person and take responsibility for supporting their child. They might themselves need counselling because of traumatising.

Second therapy

When low self-efficacy is mainly secondary to other problems, e.g. **Depression, Anxiety**, etc., these problems should be addressed.

Note

Refer to next level if it is thought that additional medical expertise could optimize the application of the guidelines and/or when it is advisable with respect to assessment and treatment of diseases, symptoms and disorders.

HEALTHCARE SPECIALIST

Assessment

Rule out any hitherto unidentified/untreated somatic or other circumstances that contribute to the problem.

Proposed measures

According to findings.

The guidelines described above can be used for additional and refined

Psycho-education about self-efficacy.

Self-harm

HEALTHCARE ASSISTANT

Key signs

Self-harm may manifest itself in many ways and be carried out for many reasons. The methods depend to some extent upon the cultural setting but also on gender, age and “fashion”. Common forms of self-harm include intake of pills, self-poisoning or cutting one’s skin. Various forms of **Antisocial behaviour**, such as reckless driving, gambling, unsafe sex, taking drugs or excessive amounts of alcohol may all be signs of self-harmful behaviour.

With children/adolescents:

Self-harming behaviour is frequent among adolescents. It can take different forms such as cutting the skin, banging one’s head against the wall, burning oneself with cigarettes, excessive use of alcohol and drugs, eating disorders or suicide attempts. The purpose of the self-harming behaviour is to relieve inner tension or to get attention from the environment.

Note that a history of child abuse, incest or family violence must be considered.

Action

- Ask about previous trauma, previous episodes of self-harm, of recent life stressors and family history.
- Get a history about this from relatives of the person.
- Show an understanding attitude, listen to his/her story and avoid blaming the person.
- Ensure that harmful substances, pills, etc. are kept out of reach of the person.
- Try to get information about the person's belief system, religious or ideological, that may provide support in difficult moments and encourage him/her to use this.
- Use of distraction to take the mind off harmful impulses.
- Ensure that he/she is not left alone but that there are relatives or others nearby.
- Listen and show that you do not think that something is wrong with the person or that he/she is "weird" or "crazy".
- Share suicidal thoughts and feelings, fears, **Anger**, disappointment and sorrow.
- Encourage the person to be active, to go for a walk and get some exercise. Often depressing and suicidal thoughts and feelings fade when you are engaged in other things.
- Remember that along with sad thoughts and feelings there are also thoughts and feelings which are not suicidal.
- If the person is a child or an adolescent, inform parents and teachers of the problem. Talk with the young person and offer supportive guidance.

Note

Many may dissimulate their intentions.

Refer to next level if the self-harming behaviour continues or in the case of suicide attempts.

HEALTHCARE PROFESSIONAL

Characteristics

People who harm themselves may do so in a repetitive manner using the same method in moments of distress. Many explain that they get an immediate feeling of relief after the harmful behaviour.

Self-harm may be a sign of an underlying mental disorder. A large proportion of those showing suicidal behaviour may have depressive episodes.

Always keep in mind signs of emotionally unstable behaviour with episodes of impulsiveness and reckless or suicidal behaviour.

With children/adolescents:

Impulsive self-harm arises as a formidable and irresistible urge to harm oneself. If performed it gives an immediate feeling of emotional relief.

Another type of self-harm are compulsive and are recurring acts which take place irrespective of the emotional condition of the young person; it has become a habit that takes place automatically and without reflection.

Self-harm can be used by traumatized young people in order to stop flashbacks.

First therapy

- Take the history of the person. Details about previous episodes of self-harm, recent stressful events, losses.
- Interview the person to see if there are signs of depression. If so treat this (see **Depression**).
- Show an understanding attitude, listen to the person's story and avoid blaming him/her.
- Ensure that harmful substances, pills, etc. are kept out of reach.
- Try to get information about the person's belief system, religious or ideological, that may provide support in difficult moments and encourage him/her to use this.
- Use distraction to take the person's mind off his/her harmful impulses.

- Ensure that the person is not left on his/her own but that there are relatives or others nearby.
- Help the person to remember that he/she may have experienced times in life when they did not have suicidal thoughts and feelings but were hopeful.
- Acknowledge that having suicidal thoughts in the midst of other thoughts is emotionally draining. It is a sign of strength not to give in.

Second therapy

Establishment of self-help groups with others who may exhibit similar behaviour.

Try to look together for solutions to any imminent problems that may cause concern.

See **Counselling**.

HEALTHCARE SPECIALIST

Assessment

Self-harming behaviour can be part of a psychiatric condition, e.g. **PTSD**, **Anxiety** disturbances, **Depression** or personality disturbances.

Use structured interview (See **Assessment of Torture Survivors**; SCID or SCAN, or in case of children DISC or K-SADS-PL).

Proposed measure

Treat possible mental illness according to findings.

Self-mutilation

See **Self-harm**.

Taking care of others

HEALTHCARE ASSISTANT

Key signs

After a trauma such as torture, the person is often in a state of acute or chronic distress, where for the chronic state, **PTSD** is often diagnosed. Inactivity due to **Depression**, **Anxiety** or pain can cause problems in taking care of others as well as oneself (see **Parenting** and **Family life, participation in**).

Action

- Visit home and assess problems together with spouse or other family member.
- Help the person to become active in simple daily routines and give advice on structuring the day.
- Give **Counselling** on **Stress management**.
- Reduce alcohol intake and sedatives.
- If the person seems depressed, see a healthcare professional for medication.

HEALTHCARE PROFESSIONAL

Characteristics

Inactivity and hopelessness can be a problem for people after a traumatic experience. This can be part of a somatic or mental **Disability** causing problems for the individual when taking care of close and extended family.

First therapy

Diagnose treatable causes of inability to care for family.

Treat **Depression** and **Anxiety** accordingly.

Treat **Pain, chronic** accordingly.

Second therapy

Support the patient in focussing on his/her abilities rather than the opposite.

HEALTHCARE SPECIALIST

Assessment

Diagnose specific somatic or mental disease causing problems in finding gainful activity and taking care of family.

Proposed measures

CBT supported by multi-professional rehabilitation may be needed.

Toileting problems

HEALTHCARE ASSISTANT

Key signs

A traumatised child might have problems controlling the bladder or bowel even if he/she was able to do so earlier.

Action

Try to find the reason. The child might be upset because of traumatic events. He might also be reacting to changes in the family situation, e.g. loss of or separation from a parent or because of **Anxiety** or fears, e.g. of going to the toilet. Never scold or punish the child. Pain due to anal fissures or haemorrhoids may also be a cause.

Note

Children cannot be expected to exert bowel and bladder control until approximately 3 years of age, and at night not before approximately 5 years of age. Refer to next level if the problem continues, particularly when the child cannot control the bowel, and if it co-occurs with other symptoms.

HEALTHCARE PROFESSIONAL

Characteristics

Traumatic events can cause a child to react with **Regressive symptoms** such as losing control of bladder and bowel. This might cause considerable secondary problems for the child if it happens in school or when the child is playing with other children.

First therapy

Make sure the symptoms are not signs of physical illness. Inform and counsel parents and make sure they do not scold or punish the child. Let the child talk about upsetting events. If it happens in school you need to inform the teacher of the nature of the problem and the teacher needs to explain to the class that wetting is normal and that it can happen to any child. Attempts from other pupils to tease the child should be stopped.

Second therapy

Family **Counselling**. See also **Interventions with traumatised children**.

Note

Refer to next level if the problem persists and is part of a larger symptom complex.

HEALTHCARE SPECIALIST

Assessment

Take a detailed history in order to establish the nature of the problem.
Eliminate physical illness.

Proposed measures

According to findings.
CBT.

Traumatic play

HEALTHCARE ASSISTANT

Key signs

Traumatic play is compulsory repeated behaviours or monotonous play in which themes or aspects of the traumatic experience are expressed. This re-enacting of the event is the way particularly young children try to deal with and conquer the experience.

Action

- Help the parents to encourage children to talk about their feelings and experiences in words or in drawings or play and to listen carefully.
- Counsel parents never to scold or punish the child for his/her behaviour.

See also **Interventions with traumatised children.**

Note

If the child has more emotional symptoms and does not respond to parents' change of behaviour, refer to next level.

HEALTHCARE PROFESSIONAL

Characteristics

Elements of traumatic events will often show up in children's play as their way of conquering the situation. Re-enacting traumatic events in play in a compulsory or monotonous way, however, is a symptom of traumatisation in children.

First therapy

Family **Counselling** and **Psycho-education** of parents focused on understanding the child's reaction to traumatic events.

Second therapy

Group work for older children and adolescents. See **Interventions with traumatised children**.

Note

If the traumatic play is part of a larger symptom complex, refer to next level.

HEALTHCARE SPECIALIST

Assessment

Assess for **PTSD** or other emotional disorders using a structured interview (see **Assessment of Torture Survivors**; e.g. DISC or K-SADS-PL).

Proposed measures

According to findings, including **CBT** in an individual family or group setting.

Using transport

HEALTHCARE ASSISTANT

Key signs

Being transported as a passenger by bus, train or subway is often connected with both physical and mental strain. Physically, because it requires a lot of energy and good body function and ability to move around; mentally, because of having to remain in frequently cramped and overcrowded vehicles. **Anxiety** and fear of facing obstacles under strenuous condition may prevent the tortured person away from getting around. This may cause problems for the person and for the whole family.

Travelling on one's own and being in control of and driving a vehicle, or the animal that pulls it, such as a car, bicycle, boat or an animal-powered

vehicle or riding an animal such as a horse, ox or camel, may also cause problems because of lack of physical strength and pain.

Action

- Ask for history and ability to use transport.
- Identify restrictions to use of transport, and try to find context-related solutions to overcome these.

Note

Refer to healthcare professional if health-related problems are the barriers.

HEALTHCARE PROFESSIONAL

Characteristics

See above.

First therapy

Identify health-related problems, including **Anxiety**, and treat these.

Second therapy

Counselling or **Psycho-education**.

Note

Refer to a healthcare specialist in psychiatry or in relevant somatic area if serious health problems are identified.

In some countries, where there are restrictions to free circulation, people may be subject to frequent police or military registration or object of trauma by **Organised violence** during transport. In such cases it may be very stressful to travel and the person could develop **PTSD**-related symptoms.

HEALTHCARE SPECIALIST

Assessment

Assess for more complicated mental and physical problems.

Proposed measures

According to findings.

Walking problems

HEALTHCARE ASSISTANT

Key signs

The person may have problems walking:

- short distances (less than a kilometre).
- on different surfaces (slopes, grass, gravel) with shoes or barefoot.
- long distances (more than a kilometre such as across a village or town, between villages or across open areas).
- around obstacles such as people, animals and vehicles, walking around a marketplace or a shop, around or through traffic or other crowded areas.

Back pain, Leg pain, Foot pain and Muscle, joint and bone pain can all cause walking problems.

Action

- Ask for history and about the ability to walk and move around.
- Support the person with a cane or stick (of proper height). This may increase walking distances.
- Recommend walking and moving around. The effect is often the reduction of pain and better walking function.
- Look for wounds or discolouring of the feet and legs. If present, refer immediately to a healthcare professional.

Note

Loss of blood supply to the legs rapidly produces pain and inability to walk. Go to the next level immediately.

The falanga torture method may produce nerve injury in the foot soles, giving **Pain, neuropathic**.

HEALTHCARE PROFESSIONAL

Characteristics

Walking is moving along a surface on foot, step by step, so that one foot is always on the ground, such as when strolling, sauntering, walking forwards, backwards, or sideways.

Action

- Look for infections in the foot or leg.
- See **Back pain, Leg pain** and **Foot pain**.
- Examine for neurological problems (nerve injury after falanga or compression of leg; spinal cord injury or brain injury after beating or stabbing).

First therapy

Treat local infections

Counsel about movement.

Treat **Pain** (back, leg, foot, neuropathic).

Try out or improve walking aids.

Second therapy

Provide wheel chair or other object with simple wheels for own propulsion.

Washing problems

HEALTHCARE ASSISTANT

Key signs

In prisons and detention centres washing facilities are lacking and the victim is often deprived of access to water as part of the torture and breaking down of human dignity. The survivor may be struck by recurrent infections and diseases. Because of pain in various parts of the body or because of **Depression**, the person may not have the energy to wash his/her body and to keep the teeth clean.

Action

- Ask for history and about ability to wash own body parts.
- Encourage the person to wash the teeth to avoid deterioration and loss of the teeth and infections in the mouth.
- Encourage the person to wash the whole body including intimate areas to avoid infections. Encourage family members to help washing the person if he/she is too disabled.

Note

Refer to healthcare professional if serious infections are identified.

HEALTHCARE PROFESSIONAL

Characteristics

See above.

First therapy

Treat infections.

Second therapy

See **Anxiety, Depression, Tiredness and Counselling**.

Note

As a consequence of the filthy conditions in prisons and detention centres, the torture victim may develop an excessive need to wash (phobia) after release. Refer to a healthcare specialist if needed.

Worrying about symptoms

HEALTHCARE ASSISTANT

Key signs

Worrying is a common behaviour, and is in itself not abnormal and does not require any intervention. A tendency to worry about minor problems is part of some people's personalities. There may be good reasons for the behaviour - physical, social, psychological or legal - and the worrying will usually subside over time or when the problem causing it is solved or vanishes (see **Problem solving**).

Worrying about health problems is frequently encountered in torture survivors who may seek help for various, often vaguely described, physical problems. But worrying may take an excessive turn and occupy the person's mind disproportionately. In such cases the person may typically not be calmed by explanatory measures or comforting, but will continue to have his/her mind occupied with worrying thoughts. The worrying may be accompanied by signs of anxiety and depressive symptoms (see **Anxiety** and **Depression**).

Action

- Ask about whether the person has a worrying nature.
- Try to get an impression of what usually helps the person to calm down, e.g. distraction, company of others, being calmed.
- Show an understanding attitude, listen to the story, acknowledge the person's worry and do not aggravate the reasons for the worries.

- Refer to next level if the worrying reaches unrealistic proportions, colouring the entire outlook of the person.

Note

Worrying may be a part of a depressive episode (see **Depression**) or a sign of anxiety.

HEALTHCARE PROFESSIONAL

Characteristics

Worrying may change from a normal phenomenon of a benign nature, to becoming excessive and occupy the person's mind and outlook disproportionately. In such cases the person may typically not be calmed by explanatory measures or comforting, but continues worrying and his/her mind may be entirely occupied with worrying thoughts.

The person may show other signs such as anxiety or depression (see **Anxiety** and **Depression**).

First therapy

Show an understanding attitude; listen to the person's story.

Try to get an impression of the reasons for the worrying.

Second therapy

See **Counselling**.

Interview the person to see if there are signs of depression or anxiety. If so, treat this (see **Depression** and **Anxiety**).

Consider complimentary types of therapy, such as art or music therapy.

Note

Refer to next level if the worrying gets so intense that the person sees himself/herself as unworthy and that he/she does not deserve to live, or if other signs are observed indicating that worrying is far beyond any normal proportion. Refer a child to the next level if the child has other severe symptoms of emotional imbalance.

HEALTHCARE SPECIALIST

Assessment

Use structured interview (see **Assessment of torture survivors**; SCID or SCAN) to evaluate underlying mental illness.

Proposed measure

Treat possible mental illness (**Depression** or **Anxiety**) according to findings.

2.3. CONTEXT

Armed conflict

See also **Local community breakdown**.

HEALTHCARE ASSISTANT

Key signs

Armed conflict causes significant physical, psychological and social suffering to the affected populations. The psychological and social impacts may be acute in the short term, but they can also undermine the long-term mental health and psychosocial well-being of the affected population. One of the priorities is thus to protect and improve people's mental health and psychosocial well-being. Mental health and psychosocial problems in armed conflict encompass far more than the experiences of **Post-traumatic stress disorders (PTSD)** and the problems are interconnected.

Significant problems of a social nature include:

- Extreme poverty; discrimination, marginalization or political oppression; mourning because of loss of family members or close friends.
- **Family separation**; disruption of social networks; **Local community breakdown**; increased gender-based violence.

Significant problems of a predominantly psychological nature include:

- Pre-existing problems, e.g. severe mental disorder; alcohol or other drug abuse.
- Psychological problems induced by the armed conflict, e.g. grief; non-pathological distress; **Depression** and **Anxiety** disorders, including PTSD.

People at increased risk of such problems are:

- Women, e.g. pregnant women, mothers, widows and in some cultures unmarried adult women and teenage girls.
- Men, e.g. combatants, idle men who have lost the means to take care of their families, young men at risk of detention, abduction or being targets of violence.
- Children such as separated or unaccompanied children (orphans), children recruited or used by armed forces or groups, trafficked children, children in conflict with the law; children engaged in dangerous labour, children who live or work on the streets and undernourished/under-stimulated children.
- Elderly people, especially when they have lost family members who were care-givers.
- Extremely poor people.
- Refugees, persons subjected to **Forced displacement**, i.e. internally displaced persons (IDPs) and migrants in irregular situations especially women and children without papers.
- People who have been exposed to extremely stressful events/trauma, e.g. people who have lost close family members or their entire livelihood, rape and TOV, etc.
- People in the community with pre-existing severe physical, neurological/mental disabilities or disorders.
- People in institutions: orphans, elderly people, people with neurological/mental disabilities or disorders.
- People with pre-experience of severe social stigma, e.g. commercial sex workers, people with severe mental disorders, survivors of **Sexual violence**.
- People at specific risk of human rights violations, e.g. political activists, ethnic or linguistic minorities, people in institutions or detention, people already exposed to human rights violations.

Assessment

Although at-risk people need support, they often have capacities and social networks that enable them to contribute to their families and to be active in social, religious and political life.

- The nature and extent of resources available and accessible may vary with age, gender, socio-cultural context and the conflict environment.
- Identify resources such as skills in **Problem solving**, communication, negotiation and earning a living.
- Identify potential social resources such as families, community leaders, traditional healers, community health workers, teachers, women's groups, youth clubs, etc.
- Identify economic resources such as land, crops and animals and educational resources such as school teachers and health posts and staff.
- Identify individuals with particular resources like community leaders, persons with experience in voluntary/grass root work, school principals.
- Identify significant religious and spiritual resources including religious leaders, local healers, practises of prayer and worship, and cultural practises such as burial rites.
- Assess whether the resources are helpful or harmful, and the extent to which affected people can access them.

Action

- Establishment of security and services that address basic physical needs (access to food, water, sanitation, shelter, basic healthcare and control of communicable diseases).
- Protection of individuals and groups who are at increased risk of human rights' violations.
- Psychological first aid and basic mental healthcare by primary health care workers.
- **Counselling** of the smaller number of individuals, families or groups about needs, for example survivors of gender-based violence might need a mixture of emotional and livelihood support from community workers/health assistants.
- Establishment of self-help groups of people resembling each other (e.g. all women, those from a particular community).

- Participation of local people to retain or resume control over decisions that affect their lives and to build the sense of local ownership that is important for achieving quality, equity and sustainability.
- Involve local people to the greatest extent possible in the assessment, design, implementation, monitoring and evaluation of assistance.
- Support self-help and strengthen resources already present.
- Identify, mobilise and strengthen the skills and capacities of individuals, families, communities and society.

Activities that are integrated into wider systems, e.g. existing community-support mechanisms, formal/non-formal school systems, general **Health services**, general mental health services, etc. tend to reach people and are often more sustainable and tend to carry less stigma. See **Local community breakdown**.

Specialised services represent the additional support required for the small percentage of the population whose suffering, despite the supports already mentioned in levels 1 and 2, is intolerable and who may have significant difficulties in basic daily functioning. This assistance should include psychological or psychiatric support for people with severe mental disorders, whenever their needs exceed the capacities of existing primary/general health services. Such problems require either referral to specialised services if they exist, or initiation of longer-term training and supervision of primary/general healthcare providers at levels 1 and 2.

Basic needs not satisfied

Assessment

Meeting essential needs and restoring life with dignity are core principles that should include all humanitarian action in conflict and post-conflict areas. *The medical problems of torture survivors are complex because psychological symptoms and multiple social problems compound them.* If needs are not fulfilled, humans *physiological needs* take highest priority.

The physiological needs of the organism, those enabling homeostasis, consist mainly of:

- The needs to breathe, drink water, sleep, regulate body temperature, regulate homeostasis,
- The needs to eat, to dispose of bodily wastes and the need for sexual activity.

When physiological needs are met, the *need for safety* will emerge, these include:

- Physical security – safety from violence, aggression, security of employment, health, family and personal property.

When physiological and safety needs are met, the *social needs* will emerge. These involve emotion-based relationships in general such as:

- Friendship, sexual intimacy, having a supportive and communicative family.

Humans generally need to feel a sense of belonging and acceptance, whether it comes from a large social group (clubs, religious groups, professional organisations, sports teams, gangs) or small social connections (family members, intimate partners, close colleagues). They need to love and be loved by others. In the absence of these elements, many people become susceptible to loneliness, social **Anxiety** and **Depression**.

All humans have a need to be respected - to have self-respect and to respect others. Imbalances in these needs can result in low self-esteem. Often torture survivors, refugees and forcibly displaced people have restricted access to work, **Education**, housing, welfare and basic healthcare.

The most urgent needs of torture survivors are:

- Shelter or housing
- Safety and security
- Food support (food security and nutrition)

- Water and sanitation
- Control of communicable diseases
- Medical care for individual and/or family
- Mental health care for individual and/or family
- Income support and employment
- Advice on legal or migration matters and social support
- Spiritual needs
- Schooling for children (access to **Education**)
- Child care
- Local language classes

Action

- Map social dimensions of existing resources, gaps and at-risk groups regarding basic needs listed above.
- Map existing formal and non-formal resources and practices.
- Needs assessment in order of priority:
 - Provide basic life support needs.
 - Protect victims from violence and aggression.
 - Address the psychological/social **Stress** and provide the victims with psychological and social support.
 - Meet the growth needs.
 - Spiritual needs.
- Establish outreach teams or mobile clinics to increase accessibility to health service for people in distant, rural areas (see **Breakdown of infrastructure** and **Local community breakdown**).
- Ensure security and protection of the vulnerable groups (physiologically, socially, economically and politically), see **Torture and Organised Violence: An example of Sexual violence**.
- Strengthen the national capacity of health systems to provide **Health services** including mental health care and psychosocial support, see **Public health approach**.
- The aim of such actions is to improve accessibility to health especially for those at increased health risk; include specific psychological and social considerations in provision of general healthcare.

- Provide access to care for people with severe mental disorders.
- Minimum Standards for e.g. shelter space per person; water litres/person/day available; food kcal/person/day available, etc. can be found at: www.sphereproject.org. The Sphere standard, the Humanitarian Charter and the code of conduct have been developed to increase effectiveness and accountability. The minimum standard can help in prioritising the limited resources.

Breakdown of infrastructure

Key signs

In post-conflict areas the influence on infrastructure, the degree of damage differs depending on the strategic targets for destruction, the resources that are available to rebuild the infrastructure, and lastly the existence of safety and security for transportation. The breakdown often includes roads, with bridges over rivers, often being in poor condition, and lack of security or lack of any form of public transportation are issues to consider.

Often power stations for supply of electricity or infrastructural communications have been the strategic targets for attacks during an **Armed conflict** and are deficient.

Lack of man power or recruitment of staff to organise the logistic issues.

All these may result in: Lack of food and of supply of materials, lack of water, sanitation, power and fuel, security problems, lack of accessibility to healthcare and essential drugs and increased risk of health problems among vulnerable people.

Assessment

Assessment of the extent of breakdown and functioning of the infrastructure.

Assessment of geo-political factors (climate, political willingness, security, locations, roads, communication, electricity, health facilities).

Assessment of victim demography.

Assessment of environmental factors (water, sanitation, topography of the area).

Assess how communication can be established within the affected area - the equipment required; Telex, fax, telephone, radio, etc. - establish good communication channels.

Map location and condition of roads, railways, harbours and airports/strips.

Action

- Create co-ordination body and leadership.
- Needs assessment in order of priority:
 - Provide basic life support needs.
 - Protect victims from violence and aggression.
 - Address the psychological and social **Stress**, provide the victims with psychological and social support.
- Establish outreach teams or mobile clinics to increase accessibility to **Health services** for people in remote, rural areas.
- Ensure security and protection of the vulnerable groups (physiologically, socially, economically and politically), see **Torture and Organised Violence**: An example of a **Population at risk** of developing mental illness.
- If electric power lines are not available in the area, a generator is required.
- Rebuild roads, etc.
- Locate available vehicles.

Domestic Violence

HEALTHCARE ASSISTANT

Key signs

Violence against women is a universal phenomenon that persists in all countries of the world, and perpetrators of that violence are often well known to their victims. Violence against women by an intimate partner is a

major contributor to the ill-health of women. It has a far deeper impact than the immediate harm caused. It has devastating consequences for the women who experience it, and a traumatic effect on those who witness it, particularly children. Violence against women is a violation of basic human rights that must be eliminated through political will, and by legal and civil action in all sectors of society.

Violence against women by their male partners is common, widespread and far-reaching in its impact. The violence includes: Physical and **Sexual violence**, emotional abuse and controlling behaviours by the intimate partner.

The physical violence may include:

- Slapping, or throwing something at her that could hurt her.
- Pushing her.
- Hitting her with a fist or something else that could hurt.
- Kicking, dragging or beating her up.
- Burning her on purpose or throwing acid on her.
- Threatening her, or using a gun, knife or weapon against her.
- Violence during pregnancy.

The sexual violence may include:

- Being physically forced to have sexual intercourse against her will.
- Having sexual intercourse because she was afraid of what her partner might do.
- Being forced to do something sexual she found degrading or humiliating.

The emotional abuse may include:

- Being insulted or belittled in front of others.
- Being intimidated or scared on purpose, for example by a partner yelling and smashing things.
- Being threatened with harm.

Controlling behaviour may include:

- Keeping her from seeing friends.
- Restricting contact with her family of birth.
- Insisting on knowing where she is at all times.
- Ignoring or treating her indifferently.
- Getting angry if she speaks with other men.
- Often accusing her of being unfaithful.
- Controlling her access to healthcare.

Taking an “ecological” approach to improve factors that protect women from violence:

Higher **Education** is associated with less violence in many settings.

An understanding of the cycle of domestic violence can be helpful to the helper, and the person involved in this situation: *Tension-Building* (criticisms, swearing and threats) → *Violence* (physical and sexual attacks) → *Seduction* (apologies and promises to change, gifts).

Pointing out this cycle may help to increase the awareness of the person being abused about the ongoing nature of the violence, or at least help her or him to identify warning signs particular to her or his situation. Many people wonder what makes it so difficult for someone to leave an abusive situation, and why so many people return to the abusive relationship. It is often because the central components of the cycle involve *love, hope and fear*.

Children:

The emotional lability that is an effect of **Torture and Organised Violence** sometimes develops into domestic violence when both parents are traumatized and unable to control the situation. This can have a profound effect on the children who can both become victims of parental violence and secondary victims from watching violence between the parents.

Action

- *Safety plan:* In a situation of great danger and ongoing abuse, it is a good idea to talk about a safety plan for the person being abused. Identifying times of risk, based on the model of a build-up in tension is essential. Then the person may plan to leave the situation ahead of time, until things settle down. Alternatively, developing an escape plan for actual situations of violence is important. This may mean thinking of friends or neighbours to go to for help, or having money available somewhere for transport.
- *Legal support:* It may be useful to provide referrals to legal agencies that specialise in this area.
- *Family support and counselling:* Often the best people to assist in the situation of abuse are the family members of the person. With permission, it may be helpful to make contact with family, and encourage assistance.
- *A qualified women's organisation as a support group.*

Children:

- Ensure that the violence towards the child is stopped immediately. It might be necessary for the violent parent to leave the family for a while or for the mother and child to be taken into safety in another place, if the father is violent.
- If the violent parent is aware of the situation, **Counselling** can be used.
- As **Substance abuse** often aggravates the situation; take a detailed history of any substance abuse and counsel parents on this issue.
- Involve the broader family or community network in order to ensure that help is available to the family and that there is protection for the children.

Note

In some situations the development of domestic violence is related to earlier experience of torture in the perpetrator, and he/she might themselves be a victim who also needs help related to their own traumatic

experiences. They may even have repetitive behaviour and reproduce their own violent history in their family.

If the violence is directed towards children, it may be a legal requirement to report the case so that the authorities can intercede. See also **Aggressive outbursts**.

HEALTHCARE PROFESSIONAL

Characteristics

See above.

The Wheel of Violence:

The violence usually increases as the abusing partner gains more control over the person's life. *The core issue is about power and control* and many abusers will try to take away any control and power that the person has.

The abuser uses *threats* as well as intimidation and may repeatedly attack the person verbally, eroding *self-esteem* and beliefs about self and others who care about him/her.

Isolation is common, and restricting the victim's social movements, even cutting them off from family and close friends.

Economic control, such as ensuring that the person has no money, is a concrete way of gaining power and limiting options.

First therapy

- The health sector can play a vital role in preventing violence against women, helping to identify abuse early, providing victims with necessary treatment, and referring women to appropriate care. **Health services** must offer places where women feel safe and are treated with respect, not stigmatised, and where they can receive quality, informed support. Addressing in particular the reluctance of abused women to seek help.

- It is important to improve health-seeking behaviour in women and overcome fear of the consequences of seeking help such as further violence, losing children, or bringing **Shame** on their family and the stigma. They might also fear that they would not be believed or that it would not help if they did seek help.
- Promote gender equality and women's human rights.
- Improving women's legal and socio-economic status to reduce women's vulnerability to violence. This includes improving women's awareness of their rights related to owning and disposing of property and assets, access to divorce and child custody following separation.
- Women's access to **Education**, particularly keeping girls enrolled throughout secondary education, and to safe and gainful employment, should also be strongly supported as part of the overall anti-violence efforts.
- Governments must commit themselves to reducing violence against women.
- People, particularly men, in positions of authority and influence (e.g. political, religious and traditional leaders) can play an important role in raising awareness about the problem of violence against women.
- Establish a system of surveillance to monitor approaches and assess the impact of interventions such as a **Public health approach**.
- Prevention efforts should include multimedia and other public awareness activities.
- Prioritise the prevention of child sexual abuse and make schools safe for girls and eradicate teacher violence.
- Integrate responses to violence against women in existing programmes for the prevention of HIV and AIDS, and for the promotion of adolescent health.
- Make the physical environment safer for women, e.g. by identifying places where violence against women often occurs.
- Develop a comprehensive health-sector response to the various impacts of violence against women. And action by specific healthcare services is also needed.

Education

Key signs:

Education is the key to psychosocial intervention: It provides a safe and stable environment for learners and restores a sense of normalcy, dignity and hope by offering structured, appropriate and supportive activities. Many children and parents regard participation in education as a foundation for a successful childhood.

Loss of education is often among the greatest stressors for learners and families, who see education as a path to a better future. Education can be an essential tool in helping communities to rebuild their lives. Access to formal and non-formal education in a supportive environment builds the learner's intellectual and emotional competencies, provides social support through interaction with peers and educators and strengthens the learner's sense of control and self-worth. It also builds life skills that strengthen coping strategies, facilitating future employment and reducing economic stress.

Action

- Assess needs and capacities for formal and non-formal education.
- Maximise the participation of the affected community, including parents.
- Improve access to education for all.
- Prepare and encourage educators to support the psychosocial well-being of the learners.
- Strengthen the capacity of the education system to support learners experiencing psychosocial and mental health difficulties.

Family breakdown

Key signs

Relationships between family members, mutual understanding and communications in the family are often disturbed and members might not be able to support each other. The person's response to trauma including fear, **Mistrust**, irritability, withdrawal or being too dependent, naturally has an impact on the relationship to family and friends and the survivor becomes very sensitive towards other people. They may also not tell their loved ones what happened to them for fear of upsetting them unnecessarily. Thus, secrets may become a big issue in the family.

Family breakdown impacts heavily on children, who might experience disruption, lack of support, loss and separations, too much responsibility and entrance into the adult world.

Action

- Family or individual **Counselling**, attempts to restore the basic social unit of the family. Counselling and the creation of a space in which to talk about daily difficulties and more painful experiences of the past can help the family members and prevent **Re-traumatisation**.
- Facilitate family discussions, where problems (secrets) and expressions of emotions can be shared in order to improve communication, and thus relationships, and solve the problems of the family.
- The family is encouraged to participate in social functions such as religious ceremonies/festivals to nurture family unity and positive health dynamics.
- **Psycho-education** can also be used in family interventions to support the process of integration, empowerment, to develop coping strategies and improve the ability to solve problems.

HEALTHCARE PROFESSIONAL

First therapy

Family or individual **Counselling**, attempts to restore the basic social unit of the family. Counselling and the creation of a space in which to talk about daily difficulties and more painful experiences of the past can help the family members and prevent **Re-traumatisation**.

Facilitate family discussions, where problems (secrets) and expressions of emotions can be shared in order to improve the communication, and thus relationships, and solve the problems of the family.

Psycho-education can also be used in family interventions to support the process of integration, empowerment, to develop coping strategies and improve the ability to solve problems.

Family disappearance

Key signs

Families that have to live with the uncertainty of what has happened to their loved ones or family members face a very difficult situation.

Action

- **Counselling** is needed to support the mourning process and help the family to cope with the uncertainty.
- The International Red Cross should be contacted to help in the search for missing persons.
- Encourage and support the people to join self-help groups in the community, to discuss things with others in similar situations.

Family separation

Key signs

- Traumatized families are often separated for longer periods of time during and after a crisis. Family members may have disappeared, are imprisoned for shorter or longer periods, forced into military service or because one or several family members have been forcibly displaced, forced to flee or forced to hide elsewhere in the country if they are at risk of being arrested and tortured.
- Such a separation has a great influence on the individual family members and on the whole family unit. Often changes in roles occur in family members; where the mother or the oldest boy may take on the role as head of the family if the father is missing for a longer period.

Action

- Family **Counselling** to help the family to function together and to re-unite and re-integrate family members into the unit.
- Help the parents to support the children. See **Interventions with traumatized children** (STROP model).

Forced displacement, including refugees

Key Signs:

1. Forced Displacement:

Large populations are forced to flee or leave their homes in order to:

- Escape the effects of **Armed conflict** and violence resulting from weakened states or external aggression.
- Find food, water, shelter, which are lacking due to poverty and economic collapse.
- Seek protection from persecution because of race, religion, political opinion, nationality or membership of a social group.
- Escape the devastation of an environmental disaster.

The majority of displaced people are Internally Displaced Persons (IDPs). They have been forced to flee their homes suddenly or unexpectedly, in large numbers as a result of armed conflict, systematic **Violations of human rights**, etc., but remain within their own territory of their country.

Displaced populations may have unique concerns including increased *vulnerability* and *increased health risk*.

- Internally displaced persons may be in transit from one place to another, may be in hiding, be forced to move to unhealthy or inhospitable environments, or face other circumstances that make them especially vulnerable.
- The social organisation of displaced communities may have been destroyed or damaged by the act of physical displacement; family groups may be separated or disrupted; women may be forced to assume non-traditional roles or face particular vulnerabilities.
- Internally displaced populations, and especially such groups as children, the elderly, or pregnant women, may experience profound psychosocial distress related to displacement.
- Removal from sources of income and livelihood may add to physical and psychosocial vulnerability for displaced people.
- Schooling for children and adolescents may be disrupted.
- Internal displacement to areas where local inhabitants are of different groups or inhospitable may increase risk for internally displaced communities; internally displaced persons may face language barriers during displacement.
- The condition of internal displacement may raise the suspicions of or lead to abuse by armed combatants or other parties to conflict.
- Internally displaced persons may lack identity documents essential for receiving benefits or legal recognition; in some cases, fearing persecution, displaced persons have sometimes rid themselves of such documents.

2. *Lack of protection:*

All displaced persons are under constant threat of physical violence if the normal defence provided by policing systems is disrupted, during their flight and in the relief camp, or in detention-like situations.

- People in power may demand sexual favours from women and adolescent girls in exchange for protection and basic supplies such as food and water.
- Unaccompanied children are at higher risk of **Sexual violence**.
- See also **Local community breakdown, Violations of human rights**.

3. *Psychological trauma*

Common reactions to **Stress** may include **Anxiety**, fear and aggressive behaviour and in a more chronic state: Psychosomatic illness, **Depression**, **Substance abuse** and possible suicide.

Action

- Contact the International Red Cross in order to help the displaced people to re-unite or find out about the fate of *missing family members*.
- Ensure access to *basic needs* and services.

Refugees:

"are people who, because of fear of persecution for reasons of race, religion, nationality and membership of a particular social group or political opinion, flee from their home country (and are unwilling to return) and seek protection across an international border" (UNHCR 1951).

Note

Access to **Health services** and human rights issues are protective factors that improve resilience in the population at health risk.

Health services

Assessment

In post-conflict areas and in countries where torture takes place, resources are usually very limited and the need related to health is very high. The basic healthcare coverage at all levels is often very limited, especially at the central health facility level and the hospital referral level.

The Primary Health Care (PHC) system usually includes:

- The family level, where preventive and curative care is provided by the family itself or by community health workers/assistants.
- The community level, where data are collected and health promotion/**Education** takes place.

Additionally, the access to health service may be limited due to **Armed conflict**, insecurity, **Breakdown of infrastructure** or environmental factors (geography, seasonal factors), or to gender aspects.

Lack of human resources or difficulties in recruiting qualified health staff are common in remote/rural areas, as they are less attractive for various reasons. Lack of trained health professionals in general can be due to the political crisis, or educational discrimination (caste, ethnicity, etc.). Health facilities or hospitals might have been damaged as a result of the armed conflict. PHC requires making healthcare acceptable, affordable and available to all members of the community and is based on 4 principles: Equity, appropriate technology, intersectorial action and community participation (see also **Public health approach**).

Action

- Healthcare should be based on the concept of PHC and include preventive and curative measures. In general, PHC provided in post-conflict situations should be basic and at a level comparable to that of the local health services.

- The strategy should emphasise *preventive* rather than curative care, since curative care places a much heavier burden on resources.
- Assessment of the needs and human/educational resources of the healthcare professionals available.
- Assess the capacity of the local healthcare system and explore possible ways to support it.
- Strong emphasis should be placed on *training and upgrading* the medical skills of selected persons in the area, particularly in their former roles within the community, e.g. traditional healers and midwives.
- A *community health programme* that mobilises the affected people and selects and trains health workers in the community should be initiated. It is often the community-based health service that identifies those in need of healthcare and provides it at the appropriate level.
- Establish effective outreach and early referral to identify vulnerable individuals and groups.
- Collect demographic and epidemiological data relevant for estimating needs (**Population at risk**, Crude Mortality Rate (CMR), incidence and prevalence of diseases and torture.
- Estimate the immediate and possible long-term healthcare needs by identifying size of target population, areas and co-ordination of action with other agencies involved.
- Use the World Health Organization (WHO) essential drug lists and WHO standard treatment guidelines.
- Set up links and co-ordinate with existing programmes if any exist, e.g. maternal and child health clinics.
- Co-ordinate with other organisations; International Red Cross, Médecins Sans Frontières (MSF), refugee representatives, UN-agencies: UNHCR, UNICEF, WFP, WHO, etc, to improve access to health services for those in need.
- See also **Breakdown of infrastructure**.

Note

Access to health, like human rights issues, is a protective factor that improves the resilience of the populations at health risk.

Job - acquiring, keeping and terminating one

Key signs

Survivors of torture are often poor people, dependent on manual labour and cannot afford to lose an income to support their families.

Furthermore, their socio-economic situation often deteriorates after being tortured, due to physical health problems such as pain and to the psychological consequences of the torture experiences. Thus the survivors may not be able to manage the same job as before.

Action

- The approach when assisting survivors of **Torture and Organised Violence** has to be holistic because the problems of the survivors are related to different areas such as physical, mental health and socio-economic problems. The **Public health approach** to the community is recommended because it uses a decentralised and self-sustaining approach aimed at adults, adolescents and children.
- Rebuilding community networks and institutions is frequently a focus area. Increased employment and economic activity to improve the standard of living may also be an integrated part of this work, as demonstrated in studies.
- Help collaboration with institutions to develop and improve skills and employment. The approach should include income-generating-activities or micro-credit schemes, helping poor people to earn an income and possibly achieve economic self-sufficiency. Employment, or other possibilities to generate income, is a protective factor that improves resilience.

Local community breakdown

Key signs

Armed conflict disrupts traditional norms, individual roles and security resulting in disruption of social patterns and the disappearance of people's

safety net. The post-conflict communities may suffer from massive socio-economic and political problems as well as problems related to broken networks and stigmatising attitudes which further the isolation of certain groups.

Torture and Organised Violence has been viewed as a component of the socio-political process, requiring preventive action and social change.

Most communities affected by violence develop secondary problems in the aftermath of an armed conflict, such as increased crime, unemployment, domestic violence, sexual abuse and sexually transmitted diseases.

Impact on, or even closure of, local community institutions, healthcare facilities or schools and other institutions in the community.

People suffer from long-lasting **Stress**, and painful experiences because of the armed conflict or torture, and they need psychosocial support and **Counselling** for their traumatic experiences as well as for the everyday problems of the family and the local community.

Assessment of specific populations at health risk:

Identify the populations at increased *risk* of developing mental health disorders; torture survivors, single female victims and those suffering from: Socio-economic hardship often due to poverty, unemployment, low **Education** and lack of professional skills that suit the new environment; problem of marginalization, discrimination, poor physical health due to poor sanitation and poor healthcare, poor nutrition, crowded environment and poor physical conditions, including head trauma and other physical injuries.

Traumatic events such as death, loss, or fear of such events.

Daily-life stress, youth domestic stress, conflict-related events during flight.

Failure to cope one month after the traumatic events.

Perceived lack of control over the traumatic events.

Collapse of social networks resulting in **Alienation** and poor support.

Pre-existing history of psychiatric problems in individual or family, and psychiatric co-morbidity.

See also **Population at risk** and **Forced displacement, including refugees**.

Action

- Support integrated community-based mental health programmes that focus on social needs arising from mental disturbance, rather than issues of particular diagnoses.
- Give medical care if needed, especially accessibility to hospitals. Trauma-focused care may best be integrated into general mental healthcare services.
- Support community participation and activities to improve empowerment.
- Establish a sense of ownership by the community and encourage joint decision-making and consensus.
- Create a link between the affected population and the helping agencies (individuals, Non-Governmental Organisations (NGOs) and Government Organisations who come from outside the community).
- Re-develop initiatives such as micro-credit schemes or income-generating activities. Increased employment and economic activity to improve standards of living may also be an integrated part of this work.
- Give guidance about obtaining compensation, assistance in paralegal work, practical help in e.g. getting forms and accompanying survivors to offices or helping the individual to open a bank account, etc.
- Support in getting livelihood reorganised.
- Support and rebuild shattered lives in areas of housing, work, health and community.
- Organise psychosocial interventions related to the needs of the populations at risk and of the community, and counsel the individuals and families if necessary and mobilise help from neighbours/relatives.
- Organise community-based self-help support, focusing on problem sharing, brainstorming solutions, or effective ways of coping, generating mutual emotional support, etc.
- Rebuild community networks and institutions as focus areas.
- Prevent **Torture and Organised Violence** as part of the perspective for this work, working on the assumption that if people talk about the

problems they have, many future problems and those that are more serious may be prevented.

- Support activities that relate to practising religion, spirituality and encourage relating to environment and nature.

Organised violence

See **Local community breakdown** and **Torture and Organised Violence**.

Population at risk

See **Torture and Organised Violence**.

Post conflict society

See **Local community breakdown**.

Practising religion and spirituality

Key signs

Core social strategies like practising religion and spirituality are likely to reduce **Stress**. Such events typically include funeral ceremonies and grieving rituals involving spiritual and religious practitioners.

Action

- Re-establishing cultural and religious events is seen as helpful.
- Encourage normal activities and encourage active participation in the community.
- Enhance the possibilities of performing culturally prescribed rituals and ceremonies.
- See also **Interventions with traumatised children** (STROP model).

Relating to environment and nature

Key signs

People in **Stress** need to take responsibility for their own care and this includes the caretakers and beneficiaries.

Action

- People are encouraged to re-create a culture of recreational release (“recharge their batteries”). This can be done by relating to the environment and nature, alone or together with friends or family.
- Encourage people to use their traditional ways of coping, e.g. through folklore such as singing and dancing traditions. In some situations these old well-known traditions are very helpful in the process of supporting severely traumatised people who find it difficult to talk about the painful event.
- Recreation and leisure activities are protective factors that improve resilience.

Re-traumatisation

See **Rule of law problems and re-traumatisation**.

Rule of law problems and re-traumatisation

Key signs

Increase in **Torture and Organised Violence**, killing, disappearances, crimes and criminality, rape of women, increase in corruption, drug smuggling and trafficking and high-jacking of strategically important people.

The police force is “out of control” and there might be several police forces that have taken or are allowed to work outside the normal system of policing, given special jobs such as a secret police or rapid action forces.

The juridical system is unjust and often fraudulent doctors may write false medical documents, or police may give false evidence in court cases. Killing of witnesses takes place and there is a great need for protection of witnesses.

Action

- Protect vulnerable groups and create "safe areas".
- Share information on human rights abuses – Watchdog function.
- Establish presence of humanitarian and human rights organisations.
- Establish training of law-enforcement agents.
- Develop international court cases that will increase awareness of human rights abuses and might help improve justice, and international representations in court rooms, during trials (“as Watchdogs”).
- Demand international support from e.g. the UN rapporteur on torture, the EU local human rights defenders and their programs.
- Organise **Counselling** with victims of the torture before, during and after trials to support the victims and prevent re-traumatisation and relapse.
- Support media journalists, and documentation of torture in the media.
- Support use of ratification of instruments that can help local human rights defenders: Istanbul Protocol (medical documentation), UN Convention Against Torture and the Optional Protocol.
- See also **Violations of human rights**.

Note

Access to human rights issues is a protective factor that improves the resilience of the population at health risk. The Human Rights Laws (HRL) and International Humanitarian Law (IHL) have a common goal – to protect against inhuman acts and promote fundamental rights (civil, political, economic, social and cultural). The treaties behind HRL guarantee citizens the right to life, humane treatment and freedom from slavery; HRL generally applies during peacetime. The IHL is designed to protect victims during warfare and applies to soldiers, civilians and wounded and sick people.

Sexual violence

HEALTHCARE ASSISTANT

Key signs

Sexual violence is part of the regular repertoire of crimes against humanity that are committed by prison guards, soldiers and policemen in countries in **Armed conflict** and post-conflict situations. This kind of violence is not easily open to discussion and is surrounded by shame, taboos and irrational beliefs.

For female victims, sexual violence usually means rape. The reaction to rape by the social environment is partly dependent on the cultural context. If the victim is a virgin, the deflowering may, in some cultures, result in the woman no longer being considered acceptable as a marriage candidate. A married woman after a rape may be stigmatised as a “whore” and ostracised by her husband and family.

“The conspiracy of silence” is an ongoing problem, not only in society but also among mental-health professionals who still contribute, in many areas, to stigmatising the survivor rather than protecting her/him. Shame, concern for others, social taboo, fear of putting the pain into words, chaotic feelings, prohibiting them (e.g. the Bosnian women) from communicating with each other, and with others result in considerable emotional **Isolation**.

For female victims, the physical consequences of rape include injury, infections or venereal diseases and pregnancy, as well as pain in the lower abdomen or low-**Back pain** and also the risk of becoming sterile.

For male victims, undergoing sexual violence may contribute to serious doubts regarding one’s sexual identity, as well as **Relational problems** and disturbances in sexual functioning.

The special impact of this form of violence is thought to be a result of the intense feelings of guilt, shame and self-blame, and the moral conflicts within the victim that are provoked by sexual violence. Sexual violence may lead to various symptoms, including reduction of sexual interest or pleasure, delay or absence of an orgasm, and disturbing thoughts or feelings during sexual activity (**Guilt feelings, Shame**, flashbacks to the traumatic incident).

Victims are reluctant to discuss their experience of sexual violence with their partner or therapist. They are burdened with a secret, which will hinder communication and contribute to relational problems.

Sexual torture during war - an example of a population at health risk

The rapes in Bosnia-Herzegovina have led to a change in the conceptualisation of war rape, especially in its legal aspects, that cannot be overvalued with regard to protection of the survivor.

The goal during war is not only to defeat the enemy by military means, but also to break the morale of the civilian population. A sure way to do this is to target women and children. Sexual torture as a mass weapon in war injures and stigmatises socially in traditional societies, not only the female victim, but also her whole family, even the whole nation. Women are symbolically connected with the earth, the territory. Rape of women is equated with rape of the territory, and violent occupation of territory is often equated with rape.

Sexual torture of women has always been an instrument of terror in war but despite this, until recently war rape has been a neglected and underreported aspect of armed conflict.

The societal and individual silence means that we have known very little about the extent and patterns of war rape in different wars, and even less about how women, their families, and the community react to psychosexual trauma.

“The conspiracy of silence” was/still is valid, not only in society but also among mental-health professionals who contributed/still contribute in many areas, to stigmatising the survivor rather than protecting her/him.

Shame, concern for others, social taboo, fear of putting the pain into words, chaotic feelings, prohibition (e.g. the Bosnian women) from communicating with each other and others, result in great emotional isolation.

Sexual abuse of men; discrimination and torture of homosexuals.

Action

Components of response to rape in the community:

- Normalise the experiences (give information). Assume that victims are reluctant to disclose the assault. Give support and encouragement.
- Phrase questions to detect unacknowledged victims. Assume that many victims do not realise that their victimization was a rape.
- Avoid becoming judgemental. Many people, including clinicians, define rape narrowly.
- Crisis services; A 24-hour rape hot line, staffed by trained personnel (paid or volunteer) who are able to listen sensitively and respond with concrete information and appropriate referrals to additional care venues, only a possibility in certain areas.
- Crisis **Counselling** provided in personal contact with trained staff. The contact may be made at the hospital or at another less institutional setting.
- Hospital accompaniment and hospital counselling ensure that victims are allowed to make fully informed choices about evidence collection, complaint filing and prosecution.
- Police services – a serious community response to rape requires that police departments operate specialised rape investigation units, staffed by trained officers – including female officers – who are able to take into account the victims’ emotional and physical state during initial interviews.
- In the aftermath of rape, many victims will require short-term counselling to facilitate their recovery from crisis-induced **PTSD** and to aid their families in adjusting to rape. Others will, for a variety of reasons, profit from long-term therapy with a therapist who is knowledgeable about rape.

Note

A community's response to rape is also evident in the seriousness with which its law-enforcement agencies pursue arrest and prosecution, in the sentences that local judges hand down, and in the availability of offender-treatment alternatives.

Community **Education** programs educate citizens about rape. They demystify the crime and challenge rape-supporting belief systems and promote safety. Training for police, attorneys, hospital personnel, mental-healthcare providers and rape crisis volunteers.

Discuss and inform community leaders and religious leaders about the problems of sexual violence, to improve the support of the sexually violated people and to increase changes in negative attitudes towards the raped women.

HEALTHCARE SPECIALIST

Assessment

The complex symptoms seen in the aftermath of rape often meet the criteria for the diagnosis of **PTSD**. Somatic symptoms during impact phase include the direct effects of physical trauma – general soreness, bruising, irritation and other injuries. Skeletal muscle tension manifests itself in tension **Headaches**, fatigue and sleep-pattern disturbances. Finally, genitourinary symptoms such as vaginal discharge, itching, burning on urination, generalised pain, chronic vaginal infections and rectal bleeding and pain are also seen (see also **Sexual problems**).

HEALTHCARE ASSISTANT

Key signs

Situations that provoke an acute stress reaction are called “stressors”. There are many potential stressors, e.g. external threats such as attacks from animals or enemies, physiological stressors such as thirst, starvation, heat, noise, too much/too little activity and psychological problems such as conflicts and arguments. Whether or not a situation is a stressor is often dependent on a person’s perception and interpretation of the situation.

Example: An increased heart rate during an argument is an innocent sign of acute stress; the interpretation that it is a sign of an imminent heart attack, however, induces a high degree of additional stress.

An acute stress reaction causes physiological changes that optimize the body’s ability to survive in a threatening situation. This “fight-flight” response involves e.g. increased **Heart palpitation** and **Sweating** and an altered distribution of blood (more to muscles, less to guts, which can be felt as “butterflies in the stomach”). Acute stress reactions are a normal part of life, with no negative impact on health. If the frequency and intensity of stress reactions, however, increase above a tolerable level, a state of chronic stress is established that, in the long run, has adverse impacts on health.

In animal studies it has been shown that chronic stress results in functional and even structural (e.g. certain parts of the brain diminish in size) changes in the brain. Knowledge about how the human brain is affected is still limited but some findings have shown corresponding stress-related changes in the human brain. Chronic stress enhances e.g. the reactivity of a brain region that is important in the experience of **Anxiety**, but the changes in the brain can be reversible. Thus, it has been shown that increased reactivity in parts of the brain in persons suffering from anxiety disorders,

including **PTSD**, is normalized after effective treatment (either antidepressant medication or **Exposure therapy**).

Chronic stress per se results in an abundance of potential physical symptoms and can cause various functional disturbances. It can also interact with many diseases, worsening the symptoms and their course. The risk of developing chronic stress is especially high if new long-standing stressors are added to a life situation, such as contracting a chronic disease or pain (see **Pain, chronic**), developing an anxiety disorder or being involved in chronic, conflictual, social contexts (dysfunctional marriage, ethnic and armed conflicts, chronic threats, unemployment, etc.).

Children:

Acute stress reactions in children are fear and anxiety, clinging behaviour, hyperactivity, **Regressive symptoms** or physical pain without explanation. Chronic stress can lead to depressive symptoms, lack of confidence in self and others, self-destructive behaviour and problems with social contacts.

Action

Since chronic stress is a very widely defined core concept applied to a great variety of problems, with considerable inter-individual differences, only general outlines for the treatment of chronic stress can be given. The outlines have to be tailored and made specific to the individual case and circumstances.

To reduce chronic stress, the following guidelines can be followed:

- Advise the person to perform physical exercises/activity regularly.
 - Background: The “fight-flight” response prepares the body for physical activity. The natural way to return to normal is, accordingly, physical engagement (which e.g. contributes to normalize fat and sugar concentrations in the blood).
 - Note: If the person already has a sufficient level of physical activity, e.g. through daily work, the advice may not be relevant.

Too much physical activity may even contribute to chronic stress. In such cases the person should be advised to reduce activity.

- Advise the person to perform some type of relaxation exercises regularly (mindfulness meditation or similar types of exercise); if there is no useful local tradition available, educate the person in some technique (see **Stress management**).
 - Background: For the purpose of stress reduction, there are no major differences in effectiveness regarding a wide variety of relaxation techniques. The choice of technique is a matter of local availability and/or personal preference. In the person's culture-bound repertoire of behaviour patterns there might be other behaviours that can have a stress-counteracting effect similar to relaxation/meditation; the person might e.g. be advised to use prayer, music, dancing, story telling or 'conversation with nature'.
- Assist the person in analysing his/her present life situation in order to identify stressors and to differentiate between stressors:
 - Background: Stressors can occur in different intensities. Some (e.g. suffering from a chronic disease or pain) cannot be alleviated, others (e.g. engaging in social conflicts) can.
 - Identify stressors the person can potentially control and alleviate, e.g. ceasing to engage in social conflicts.
 - Identify stressors that cannot be alleviated but may be reduced in intensity. Chronic stress can be reduced e.g. by optimizing treatment and handling of chronic pain. This will probably not abolish the stressor pain but can diminish its intensity.

Children:

- Identify the source of stress and try to change the child's environment in order to provide safety and support.
- Inform parents of the reason for the child's reactions and support them in treating the child in a calm and patient way.

Note

If the chronic stress is mainly due to one major stressor, e.g. development of **PTSD** after torture, the primary focus should be to treat and alleviate/diminish the intensity of this stressor. Refer in these cases to level 2 if it is expected that the treatment will thereby be optimized and/or accelerated. Refer to next level if you cannot successfully correct erroneous beliefs and worry about physical symptoms due to stress.

Children:

Refer to next level if the stressful life conditions cannot be changed and the parents are unable to give the child sufficient support.

HEALTHCARE PROFESSIONAL

Characteristics

Since chronic stress can produce an abundance of physical symptoms and interacts with symptoms from most diseases, somatic worries are common, fostering additional stress and creating vicious circles. Limited medical knowledge at level 1 may mean that the person's worries and questions are not adequately addressed there.

Children:

Acute stress often elicits a range of emotional and behavioural problems in a child such as fear and **Anxiety**, clinging behaviour, hyperactivity, **Regressive symptoms** or physical pain with no explanation. In the case of prolonged, stressful life conditions such as war or living with mentally ill or traumatized parents, it can have a more profound influence on the child's personality and interfere with normal development. The child can e.g. react with **Depression** and self-harming behaviour. It can alienate the child from his/her social surroundings and negatively influence school achievements.

First therapy

Same guidelines as above but supported by more detailed explanation of medical and physiological mechanisms and of the interaction of stress with disease. On the basis of the persons individual life-circumstances, give information about stress. Try to address worries about physical symptoms (compare **Worrying about symptoms**) and explain these in terms of stress and that worrying fosters additional stress.

Second therapy

Assessment and treatment of diseases, symptoms (e.g. **Pain, chronic**) and disorders (e.g. **PTSD**) as outlined under respective entry.

Children:

Family **Counselling**.

Stress management.

Note

Refer to next level if it is thought that additional medical expertise could optimize the application of the guidelines and/or when it is advisable with respect to assessment and treatment of diseases, symptoms and disorders.

Children:

Refer if the symptoms are intense and long-lasting and interfere with the child's possibilities regarding academic achievements and social life.

HEALTHCARE SPECIALIST

Assessment

Rule out whether there are any hitherto unidentified/untreated somatic or other circumstances that are contributing to chronic stress.

Children:

Take a detailed history in order to understand the living conditions of the child and his/her family. Use a structured diagnostic interview for children

(see **Assessment of torture survivors**, e.g. DISC or KSADS-PL). Assess for **PTSD**.

Proposed measures

According to findings.

The guidelines described above can be used for additional and refined **Psycho-education** about stress.

Note that chronic stress contributes to the development of **Depression** and depression-like states (“burn-out” and similar descriptions). If the person shows prodromal symptoms, an antidepressive treatment can be considered.

Children:

CBT in an individual, group or family format (for children from about 6 years of age), family therapy.

Torture and Organised Violence

Torture

Despite being stringently outlawed, torture continues to be practised in a majority of countries round the world.

In the UN convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT), **Torture** is defined as:

"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 or 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". (Article 1)

According to UNCAT the prohibition of torture is absolute, i.e. “no exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture”.

Some methods of torture frequently used include:

Physical torture

- Blows against the soles of the foot (falanga)
- Sexual torture
- Electrical torture
- Choking torture
- Water torture (submarino)
- Burns
- Suspension (palestinian hanging)
- Pharmacological torture
- Mutilation
- Physical exhaustion
- Hood (capucha)

Mental torture

- Isolation
- Watching other people being tortured
- Threats
- Mock executions
- Sexual humiliation
- Lack of food and sleep

Organised violence

The World Health Organization’s definition of organised violence:

“The inter-human infliction of significant, avoidable pain and suffering by an organised group according to declared or implied strategy and/or system

of ideas and attitudes. It comprises any violent action that is unacceptable by general human standards, and relates to the victim's feelings. Organised violence includes "torture, cruel, inhuman or degrading treatment or punishment" as in Article 5 of the United Nations Universal Declaration of Human Rights (1948). Imprisonment without trial, mock executions, hostage-taking, or any other fall under the heading of organised violence" (WHO, 1986; Geuns, 1987).

This definition covers a broad range of forms of violence including conflicts within and between countries, organised violent crime, and various forms of structural violence that may or may not be perpetrated by the state.

Population at Health Risk

In armed conflict situations, up to 80% of the affected population are women, children and elderly people. Many of them live in forced displacement (see **Armed conflict**) and they become more prone to violence, starvation and even death. They are vulnerable because they lack the capacity to cope and they are:

- Physiologically vulnerable – i.e. they lack access to basic needs (see **Basic needs not satisfied**), including poor physical health due to poor sanitation and poor healthcare; they include e.g. malnourished, sick, pregnant and lactating women, young children and the elderly.
- Socially vulnerable – i.e. they lack access to **Education** and social support and include e.g. female-headed households, unaccompanied minors and the disabled.
- Economically vulnerable – i.e. they lack sufficient income, e.g. the poorest.
- Politically vulnerable – i.e. they lack autonomy and have no control over their situation, e.g. Internally Displaced Persons (IDPs), refugees and ethnic minority groups (language).
- Personally unprepared, and therefore less able to cope with the torture.

If the above vulnerabilities are not effectively identified and reduced, those affected may suffer more serious consequences, and their "return to normality" may be more difficult.

Action

- Assess needs for medical and mental healthcare service for the rape victims.
- Initiate a monitoring system.
- Protect vulnerable groups and create "safe areas".
- Provide health and mental-health professionals who may play an important role in documenting rape in war, as well as in the treatment of survivors.
- Train healthcare professionals to recognise the signs and enable them to identify victims of torture and rape.
- Develop a strategy in the case of stigmatization and exclusion of women raped as a criminal act during war, including all levels of society - political and community. Here, important key persons can help to change attitudes towards the women, e.g. religious leaders, community leaders, the media, teachers, etc.
- Assess needs for **Counselling/Psychotherapy**, either via an individual approach (in the beginning) and later possibly in groups with others in the same situation.
- Respect and encourage traditional ways of coping; especially shortly after the rape it might be difficult to talk about the trauma and therefore other ways of expressing feelings are seen to be helpful (the example of Kosovo, traditional music and songs).

Note

Access to healthcare services and human rights issues, as well as being prepared for the risk of torture, are protective factors that improve resilience.

Values and attitudes

Key signs

Survivors of torture might experience intense **Stress** if they are unable to engage in the conduct of appropriate cultural, spiritual and religious practises. The local community, for example, can either support or prevent emotional healing after an assault. After a rape, the victim's membership in the local community can be affirmed and attention and support can facilitate her healing. But this may be totally different in another community. Here the rape can stigmatise and cause exclusion from the local community, which will eventually aggravate her trauma.

Action

- Approach local religious and spiritual leaders and other cultural guides to learn their views on how people have been affected and on practises that would support the affected people.
- Exercise ethical sensitivity (using a skilled translator if necessary), work in the local language, asking questions that a cultural guide has indicated are appropriate.
- Learn about cultural, religious and spiritual support and coping mechanisms (see also **Counselling**).
- Facilitate conditions for appropriate healing practises.
- Assess traditional ways of helping people – what is appropriate in the local context, taking into consideration local beliefs, culture and values.
- Respect local values, beliefs and customs but on the other hand if people are being violated or marginalised, discriminated against in “the name of culture”, they must be protected. If individuals or groups are harmed by cultural rituals, e.g. girls and females are mutilated; they should be protected by individual human rights and be helped to avoid harm.
- When approaching the local community, techniques that ensure participation should be used. Participatory learning assessment (PLA) or other similar participatory instruments should be employed in the

process of keeping ownership local and when empowerment of the community is a major issue.

- Approach religious and community leaders to give them information, create understanding and ask for permission to enter into the local community. The community leader can facilitate the meeting with the community members.
- Gain knowledge about the local community's resources, institutions, culture, history and traditions.
- Note that the local community healthcare assistants are known to and accepted by the community. As they are part of the community they have insight and knowledge concerning specific values, etc.
- Realise that the local traditions, values and customs determine the appropriateness and applicability of different approaches such as counselling in the community.

Violations of human rights

Key signs

The United Nations Universal Declaration of Human Rights (1948) declares the universality of certain Human Rights; rights possessed by every individual human being – regardless of sex, ethnicity, religion, social status or nationality.

Where it has been adopted, legislation on human rights commonly comprises:

- *Security rights* that protect people against crimes such as murder, massacre, torture and rape.
- *Liberty rights* that protect freedoms in areas such as belief and religion, association, assembly and movement.
- *Political rights* that protect the freedom to participate in politics by expressing themselves, protesting, participating in a republic.
- *Due process rights* that protect against abuses of the legal system such as imprisonment without trial, secret trials and excessive punishments.

- *Equality rights* that guarantee equal citizenship, equality before the law and non-discrimination.
- *Welfare rights* (also known as economic rights) that require the provision of **Education** and protection against severe poverty and starvation.
- *Group rights* that provide protection for groups against ethnic genocide and ownership by countries of their national territories and resources.

Torture is a serious violation of human rights and is strictly prohibited by international law. As the use of torture strikes at the very heart of civil and political freedoms, it was one of the first issues dealt with by the United Nations (UN) in its development of human rights standards. Healing after painful events is often linked to the fight for legal and human rights and justice. Improving knowledge concerning rights is reported to have an empowering and healing effect.

Action

- Organizing community-based self-help groups that focus on empowerment of the victims of torture along the lines of “together we are strong”. The groups discuss human rights violation issues and support people when they are arrested. Human Rights defenders and former victims of torture can support each other and may engage in other activities, such as awareness campaigns and regular meetings where they discuss health and mental-health problems related to torture and how to cope with them.
- Protection of vulnerable groups and creation of "safe areas".
- Sharing information on human rights abuses.
- Presence of humanitarian and human rights organisations.
- Initiate or improve ‘Watchdog’ function.
- Access to human right organisations is a protective factor that improves resilience.

Note

The connection between a health situation and a human right violation can be very helpful in organizing the community and explaining how both are affected in a personal as well as in a collective manner.

2.4. SELECTED REFERENCES

American Psychiatric Association. Diagnostic and statistical manual of mental disorders (DSM-IV). 4th ed. Washington: American Psychiatric Press; 1994.

Amris K, Prip K. Physiotherapy for torture victims (I): chronic pain in torture victims: possible mechanisms of pain. *Torture*. 2000;10(3):73-6.

Amris K, Prip K. Physiotherapy for torture victims (II): physiotherapy for torture victims with chronic pain. *Torture*. 2000;10(4):112-7.

Andersson G. Psychological aspects of tinnitus and the application of cognitive behavioral therapy. *Clin Psychol Rev*. 2002;22(7):977-90.

Arcel L, Kastrup M. War, women and health. *Nora*. 2004;12(1):40-47.

Basoglu M, editor. *Torture and its consequences: current treatment approaches*. London: Cambridge University Press; 1992.

Bisson J, Andrew M. Psychological treatment of post-traumatic stress disorder (PTSD). *Cochrane Database Syst Rev*. 2005;(2):CD003388.

Bonanno GA, Kaltman S. The varieties of grief experience. *Clin Psychol Rev*. 2001;21(5):705-34.

Brandtstädter J, Greve W. The aging self: stabilizing and protective processes. *Development Review*. 1994;14(1):52-80.

Chowdhury AH, Choudhury ZuA, Zaman SN. Designing counselling support service in victims' associations in Bangladesh. In: Olsen JS, Haagensen JO, Madsen AG, Rasmussen F, editors. *From counselling to psychosocial development*. Copenhagen: Rehabilitation and Research Centre for Torture Victims (RCT); 2006. p. 79-85.

Cooper CL, editor. *Handbook of stress medicine and health*. 2nd ed. Boca Raton: CRC Press; 2005.

Cyriax J. *Textbook of orthopaedic medicine*. Vol. 1. *Diagnosis of soft tissue lesions*. 8th ed. London: Baillière Tindall; 1982.

- De Jong J. Trauma, war and violence: public mental health in socio-cultural context. New York: Kluwer Academic/Plenum Publishers; 2002.
- Dehghani M, Sharpe L, Nicholas MK. Modification of attentional biases in chronic pain patients: a preliminary study. *Eur J Pain*. 2004;8(6):585-94.
- Dysvik E, Natvig GK, Eikeland OJ, Lindström TC. Coping with chronic pain. *Int J Nurs Stud*. 2005;42(3):297-305.
- Edinger JD, Wohlgemuth WK. The significance and management of persistent primary insomnia: the past, present and future of behavioral insomnia therapies. *Sleep Med Rev*. 1999;3(2):101-18.
- Gatchel RJ, Turk DC, editors. Psychological approaches to pain management: a practitioner's handbook. New York: The Guilford Press; 1996.
- Gelder MG, López-Ibor JJ, Andreasen N, editors. *New Oxford Textbook of Psychiatry*, Vol. 1-2. Oxford: Oxford University Press; 2003.
- Gerrity E, Keane TM, Tuma F, editors. The mental health consequences of torture. New York: Kluwer Academic; 2001.
- Glucklich A. Sacred pain: hurting the body for the sake of the soul. Oxford: Oxford University Press; 2001.
- Grant AC, Cook AA. A prospective study of handcuff neuropathies. *Muscle Nerve*. 2000;23(6):933-8.
- Hackmann A, Ehlers A, Speckens A, Clark DM. Characteristics and content of intrusive memories in PTSD and their changes with treatment. *J Trauma Stress*. 2004;17(3):231-40.
- Hardon A. Applied health research manual: anthropology of health and health care. 3rd ed. Amsterdam: Het Spinhuis; 2001.
- Helander E, Mendis P, Nelson G, Goerdts A, editors. Training in the community for people with disabilities. Training package for a family member of a person who has difficulty moving. Vol. 13: How to train the person to move around. Geneva: WHO; 1989.

Holman EA, Silver RC. Getting “stuck” in the past: temporal orientation and coping with trauma. *J Pers Soc Psychol*. 1998;74(5):1146-63.

Holmes EA, Brown RJ, Mansell W, Fearon RP, Hunter EC, Frasquilho F, et al. Are there two qualitatively distinct forms of dissociation? A review and some clinical implications. *Clin Psychol Rev*. 2005;25(1):1-23.

Hoppenfeld S. *Physical examination of the spine and extremities*. New York: Appleton-Century-Crofts; 1976.

Humanitarian Charter and Minimum Standards in Disaster Response. Geneva: The Sphere Project; 2004. Also available online, at: <http://www.sphereproject.org/content/view/27/84/lang,English/> [accessed 2008 Jan 22].

International Federation of Red Cross and Red Crescent Societies. *Public health guide for emergencies [CD-ROM]*. Baltimore: The John Hopkins Medical School. International Federation of Red Cross and Red Crescent Societies: 2000. Also available online, at: http://www.ifrc.org/what/health/relief/guide.asp?gclid=CM66y4r1iZECF SZPMAodJluI_Q [accessed 2008 Jan 22].

James A, Soler A, Weatherall R. Cognitive behavioural therapy for anxiety disorders in children and adolescents. *Cochrane Database Syst Rev*. 2005;(4):CD004690.

Kastrup MC, Arcel LT. Gender-specific treatment. In: Wilson J, Drozdek B, editors. *Broken spirits: the treatment of traumatized asylum seekers, refugees, war and torture victims*. New York: Brunner & Routledge; 2004. p. 547-71.

Kato PM, Mann, T. A synthesis of psychological interventions for the bereaved. *Clin Psychol Rev*. 1999;19(3):275-96.

Kellner R, Neidhardt J, Krakow B, Pathak D. Changes in chronic nightmares after one session of desensitization or rehearsal instructions. *Am J Psychiatry*. 1992;149(5):659-63.

- Kisiel C, Blaustein M, Spinazzola J, Schmidt CS, Zucker M, van der Kolk B. Evaluation of a theater-based youth violence prevention program for elementary school children. *J School Violence*. 2006;5(2):19-36.
- Kleinman A, Brodwin PE, Good BJ, Good MJD. Pain as human experience: an introduction. In: Good MJD, Brodwin PE, Good BJ, Kleinman A, editors. *Pain as human experience: an anthropological perspective*. Berkeley: University of California Press; 1992. p. 1-26.
- Koss MP, Harvey MR. *The rape victim: clinical and community interventions*. Thousand Oaks: Sage; 1991.
- Laberge L, Tremblay RE, Vitaro F, Montplaisir J. Development of parasomnias from childhood to early adolescence. *Pediatrics*. 2000;106(1 Pt 1):67-74.
- Lask B, Taylor S, Nunn K. *Practical child psychiatry: the clinician's guide*. London: BMJ Publishing Group; 2003.
- Lorimer DL, French G, West S, editors. *Neale's common foot disorders: diagnosis and management*. 5th ed. New York: Churchill Livingstone; 1997.
- Luxenberg T, Spinazzola J, van der Kolk BA. Complex trauma and disorders of extreme stress (DESNOS): diagnosis: part one: assessment. Lesson 25. *Directions in Psychiatry*. 2001;21. Available online, at: http://www.traumacenter.org/products/pdf_files/DESNOS.pdf [accessed 2008 Jan 22].
- Macksoud M. *Helping children cope with the stresses of war: a manual for parents and teachers*. New York: Unicef; 2000.
- Main CJ, Sullivan MJL, Watson PJ. *Pain management: practical applications of the biopsychosocial perspective in clinical and occupational settings*. 2nd ed. Edinburgh: Churchill Livingstone; 2008.
- Médecins Sans Frontières (MSF). *Refugee health: an approach to emergency situations*. London: Macmillan Education LTD; 1997.
- Melchart D, Linde K, Fischer P, Berman B, White A, Vickers A, et al. Acupuncture for idiopathic headache. *Cochrane Database Syst Rev*. 2001;(1):CD001218.

Murtagh DR, Greenwood KM. Identifying effective psychological treatments for insomnia: a meta-analysis. *J Consult Clin Psychol.* 1995;63(1):79-89.

Neidhardt EJ, Krakow B, Kellner R, Pathak D. The beneficial effects of one treatment session and recording of nightmares on chronic nightmare sufferers. *Sleep.* 1992;15(5):470-3.

Nicolson P. Loss, happiness and postpartum depression: the ultimate paradox. *Canadian Psychology.* 1999;40(2):162-78.

O'Sullivan P. Diagnosis and classification of chronic low back pain disorders: maladaptive movement and motor control impairments as underlying mechanism. *Man Ther.* 2005;10(4): 242-55.

Office of the High Commissioner for Human Rights. Istanbul protocol: manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment. New York: United Nations; 2004. Also available online, at: <http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf> [accessed 2008 Jan 22].

Olsen DR, Montgomery E, Bojholm S, Foldspang A. Prevalent musculoskeletal pain as a correlate of previous exposure to torture. *Scand J Public Health.* 2006;34(5):496-503.

Olsen DR, Montgomery E, Carlsson J, Foldspang A. Prevalent pain and pain level among torture survivors: a follow-up study. *Dan Med Bull.* 2006;53(2):210-214.

Pauli P, Schwenger M, Brody S, Rau H, Birbaumer N. Hypochondriacal attitudes, pain sensitivity, and attentional bias. *J Psychosom Res.* 1993;37(7):745-52.

Payne RA. *Relaxation techniques: a practical handbook for the healthcare professional.* 3rd ed. Edinburgh: Churchill Livingstone; 2005.

Prip, K, Persson, AL. Clinical findings in men with chronic pain after falanga torture. *Clin J Pain* 24, 2008:135-141.

Quiroga J, Jaranson JM. Politically-motivated torture and its survivors: a desk study of the literature. *Torture*. 2005;15(2-3):1-111. Also available online, at: <http://www.irct.org/Default.aspx?ID=550> [accessed 2008 Jan 22].

Rasmussen OV. Medical Aspects of Torture. *Dan Med Bull*. 1990;37 Suppl 1:1-88.

Riots: psychosocial care for individuals. Bangalore: Books for Change; 2002. (Information manual; no 1). Also available online, at: http://www.nimhans.kar.nic.in/dis_man/man_hm1.pdf [accessed 2008 Jan 21].

Riots: psychosocial care by community level helpers for survivors. Bangalore: Books for Change; 2002. (Information manual; no 2). Also available online, at: http://www.nimhans.kar.nic.in/dis_man/man_hm2.pdf [accessed 2008 Jan 21].

Riots: psychosocial care for children. Bangalore: Books for Change; 2003. (Information manual; no 3). Also available online, at: http://www.nimhans.kar.nic.in/dis_man/man_hm3.pdf [accessed 2008 Jan 21].

Rutter M, Taylor E, editors. *Child and adolescent psychiatry*. 4th ed. Oxford: Blackwell Science; 2005.

Scarry E. *The body in pain: the making and unmaking of the world*. Oxford: Oxford University Press; 1985.

Sephton SE, Studts JL, Hoover K, Weissbecker I, Lynch G, Ho I, et al. Biological and psychological factors associated with memory function in fibromyalgia syndrome. *Health Psychol*. 2003;22(6):592-7.

Srinivasan L. *Tools for community participation: a manual for training trainers in participatory techniques*. New York: PROWESS/UNDP; 1990.

Stein DJ, Ipser J, Seedat S. Pharmacotherapy for post traumatic stress disorder (PTSD). *Cochrane Database Syst Rev*. 2006;(1):CD002795.

Strengthen access to safe and supportive education : action sheet 7.1. In: IASC. Guidelines on mental health and psychosocial support in emergency settings. Geneva: Inter-Agency Standing Committee, IASC; 2007. p. 148-156. Also available online, at:
http://www.who.int/hac/network/interagency/news/mental_health_guidelines/en/index.html

Thomsen AB, Eriksen J, Smidt-Nielsen K. Chronic pain in torture survivors. *Forensic Sci Int*. 2000;108(3):155-63.

UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. 1987. Available online, at:
http://www.unhcr.ch/html/menu3/b/h_cat39.htm [accessed 2008 Jan 22].

Vlaeyen J, Linton SJ. Fear-avoidance and its consequences in chronic musculoskeletal pain: a state of the art. *Pain*. 2000;85(3):317-32.

Vogel W, Peterson LE. A variant of guided exposure to mourning for use with treatment-resistant patients. *J Behav Ther Exp Psychiatry*. 1991;22(3):217-9.

Wegner DM. Thought suppression and mental control. In: Nadel L, editor. *Encyclopedia of Cognitive Science*. Macmillan London: Nature Publishing Group; 2003. p. 395-7. Also available online, at:
<http://www.wjh.harvard.edu/~wegner/pdfs/ECS.pdf> [accessed 2008 Jan 22].

Werner D, Thuman C, Maxwell J. *Where there is no doctor: a village health care handbook*. 2nd ed. London: Macmillan; 1993.

Werner D. *Disabled village children: a guide for community health workers, rehabilitation workers, and families*. 2nd ed. Berkeley: Hesperian Foundation; 2003. Also available online, at:
<http://www.dinf.ne.jp/doc/english/global/david/dwe002/dwe00201.htm> [accessed 2008 Jan 22].

Westenberg HGM. The neurobiology of anxiety disorders. *Eur Psychiatry*. 1998;13 Suppl 4:209.

WHO. ICF: international classification of functioning, disability and health. Geneva: WHO; 2001. Also available online, at:

<http://www.who.int/classifications/icf/en/> [accessed 2008 Jan 22].

WHO. WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses; summary report. Geneva: WHO; 2005. Also available online, at:

http://www.who.int/gender/violence/who_multicountry_study/en/ [accessed 2008 Jan 22].

WHO. ICD-10: international classification of diseases. 10th revision. Geneva: WHO; 1994. Also available online, at:

<http://www.who.int/classifications/apps/icd/icd10online/> [accessed 2008 Jan 22].

3. THERAPIES

Assessment of torture survivors

The first contact with torture survivors may occur with both healthcare assistants and healthcare professionals and in some contexts no specialized help is available. Thus, all primary care professionals, e.g. general practitioners and nursing staff, should always keep in mind that the problems and symptoms exhibited by people may have their origin in **Torture and Organised Violence**. This is so even if one works in settings where there is no organised violence. In other cases, the assessment of torture survivors will, in general, be carried out by healthcare professionals.

There is an increasing emphasis on valid and reliable measurements and evidence-based interventions. It is also the case in the study of torture that we need to pay more attention to the development of valid and reliable instruments for assessment. When assessing the situation, it is important to ensure cultural equivalents of the instruments used. Western researchers have developed psychometric tests, structured interviews and rating scales but so far there has been insufficient attention paid to their applicability and acceptability in other cultural settings. When applying any test we have to recognise that some concepts may have different connotations depending on the cultural group.

Having said this, however, it may be useful to use both structured interviews and rating scales when assessing the mental health of torture survivors. This is particularly so when dealing with a desire to document the consequences of torture in a reproductive manner or when assembling data to be used for research purposes. It should, however, be emphasized that such measurements cannot stand alone, but need to be combined with clinical interviews to gain an impression of the total situation.

A comprehensive assessment should include:

- Mental status examination.
- Physical examination.
- Assessing the person's level of functioning – at present and previously.
- Pre-existing psychological or physical problems.
- History of exposure to violence including torture.

It is important to keep in mind:

- When assessing a person, please be aware of whether the person is a member of a high-risk group, e.g. politically active, since it increases the likelihood that he/she may be a victim of torture.
- Survivors may be reluctant to talk about their experiences. It is useful to observe both verbal and non-verbal communication.
- Establishing mutual trust is paramount for starting an intervention.
- Certain situations may trigger recollections of traumatic experiences; try to avoid such triggers.
- Let the person tell the story at his/her own pace; do not press or force them to speed up, as this may aggravate the situation.
- Ensure that the environment in which the assessment takes place feels safe for the person.
- Be aware that the person may have multiple problems: Physical, psychological and social.
- If possible, provide support to meet the physical, practical and social needs of the person.
- When assessing the person, be aware that the symptoms may not be constant but vary according to external factors.
- Support the ideological or religious beliefs of the person; this may be valuable in coping with the situation.

Note

Cultural context, lack of **Education**, and the fact that police or military forces use structured questionnaires and a writing process, makes it very common that a torture survivor rejects these procedures. A thorough clinical interview is then more accepted, also since there may not be enough

time and space due to the need for the therapist to travel to distant communities, with the assessments being conducted under extremely difficult and risky conditions. Even if an excellent translation of a scale is available, it may have to be retranslated to persons speaking a native language or it may be necessary to develop a semantic field in order to give meaning to the words because of the level of education or the difference in cultural setting.

APPENDIX:

EXAMPLES OF CLINICAL INTERVIEWS

Several clinical interviews, questionnaires and rating scales have been developed, serving different purposes.

Listed below are examples of some of the most frequently used:

Global Assessment of Functioning

Global Assessment of Functioning is for reporting the clinician's judgment of the individual's overall level of functioning and ability to carry out activities of daily living. The Global Assessment of Functioning (GAF) Scale is a 100-point scale that measures a person's overall level of psychological, social, and occupational functioning on a hypothetical continuum. The GAF Report decision tree is designed to guide clinicians through a methodical and comprehensive consideration of all aspects of a person's symptoms and functioning to determine the person's GAF rating.

Global Assessment of Functioning Scale

The Scale considers psychological, social and occupational functioning on a hypothetical continuum of mental-health illness.

It does not include impairment in functioning due to physical or environmental limitations.

You do not need to know the numbers but rather what the GAF measures are. (Note: Use intermediate codes when appropriate, e.g., 45, 68, 72).

91-100

Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

81-90

Absent or minimal symptoms (e.g. mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

71-80

If symptoms are present, they are transient and anticipated reactions to psychosocial stressors (e.g. difficulty concentrating after family argument); no more than slight impairment in social, occupational or school functioning (e.g. temporarily falling behind in school work).

61-70

Some mild symptoms (e.g. depressed mood and mild insomnia) or some difficulty in social, occupational or school functioning (e.g. occasional truancy or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

51-60

Moderate symptoms (e.g. flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational or school functioning (e.g. few friends, conflicts with peers or co-workers).

41-50

Severe symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g. no friends, unable to keep a job).

31-40

Some impairment in reality testing or communication (e.g. speech is at times illogical, obscure or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking or mood (e.g. depressed man avoids friends, neglects family and is unable to work; child frequently beats up younger children, is defiant at home and is failing at school).

21-30

Behaviour is considerably influenced by delusions or hallucinations or serious impairment in communication or judgment (e.g. sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g. stays in bed all day, no job, home or friends).

11-20

Some danger of hurting self or others (e.g. suicidal attempts without clear expectation of death, frequently violent, manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g. smears faeces) OR gross impairment in communication (e.g. largely incoherent or mute).

1-10

Persistent danger of severely hurting self or others (e.g. recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death. Inadequate information.

The following are of particular relevance in assessing persons who have been subjected to organised violence:

Hopkins Symptom Checklist-25 (HSCL-25)

HSCL-25 is a symptom inventory, which measures symptoms of anxiety and depression. It consists of 25 items: Part I of the HSCL-25 has 10 items for anxiety symptoms; Part II has 15 items for depression symptoms. The scale for each question includes four categories of response ("Not at all,"

"A little," "Quite a bit," "Extremely," rated 1 to 4, respectively). Two scores are calculated: The total score is the average of all 25 items, while the depression score is the average of the 15 depression items. It has been consistently shown in several populations that the total score is highly correlated with severe emotional distress of unspecified diagnosis, and the depression score is correlated with major depression, as defined by the Diagnostic and Statistical Manual of the American Psychiatric Association, Version IV(DSM-IV).

Harvard Trauma Questionnaire

The Harvard Trauma Questionnaire (HTQ) is a checklist similar in design to the HSCL-25. It inquires about a variety of trauma events, as well as the emotional symptoms considered to be uniquely associated with trauma.

Currently there are several versions of this questionnaire. The Vietnamese, Cambodian, and Laotian versions of the HTQ were written for use with Southeast Asian refugees. The Japanese version was written for survivors of the 1995 Kobe earthquake. The Croatian Veterans' Version was written for soldiers who survived the wars in the Balkans, while the Bosnian version was written for civilian survivors of that conflict. There is also a Farsi and an Arabic version.

SCID

The Structured Clinical Interview for DSM-IV-TR (SCID) is a semi-structured diagnostic interview designed to assist clinicians, researchers and trainees in making reliable DSM-IV psychiatric diagnoses.

The instrument is designed to be administered by a clinician or trained mental-health professional. Ideally, this will be someone who has had experience performing unstructured diagnostic evaluations. However, for the purposes of some research studies, non-clinician research assistants, who have extensive experience with the study population in question, have been trained to use the SCID. The less clinical experience the potential interviewer has had, the more training is required.

Reliability and validity of the SCID for DSM-III-R has been reported in several studies. With regard to reliability, the range in reliability is very wide, depending on the nature of the sample and research methodology (i.e. joint vs. test-retest, multi-site vs. single-site with raters who have worked together, etc.). Determining the validity is an even more difficult question because of the lack of established gold standards for psychiatric diagnoses. In lieu of such a gold standard, "best estimate" diagnoses are often used as the clinical standard.

GHQ - General health Questionnaire

This self-administered questionnaire focuses on two major areas: The inability to carry out normal functions and the appearance of new and distressing phenomena. The General Health Questionnaire (GHQ) screens for non-psychotic psychiatric disorders and is available in the following versions:

- GHQ-60: The fully detailed 60-item questionnaire.
- GHQ-30: A short version.

The Mini Mental State Examination

MMSE is the most commonly used test for memory problems and contributes to a possible diagnosis of dementia. The MMSE test is used to screen for the presence of cognitive impairment over a number of areas. Cognition is defined as mental activity such as memory, thinking and attention.

SCL-90-R

The Symptom Checklist-90-R (SCL-90-R) instrument helps evaluate a broad range of psychological problems and symptoms of psychopathology. The instrument is also useful in measuring person progress or treatment outcomes.

The SCL-90-R instrument is used by clinical psychologists, psychiatrists and professionals in mental-health, medical and educational settings as well as for research purposes. It can be useful in:

- Initial evaluation of persons at intake as an objective method for symptom assessment.
- Measuring person progress during and after treatment to monitor change.
- Outcomes measurement for treatment programs and providers through aggregated person information.

Hamilton Rating Scale for Depression

The total Hamilton Depression (HAM-D) Rating Scale provides an indication of depression and, over time, provides a valuable guide to progress. It comprises 17 items that all refer to depressive symptoms. In general the higher the total score, the more severe the depression. HAM-D score levels of depression: 10-13 mild; 14-17 mild to moderate; >17 moderate to severe.

Hamilton Rating Scale for Anxiety.

The Hamilton Anxiety Scale (HAMA) is a rating scale developed to quantify the severity of anxiety symptomatology. It consists of 14 items, each defined by a series of symptoms. Each item is rated on a 5-point scale, ranging from 0 (not present) to 4 (severe).

The Beck Depression Inventory (BDI, BDI-II)

The Beck Depression Inventory is a 21-question multiple-choice self-report inventory that is one of the most widely used instruments for measuring the severity of depression. The questionnaire is designed for adults aged 17-80 and is composed of items relating to depression symptoms such as hopelessness and irritability, cognitions such as guilt or feelings of being punished, as well as physical symptoms such as fatigue, weight loss, and lack of interest in sex.

Diagnostic Interview Schedule for Children (DISC)

The NIMH *Diagnostic Interview Schedule for Children* is a highly structured interview designed to assess DSM-IV psychiatric disorders and symptoms in children and adolescents aged 6-17 years. It is designed to be administered by interviewers without clinical training. The interview covers

DSM-IV, DSMIII-R and ICD-10 for over thirty diagnoses. These include all common mental disorders of children and adolescents that are not dependent on specialized observation and/or test procedures. There are parallel parent and child versions of the instrument: The DISC-P (for parents of children aged 6-17) and the DISC-Y (for direct administration to children aged 9-17). In most instances both should be used as parents and children have been found to differ considerably in their assessments. More information can be found at: www.fasttrackproject.org/techrept/c/cdc

The Schedule for Affective Disorders and Schizophrenia for School-Age Children – Present and Lifetime Version (K-SADS-PL)

The K-SADS-PL is a semi-structured diagnostic interview designed to assess current and past episodes of psychopathology in children and adolescents according to DSM-III-R and DSM-IV criteria. Probes and objective criteria are provided to rate individual symptoms. It is administered by interviewing the parent(s) and the child, finally achieving summary ratings which include all sources of information (parent, child, school, chart, and other). It requires some clinical training to administer. Administration of the K-SADS-PL requires the completion of: 1) an unstructured Introductory Interview; 2) a Diagnostic Screening Interview; 3) the Supplement Completion Checklist; 4) the appropriate Diagnostic Supplements; 5) the Summary Lifetime Diagnoses Checklist; and 6) the Children's Global Assessment Scale (C-GAS) ratings. The K-SADS-PL is completed with each informant separately initially, and then the Summary Lifetime Diagnoses Checklist and C-GAS ratings are completed after synthesizing all the data and resolving discrepancies in informants' reports. More information and the interview can be found at:

www.wpic.pitt.edu/ksads

The Strength and Difficulty Questionnaire (SDQ)

The SDQ is a brief behavioural screening questionnaire for about 3-16-year-olds. It exists in several versions to meet the needs of researchers, clinicians and educationalists. It is provided free of charge and exists in

many different languages. More information can be found at:
www.sdqinfo.com

The Child Behaviour Checklist (CBCL) and YSR (Youth Self-Report)

The Achenbach System of Empirically-Based Assessment (ASEBA) includes checklists for parents and self-reports for adolescents and young adults and covers important aspects of adolescent and young adult psychopathology. It has been widely used in both clinical and research settings around the world and exists in many different languages. The system is, however, not provided free of charge. More information can be found at: www.aseba.org

Note

Due to the cultural context, lack of **Education**, or because police or military forces use structured questionnaires during interviews, frequently torture survivors object to these procedures. Using a clinical interview is more accepted in the third world countries. In most cases there is also not enough time and space to carry out such extensive procedures as the therapist may have to travel to the communities and the interview could take place under extremely difficult and risky conditions. Even if there is an excellent translation of the various scales, you have to translate them again for the people because they may speak a native language or even if they speak, for instance Spanish, the level of education or a different cultural setting may necessitate the development of a semantic glossary so that they can understand the meaning of the words.

It is also important to be aware that some people may not readily reveal what bothers them; for many reasons, it may be difficult to verbalize or articulate the pain and their experiences. This may be due to e.g. the cultural background, the lack of a tradition of verbalizing emotional matters or to a feeling of shame over what the person has been subjected to.

References:

Gerrity E, Keane TM, Tuma F, editors. The mental health consequences of torture. New York: Kluwer Academic; 2001.

Care for caregivers

HEALTHCARE ASSISTANT

Key signs

Helpers are themselves part of the collective crisis and might themselves be torture survivors.

The workload is heavy and they repeatedly deal with the painful stories of those they care for.

They become affected by powerful emotions (**Anger, Anxiety**, sadness and powerlessness) and they may face the perceived feeling of not doing enough.

Facing moral and ethical dilemmas.

Action

- To find out whether you also need support ask yourself some questions:
 - Have you had an opportunity to talk to others about your experiences?
 - Do you have such an opportunity now?
 - Do you ever have a chance to relax after work?
 - Can you recall what happened to you and your family without crying or getting angry?
 - Can you be pleasant and nice to people you work with and to family members?

If your answer to most of the questions is “no”, you may have had a difficult time. This will make it hard to support others who have lived through similar hardships.

- To find out if supporting others will be difficult for you, ask yourself some further questions:
 - Do people seem too ill-at-ease in your presence to talk about the violence or the torture they endured?
 - When people discuss their experiences with you, do you find it hard to give them your full attention?

- Do your thoughts often wander and you feel as though you are not really there?

- Do you get very bored, tired, annoyed or restless?

If your answer to most of the questions is “yes”, it may be wise to organise some kind of support for yourself.

- If you want to support others, it is best to solve your own problems first. When you have dealt with your own hardships, you will be able to support others better.

- How to set up a support group for colleagues:

Purpose:

- To give one another the opportunity to talk about the past.

- To gain experience of how to deal with the effects of torture and other forms of violence in a group.

- To learn from one another’s experiences about effective ways of helping people who have suffered.

- To allow group members to talk about feelings in dealing with victims.

- To learn to respect confidentiality, that what you tell each other must remain within the group.

- Frames and content of group meetings:

- Invite some colleagues (6-10 people) to form a mutual- support group to exchange experiences in dealing with victims of **Torture and Organised Violence**.

- Discuss how the group should be organised: Meetings to be held weekly and last 1-1½ hours. Group members can take turns in leading the meeting.

- Each meeting should start with group relaxation exercises. You can use various techniques mentioned in other chapters in this manual. As well as breathing exercises and relaxation techniques or physical exercise, it is important to find some forms of recreation.

- Discuss **Stress** and people’s reactions to *stress* at the meetings.

- Discuss how *coping* can be used for group and individual **Counselling**.

- See also level 2, exercises and relaxation techniques.

Note

The community healthcare assistant should also be working within a network or an organization in the community which can provide training, follow-up, supervision or initiate peer supervision to prevent burnout and maintain the quality of counseling.

HEALTHCARE PROFESSIONAL

Characteristics

Compassion fatigue or secondary traumatization refer to the phenomena that healthcare professionals, involved with primary traumatised people, are at risk of suffering from i.e. physical and psychological effects of traumatic experiences. The symptoms are those in **PTSD** or are similar to PTSD.

Often unwanted feelings are transferred from the suffering person to his/her surroundings. **Anger, Anxiety** and helplessness are feelings that the CHP can experience himself/herself. The symptoms of secondary traumatization are similar to those in PTSD, for example:

- Sleeping problems, concentration problems, depressive symptoms, tendency to isolate oneself, anxiety symptoms, nightmares and **Intrusive memories**.
- Impact on the view of oneself and others, the whole worldview is changed and shaken.
- Daily problems become less interesting and it becomes more difficult to be intimate with close relatives.
- Feeling of guilt because own life is all right/better
- Feeling of **Shame** as an indirect witness to the abuses.

See also level 3, risk of burnout.

First therapy

Physical exercise is necessary for good health and is useful in reducing **Stress**. Walking is very good exercise, especially for those over 45 years of age or in poor health. Younger people should do something more active – swimming, football or something suitable in the circumstances. Massage is widely used in many cultures to relieve tension and promote health. People can massage themselves or be helped by other members of their family.

Second Therapy

See **Stress management**.

HEALTHCARE SPECIALIST

Assessment

The risk of burnout, related to the working conditions and the way work is organised:

- Explore extent of constant contact, workload and the number of contacts.
- Detect unclear goals with the work.
- Detect unclear roles and expectations from leaders and from society.
- Assess contamination by association with case.
- Too few possibilities for personal development?
- A negative spiral of exhaustion will cause your work to lose its meaningfulness. There are typical psychosomatic symptoms such as: **Headache**, fatigue, digestion problems and hypertension.

Attitudes change in the client relationship:

- Becoming more distant and developing feelings of disgust.
- Suspicious toward clients.
- Cynical.

In the work the healthcare specialist:

- Becomes more rigid, resistant towards change and less creative.

- Experiences reduced working capacity.
- Is plagued by a dominant feeling of being incompetent and feeling anxious that colleagues will discover ‘the fact that you are useless’.

See also secondary traumatisation at level 2.

Proposed measures

- Be familiar with the signs of burnout and able to identify causes.
- Physical health problems: See a doctor – have a physical check-up, sleep, eat right and exercise.
- Mental health problems: Develop skills for dealing with **Stress**, including using muscle relaxation techniques, mental imagery and positive self-talk. Develop your self-insight and understanding of your own strengths and weaknesses.
- Monitor **Depression**.
- Effective time-management; set realistic goals.
- Put yourself first (what recharges your batteries); nurturing your closest relationships, partners, children or friends; connect with a cause or a community group that is personally meaningful for you.
- Address your dissatisfaction at work; consider a job or career change.
- Practice healthy communication.
- Get guidance and support from managers and peers; be open and sharing; consider organizational culture; hold regular and frequent staff meetings.
- Respect for confidentiality.
- Creation of peer-support system.
- A supportive environment is required if the psychological needs of caregivers are to be addressed.
- A culture of mutual support should be encouraged.

References

Figley CR, editor. Compassion fatigue : coping with secondary traumatic stress in those who treat the traumatized. New York: Brunner/Mazel; 1995.

Kanji N, White AR, Ernst, E. Autogenic training for tension type headaches : a systematic review of controlled trials. *Complement Ther Med*. 2006;14(2):144-50.

Kabat-Zinn J. *Full catastrophe living : how to cope with stress, pain and illness using mindfulness meditation*. London: Piatkus; 2007.

Somasundaram DJ, Sovayokan S, editors. *Mental health in the Tamil community*. 2nd ed. Jaffna: Shanthiham; 2005. p. 1-13.

Cognitive-Behavioural Therapy (CBT)

Key signs

Cognitive-Behavioural Therapy (CBT) is a form of **Psychotherapy** that has developed since the 1950s. It was initially based on experimental learning theory and later, more generally, on experimental psychology and other relevant sciences. CBT focuses on current problems, analyzing eliciting situations, reactions inside the organism (physiological, emotional, thoughts/interpretations), the behaviour elicited and the behaviour's consequence (in the short and long run). Depending on the type of problem, different parts of the components just described are more or less important. With phobic **Anxiety** for example, specific objects (situations) elicit anxiety (emotionally/physiologically inside the organism) in a reflex-like manner resulting in escape behaviour, whereas the interpretation of the situation has no or little relevance. With panic-type anxiety on the other hand, the interpretation of physical symptoms, e.g. increased **Heart palpitations** (eliciting situation), as catastrophic, e.g. as an imminent heart attack, is central to the occurrence of anxiety and the resulting behaviour, e.g. seeking immediate medical assistance. In the first case, the anxiety problem cannot be "reasoned" or "informed" away, whereas providing 'decatastrophizing' information about heart palpitation and the physiology encompassing panic attacks is crucial for treatment in the second case.

For many problems, the consequences of behaviours are important, typically in the form of positive consequences in the short and negative consequences in the long term (see **Avoidance behaviour**). In these cases, the systematic changing of consequences is a central part of the treatment, which is widely used, e.g. in the form of teaching parents about a suitable use of reinforcement in order to alter problematic child behaviour.

CBT can be applied in individual as well as in group/family format. Usually the treatment is given in face-to-face contact with the therapist(s) but there are also applications using only written communication, the internet or self-help instructions. In CBT there is no single theory that is applied to all problems, and many different individual treatment methods can be used, depending on the problem addressed. For some problems, several alternative methods are available. Knowledge derived from sciences other than psychology is applied and integrated into CBT-treatment when relevant, e.g. in the field of so called “behaviour medicine” in which CBT is applied for physical problems and illnesses such as pain, sleep disturbances or cardiac problems. CBT strives to evaluate and develop treatment methods according to (traditional) scientific methodology with the consequence that the current methods are often not stable but are continuously modified.

There are CBT-treatment methods for a wide variety of psychological and somatic problems with the aim of such treatment ranging from curing the person (e.g. from specific phobias) to ameliorating symptoms and/or improving functioning (e.g. in the case of chronic disease or innate mental retardation).

The space here does not allow for a description of CBT-treatments that might be relevant for all the problems that can be seen in torture survivors. Guidelines for major problems such as pain, sleep and anxiety are given under the respective entries. For other problems that are not covered in this text, treatment manuals published for a great variety of difficulties may be helpful. It must, however, be remembered that treatment manuals

cannot be a substitute for a training in CBT but should be seen instead as possible sources for inspiration, if there is no access to a trained CBT therapist.

References

Lambert MJ, [editor]. Bergin and Garfield's handbook of psychotherapy and behavior change. 5th ed. New York: John Wiley & Sons; 2004.

O'Donohue W, Fisher JE, Hayes SC, editors. Cognitive behavior therapy : applying empirically supported techniques in your practice. Hoboken, NJ: John Wiley & Sons; 2003.

Homepages of Cognitive-Behavioural Therapy Associations in many countries provide information about CBT and literature, in some cases even treatment manuals.

Disorder-specific treatment manuals and books can be identified in great numbers from an internet search, e.g. combining "CBT" plus the disorder or problem in question.

Community Approach

Key signs

The term "community" describes all kinds of human groupings, and a distinction between place, non-place and kinship communities can be made.

Place: The community is defined in terms of geographic boundaries and consists of a city, town or neighbourhood where community members live.

Non-Place: The community is defined not by residence but by other attributes shared by community members.

Kinship communities are defined by common bloodlines and familial relationships. Clans, tribes and large extended families constitute communities based on kinship relations.

The definition below covers all these kinds of grouping:

“People who share common activities and/or beliefs and who are bound together principally by relations of affect, loyalty, common values, and/or personal concern (i.e. interest in the personalities and life events of one another” (Quiroga & Jaransson 2005)).

Considering the basic context of interaction, two major subgroups can be identified: 1) communities bound together for “geographical” reasons because they live close together or 2) those that are bound because of “choice”, independent of geographical proximity. At the same time these two groups can be subdivided into “activity-based” and “belief-based” (Quiroga & Jaransson 2005). Community participation is key to Primary Health Care (PHC) because it ensures that healthcare beneficiaries become involved in the decision-making process; both deciding on health and in making decisions on resource allocation.

“Community participation is a social process where specific groups who have the same needs in a defined geographic area, actively strive to identify their needs. They make decisions and establish strategies to meet those needs” (Rifkin et al 1983).

The participation can be differentiated into three levels: community-oriented, community-controlled or community-based programs.

There are two basic approaches with different possibilities for participation:

- The top-down medical and health planning approach where community participation is based on participants performing tasks that are defined by professionals. This is the community-oriented approach.
- The bottom-up community developmental approach that views improvements according to the level of participation and responsibility of members of the local community. This is the community-controlled approach. (Rifkin et al 1983).

Action

Interventions at the community level often refer to psychosocial interventions and typically seek to foster psychosocial health through personal, group and environmental change for the individuals and to restore a sense of security, create a sense of belonging, and a self-generating community healing and empowerment. To support rebuilding community networks, employment and economic activity, to improve standard of living and support rebuilding institutions are other relevant focus areas.

See also **Torture and Organised Violence** and **Local community breakdown**.

Community participation may include involvement in information collection and analysis as a process, using multidisciplinary and interactive methods. There is an emphasis on communication and listening skills in order to involve community members in the decision-making process. The assessment is often called Rapid Appraisals (RA) or Participatory Learning Appraisal (PLA). Key to empowerment is fostering dignity, which comes from the ability to influence key decisions with knowledge internal to the community. The process can only occur when the community takes ownership. In this approach the process is iterative, innovative, interactive, informal and in the field.

- Identify human resources in the local community, such as significant elders, community leaders, traditional healers, religious leaders, teachers, health and mental-health workers, social workers, youth and women's groups, union leaders and business leaders. A valuable strategy is to map local resources by asking community members about the people they turn to for support at times of crisis.
- Facilitate the process of community identification of priority actions through participatory rural appraisal and other participatory methods.
- Promote a collective process of reflection about people's past, present and future that enables planning. By reflecting on where they want to be in several years' time, they can envision their future and take steps to achieve their vision.

- Discuss with key actors or community groups: Mechanisms (rituals, festivals, discussion groups, victims groups, human rights groups, etc.) that have helped community members in the past to cope with torture, violence or loss.
- Discuss how the current situation has disrupted social networks and coping mechanisms.
- Discuss how people have been affected by the situation and what actions should be taken to support the process of healing.
- Support community initiatives that promote family and community support, including people at greatest risk, for example by group discussions on how the community may help at-risk groups, or in child protection, etc.

Note

The local traditions and values determine the appropriateness of the psychosocial approach in the community. The local community, for example, can either support or prevent emotional healing after a traumatic event. The victim's membership in the local community can be affirmed and attention and support can facilitate healing. But this may be totally different in another community, where the traumatic event may be stigmatic and cause exclusion from participation in the community life, which eventually aggravates the trauma. It is important to understand the power relations in the communities: between authorities, religious and social leaders, traditions and cultural values.

References

Facilitate community self-help and social support : action sheet 5.1.. In: IASC. Guidelines on mental health and psychosocial support in emergency settings. Geneva: Inter-Agency Standing Committee, IASC; 2007. p. 100-5. Also available online, at:

http://www.who.int/hac/network/interagency/news/mental_health_guidelines/en/index.html

Rifkin SB. Planners' approaches to community participation in health programmes : theory and reality. *Contact*. 1983;75(Oct):3–16.

Rifkin SB. Rapid appraisals for health : an overview. RRA notes. 1992;(16):7-12.

Complementary and Alternative Medicine (CAM)

HEALTHCARE ASSISTANT

Key signs

The definition of Complementary and Alternative Medicine (CAM) varies; a sociological definition is “practices that are not accepted as correct, proper or appropriate or are not in conformity with the beliefs or standards of the dominant group of medical practitioners in a society”. Major components in traditional medicine are herbal therapy, physical treatment such as massage, pressure, traction, treatment with sharp objects such as needles in acupuncture, and spiritual components.

In many countries of the South, traditional medicine is both a first important local remedy and the major remedy for chronic conditions. Its contextual importance should not be underestimated, perhaps most importantly, to modify thought patterns in a health-oriented direction in people with chronic conditions.

Action

Procedures not involving tissue injury or treatment with infected materials should usually be accepted.

Note

If there is no effect within a few weeks, seek other treatment.

HEALTHCARE PROFESSIONAL

Characteristics

For medical purposes, the following definition of CAM is often employed: “Diagnosis, treatment and/or prevention which complements mainstream medicine by contributing to a common whole, satisfying a demand not met by orthodoxy or diversifying the conceptual framework of medicine” (Ernst et al, 1995). That adopted by the Cochrane Collaboration reads "CAM is a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well-being. Boundaries within CAM and between the CAM domain and that of the dominant system are not always sharp or fixed."

A recent search of the PubMed database for "Complementary Medicine and Pain" produces 6509 hits. Narrowing the search down to randomised controlled trials still produces 778 hits, 188 of which have been published since 2002. Thus, the interest in complementary medicine has grown very rapidly in the North and at present, valid clinical research is being performed in this field. This growth of interest also holds for the general public, since according to a poll from the UK, the visits to alternative practitioners equalled the number of visits to conventional primary care in 1990 and had increased by 50% six years later, while conventional care consumption had not.

Two interesting examples of the distance between traditional medicine and the modern practise of CAM mentioned by Ernst et al (2001), is that CAM practitioners often advocate chiropractics for asthma (which has been shown convincingly in multiple, randomised, controlled studies not to work), but do not regularly recommend acupuncture for **Nausea** (which, from systematic reviews, has been found to work effectively). This clearly

illustrates the still unscientific application of CAM principles by different service providers.

As regards a possible scientific basis, two approaches can be taken: One is to try to understand the action mechanism of a specific therapy, as has been partly successful with acupuncture and endorphin release or St John's Wort and serotonin. The other approach is to consider the nervous system as a black box, only assuming that whatever the action of a remedy, it takes place inside. Here, the whole scientific effort is aimed at clarifying whether or not there is a measurable and meaningful clinical effect of the therapy. Since CAM therapies are often non-pharmacological, there may be formidable difficulties in constructing credible placebo therapies and accounting for "non-specific effects". Nevertheless, the latter road has to be taken, just as for conventional medicine therapies, to avoid opinion-based and encourage evidence-based medicine.

Another important matter is when and how to apply the CAM treatment principles, where the training of its practitioners becomes an important issue. In China, for example, large colleges of Traditional Chinese Medicine have government support, whereas in most societies, training occurs informally in local communities.

References

Ernst E, Pittler MH, Wider B, editors. The desktop guide to complementary and alternative medicine : an evidence-based approach. 2nd ed. Edinburgh: Mosby; 2006.

Counselling

HEALTHCARE ASSISTANT

Purpose

The community healthcare assistant should be able to recognise the problems and symptoms that may occur in people who have been tortured. These are some of the problems that torture survivors may face and need help dealing with:

- Painful experiences related to the past.
- Physical health and physical problems: **Chest pain**, increased heart rate, **Sweating**, heavy breathing, **Tiredness**.
- Eating disorder e.g. lack of appetite.
- Feelings of **Isolation** and sadness.
- Loss of family, friends, home or other painful experiences related to the past.
- Social problems related to their family.
- Feeling afraid or having a tendency to become angry about little things or having rapid mood changes.
- Sleeping problems, bad dreams and nightmares.
- Feelings of guilt and **Shame**.
- Avoiding situations or discussions that remind them of the painful experience.
- Consuming too much alcohol or taking drugs.

Counselling can be defined as a helping activity that does not necessarily require an academic degree or specialist training. Rather, it is a form of support that can be offered to individuals, families, groups or communities in order to deal with the problems they themselves identify as important. Good counselling means helping the people to help themselves.

Counselling has two main purposes:

- A curative one aimed at alleviating mental suffering.

- An empowering one where the person rediscovers and mobilises his/her resources to deal with present demand and future situation.

The clients are considered to be the experts in their own lives and the counsellor supports the person's own resources and ability to process and cope with past trauma and current demands. In principle, the counselling can be divided into three phases: The meeting phase, the working phase and the ending phase. The community healthcare assistant must learn how to deal with the memories of their clients' painful experiences, so that they will find it easier to help others. It is important for the counsellor to work through his/her own traumatic experiences and to develop an awareness of their own feelings, strengths and limitations.

Action

Set up and organise groups with other torture survivors to share and discuss experiences.

Note

Refer to next level if necessary.

Peer supervision and **Care for caregivers** are required.

HEALTHCARE PROFESSIONAL

Common elements in basic counselling

Importance of counsellors' self-reflection:

See previous level.

Establishing trust and rapport:

A counsellor must be a caring person able to establish trust, including the ability to convey empathy. These characteristics ensure that the person feels respected and understood. Conveying respect and a non-judgemental attitude are essential ingredients for establishing rapport. The counsellor may build trust if he/she is consistent, reliable, organised, confident and able to convey empathy.

Assessment and motivation

The motivation of the client is crucial for successful counselling. Therefore, motivation for counselling has to be assessed before a counselling process is entered into.

Meeting the needs of the client and the precise identification of the problems the client is facing are part of this assessment.

The assessment should include a bio-mental-social-health status. Not only the symptoms but also the levels of functioning before and after the trauma experience are important factors in the assessment.

Choice of approach

The choice of approach is based on 3 overall aspects: The socio-cultural context, the needs of the client and the resources available in the actual context, including human, educational and financial resources.

The needs of the torture survivor

Torture survivors have multiple medical, psychological and social needs.

The combination and degree of these needs differ in each individual or each family. The most urgent needs of torture survivors or refugees are: Housing (shelter), security, food support, income support, employment, medical care, advice on legal matters, child care and schooling for children and social support.

The choice of a given approach depends on the specific needs and the degree to which the family and community is affected (see **Assessment of torture survivors**).

The significance of the socio-cultural context

Counselling is one of the practices that almost all organisations treating TOV survivors undertake, including RCT partner organisations.

Different counselling approaches and psychosocial interventions have been developed in response to the various contexts, cultures, political and resource situations in which rehabilitation takes place, all catering to the perceived needs of defined target groups.

No universal approach can be defined since counselling has to be understood according to the socio-cultural context where it is practised. The local traditions and values determine the appropriateness and applicability of counselling in the community.

Survivors might feel significant **Stress** due to their inability to perform culturally appropriate burial rituals, in situations where the bodies of the deceased are not available for burial. Similarly people might experience intense stress if they are unable to engage in normal religious, spiritual or cultural practices.

The approaches in counselling among the RCT partners include approaches that emphasise empowerment and support, e.g. the psycho-legal approach in victims' associations in rural Bangladesh, where the overall goal is that together we are strong. For all partners human rights issues are important and necessary and are included in counselling. The political situation influences all the work going on in counselling and this is particularly emphasised in the context of Gaza. Other approaches relate to spiritual and religious needs, working in reflection groups, particularly emphasised in the Guatemalan context. All organisations work with community, family-oriented and individual counselling, but most of them emphasise the importance of the community-oriented and family approach.

Four levels of intervention

- *Counselling at the individual level* supports the person's own resources and ability to cope with past trauma and current demands. It is a systematic process concerned with resolving problems, making decisions, coping with problems, working through conflicts or improving relationships with others. In this process, a space is created for talking about the problems that the person needs to talk about most. This means talking about daily difficulties as well as about more painful and traumatic experiences of the past. Often mental and body-awareness exercises are integrated into "the talking cure" (see **Stress management**).
- *In-group counselling* is for the individual to benefit from being part of a group of people who have had similar traumatic experiences. The support from the other group members may minimise the feeling of

being isolated, of facing problems alone, as well as the feeling of **Mistrust** towards others. Group members may often benefit from learning from other members' experiences. The approaches used in in-group counselling are often based on empowerment strategies and participation.

- *Family counselling* attempts to restore the basic social unit. The family structure is often the most appropriate place to find the support and care needed to improve healthy dynamics. When relationships between family members, mutual understanding and dynamics are disturbed, assisting the family can be very beneficial. Family discussions, deliberations, sharing of problems, expression of emotions, unified functioning, co-operative efforts and joint participation in social functions and religious ceremonies/festivals can nurture family unity and produce positive health dynamics. *Psycho-education* can also be used in family interventions supporting the process of integration, re-integration and the empowerment of coping strategies related to reactions to painful experiences. Family counselling and the creation of a space in which to talk about daily difficulties and more painful experiences from the past can help prevent *re-traumatisation*.
- *Counselling at the community level* typically seeks to foster psychosocial health through personal, group and environmental change for the individuals and to restore a sense of security, create a sense of belonging and a sense of a self-generating community (healing and empowerment). Community-based counselling is often combined with individual and family counselling. In particular, this is done to ensure that those who are in need of more assistance than others will be identified and referred for additional supportive measures.

Approaches to counselling

- The cognitive-behavioural approach (**CBT**).
- **Testimony therapy**.
- Client-centred, non-directive counselling.
- **Exposure therapy**.
- Psycho-education (see **Information and psycho-education**).

- Autogenic exercise, mindfulness meditation, visualisation exercises (see **Stress management**).
- Supportive and **Problem solving** approach.

Trauma Counselling

The model consists of five components:

- Establishing *trust*. Without a trusting relationship the trauma counselling cannot be effective. The counsellor builds trust in the following ways: The counsellor must be a caring person able to convey empathy, respect and a non-judgemental attitude; and be consistent, reliable, organised and confident.
- *Psycho-education*. The person's symptoms are discussed and recognised, while at the same time education about PTS symptoms is provided. Reassure the person that his/her responses are normal reactions to an abnormal event. It is important to explain this to family and friends of the person as well.
- *Telling/retelling the story*. The person is asked if he/she is ready to tell the story. Once they say they are, they are gently encouraged to tell the story of what happened and the counsellor listens carefully. This allows the person to give expression to the often unexpressed feelings and fantasies, an act which may prevent repression and displacement into other symptoms. The detailed telling of the story encourages confronting rather than avoiding stimuli and this serves to reduce anticipated **Anxiety** associated with the stimulus.
- *Addressing feelings of anger, survivor guilt or self-blame*. Almost all survivors feel extremely angry about what happened. This is justified since the person was frightened and helpless. Dealing with feelings of **Anger** after a traumatic experience is a difficult process and needs to be treated with respect. Most survivors feel very guilty about what happened. They may also feel a strong sense of **Shame** about aspects of their trauma. Create a non-judgemental space in which the person can talk about his/her guilt; this serves various functions, e.g. facilitating the restoration of self-esteem.

- *Exploring coping and social support.* In this phase the counsellor assists the person to carry on with the tasks of daily living and to restore the person to previous levels of *coping*. It is helpful to ask about how the person coped with what happened and when they feel scared what do they find helpful. This removes the sense of helplessness. It is important to explore what social support is available. This is important because it helps the person feel less isolated. It has been shown that people with good social support recover from trauma much more quickly.

Facilitating creation of meaning out of a particular event requires the counsellor to engage with the person's belief system.

Note

If the problems are more severe and long-lasting, an assessment by an experienced health professional is needed. The assessment should clarify whether there is a need for specialised treatment, including medical or psychiatric treatment, and whether or not counselling is the right choice.

Care for caregivers is a requirement – Supervision or peer supervision. Training – follow-up on training is required.

References

Freire P. *Pedagogy of the oppressed*. London: Penguin; 1996.

Hajiyiannis H, Robertson M. Counsellors' appraisals of the Wits Trauma Counselling Model : strengths and limitations. Cape Town: Centre for the Study of Violence and Reconciliation (CSVr); 1999. Available online, at: <http://www.csvr.org.za/wits/papers/paphhmr.htm> [accessed 2008 Jan 28].

Jong JTVM, Clarke L, editors. *Mental Health of Refugees*. Geneva: WHO; 1996.

Madsen AG. Framing the concept of counselling. In: Olsen JS, Haagensen JO, Madsen AG, Rasmussen F, editors. *From counselling to psychosocial development*. Copenhagen: Rehabilitation and Research Centre for Torture Victims (RCT); 2006. p. 19-30.

Quiroga J, Jaranson JM. Politically-motivated torture and its survivors: a desk study of the literature. *Torture*. 2005;15(2-3):1-111. Also available online, at: <http://www.irct.org/Default.aspx?ID=550> [accessed 2008 Jan 22].

Treatment choice in psychological therapies and counselling : evidence based clinical practice guideline. London: Department of Health [UK]; 2001. Available online, at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007323 [accessed 2008 Jan 28].

Exposure Therapy

HEALTHCARE ASSISTANT

Key signs

“Exposure” is a treatment-method widely used in **Cognitive-Behavioural Therapy (CBT)**. The method is specifically applied in the treatment of anxiety that is primarily of the phobic type (compare **Anxiety**), i.e. automatically, reflex-like anxiety elicited by certain situations. An anxiety reaction implies an urge to flee from (or avoid) the situation that elicits the anxiety. This is highly meaningful and protective in the case of normal anxiety, i.e. when a real threat is present or imminent, e.g. a dangerous animal such as a poisonous snake. The same anxiety and urge to flee/avoid can, however, also occur in an exaggerated manner, i.e. without any real threat but with harmless objects, e.g. non-poisonous spiders or even pictures of spiders. A person with phobic anxiety is usually fully conscious of the reaction’s irrational and exaggerated character. This insight, however, does not alleviate the highly abhorrent anxiety and the urge to flee/avoid. Apart from anxiety, even other feelings of aversion might be affected in a similar way, e.g. disgust or intense dislike of certain tastes, smells or sounds.

The principle of exposure treatment is to withstand the urge to avoid/flee from the anxiety-eliciting situation and to sustain the experienced anxiety

repeatedly for a sufficient length of time so that its effect is spontaneously reduced and finally vanishes. The therapeutic effect is not only felt but can be observed as a normalizing of nervous activity in those parts of the brain that are involved in anxiety; the exact biological mechanism behind this “healing”-process is not yet fully understood.

Exposure treatment is not one, given treatment-method but rather a principle that can be applied in many different ways, e.g. as real life or imagined exposure to concrete objects/situations or as exposure to memories by talking, writing, drawing or playing. Exposure can be performed in a “pure” way or in combination with anxiety-reducing behaviours such as distraction or relaxation techniques. Usually exposure is performed in a gradual manner, i.e. an object is first approached at a great distance and in the following stages the distance is reduced in order to restrict the intensity of anxiety to a moderate level at each step (compare **Avoidance Behaviour**). Another example of gradual adjustment is to talk or write about memories, initially without details and subsequently more comprehensively and finally a fully detailed account. Though gradual exposure is advantageous in most cases, it might be difficult to achieve in some cases and it is not absolutely necessary. Direct full confrontation (“flooding”), with high degrees of experienced anxiety, is also possible.

A number of treatments are not labelled as exposure treatment but can, from a CBT-perspective, be seen as variants of the same, e.g. “**Testimony therapy**” (compare this entry), where exposure is achieved by talking about and producing written documentation of traumatic experiences or “Eye Movement Desensitization and Reprocessing” (EMDR), which combines imaginative exposure to traumatic memories with some form of activity (that might function as a distraction). These types of treatments can be recommended as being similar to exposure therapy.

There is an extensive body of research indicating the effectiveness of exposure treatment (and EMDR) for anxiety in general. There is even knowledge about which specific forms of exposure are most suitable for

various types of anxiety; there is steadily ongoing research aimed at further refining the specific exposure methodology that is best suited for specific types of anxiety. Based on the knowledge that exposure treatment is effective for even severe cases of **PTSD** in general, from case studies and based on its effectiveness demonstrated in groups that are similar to torture victims (such as traumatized refugees), there is little doubt that exposure treatment can also be expected to be suitable for torture survivors. Even if the clinical experience with tortured persons supports this assumption, there are at present no scientifically based guidelines about how exposure treatment should be conducted in practice with this type of person and how eventual complications and obstacles specific for this group should best be dealt with. The guidelines below should not therefore be taken as rules but rather as suggestions that might be greatly modified and adapted to the individual person.

Action

The following descriptions are based on the assumption that the torture survivor is suffering from the sort of **Anxiety** that is suitable for exposure treatment, i.e. typically exaggerated (which the person is aware of) anxiety about objects/situations and/or memories that the affected person tries to avoid/to flee from. Other types of anxiety, e.g. due to erroneous interpretation of physical symptoms or mental disease, need other types of treatment. If there are doubts, an assessment might be necessary at levels two or three prior to treatment.

Step 1: Assess the situations that elicit anxiety.

Step 2: Assess how the person tries to avoid/flee from these situations.

Step 3: Assess the degree of anxiety that is elicited in the various situations, a scale from 0 (no discomfort at all) to 10 (extreme discomfort) can be used. Order the situations in a hierarchy, from low through medium to high levels. If there are many situations – choose a

sample of about 6-8 situations that are equally distributed over the scale.

Step 4: Explain to the person how avoidance and flight is sustaining the problem and that not engaging in avoidance/flight implies some increased/prolonged discomfort initially, but decreased/lack of discomfort in the long run. Drawing simple diagrams that illustrate the degree of anxiety over time can be used.

Step 5: If concrete objects/situations are addressed:

Start exposure with the situation that elicits least anxiety and proceed to the next level but not before there is a substantial reduction in anxiety on the previous level. It might be necessary to introduce further grading within each level. Example: The sight of a uniform worn by a police officer on the street is identified as an object that elicits a low degree of discomfort (1 or 2 on the scale) and the therapist decides to start treatment by presenting such a uniform to the person.

If it turns out that the presentation of the uniform in this situation, at a close hand, elicits a high degree of anxiety (9 or 10 on the scale), the distance at which it is presented should initially be markedly increased and later decreased stepwise.

If memories are addressed:

Since exposure to one traumatic memory may also have beneficial effects on other memories without any special training for these, it is worth trying to start exposure for the one that elicits most anxiety. The most common and simple exposure method is to let the person talk about the memory, initially without detail and increasingly in greater detail (in order to keep the experienced anxiety at a tolerable level at each step). Instead of, or in combination with, talking about the memory writing or drawing/painting might also be used, following the same principle of a stepwise increase in the degree of details in the reproduction.

If the degree of anxiety elicited by exposure for the most distressing memory is too high/difficult to grade, choose another memory at a lower level on the hierarchy to start with.

Note

Prior to exposure the instruction has to be given (and followed) that the therapist will try to motivate/to assist the person in not engaging in avoidance/flight from the situation but that there will never be any enforcement used – the person has the freedom to interrupt the procedure at any time.

An exposure session should not be finished when a high degree of anxiety is evident. If this happens as a result of unpredictable interruptions, the information has to be given that the consequence might be an increased frequency and intensity of nightmares which is transient and not dangerous.

Between the therapy sessions, homework assignments have to be given in order to further increase and stabilize the success achieved during the sessions; examples are the person approaching anxiety-eliciting objects/situations on his own, further talking to relatives/friends about traumatic memories (or write about/draw/paint) or, if possible, listening repeatedly to the tape-recorded therapy session.

The time needed for a substantial reduction in anxiety during a single exposure can vary greatly, i.e. from a couple of minutes to up to an hour, which implies the need for great patience in some cases for both the therapist and person.

Upon termination of treatment, the person has to be informed about the risk of relapse and be instructed to follow a preventive maintenance program that implies following the principle of exposure, e.g. not to fall for the temptation of avoidance/flight if situations occur that elicit exaggerated

anxiety, but rather to seek out such situations and to apply the exposure principle.

The person's social environment should be involved in the exposure treatment in order to get assistance in the treatment (e.g. by relatives motivating/reinforcing the person to complete exposure homework) or at least in order to avoid a counter-productive influence from this source (e.g. the communication of erroneous beliefs to the person that exposure could aggravate the problems even in the long run).

If the person's family cannot be motivated to accept exposure treatment or if there are difficulties in conducting it - refer to next level.

HEALTHCARE PROFESSIONAL

Characteristics

The principle of exposure treatment is simple and relatively easy to explain to the person and his/her social surrounding, but there are many potential obstacles and difficulties in its practical implementation. Problems may occur at the diagnostic level, e.g. regarding the differential diagnosis of blood phobia; judgment about whether the person's current usual health and/or stress level allows for exposure treatment at the moment; problems motivating the person to start treatment and difficulties in conducting the treatment. Some of these potential problems might be difficult to handle at level 1 and are discussed below.

First therapy

People with **Anxiety** may experience loss of consciousness, which is often one of the symptoms of having a panic attack (caused by hyperventilation), typically in cases of panic disorder. It might, however, also be due to the person suffering from phobic anxiety about blood and injury. The physiological response in the case of anxiety about blood and injury is characterized by a lowered blood pressure, contrary to the usual anxiety response. In many cases of blood/injury phobia true fainting occurs, which

almost never happens in other forms of anxiety (whereas the subjective feeling of imminent fainting is common). In many cases, blood phobia is coupled with situations where blood samples are taken, and is mistaken as injection phobia. The latter, however, is a “normal” phobia that results in, not lowered, but increased blood pressure.

If there is a blood/injury phobia, exposure has to be combined with “applied tension”. Applied tension implies training in quickly tensing the great muscle groups of the body, thus increasing blood pressure. After the tension-procedure training, the person is exposed to the phobic situation, e.g. to blood in a glass or to pictures of injury. When the blood pressure starts to go down, which is experienced as a feeling of **Nausea** and nearly fainting with observable symptoms such as becoming pale in the face, muscle tension is applied in order to normalize blood pressure. The procedure is continued and repeated until the reflex of fainting and the high degree of anxiety is extinguished, which can be achieved in a few sessions but might also take longer treatment.

Second therapy

Though people are usually fully conscious of the irrational and exaggerated character of their phobic anxieties, there might be other, erroneous beliefs and concerns that are de-motivating regarding exposure treatment. People may e.g. believe that exposure could result in such high levels of anxiety that they become “trapped” in it, i.e. that the anxiety will never diminish again. Other beliefs are that high and/or prolonged anxiety could produce insanity and/or somatic damage and could even result in sudden death. In these cases a thorough explanation and correction of the erroneous concerns is necessary and all medical questions that the person might have should be answered in a trustworthy way. After this intervention, given on the basis of the medical authority that is represented at level 2, treatment might continue at level one; in some cases corrective information might have to be given at next level.

Third therapy

Exposure therapy is by definition a treatment method that (initially) implies at least some degree of aversive experience and a further increase in **Stress** might not be tolerable for people with already high stress levels due to other reasons. It might be advisable to postpone the treatment until the level of stress has decreased. In some cases, prior to exposure treatment, the somatic health status might have to be improved by treating somatic problems, e.g. malnutrition, **Substance abuse**, systemic diseases, high levels of pain, etc.

Fourth therapy

Torture survivors might have been exposed to many different traumatic events during long periods of time, which might make it difficult to construct a meaningful hierarchy of anxiety-eliciting memories. Another complication might be that exposure to one memory initially does not result in reduced anxiety for that memory but that new memories and details appear that create new, high levels of anxiety with the consequence that a working fully through of all the experiences would become very time-consuming. In these cases it might be a better alternative not to follow the standard exposure procedure described above, which aims to obtain an account of traumatic experiences, as detailed as possible. Instead, a strategy might be preferred that aims at achieving a full account of the person's history, including all central traumatic experiences, even if these accounts might not be as detailed as is usual in exposure treatment. If this strategy seems to be preferable, **“Testimony therapy”** or “narrative exposure therapy” (see references below) can provide useful guidelines.

Note

Refer to next level if additional medical expertise might be expected to optimize the application of the guidelines (e.g. correcting erroneous concerns that de-motivate for exposure treatment) and/or when it is advisable with respect to assessment and treatment of diseases, symptoms and disorders (e.g. if these are the causes for postponing exposure treatment).

HEALTHCARE SPECIALIST

Assessment

Rule out any hitherto unidentified/untreated somatic or other circumstances that contribute to the inability to implement exposure treatment.

References

Davidson PR, Parker KSH. Eye movement desensitization and reprocessing (EMDR) : a meta-analysis. *J Consult Clin Psychol.* 2001;69(2):305-16.

Neuner F, Schauer M, Klaschik C, Karunakara U, Elbert T. A comparison of narrative exposure therapy, supportive counseling, and psycho-education for treating posttraumatic stress disorder in an African refugee settlement. *J Consult Clin Psychol.* 2004;72(4):579-87.

O'Donohue W, Fisher JE, Hayes SC, editors. *Cognitive behavior therapy : applying empirically supported techniques in your practice.* Hoboken, NJ: John Wiley & Sons; 2003.

Paunovic N. Exposure counterconditioning (EC) as a treatment for severe PTSD and depression with an illustrative case. *J Behav Ther Exp Psychiatry.* 1999;30(2):105-17.

van Dijk JA, Schoutrop MJ, Spinhoven P. Testimony therapy : treatment method for traumatized victims of organized violence. *Am J Psychother.* 2003;57(3):361-73.

Information and psycho-education

(Partly from Linton, 2007)

HEALTHCARE ASSISTANT

Key signs

In order to achieve self-management, people need to understand their problem, how they can manage it and consequently change their behaviour. Therefore, a lack of information or knowledge may have severe consequences in the treatment, for three reasons (Linton, 2007). First, the lack of a correct explanation for the illness, its cause, course and the treatment may lead to uncertainty, increased **Anxiety** and psychological distress. Second, when not properly informed, decisions about assessment and treatment may be perceived as being taken over the head of the person. Third, self-care by the person may be limited if they do not understand its importance. For example, people may be unclear about what they should do to enhance recovery. Moreover, if the person instead feels that he/she is being “taken care of”, this may reduce motivation to engage in self-care activities, because many of the self-care activities, such as exercise, involve considerable time and effort. Thus, there is good reason to believe that educational interventions may serve an important purpose.

Since communication problems in medicine are common, several attempts have been made to provide people with clear information. In a rehabilitation program, information is sometimes used as a basic building block in multidimensional treatments that include many components. It is difficult to ascertain the extent of the effect of such information in relation to the effects of the other components. At best, the information may be necessary but not sufficient to produce significant improvements (Burton & Waddell, 2002).

Another approach has been to provide general health information. However, controlled scientific tests of the effectiveness of booklets have

been quite disappointing as these booklets have little or no effect in reducing the number of clinical consultations e.g. (Heaney et al., 2001).

Action

Written materials

To be effective, written information needs to be read, understood, believed to be relevant and acted upon (Ley, 1997). Written information as the only intervention appears to have a small effect on changing behaviour.

However, it might be incorporated into practice, to enhance communication.

HEALTHCARE PROFESSIONAL

Characteristics

There is now extensive knowledge on which to base effective personal information by combining the growing evidence about the role of psychosocial factors and the emergence of guidelines. It has become evident that psychosocial factors may create barriers to recovery. There are a number of key recommendations included in most written information, including prescribing activity rather than rest and providing reassurance to reduce **Anxiety** and fear. Consequently, such pamphlets provide clear messages aimed at reducing fear, avoidance of activities and distress.

While written information remains a rather weak intervention, a co-ordinated effort, where the information is employed to enhance the same messages and advice provided by clinicians, may be of value. Carefully selected and presented information, communicated in an uncompromising style that is in line with current management guidelines, can have a positive effect on the beliefs people have as well as on clinical outcomes.

Schools

A number of educational efforts have been initiated in the form of a school or study group; these include back schools, neck schools and **Pain management** schools. They assume that one important reason people develop problems is a lack of knowledge. Back schools, for example, may

include a wide range of topics, but typically focus on body mechanics and ergonomics. Other topics normally included are exercise, lifting and **Stress**.

A trained professional such as a physical therapist almost always provides these educational efforts in groups. However, there is great variation regarding the content, number and length of sessions.

Unfortunately, the school concept has shown only limited effects. In a review of the effects as an early, preventive intervention it was concluded that neck and back schools were not effective (Linton & van Tulder, 2001). While other reviews find some effects on knowledge and correct back posture, there is considerable agreement that back schools, at best, have only slight effects on variables such as healthcare utilization or absenteeism and virtually no effects on clinical variables such as pain intensity (Maier-Riehle & Harter, 2001).

Psycho-education

These learning experiences focus on psychological aspects of pain, anxiety and other symptoms, such as developing effective coping strategies, altering dysfunctional attitudes or alleviating fears about the problem. Such interventions are usually provided in groups and are a method of providing a psychologically oriented therapy in an effective and inexpensive way. A key concept is promoting self-help.

Many clients are preoccupied with their emotional reactions, sometimes to the extent that they are afraid of going mad (see **Coping and preoccupation with pain**). This fear may be related to the fact that the person does not understand his/her own emotional reactions and personality changes. For example, torture survivors suffer from stress and anxiety but may fear that they are actually suffering from severe physical illness. There is often a lack of understanding about how mental problems can produce physical symptoms (see **Somatisation, Stress, Anxiety**).

The aim is to help the person understand the reaction that he/she is experiencing, as this understanding offers relief and helps the person to feel normal. A careful explanation of how severe psychic trauma is connected with current symptoms can help the person to develop insight into his/her problems. The community healthcare assistant/healthcare professional/specialist will convey the message to the person that these problems are in some way familiar and that treatment is possible.

Examples of themes to discuss are: Self-care, coping strategies and problem-solving methods, but issues related to social health and human rights aspects are also examples of themes that can be discussed in psycho-education.

The purpose is to enable the person, the family or the community to take action and to make decisions and choices. In a group, this is done through dialogue with the participants. Knowledge is considered as power and the sharing of knowledge as empowerment. The purpose is also to demystify and de-stigmatise the symptoms and to improve readiness for coping under stress.

In one study (LeFort et al, 1998), chronic pain sufferers were randomly assigned to either the psycho-education program or to a waiting-list control. The course offered 6 two-hour sessions designed to maximize group **Problem solving** and self-management skills. The results indicated that the educational intervention group, in comparison to the control group, made significant improvements.

Psychological factors have been found to be an important link in the transition from acute to persistent pain, and therefore psychologically oriented interventions seem to be needed to properly address the problem. This is a particularly relevant idea because early interventions focus on changing participant behaviour and lifestyle.

The effects of providing an early, cognitive-behavioural group intervention were tested in a randomized study of 255 primary care, back-pain patients (Von Korff et al., 1998). The cognitive-behavioural intervention consisted of four sessions focusing on problem-solving skills, activity management and educational videos. Relative to the control group, those receiving the cognitive-behavioural group intervention significantly reduced their worry and **Disability** and increased their self-help skills. Similar results have been reported in other studies (Moore et al, 2000; Saunders et al, 1999).

Note

Psycho-education is a clinical pedagogical method, often supplemented with small activities and exercises, carried out in small groups or individually.

Empowerment and help to self-help are important elements in psycho-education, where the idea is to increase learning through participation and action.

References

- Burton AK, Waddell G. Educational and informational approaches. In: Linton SJ, editor. *New avenues for the prevention of chronic musculoskeletal pain and disability*. Amsterdam: Elsevier; 2002. p. 245-58.
- Heaney D, Wyke S, Wilson P, Elton R, Rutledge P. Assessment of impact of information booklets on use of healthcare services : randomized controlled trial. *BMJ*. 2001;322(7296):1218-21.
- LeFort SM, Gray-Donald K, Rowat KM, Jeans ME. Randomized controlled trial of a community-based psychoeducation program for the self-management of chronic pain. *Pain*. 1998;74(2-3):297-306.
- Ley P. Written communication. In: Baum A, Newman S, Weinman J, West R, McManus C, editors. *Cambridge handbook of psychology, health, and medicine*. Cambridge: Cambridge University Press; 1997. p. 331-4.
- Linton SJ, van Tulder MW. Preventive interventions for back and neck pain problems : what is the evidence? *Spine*. 2001;26(7):778-87.

Linton SJ. Information and psychoeducation in the early management of persistent pain. In: Schmidt RF, Willis WD, editors. The encyclopedia of pain. Berlin: Springer; 2007. p. 996 –9.

Maier-Riehle B, Härter M. The effects of back schools : a meta-analysis. Int J Rehabil Res. 2001;24(3):199-206.

Moore JE, Von Korff M, Cherkin D, Saunders K, Lorig K. A randomized trial of a cognitive-behavioral program for enhancing back pain self care in a primary care setting. Pain. 2000;88(2):145-53.

Saunders KW, Von Korff M, Pruitt SD, Moore JE. Prediction of physician visits and prescription medicine use for back pain. Pain. 1999;83(2):369-77.

Von Korff M, Moore JE, Lorig K, Cherkin DC, Saunders K, González VM, Laurent D, Rutter C, Comite F. A randomized trial of a lay person-led self-management group intervention for back pain patients in primary care. Spine. 1998;23(23):2608 -15.

Interventions with traumatised children

HEALTHCARE ASSISTANT

Key signs

Normal reactions to traumatic experiences in children are:

- Anxiety.
- Sleep difficulties.
- Sadness.
- Aggressiveness.
- Reappearance of bed-wetting or thumb sucking.
- Stomach ache, **Headache**.
- Poor concentration and learning problems.

The specific reactions of children depend on their age. Pre-school children will often show their anxiety by clinging to their parents and they can have a panic reaction if left alone (separation anxiety). They might show fear of

going to sleep, fear of strangers, they frequently suffer from bad dreams and can start wetting their beds or clothing again. School-age children often react with concentration difficulties, general arousal and fear of the future as well as with stomach ache and headache without any physical explanation. Adolescents can use self-destructive behaviour to divert **Anxiety**; they can be pessimistic about the future and confused about who they are.

Action

- Ask the parents or other caregivers about the experiences of the child. Be aware that children from families who have been tortured are under **Stress** from:
 - Traumatic events, such as shelling, witnessing violence, having to flee, imprisonment or torture.
 - Loss and separations from one or both parents or other caretakers.
 - Parents' inability to take care of them because of their own problems.
- Children might not understand violent events in the same way as adults. Often parents can tell *when* the behaviour of the child changed, and that can help you to find the external source of the child's distress. Older children might be able to tell you themselves, but it is important not to press the child to give a verbal account of the stressful events. Doing so before the child is ready might traumatize him/her further. A parent or teacher who knows the child can use play, drawings or story-telling activities to help the child "tell" what is bothering him/her.
- Traumatized children can be helped by observing a few important rules in their daily life at home and at school. The model is called 'the STROP model' and was developed by the Swedish paediatrician Lars Gustafsson:
 - **S**: Structure: A traumatised child experiences inner chaos and a strict outer structure can help the child to avoid becoming overwhelmed. School and kindergarten activities are very valuable: The school becomes an oasis in the middle of a chaotic life and

- provides a safe place. It is important for the smaller children to have few and the same responsible adults around them.
- **T:** Talking and time. All children who have experienced difficult things need to be able to talk about them with a grown-up who is willing and able to listen. By talking, the child structures what has happened to him/her and makes sense of it. Small children need to draw or play in order to communicate their experiences. The adult should have an understanding and accepting attitude and offer relevant guidance without interpreting the child's experiences and without pressing the child to talk more than they wish to.
 - **R:** Rituals. All societies have culture-specific rituals or ceremonies for mourning and healing. It is important to ask the child and his/her family what would be appropriate for them and encourage them to follow up on that. It might be helping them to contact a priest or traditional healer to arrange a special memorial for a lost family member or for a family member who was not buried appropriately or to commemorate the day a family member died or disappeared.
 - **O:** Organised play. Children learn through play, but many traumatised children are no longer able to play. During play the children can forget their terrors for a moment, and their hopes for a better future are strengthened. An adult must be present to help the children organise their play in a healthy and meaningful way.
 - **P:** Parent support. Separation anxiety can be strong in traumatised children and even shorter periods of separation can elicit terror in smaller children. Parents need to be supported in coping with a traumatised child, and they also need support to deal with their own problems, in order to become available to their children. Parents need to be informed about children's reactions during stress. When offering advice to the parents it is important to reach a common understanding of the nature of the problem as well as to listen to the parents' own solution to the problem, even if it differs from the solution the healthcare assistant would have offered.

Note

Scolding or punishing the child for having symptoms is *not helpful*. Refer to the next level if the symptoms do not ease within three months or if the child expresses thoughts about taking his/her own life.

HEALTHCARE PROFESSIONAL

Characteristics

Children's reactions to *acute traumatic experiences* often follow a pattern depending on their age and stage of development. In children the experience of fear, helplessness and terror may be expressed in disorganised or agitated behaviour. Specific for trauma in children are also: Compulsory repeated behaviours or monotonous play; nightmares; reduced interest in activities the child used to engage in with pleasure; fear of e.g. falling asleep; the dark: going to the bathroom; lack of confidence in self and others; a **Sense of a limited future**; and, for small children, loss of already mastered tasks such as cleanliness or language.

The manner in which children understand their experience of violence and the meaning they attribute to the traumatic events is of central importance for the long-term effect. Healthy adjustment after specific traumatic experiences is dependent on cognitive competence, self-esteem, active coping-strategies, and a stable emotional relationship with a parent or parental substitute, in addition to access to a broad system of social support outside the family.

Children who live under prolonged situations of **Organised violence** might develop 'complex trauma' as a result of multiple, chronic and prolonged traumatic events. Such events often interfere both with the immediate and the wider systems around the child, on which the child is dependent for help and support, and can result in neglect in several areas. Loss of, or separation from, parents may be a direct consequence of the traumatic events, but considerable secondary **Stress** may also result from

disruptions in parental attention to children as well as from other limitations in parental ability. Children lose trust in the ability of adults to provide protection and care and this may prove damaging to the child's perception of security in the world and faith in other people. Children in such situations may grow up to become anxious, angry and helpless, sometimes showing antisocial and aggressive behaviour. They are reacting as if they were being constantly traumatized.

First therapy

A traumatized child or adolescent need to be helped to:

- Establish safety, stability and trust.
- Support healthy coping strategies and feelings of competency.
- Attain self-regulation and focus.
- Create meaning.
- Establish connections.
- Integrate traumatic memories.
- Experience joy.

This can be accomplished through individual or group activities using play, drawing, drama or other types of creative and physical exercises organised by reliable and emphatic adults, who understand the child's reactions. The child needs to attain body and affect regulation before he/she can talk about the traumatic events. This can be accomplished through breathing exercises, yoga, meditation (mindfulness) and movement (see **Stress management**). At the same time this can introduce playfulness and joy into the child's life (see examples at 'project joy' at www.traumacenter.org).

Second therapy

In order to help children, it is also necessary to help the family regain their function. This can be done through family **Counselling**.

Specific themes in family counselling with traumatized children and adolescents can be:

- Roles and expectations among family members
- Loss and mourning of family members

- Meaning and cohesion
- Safety and trust in self and others
- Motivations, dreams and wishes for the future
- (Re)establishment of social networks

It is important that healthy attachments are (re)built between traumatized children and their caregivers. This can be done by instructing parents or other caregivers to create a structured and predictable environment around the child, with stable routines; by supporting their ability to respond to the child's affects in an emphatic and patient way and by instructing parents in the use of praise and positive reinforcement when dealing with their child. In the case of older children and adolescents, it is important that all are given the possibility to tell their story during family counselling and tell the other family members how they understand the traumatic events and life circumstances.

In cases of child abuse and neglect, parents should initially be counselled without the presence of their child. In such cases the counsellor must be aware of the necessity of providing safety for the child and they might be legally required to report the case to the authorities for action.

Note

For counsellors working with traumatised refugees an important question is the extent to which family members should be encouraged to talk about past experiences, and to what extent the children should be protected from the terrible events. There is no clear-cut answer to this question. While too much talking about the traumatic past could re-traumatise the individual and keep him/her locked up in the past and unable to deal with the future, too little could leave the traumatised person alone in dealing with his scattered, traumatic memories. Traumatic experiences are not related to mental symptoms in any direct way, but depend, among other things, on the meaning attached to the events. Therefore, factual information about what has happened to other family members is not in itself a good or a bad thing. The ability to create meaning in family stories depends more on the

manner in which the parents and children communicate than on the subject about which they communicate.

If the symptoms are so persistent that the child's development is at risk, the child must be referred to a child specialist for examination and treatment. This may, for instance, be the case in situations of intense separation **Anxiety** in a child, which prevents them from exploring their surrounding, participate in the activities at school or in kindergarten, etc. In cases of severe child abuse and neglect, referral is also necessary and the case should be reported to the authorities for action.

HEALTHCARE SPECIALIST

Assessment

When children are exposed to traumatic events, the developmental process is disturbed, and problems in mastering immediate and later developmental tasks arise. Long-term living conditions related to violence affect the child's perception of self and others – thus resulting in more severe long-term effects – than most single acts of violence. The stresses and strains of everyday life during and after conflict are a threat to the child's coping ability and resilience. The security of feeling related to other people who care for one is fundamental for the development of the personality. When this relation is shaken, e.g. when the child is confronted by the parent's lack of ability or will to provide protection during assault, the child loses his/her faith in both self and others.

Important diagnostic categories that should be included in the assessment of children who have been exposed to violent living conditions are:

Post-traumatic Stress Disorder (PTSD). In children the experience of fear, helplessness and terror may be expressed in disorganised or agitated behaviour. Specific for trauma in children are also: Compulsory, repeated behaviours or monotonous play, in which themes or aspects of the

experience are expressed (traumatic play); nightmares often without recognizable content; reduced interest in activities the child used to engage in with pleasure; trauma-specific fear that is expressed at sensitive times, for instance before falling asleep, in the dark, in the bathroom; reduced confidence in self and others; a sense of a severely limited future; and, for small children, loss of already mastered developmental competencies, such as cleanliness or language.

Depression. Important signs of depression in children are crying, sadness, **Loss of appetite, Tiredness**, sleep disturbances, lack of desire to explore the surroundings and contemplating suicide and sometimes also attempting suicide.

Attention deficit hyperactivity disorder (ADHD), which may be expressed in an inability to sit still, difficulties in concentrating, increased **Risk-taking behaviour** and impulsive actions, low tolerance of frustration and learning difficulties.

Proposed measures

- CBT in individual, group or parental/family format.
- EMDR.
- Narrative therapy.
- Family therapy.
- Creative therapy (drawings, drama, etc.).

References

James A, Soler A, Weatherall R. Cognitive-behavioural therapy for anxiety disorders in children and adolescents (Review). *Cochrane Database Syst Rev.* 2005;(4):CD004690.

Kinniburgh KJ, Blaustein M, Spinazzola J, van der Kolk BA. Attachment, self-regulation, and competency : a comprehensive intervention framework for children with complex trauma. *Psychiatric Annals.* 2005;35(5):424-30.

Kisiel C, Blaustein M, Spinazzola J, Schmidt CS, Zucker M, van der Kolk B. Evaluation of a theater-based youth violence prevention program for elementary school children. *J School Violence*. 2006;5(2):19-36.

van der Kolk B. The neurobiology of childhood trauma and abuse. *Child Adolesc Psychiatric Clin N Am*. 2003;12(2):293-317.

Local physical therapy (joint mobilization, stretching, heat/cold)

HEALTHCARE ASSISTANT

Key signs

Reduced mobility and pain in various joints and short and tense muscles are common findings after torture. Another common complaint is stiffness in the joints and muscle soreness in the morning. This stiffness and soreness usually improve during the day when the person has moved around and most joints and muscles have been in use.

Action

Ask about the history.

Joint mobilization:

Assess the person's ability to move around and participate in normal daily activities:

- Moving all joints to the end of range several times a day has a pain-relieving effect.
- Encourage the person to mobilize the head and neck, the shoulder girdle, the shoulders, elbows and hands/fingers.

Difficulty and restrictions in bending down and lifting objects is often caused by a stiff, sore back.

- Instruct the person to do exercises for the back, preferably in the morning.

Stretching:

Short and tense muscles are often responsible for reduced mobility of the joints:

- Advise the person to start the morning by stretching the whole body before getting out of bed.
- Stretching the neck and shoulder girdle muscles should be carried out as a natural sequence when mobilizing the joints to the end of the range of movement.
- Stretching the muscles in the legs (see **Leg pain**).

Heat and cold:

- Heat may be used to relax the muscles and often has an immediate positive effect on pain and **Stress**, but it does not have a long-lasting effect and should therefore be repeated.
- If a joint is swollen and sore, use the RICE principle: *Rest*, dependent on the severity of injury; Apply *Ice* crushed in a towel or cloth (or cold water) on painful areas to minimize **Swelling** and reduce pain; Apply *Compression* if possible (with an elastic bandage) to swollen area to minimize swelling. *Elevate* (if possible) the swollen joint until the swelling has subsided.

Note

If there are visible signs of swelling and/or infection do *not* use heat!

HEALTHCARE PROFESSIONAL

Characteristics

In some cases specific or general joint mobilization may be needed to reduce pain and restore normal joint function, and short muscles may need stretching.

First therapy

Instruct the person to perform active basic movements to end of range.

Mobilize affected joints actively and/or passively and stretch short muscles carefully without aggravating the pain.

Note

If the person's pain increases severely during or after treatment, the treatment has been too rough or vigorous. Wait for the pain to subside and start again more gently.

If treatment has no effect on range of motion and pain, send to a healthcare specialist.

HEALTHCARE SPECIALIST

Assessment

Physiotherapeutic assessment. Use physical modalities as indicated.

References

Cyriax J. Textbook of orthopaedic medicine. Vol. 1. Diagnosis of soft tissue lesions. 8th ed. London: Baillière Tindall; 1982.

Hoppenfeld S. Physical examination of the spine and extremities. New York: Appleton-Century-Crofts; 1976.

Pain management

HEALTHCARE ASSISTANT

Key signs

Pain can be classified in various ways. To correctly treat a painful condition it is important to understand not only the intensity of the pain, but also how it changes during the day; whether the pain is localised or widespread, caused by a trauma, muscle tension or other physical causes. To treat a more chronic pain state it is important to understand the suffering of pain

and how much pain per se causes **Disability** and suffering for the individual.

In treating pain, completely different approaches are used for acute and chronic pain. In acute pain, the goal is to reduce pain to a minimum, often using medication. In a chronic pain condition, the aim is often less focused on medication and more on coping with pain, using both physical and psychological actions, to restore activity and participation.

Action

By using simple questions, find out the following:

- Is the pain acute? Find possible cause, treat with paracetamol or aspirin and see a healthcare professional for further care (see **Pain, acute**).
- Is the pain chronic (of more than 3 month's duration; see **Pain, chronic**)?
- Describe the pain: Where is it? Is it constant or does it change over time? Movement is often better than rest for musculoskeletal pain conditions.
- When and how did the pain start?
- See a healthcare professional if complex chronic pain is suspected (see **Pain, neuropathic** and **Pain, psychogenic**).
- Find out the person's own thoughts about pain. Could a healthcare professional help the person to explain the cause and meaning of the pain?
- Is the person's mood affected by the pain?
- Assess the consequences of pain in restricting the activities and the life situation of the person (see also **Coping and preoccupation with pain**).
- If the person is overusing pain medication, chronic **Headache** may result.
- Avoid, if possible, heavy loads if the pain is in the back.

Note

Try to understand all aspects of pain, even the suffering part. Discuss with a healthcare professional to reach an explanation of the origin of the pain.

HEALTHCARE PROFESSIONAL

Assessment

Assess for type of pain (see **Pain, chronic**, **Pain neuropathic** and **Pain, psychogenic**) and its consequences for the life situation of the person. Is the pain accompanied by depression or anxiety?

Find out if the person is using any coping strategies, such as moving instead of lying still, activity instead of inactivity.

Action

- Make sure the person has understood the cause/meaning of pain.
- Use standard pain medication such as paracetamol and aspirin instead of opioids.
- Treat neuropathic pain.
- Treat **Depression** and **Anxiety**.
- With chronic pain, teach the person:
 - Pain-reducing strategies, such as regular activity but no heavy lifting, if possible (see also **Disability**).
 - Coping strategies (see **Coping and preoccupation with pain**).

Note

Injection blocks with local anaesthetics, steroids, phenol or alcohol are rarely, if ever, useful for chronic pain conditions.

If a psychiatric condition co-exists with the pain, such as more than mild to moderate depression (e.g. severe depression or psychosis), consult a psychiatrist.

References

Gatchel RJ, Turk DC, editors. Psychological approaches to pain management : a practitioner's handbook. New York: The Guilford Press; 1996.

Main CJ, Sullivan MJL, Watson PJ. Pain management: practical applications of the biopsychosocial perspective in clinical and occupational settings. 2nd ed. Edinburgh: Churchill Livingstone; 2008.

Problem solving

HEALTHCARE ASSISTANT

Key signs

A problem is commonly defined as the striving to move from an undesired state (e.g. being hungry) to a desired one (being full) when there are obstacles in the way (e.g. not having food at home and having difficulty walking due to pain in the feet). Problem solving is overcoming the obstacles.

Problem solving as a specific treatment method is derived from experimental psychological research. There are different specific models depending on complexity but the basic principles are the same. Problem solving can be used for a wide variety of difficulties associated with various mental and **Stress**-related problems. The method can be used in individual treatment but is most commonly and advantageously used in a group or family format. The method is designed to be a self-help method that is learned in order to promote the ability to help oneself.

Action

In the following, a 5-step scheme for problem solving is given. For each step, an explanation and rules are described. Ideally, the recipient should not be an individual but a group of people, e.g. the person and his/her family.

- Define the problem in specific and concrete terms, so that everybody understands it. Write down the problem formulation.
 - Explanation: Ill-defined problems are a major source of failure in solving problems. Only problems that can be solved with the knowledge and resources available (or that could be reasonably generated) are suitable.

- Define the aim according to step 1.
 - Explanation: Goals should be measurable and achievable within reasonable time frames. Many goals cannot be achieved immediately and minor goals on the way to the main goal should be chosen as a first step.

- “Brainstorm”: (all participants) propose as many ideas/suggestions as possible for ways in which to achieve the aim. Write down every suggestion – even those that seem unsuitable for problem solving, e.g. illegal, unrealistic and eccentric suggestions. Continue until there are no more new suggestions.
 - Explanation: “Brainstorming” is a creative process which is boosted by a stream of suggestions that create new associations and suggestions. Even unsuitable suggestions are welcome because they can contribute to opening up new and unusual ways of thinking. The basic rule is not to criticize or discuss any suggestion since this behaviour is damaging to the creative process. Humorous comments and laughing on the other hand are welcome since these behaviours promote creativity.

- Discuss and choose a strategy from the list generated during the previous step (3). At this stage obviously unsuitable suggestions are eliminated. All the remaining suggestions are discussed, criticized and eliminated until only one (or a few that may be combinable) is finally chosen.

- Explanation: At this stage criticism and rational thinking are used to choose a purposeful way of solving the problem. Sometimes additional information has to be generated before a decision between alternative solutions can be made.
- Try the chosen alternative and evaluate the result.
 - Explanation: The chosen alternative is tried out and evaluated. If the problem is not solved, the list from step 3 can be used again or a new process based on experiences during the failed attempt can be attempted.

Note

In dysfunctional groups/families (e.g. with high levels of **Anxiety**, hierarchical structures, rigid gender roles), it is advisable to perform the brainstorming in written form instead: Each participant writes (anonymously if necessary) 3 suggestions; the suggestions are made public to the other participants (e.g. listed on a big paper) and after that another 3 suggestions are written down, etc.

If the knowledge and resources available are not sufficient (and cannot be provided) to solve the problem, especially when medical and psychiatric knowledge and resources are needed, refer to next level.

HEALTHCARE PROFESSIONAL

Characteristics

The scope of problems suitable for the method described above is limited by knowledge and resources. Problems concerning medical/psychiatric issues that were not suitable for problem solving at level 1 could become so after collecting and presenting relevant knowledge at level 2 (e.g. **Psycho-education** about chronic pain, assistance in getting aids and transport).

First therapy

Same procedure as described above but on the basis of extended knowledge and available resources.

Note

If a referral to level 3 might be expected to generate additional relevant knowledge and resources for fostering problem solving, referral should be considered.

HEALTHCARE SPECIALIST

Assessment

Assess whether additional relevant knowledge and/or resources can be provided that could foster problem solving.

Proposed measures

Same procedure as described above but on the basis of extended knowledge and available resources.

References

Malouff JM, Thorsteinsson EB, Schutte NS. The efficacy of problem-solving therapy in reducing mental and physical health problems : a meta-analysis. *Clin Psychol Rev.* 2007;27(1):46-57.

O'Donohue W, Fisher JE, Hayes SC, editors. *Cognitive behavior therapy : applying empirically supported techniques in your practice.* Hoboken, NJ: John Wiley & Sons; 2003.

Psycho-education

See **Information and psycho-education.**

Psychotherapy

Characteristics

Psychotherapy is commonly defined as the treatment of psychological problems and physical problems of psychological origin by professional, trained therapists using psychological methods, typically in face-to-face interaction and oral communication with the person.

The definition, however, is not unambiguous. For example, **Counselling** is usually referred to as dealing with minor, more everyday problems but there is a considerable overlap with psychotherapy. There are also psychotherapeutic interventions using physical treatment methods, e.g. relaxation, and the communication with the person may not be oral but in written form, e.g. via the internet. In many cases, psychotherapy is applied in individual people but it can also be applied in couples, families or groups.

Psychoanalysis, being the oldest form of psychotherapy, is based on a systematic psychological theory that has been applied since the beginning of the 19th century. Today there are many different psychotherapeutic schools, based on different theoretical conceptualizations. Examples of major psychotherapeutic schools are psychodynamic (various methods, more or less based on psychoanalytic theory), cognitive-behavioural (mainly based on learning theory and experimental psychology/other sciences), systemic (mainly based on systems theory, addressing families/groups) and humanistic (mainly based on reactivation of a person's self-healing abilities). If the schools are further divided, the number of psychotherapeutic methods runs into several hundreds.

Between the different schools, and partly even within the schools, there is no consensus about how the scientific foundation of psychotherapeutic methods should be defined or how they should be put into practice. Many representatives of the psychoanalytic school, for example, hold the opinion that it is neither possible nor necessary to apply traditional scientific principles, as in the natural sciences, for the evaluation and development of

psychoanalytical psychotherapy. On the other hand, **Cognitive-behavioural therapy** is clearly oriented towards traditional scientific principles and most studies on the effectiveness of psychotherapy that have been conducted according to such principles are of the cognitive-behavioural type.

Many psychotherapeutic approaches and methods have not been researched at all or only to a limited extent. Some of these might be useful for the treatment of torture survivors. It is e.g. not unreasonable to assume that activity-increasing treatments such as music, dance and art therapy have beneficial effects, since it is known that “behavioural activation” (an evaluated CBT method for treatment of **Depression**) is an effective principle for the treatment of lowered mood. Therapies including creative activities such as painting and sculpturing, may also include elements of **Exposure therapy** (see this entry) by confrontation with traumatic material that is produced during the creative process (e.g. painting/sculpturing the content of traumatic memories and nightmares).

The psychotherapeutic methods suggested in these guidelines are partly based on findings from scientific studies, partly on currently established praxis and clinical experience in the field and may partly even be based on the individual author’s psychotherapeutic orientation.

References

Lambert MJ, [editor]. Bergin and Garfield’s handbook of psychotherapy and behavior change. 5th ed. New York: John Wiley & Sons; 2004.

Public Health Approach

Key signs

The medical problems of torture survivors are complex because they are compounded by psychological symptoms and multiple social problems.

Often many people have been affected and some people are more at risk than others.

A public health approach is population and risk-factor oriented rather than symptom or disease oriented as in the traditional approach. Risk reduction may be essential for preventing recurrence of illness; diagnosing and providing treatment for survivors with health risks are important, but reduction of risk factors in the community at large would be even better; making a community diagnosis and deciding which community programmes would be the most effective in raising the health status of the population. Information on population data, health problems, disease patterns and availability of **Health services** is required. Public health involves identifying health problems and the factors that cause them, developing a strategy to address these problems, and seeing that these strategies are implemented in a way that works.

Public health practice is the development and application of preventive strategies and interventions in order to promote and protect the health of the populations. It is focused at the community level on those factors that contribute to higher rates of health problems. The practice involves both individual and collective efforts.

Many different professions and disciplines contribute to public health practice, including environmental health specialists, health economists, health educators, medical anthropologists, nutritionists, physicians and public health nurses. Scientific knowledge is needed to guide public health practice, including: Epidemiology, statistics, environmental sciences, management, biological sciences and the behavioural sciences, such as anthropology, sociology and psychology. Political science, economics and law are also involved in modern public health practice. Public health is grounded in many different sciences and supported by a variety of other disciplines. The need for these different disciplines and skills indicates the complexity of the factors contributing to health and diseases.

“The World Health Organisation (WHO) defines health as: “a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity”. Health is a fundamental human right and that the attainment of the possible level of health is a most important worldwide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector.”

Characteristics

Six broad commitments characterise what public health does:

- Prevents epidemics and the spread of disease.
- Protects against environmental hazards.
- Prevents injuries (and violence!).
- Promotes and encourages healthy behaviours.
- Responds to disasters and assists communities in recovery.
- Assures the quality and accessibility of health services.

Primary Health Care (PHC) may serve as the means of attaining the WHO goal of health for all, *Four Themes*:

- *Equity* as a component of health. ¹(Equity in health implies that everyone should have a *fair opportunity* to attain their full health potential and no one should be disadvantaged in achieving this potential, if it can be avoided. Equal *opportunities* for health. *Access* and *available* care for equal needs. PHC should also be affordable and acceptable to all members of the community).
- *Community participation* in decision making (the individual’s responsibility for his/her own health, individual or community involvement in decisions about healthcare and the individual’s contribution to resources or community self-help schemes).

¹ The term inequity has a moral and ethical dimension and refers to differences, which are unnecessary and avoidable and considered unfair and unjust.

- *Multisectorial approach* to health problems (recognition of the multifaceted nature of the causes of ill health).
- *Use of appropriate technology* (the term refers to the combination of skilled personnel and other resources; cost-efficiency and effectiveness in dealing with the health problem; acceptability of the approach to both the target community and health-service providers; broader social and economic effects; sustainability of the approach; health-promotional activities (Green, 1999).

The district² is the key level for the management of primary healthcare. The mix of manpower and facilities providing healthcare in districts varies greatly from country to country. In the major communities, rural and urban, there may be community health workers, community health assistance, clinics and health centres, together with traditional and private medical practitioners. A government district hospital and the staff headquarters for all the district health programmes are often located in the main town. The district headquarters are usually in the main town.

Action

- Monitor health status to identify community health problems.
- Diagnose and investigate health problems and health hazards in the community.
- Inform, educate, and empower people about health issues.
- Mobilise community workers/assistants/nurses/partnerships to identify and solve health problems.
- Develop policies and plans that support individual and community health efforts.
- Enforce laws and regulations that protect and ensure safety.

² The district is the most peripheral unit of local government and administration that has comprehensive powers and responsibilities. It may be called by various names: *the block* in India, the *county* in China, the *district* in Kenya and the *upazilla* in Bangladesh. A typical district has a population of between 100,000 and 300,000 people and covers an area of from 5000 to 50,000 square kilometres.

- Link people to the personal health services needed and ensure the provision of healthcare when otherwise unavailable.
- Ensure a competent public and personal healthcare work force.
- Evaluate effectiveness, accessibility and quality of personal and population-based health services.
- Provide research for new insights and innovative solutions to health problems.
- Do no harm (e.g. cultural sensitivity, participation, use evidence-based, effective practises, develop understanding of universal human rights, power relations between outsiders and beneficiaries).
- Building on available resources and capacities.
- Integrated support systems.
- Multi-layered supports. 1. Basic services and security, 2. Community and family support, 3. Focused non-specialised supports, 4. Specialised services.

Note

Improvement in areas where there are high rates of morbidity, mortality and unequal access to health services requires a well-organised and effectively functioning system of public health practice.

Assessment

The Violence Prevention Alliance (VPA) participants share a public health approach that targets the root causes and risk factors underlying the likelihood of an individual becoming involved in violence and recognises the need for improved services to mitigate the harmful effects of violence when it does occur.

The public health approach offers practitioners, policymakers and researchers a stepwise guide that can be applied to planning programmes, policies, and investigations. The ecological framework is based on evidence that no single factor can explain why some people or groups are at high risk of interpersonal violence, while others are more protected from it.

Proposed measures

- Surveillance; what is the problem?
- Identify risk and protective factors; what are the causes?
- Develop and evaluate interventions; what works and for whom?
- Implementation; scaling up of effective policies and programmes.

References

Hardon A. Applied health research manual: anthropology of health and health care. 3rd ed. Amsterdam: Het Spinhuis; 2001.

IASC. Guidelines on mental health and psychosocial support in emergency settings. Geneva: Inter-Agency Standing Committee, IASC; 2007. Also available online, at:

http://www.who.int/hac/network/interagency/news/mental_health_guidelines/en/index.html [accessed 2008 Jan 29].

International Federation of Red Cross and Red Crescent Societies. Public health guide for emergencies [CD-ROM]. Baltimore: The John Hopkins Medical School. International Federation of Red Cross and Red Crescent Societies: 2000. Also available online, at:

http://www.ifrc.org/what/health/relief/guide.asp?gclid=CM66y4r1iZECFSZPMAodJluI_Q [accessed 2008 Jan 22].

Vaughan JP, Morrow RH, editors. Manual of epidemiology for district health management. Geneva: WHO; 1989.

Violence Prevention Alliance [online]. Geneva: WHO. Available from:

<http://www.who.int/violenceprevention/en/index.html> [accessed 2008 Jan 29].

Rehabilitation and Physical Medicine

HEALTH CARE PROFESSIONAL

Characteristics

Physical Medicine has a long tradition in the medical field, comprising treatments of a non-pharmacological character, such as the manual (mechanical) manipulation of tissue, the delivery of heat, cold, massage, dry needling, electromagnetic radiation and the use of baths, to relieve chronic disease or symptoms, cf. spa (*Latin: Salus per aqua –health through water*).

Rehabilitation Medicine, on the other hand, originated in British experiences of people with spinal cord injuries during the Second World War, where Dr. Ludwig Guttman pioneered the development of reliable rehabilitation programs for those with paraplegia and tetraplegia. Rehabilitation literally means “redressing” (*Latin habitat – dress*). Apart from crisis intervention, these programs place strong emphasis on conservative treatment of the spinal fracture, prophylactic treatment to avoid pressure sores, to empty the urinary bladder at regular intervals and to train adequate techniques for breathing and coughing in high injuries. They also developed effective techniques for independently taking care of personal hygiene as well as transferring between a bed, a chair and a wheelchair, including the effective handling of transport vehicles. After post-acute rehabilitation, a life-long follow up ensued. The result is that the remaining number of life years has increased from 1-2 years after the injury (even in young people), to today’s normal life span for a paraplegic person, usually at an independent level, and a moderately reduced life span for the tetraplegic person, as a rule partly dependent.

To fulfil the many needs of people in rehabilitation, it was recognized that many different health professions apart from physicians and nurses were necessary in the daily work. This led to the development of *rehabilitation teams*, supervised by the physician and consisting of nurses, physiotherapists, occupational therapists, social workers, psychologists and

sometimes vocational specialists and speech therapists. The expected norm is group decision making, both in assessment, rehabilitation planning and treatment.

The disabled person is considered the most important member of the team, both in planning and in decision making. Common rehabilitation strategies are used, where the various professionals contribute important components. The group shares responsibility for the rehabilitation given and the team conference, led by anyone of the team members, is the important forum for lateral communication and for decision making. This concept allows a free exchange of ideas and may benefit from group synergies in **Problem solving** but can be time consuming and the team members need training in the team process. Coordination is facilitated.

Somatic rehabilitation has gradually been expanded to include people disabled by stroke, neurological disease, traumatic brain injury, chronic pain and other disabling conditions such as those that occur after surviving **Torture and Organised Violence**. Generally speaking, rehabilitation can be considered a re-adaptive process, where the disabled person adapts his/her set of values to a different, more restricted life situation.

In the mid-twentieth century, the two medical areas merged into Physical and Rehabilitation Medicine (PRM), “concerned with the promotion of physical and cognitive functioning, behaviour, quality of life (activities and participation) and with the prevention, diagnosis, treatment and rehabilitation management of people with disabling medical conditions and comorbidity across all ages” (Gutenbrunner et al, 2007).

An important part of the work in PRM is, therefore, **Disability** assessment, usually with a team approach, and greatly helped by the development of the International Classification of Function (ICF); previously the International Classification of Impairments, Disabilities and Handicaps) by the WHO. Special rating instruments provide supplementary information in this task.

Role of PRM in the management of torture survivors

Two important roles for PRM can be discerned in such management. First, even if the origins of pain are manifold, some of the physical medicine techniques have been found to withstand the test of Evidence-Based Medicine for the alleviation of various pain conditions, mostly connected to the musculoskeletal system. Second, multi-professional pain rehabilitation programs have developed from the pioneering work of Fordyce and Bonica in the world's first pain clinic at the University of Seattle in the 1960s, and have been found to be successful.

First Therapy - Physical modalities

Some forms of manipulation techniques, such as massage and injection therapy, show a beneficial effect in chronic musculoskeletal pain but only in the short term. Mechanical elongation of musculoskeletal tissues by application of force, such as traction and stretching, have less convincing effects. The same seems to be true for different forms of short-wave and microwave therapy. In general, monotherapy with various forms of therapist-performed (passive) physiotherapy can be questioned with reference to the effective management of chronic pain, also that of TOV origin. On the other hand, physical exercise programs have recently been shown to have a beneficial effect, even in fibromyalgia.

However, needle acupuncture, where the mechanisms have become increasingly clarified during the last decades, has been found to have demonstrable positive, long-term outcomes in controlled studies, e.g. in low-**Back pain**. With needle acupuncture, it is important to use clean needles and to employ the ancient Chinese clinical experiences and recommendations for needle placement and treatment planning (Sjölund, 2005). Pain relief for 3-12 months can be expected from one series of 6-10 treatments.

Recent data also demonstrate that Transcutaneous Electrical Nerve Stimulation (TENS) produces significant relief from chronic pain (Furlan and Sjölund, 2007). However, the patient has to have daily access to 2 x 30-

min treatment (or his/her own stimulator) for it to be meaningful, since there is no long-term effect. Stimulation at an 80–100 Hz frequency at easily perceptible but not painful stimulus strength, with the negative electrode (cathode) placed close to the painful area is recommended. Electrical buzzing should be felt where the pain is usually located. While 3–6 hours of relief can be expected, as with acupuncture, only up to 2/3 of all patients respond.

Second Therapy - Team-oriented rehabilitation

Regarding multi-professional rehabilitation programs, interdisciplinary pain rehabilitation has emerged as a successful, integrated therapy, supported by a number of randomized controlled studies as well as by systematic reviews. However, the exact characterisation of what is being treated is still lacking, as it has been denoted pain behaviours (Fordyce), pain disorder (DSM-IV), “chronic pain syndrome”, dysfunctional MPI profile as well as fear-avoidance. In ICF terms, the activity limitations and participation restrictions caused by the sensory impairment chronic pain, in conjunction with individual contextual factors best describe the condition at present (Sjölund, 2007).

The program should be based on cognitive-behavioural psychology to be effective but should also contain activity-related components, such as training in increasing amounts over weeks, body-awareness training and relaxation training, usually led by physiotherapists and/or occupational therapists. Education/information about the nature of chronic pain and principles for the management of chronic as opposed to acute pain has been found to be an essential program component. Coordination exercises may be helpful in whiplash-associated disorders and ergonomic counselling is usually relevant in all forms of spinal and upper extremity pain conditions.

Most importantly, interdisciplinary pain rehabilitation should be accompanied by vocational counselling to support a re-entry into all aspects of active life. Furthermore, it is probably an advantage to combine

evidence-based treatment modalities, both physical and pharmacological, with the multi-professional cognitive-behavioural programs, since pain is a strong negative reinforcer and minimizing such a signal would reduce the learning of further pain-related behaviours.

References

Crombez G, Vlaeyen JW, Heuts PH, Lysens R. Pain-related fear is more disabling than pain itself : evidence on the role of pain-related fear in chronic back pain disability. *Pain*. 1999;80(1-2): 329-39.

van Dijk AJ. On rehabilitation medicine : a theory-oriented contribution to assessment of functioning and individual experiences. Delft: Eburon; 2001.

Flor H, Fydrich T, Turk DC. Efficacy of multidisciplinary pain treatment centers : a meta-analytic review. *Pain*. 1992;49(2):221-30.

Furlan A, Sjölund BH. Igniting the spark? : editorial. *Pain*. 2007;130(1-2):1-3.

Gutenbrunner C, Ward AB, Chamberlain MA, editors. White book on physical and rehabilitation medicine in Europe. *J Rehabil Med*. 2007;39 Suppl 45:1-48.

Sjölund BH. Acupuncture or acupuncture? : editorial. *Pain*. 2005;114(3):311-12.

Sjölund BH. Dysfunctional pain and the International Classification of Functioning. In: Schmidt RF, Willis WD, editors. *Encyclopedia of pain*. Vol. 1. Berlin: Springer; 2007. p. 670-2.

WHO. ICF: International Classification of Functioning, disability and health. Geneva: WHO; 2001. Also available online, at: <http://www.who.int/classifications/icf/en/> [accessed 2008 Jan 22].

Stress management

INTRODUCTION

Relaxation exercises can help break the cycle of tension and complaints. By learning how to reduce their tension, people can feel more relaxed and can rest better (see also **Stress**). Stress arises from unpleasant experiences or harsh living conditions. This can disturb body and mind. A person's behaviour can also create or reduce stress. Prolonged stress causes physical harm and hinders people from doing useful work. Individuals suffering from stress do not often complain about stress directly, but rather about various physical symptoms.

Relaxation will reduce stress. There are many ways of relaxing, such as reading, singing, listening to music, taking enjoyable trips, going for a walk, talking with friends, meditating or just resting.

Ask what a person normally does to relax and try to find out whether it is suitable for relaxation. Encourage him/her to go on doing this. People under stress find it difficult to relax and should be taught special relaxation exercises.

This entry on stress management includes different techniques that can be used depending on the needs of the person, or the needs of the helper. The helper can also benefit from relaxation training.

The different methods include:

- Visualisation exercises.
- Autogenic training.
- Meditation and mindfulness meditation.
- Progressive relaxation or "hold and relax".

VISUALISATION EXERCISE FOCUSING ON MENTAL HEALTH - A SAFE PLACE

- Sit comfortably in a quiet place, with your feet on the floor.
- Close your eyes.
- Breathe easily through your nose.
- Fix your attention on your muscles and feel how they become a little more relaxed every time you breathe out. Do this for 2-3 minutes.
- Now imagine that each time you breathe in you take in energy and health. Every time you breathe out you get rid of some tension and stress. Do this for two to three minutes.
- Now remember some pleasant and beautiful place you visited in the past. Imagine you are there now. Let your mind rest easily in this place.
- When other thoughts come into your mind, just watch them come in and go out again. You see that thoughts come and go by themselves. Even worrying or unpleasant thoughts will go if you do not pursue them.
- You are resting deeply in a pleasant place. Remember what it looks like, sounds like and feels like. Let other thoughts come and go on the surface of your mind (quiet meditation music can be used).
- After about 10 minutes say goodbye to this pleasant place, but remember that you will return there.
- Take some deep breaths and then open your eyes.

This exercise can be done as often as you like, at least once a day. It can also be done lying down.

AUTOGENIC TRAINING

Autogenic training (AT) is an approach derived from self-hypnosis. The autogenic state is understood as a state at a point near sleep where you are not asleep, but not fully awake either.

Aims:

- To improve ability to concentrate and focus.

- To achieve the autogenic state.
- To achieve relaxation.

The effects:

- Decreased muscular activity.
- Decreased frequency of breathing.
- Decreased heart rate.
- Decreased blood pressure.

Principles of autogenic training

Autogenic training is a method of self-training, as the name indicates.

It is based on four requirements:

- Reduction of external stimulation, i.e. absence of loud noise, bright light or other invasive stimulus.
- An attitude of passive concentration, which in this context is defined as a state of mind that is relaxed and unconcerned with the end product.
- Distracting thoughts that might pop up are ignored or gently dismissed.
- The repetition of relaxation-inducing phrases based on six central themes:
 - Heaviness in the arms and legs.
 - Warmth in the arms and legs.
 - Calm and regular heartbeat.
 - Calm breathing.
 - Warm solar plexus.
 - Cool forehead.

You will have to guide the person by reciting phrases which they repeat. The phrases are repeated to emphasize their effect. Suggestions of heaviness can be intensified by images of lead, while those of warmth can be deepened by images of sunshine or warm water.

The Autogenic Technique

Explain to the person what is going to take place. An introduction could be:

“The method you are going to learn consists of short phrases describing sensations of heaviness and warmth in the limbs. I’ll be reading them out and as I do I’d like you to focus your attention on each in turn, repeating the phrase under your breath.

An important feature of this approach is that you should feel passive and casual about it, and that you shouldn’t try to force any response to occur”.

Conditions

Settings: The room should be quiet and the lighting dim.

Tone of voice: A slow, calm, soothing tone is appropriate.

Position of the person: A supine position is preferable to a sitting one. If, however, the person is sitting, his/her head should be supported.

Induction

Proceed with the induction:

“Please close your eyes. Imagine yourself in a place that makes you feel relaxed.....perhaps in the cool shadow of a tree. Picture yourself lying there.
(Pause)

In a moment I am going to ask you to focus your attention on different parts of your body, but first I want to remind you how important it is for you to adopt a passive and casual attitude towards the procedure. This means letting the sensations of heaviness and warmth come on their own rather than making an effort to bring them about. Spend a few moments settling yourself.....”

The exercises

- The session always begins as above with a few minutes of quiet relaxation. This is followed by 18 exercises, each composed of a group of phrases. Each phrase is recited by the therapist and repeated, mentally or vocally, by the person.
- Spend about 30 seconds on each exercise and a further 30-45 seconds for continued focusing of attention by the person. In this way each exercise has a duration of 2 minutes.

- The training should be done at least twice a day and if possible at set times.
- The aim is to obtain full concentration on the exercises and all emotions, thoughts and associations that might occur are dismissed.

Exercise 1.

Begin with the dominant arm.

I feel at peace.

My right arm is heavy.

My right arm is heavy.

I feel at peace.

My right arm is heavy.

My right arm is heavy.

Please continue to think about the heaviness in your arm as you lie in the cool shade of a tree.

Exercise 2.

I feel at peace.

My left arm is heavy.

My left arm is heavy.

I feel at peace.

My left arm is heavy.

My left arm is heavy.

Think of your arm being as heavy as lead.

Exercise 3.

I feel at peace.

Both my arms feel heavy.

Both my arms feel heavy.

I feel at peace.

Both my arms feel heavy.

Both my arms feel heavy.

See yourself lying in the cool shade of a tree, with your arms resting heavily on the soft ground.

Exercise 4.

I feel at peace.

My right leg is heavy.

My right leg is heavy.

I feel at peace.

My right leg is heavy.

My right leg is heavy.

Think of your leg being as heavy as lead.

Exercise 5.

I feel at peace.

My left leg is heavy.

My left leg is heavy.

I feel at peace.

My left leg is heavy.

My left leg is heavy.

Exercise 6.

I feel at peace.

Both my legs are heavy.

Both my legs are heavy.

I feel at peace.

Both my legs are heavy.

Both my legs are heavy.

Feel your legs sinking into the ground.

Exercise 7.

I feel at peace.

My arms and legs are heavy.

My arms and legs are heavy.

I feel at peace.

My arms and legs are heavy.

My arms and legs are heavy.

Continue to imagine yourself with heaviness in your arms and legs, lying in the cool shade of a tree.

Exercises 8-14.

You stay with the same formula until the physical reaction you want is obtained. Once the person can feel heaviness, you move on to the formula concerning the sensation of warmth.

Exercises 8-14 are similar to Exercises 1-7, but warmth is substituted for heaviness. The effect can be augmented by images of the sun's warmth.

Exercise 15.

I feel at peace.

My arms and legs are heavy and warm.

My heartbeat is calm and regular.

My heartbeat is calm and regular.

I feel at peace.

My heartbeat is calm and regular.

My heartbeat is calm and regular.

Exercise 16.

I feel at peace.

My arms and legs are heavy and warm.

My heartbeat is calm and regular.

My breathing is calm.

My breathing is calm.

I feel at peace.

My breathing is calm.

My breathing is calm.

Exercise 17.

Leave the abdomen phrases out for people with stomach inflammation.

I feel at peace.

My arms and legs are heavy and warm.

My heartbeat is calm and regular.

My breathing is calm.
My abdomen is warm.
My abdomen is warm.
I feel at peace.
My abdomen is warm.
My abdomen is warm.

Exercise 18.

I feel at peace.
My arms and legs are heavy and warm.
My heartbeat is calm and regular.
My breathing is calm.
My abdomen is warm.
My forehead is cool.
My forehead is cool.
I feel at peace.
My forehead is cool.
My forehead is cool.
Images of cool air streams may be created to reinforce the feeling of a cool forehead.

Termination

This allows the person to make a gradual return to normal activity:
“When you are ready, slowly allow yourself to become aware of the room you are in. Open your eyes. Let them scan the interior of the room. Tell yourself you are going to feel refreshed and alert. Make a few weak fists with your hands. Bend and stretch your elbows a few times, then your knees. Gently stretch your body. Roll on to your side and get up slowly”.

Meditation

Once the person can do the physical exercises and has achieved a feeling of heaviness and warmth and calm, he/she can start using meditation exercises where the person can work with images not necessarily connected to the body.

You can add extra phrases to the basic autogenic phrases, if the person wants to work with a certain topic. This is called “intentional formulae” and examples could be:

- I believe in myself (for those lacking in confidence).
- My mind is quiet and at peace (for anxious individuals).
- My pain is disappearing (for those with chronic pain).

Note

The phrase inducing abdominal warmth should be deleted for people suffering from gastric inflammation. AT is not suitable for children under five years of age or for people who are not motivated.

AT should never replace medical help.

AT is not suitable for people suffering from severe mental disorders, especially those who have difficulty in separating fantasy from reality and for those who experience hallucinations.

It is not the object of the exercise to create a hypnotic trance, nor is it likely that one will occur.

MINDFULNESS MEDITATION

Characteristics

Many cultures have a way of meditating. The ways of meditating used in a culture can be effective in reducing **Stress**. Most meditation techniques require:

- A quiet atmosphere.
- A comfortable posture.
- A “mental device” (a word, a sound, a symbol).
- A passive mental state.

Mindfulness meditation is:

- A form of self-awareness training, adapted from Buddhist mindfulness meditation.
- Having your full attention concentrated on your body, your breathing, your thoughts and your feelings in a containing, appreciative way.

- About being aware of what is happening in the present, on a moment-by-moment basis, while not making judgments about whether we like or do not like what we find, accepting things for what they are.

Systematic training in being mindful - present right now - increases one's ability to enter into containment and acceptance. And increased containment, acceptance and kindness to oneself leads to relaxation and improved quality of life.

Place:

Find a place where you can be undisturbed for a while.

Some examples of mindfulness techniques to practise:

One-Minute Exercise:

- Sit in front of a clock or watch that you can use to time the passing of one minute. Your task is to focus your entire attention on your breathing, and nothing else, for the minute. Try it – do it now!

De-stressing exercise:

- Bring yourself into the present by deliberately adopting an erect and dignified posture.
- Then ask yourself: “What is going on with me at the moment?”
- You simply allow yourself to observe whatever happens. Label any thoughts that you have and then leave them alone..... Just be prepared to let them float away. Attend to your breathing or simply take in your surroundings instead.
- Besides thoughts, there may be sounds you hear, physical sensations that you are aware of. If you find yourself constantly elaborating on thoughts, rather than labeling them and returning to the neutral, remember to observe your breathing.
- When emotions or memories of painful events occur, do not allow yourself to become caught up in them.
- Give them short labels such as “that’s a sad feeling”, “that’s an angry feeling” and then just allow them to drift or float away. These

memories and feelings will gradually decrease in intensity and frequency.

- More importantly, you will begin to identify yourself as an objective observer or witness rather than a person who is disturbed by these thoughts and feelings. This requires practice but can be used whenever you are stressed.

Meditation in sitting position:

- Sit in a comfortable position with your back upright.
- Close your eyes or keep them half closed and look down in front of you.
- Observe your breathing. Focus on the physical sensations from the movement of the stomach when breathing in and breathing out. Alternatively you can focus on the awareness of air streaming in and out of your nose.
- It is natural and normal for thoughts and emotions to reverberate in your consciousness. The aim is not to stop thoughts and feelings but instead to try and contain and gently accept all that happens inside. Give space to the thoughts and gently return and observe the breathing. During the meditation you have to move your attention back to the breathing again and again.
- Sit for 10 minutes one to several times a day and extend over some weeks the time for meditation to 20 minutes. After a while the meditation time can, if wanted, be expanded to 45 minutes.

Note

This form of meditation has been set into a frame by Jon Kabat-Zinn, and found to be useful in the treatment of e.g. **Stress**, mental problems such as **Anxiety** and **Depression**, and **Pain, chronic**. Scientific studies have shown that meditation has a beneficial effect on these conditions, often combined with **Cognitive-Behavioural Therapy (CBT)**.

PROGRESSIVE RELAXATION - OR THE HOLD-RELAX METHOD

Aims

- To achieve general relaxation, physical as well as mental.
- To improve awareness of the level of tension in the muscles.
- To correct disadvantageous tension patterns in the muscles.
- To normalize respiration.

People can use the method on their own once they have learned it from the healthcare professional or healthcare assistant.

For people with painful muscles it will, of course, be beneficial to use as little contraction as possible in order to avoid pain.

Conditions

- A room that is as quiet as possible.
- Lying is the position of choice, but should be however the person is more comfortable.

Introduction of the method

One way of introducing the method to your client could be as follows: “If you have had pain (or feel **Anxiety**) for a long time, you will most likely have a higher level of tension in your muscles than normal. (Give a relevant example of what you have found in the individual person). A tense muscle is more painful than a relaxed muscle. Pain will create more tension and a vicious circle holds you in the grip of pain and tension. To break this circle you can learn to reduce the tension in your muscles and, with time, to relax them completely.

On top of this, muscle tension is believed to be closely associated with your state of mind: It is believed that muscles which are unnecessarily tense reflect their tension in the mind. If that muscle tension can be released, you will feel mentally calmer.

The method you are going to learn now will help you to achieve relaxation both of your body and of your mind. The way you will work is by creating and releasing tension in the muscles. This way you will learn to register when your muscles are tense and when they are relaxed. Once this is done, you can more easily work at bringing the tension of the muscles down”.

Procedure

Your client lies comfortably, face upwards, with arms resting on either side of the body, legs uncrossed. The eyes can be open to begin with, but after a couple of minutes, the person is asked to close them. As with all relaxation techniques the person is given time to quietly unwind before the session starts.

The therapist gives the instructions, allowing the person to hold the tension for 5-10 seconds and relaxing it for 20-40 seconds.

The session will start by working with respiration:

“Please make yourself as comfortable as you can. Let your breathing settle down and follow its natural rhythm. After a minute or two, naturally, breath out making it a little bit longer than usual.....then let the air in..... let it gently fill your lungs.....and.....breathe out slowly, releasing your tension with the air.....and now let your breathing take care of itself.....do not immediately repeat this deep breath.”

After this, you proceed with the tense-release method, starting with the legs.

Lower legs

“Turning your attention to your lower legs which are lying flat, point your feet up towards your face, keeping the backs of your knees on the surface you are lying on.....Hold the tension.....notice the feeling of tension.....Let go.....as you let go, feel the tension draining out of your muscles.....and continuing to drain out as your lower legs and feet become more and more relaxed.....”

“Now point your feet down, as if you were using them to indicate something. Do not overdo it, especially if you are prone to cramps.....Hold the tension.....feel the tension.....Let go.....let all the tension dissolve.....feel how the muscles are now flat and relaxed.....and.....continue letting go.....”.

Thighs

“Now focus on your thighs.....press your knees towards the surface and feel how your thighs become tense.....hold the tension.....Let go.....Feel how the tension leaves your thighs and allows them to flatten out.....stay with that feeling of relaxation.....”.

Legs

“Now feel both of your legs and contract both legs from the toes to the hip.....Hold the tension.....feel how your legs are hard and tense as a pole.....Let go.....feel how the tension leaves your legs and relaxation flows through them.....enjoy the feeling of relaxation in both of your legs.....”.

Torso

Buttocks

“Move further up and concentrate on your buttocks.....tighten your buttocks, so you feel that you are lifted up a littleHold the tension.....Let go.....feel the tension disappearing.....feel your buttocks resting flat on the floor/ground.....”.

Stomach

“Turn your attention to your stomach muscles.....press the small of your back towards the surface that you are lying on and feel the stomach muscles going tense.....Hold the tension.....feel that your stomach muscles are tight, from your ribs down to your pelvis.....Let go.....feel how the tension is melting away, leaving room for a deep feeling of relaxation.....feel how there is now room for a good deep breath to fill your stomach.....breathe out and feel how the relaxation gets even deeper.....”.

Low back

“Concentrate on the small of your back..... arch it gently until you feel tension.....Hold the tension.....register this tension.....is it familiar?.....Let go.....feel how tension leaves and the small of your back returns to its resting position.....and.....feel how the relaxation spreads.....”.

Upper back

“Now move your attention up to the area around your shoulder blades.....gently pull your shoulder blades together.....Hold the tension.....Let go.....and feel the tension dissolve and the shoulder blades parting, leaving room for relaxation.....feel how the relaxation spreads around your shoulder blades.....”.

Torso

“Now include your buttocks, stomach and the whole of your back in your focus.....try to tighten it all at once.....Hold the tension.....register how it feels and what it does to your breath.....Let go.....feel how the tension disappears and relaxation spreads as your breath flows freely again.....”.

Neck

“Now focus on your neck.....hold your chin in and press the back of your head down into the pillow, until you feel tension.....Hold the tension.....notice whether this feeling of tension in your neck is a familiar sensation.....Let go.....feel how the tension is released and the head resumes its resting position.....feel how your head feels heavy and is sinking into the pillow.....”.

Face

“Focus on your face.....frown.....screw up your eyes.....wrinkle your nose.....clench your teeth together.....Hold the tension.....feel if any of this tension is familiar.....Let go.....feel how relaxation spreads and your features are smooth again..... enjoy the feeling of relaxation in your head and your neck.....”.

Shoulders

“Concentrate on the arch of the shoulders.....hunch your shoulders up as if to touch your ears.....Hold the tension.....feel the tension in the lower neck.....register that sensation.....and.....Let go.....feel the tension releasing and how it continues to release.....until.....your shoulders feel relaxed.....”.

Arms

Upper arms

“Move your attention to your upper arms.....apply a slight flexion.....Hold the tension.....register how it feels.....Let go.....feel your arms resting at your sides as tension dissolves and relaxation flows in.....appreciate the sensation.....”.

Lower arms

“Move your thoughts further down and focus on your lower arms and hands.....make a fist.....Hold the tension.....Let go.....feel the release of tension.....feel how relaxation flows in and makes the lower arm rest at your side.....”.

Arms

“Now focus on both of your arms from your shoulders and down to your fingertips.....tighten both arms so they feel like rods.....Hold the tension.....feel the tension throughout the arms.....Let go.....and.....let the arm flop down.....feel the muscles going slack and the arms becoming limp.....notice the relief.....feel how the arms are sinking into the surface.....”

The whole body

“Now in your mind feel your whole body as you are lying there, totally relaxed.....feel how you have a nice, peaceful feeling in your body.....and.....how you have the feeling of sinking into the surface.....imagine that you are lying on a soft surface that will shape itself around your body.....it could be a cloud or nice warm sand.....feel how your body in its relaxed state will sink into this surface.....register the sensation of deep relaxation.....now lie for a while and enjoy this sensation.....”

Termination

“And now I would like you to return to here.....feel the surface beneath you.....feel where your body touches it.....gently and slowly move your hands and feet.....then, slowly and gently move your arms and legs.....stretch if you feel like it.....open your eyes.....when you are ready, I will ask you to sit up.....”.

Note

This method is unlikely to create any negative effects and none have been reported, however, there are some points to consider:

- Training in relaxation should never be viewed as a substitute for medical treatment.
- Relaxation training is not recommended for people suffering from hallucinations, delusions or other psychotic symptoms, as the exercises can lead to out-of-body sensations.
- Tense-release procedures performed with excessive tightening may lead to cramp. In order to avoid this, you can advise your client to apply a small contraction or stop the tightening just before the sensation of cramp begins. Recurrent cramp would indicate the unsuitability of the technique for that individual.
- If you meet people who are afraid of letting go and relaxing, you can perhaps add “let go as much as you feel comfortable with”. With time such people may learn to feel safer while relaxing. Disturbing feelings may rise to the surface during any kind of relaxation: In letting down the wall of tension, psychological defences may be weakened. Very rarely, flashbacks can be experienced in this relaxed state. If they do you will tell them in a calm voice where they are and that there is nothing to fear. In this situation, do not touch the person.
- This relaxation method has been found to be effective for many people suffering from organic pain. It provides a physical approach to a physical disorder. Some individuals, however, find that focusing on the body intensifies their perception of pain and for them muscular approaches may be less useful than mental ones, such as autogenic training or pure imagery.

- As attention to breathing is a feature of this method, the problems of hyperventilation should be borne in mind.

Some examples of relaxation exercises from Sri Lanka:

- Breathing exercises (Pranayamam).
- Progressive Muscular relaxation (Shanti asanam): Slowly relax each part of your body and muscles while saying: “Shanti, shanti, shanti”.
- Repetition of words (jappa, rosary or prayer beads). In this method, repetition of a word or phrase will create a state of mental peace. A holy verse, your personal mantra, praying to Jesus (Jesus Christ have mercy on me), Subanallah, verses from the scriptures, meaningful words or saying God’s name, or simply the Pranava mantra, can be used.
- Meditation (Thiyanam, contemplation).
- Massage is widely used in many cultures to relieve tension and promote health.
- Ayurveda and traditional methods are also used.

Music Cure

In recent years, there has been increasing evidence that the use of certain kinds of music may impact significantly on a person’s well-being and level of **Stress**. Studies on musical intervention have taken place following clearly defined criteria and strict research methodology, e.g. by comparing the well-being and stress level of people who have been listening to the stress-reducing music compared to people who have had no such experience but who have been exposed to the same environment. The documentation is thus primarily based on the person’s experiences.

The aim of the projects has primarily been to increase the well being of people and reduce their level of stress and **Anxiety** through listening to music especially designed for this purpose. The music is composed specifically for therapeutic use with the aim of making the listener relax and at the same time experience adventurous mental stimulation. The composer has worked closely together with doctors and nurses through the entire

process of creating the music, and adjusted the productions according to feedback from the hospitals (www.musicure.com).

References

Jacobson E. Progressive relaxation : a physiological and clinical investigation of muscular states and their significance in psychology and medical practice. 2nd ed. Chicago: University of Chicago Press; 1938.

Kabat-Zinn J. Full catastrophe living : how to cope with stress, pain and illness using mindfulness meditation. London: Piatkus; 2007.

Luthe W, editor. Autogenic therapy. Vol. 1. Schultz JH, Luthe W. Autogenic methods. New York: Grune and Stratton; 1969.

Musica Humana Research [online]. Virum, Copenhagen: Musica Humana Research. Available from: <http://www.musicahumana.com> [accessed 2008 Jan 29].

MusiCure : music as medicine [online]. Virum, Copenhagen: MusiCure. Available from: <http://www.musicure.com> [accessed 2008 Jan 29].

Somasundaram DJ, Sovayokan S, editors. Mental health in the Tamil community. 2nd ed. Jaffna: Shanthiham; 2005. p. 43-56.

Testimony therapy

HEALTHCARE ASSISTANT

Key signs

Testimony therapy is a treatment method for victims who have been exposed to **Torture and Organized Violence**. The method comprises approximately 12 sessions in which the person tells his/her story, which is tape-recorded, to a therapist who transforms the story into written form.

Stories from several victims might later be combined into a document that might be published.

Case reports are described as indicating a positive effect on people. There is much theorizing (but little empirical data) about the mechanism behind positive effects, e.g. that the suffering is lifted up from an individual/private level to a public/political one. The method is described as not focusing on “exposure as such” but nevertheless, from a cognitive-behavioural point of view it can be seen as one of many potential forms of **Exposure therapy**, a treatment principle that has been shown to be effective against **Anxiety disorders**, including PTSD. There is some indirect evidence of the effectiveness of testimony therapy since a treatment method (“Narrative Exposure Therapy”) based on CBT and testimony therapy has been shown to be effective in a controlled treatment study in a sample of Sudanese refugees suffering from PTSD.

Action

Sessions 1 and 2.

Give information about the treatment and educate the person about **PTSD**. Make an outline of the person’s history, discuss the use of the document to be produced.

Sessions 3 and 4.

Account of life before the traumatic experiences took place (tape-recording).

Sessions 5 and 6.

Account of traumatic experiences (tape-recording).

Session 7.

Reading and editing (written form) the first part of the document.

Sessions 8 and 9.

Account of life after the traumatic experiences took place (tape-recording).

Sessions 10 and 11.

Account of the current situation and expectations.

Reading and editing (written form) of the second part of the document.

Session 12.

Signing of the document and termination.

Therapist's behaviour:

- Give support and structure the story if necessary.
- Steer/ask for details when the person seems to avoid essential details.
- Slow down the process when the person is at risk of becoming overwhelmed by memories.

The person decides what to do with the final document, whether to keep it, give it to family/friends, to human rights' organizations or the like. If there are several people with a similar faith, several documents can be collated.

Note

If it is difficult to carry out the treatment e.g. due to excessively aversive memories that make it difficult to account for the traumatic experiences, or if there is doubt about whether the person is sufficiently stable to start the treatment or if there are other, e.g. somatic, problems that should be addressed prior to start - refer to next level.

HEALTHCARE PROFESSIONAL

Characteristics

There might be obstacles, e.g. severe psychological and/or somatic problems that should be addressed prior to starting treatment. The treatment described above does not have to be followed slavishly but can and should be individualized if necessary; it might be an advantage to assist testimony therapy by combining it with other treatment, e.g. analgesics or anti-depressives.

First therapy

The same guidelines as above are used, but in a more individualized manner. The number of sessions, for example, might have to be increased in general or, if there are overwhelming memories that constitute an obstacle to recounting the traumatic experience, this phase of treatment should be extended.

Second therapy

Assess problems that may be obstacles to successful testimony therapy and implement treatments for these problems prior to or simultaneously with the therapy, e.g. pain-treatment, if there is an intense pain problem or anti-depressive treatment if there is low mood/motivation and/or excessive **Anxiety**.

Note

Refer to next level if additional medical expertise might be expected to optimise assessment and treatment of conditions that might block the road to successful testimony therapy.

Free hand writing in a non-structured way could also be helpful, just as drawing and painting one's feelings or corporal expressions may contribute to the healing process.

HEALTHCARE SPECIALIST

Assessment

Rule out any hitherto unidentified/untreated somatic or other circumstances that should be addressed prior to or accompanying testimony therapy.

References

van Dijk JA, Schoutrop MJ, Spinhoven P. Testimony therapy : treatment method for traumatized victims of organized violence. Am J Psychother. 2003;57(3):361-73.

Whole body physical therapies (relaxation and body awareness exercises)

MASSAGE

A review of the literature on massage reflects the variety of different methods used in the field. Massage is an ancient treatment method and has been used and developed through the centuries. Massage is said to have a short-term effect on neuro-musculo-skeletal problems. But a recent review on massage concludes that massage to the lumbar spine has a long-term effect.

The definitions and categories of massage methods given below are by-no-means definitive. The massage methods are listed in order of increasing vigour. The health worker should choose methods which are appropriate for the particular condition and the method applied should be agreed to by the person involved.

Massage for torture survivors has another important dimension which is not solely concerned with treating tissues and expecting a positive effect on neuro-musculo-skeletal problems. Hugh Lewin beautifully describes this in his poem "Touch": "I don't want fists and paws. I want to want to be touched again and to touch. I want to feel alive again. I want to say when I get out Here I am, please touch me".

The health workers should teach family members to massage the tortured person once a day for limited periods.

Methods

Stroking (effleurage): Passing of the hands over a large body area with a constant pressure.

- Superficial effleurage: Extremely light form, using only palms of the hands, described as a little more than a caress.

- Deep effleurage: Strong enough stroking to evoke a mechanical as well as reflex effect on muscles.

Compression: Use of intermittent pressure to lift, roll, press, squeeze and stretch tissue and to accelerate venous and lymphatic flow.

Kneading (petrissage): Hands take a large fold of skin and underlying tissue and forcefully roll, raise and squeeze it.

- Pinching (placement): Pinching using thumb and index finger.
- Rolling (roulement): Rolling of muscle belly.
- Wringing: Like wringing a towel.
- Fist kneading: Compression via knuckles of a partially closed fist.
- Digital kneading: Use of a single finger or three fingers positioned triangularly.

Friction: Firm contact over a limited area to loosen adherent tissue.

- Crushing (ecrasement): Localized and vigorous.
- Tearing (dilacerations): Intense deep pressure, like connective tissue massage.
- Pleating (pleissate): Ends of finger perpendicular to veins.
- Sawing (sciage): Rapid and deep transverse movement of the ulnar border of the hand.
- Come-and-go: Reciprocal movement of the two index fingers or the thumbs.

Vibration and shaking: Hands are kept in contact with the person, and movement originates with the health worker's body and is transmitted to the person via the health worker's outstretched arms. Shaking (secousses) is characterized by the alternate flexion and extension of the health worker's elbows, whereas in vibration the elbows remain fully extended.

- Point vibration: Use of a single digit.
- Percussion: Brief, brisk, rapid contacts reciprocally applied with relaxed wrists.

- Tapping (tapotement): Rapid series of blows, hands parallel and partially flexed, with the ulnar borders of the hand striking the person. Sometimes tapping is used to describe percussion with the fingertips.
- Hammering (martelage): Soft percussion with the ulnar edge of the hand of the slightly flexed last four fingers, so that the little finger strikes first.
- Clapping (claquement): Use of fingers, palm and thumb to form a concave surface.
- Hacking (hachure): Chopping strokes made by the ulnar surface hitting the person; more vigorous than tapping.
- Beating (frappement): Striking with half-closed fists so that the ulnar side of the hand makes contact.

Literature:

Furlan AD, Brosseau L, Imamura M, Irvin E. Massage for low-back pain. *Cochrane Database Syst Rev.* 2002;(2):CD001929.

Lewin H. Touch : [poem]. In: Now we are free : a handbook for ex-political prisoners and their families. Cape Town: ESG Western Cape; 1991. p. 29.

Rothstein JM, Roy SH, Wolf SL. The rehabilitation specialist's handbook. 2nd ed. Philadelphia: F.A. Davis; 1998. p. 929–49.

RELAXATION

A variety of relaxation methods may be used in coping with pain and **Stress, Anxiety** and fear. See **Stress management** (Visualisation exercises, Autogenic training, Progressive relaxation and Mindful meditation).

BODY AWARENESS THERAPY:

“Body awareness” is a broad concept often used within physical therapy. It comprises body consciousness and different aspects of motor behaviour. Body awareness therapy (BAT) is a treatment modality often used for treating people with chronic pain conditions. In BAT, movements,

breathing and awareness are used to restore balance and freedom of movement, emphasizing the resources of the body as a whole instead of concentrating on body parts where symptoms are present. Participants are taught to attend both to how the movements are performed and what they experience during the performance. This stimulates mental presence and increases the awareness of the strengths and limitations of one's own body.

Walk

Start to walk 'normally'. Between each walking instruction, the person is requested to walk 'normally' as a transition to the next exercise.

- Forwards.
- Backwards.
- Bending the knees at every step (springy).
- Stamping.
- Stamp on the spot.

The leader tries to walk at different distances from the person, very close (almost touching), as well as keeping some distance. The leader also tries to walk in front of, beside and behind the person.

Jog and run, if possible

- Jog a couple of times around the room.
- Increase to running, if possible.

Jump

- With both feet together.
- On the spot.
- On one foot at a time (hop).

Standing on one leg

- Standing legs astride, straight legged, transfer the weight of the body from foot to foot.
- Step standing, transferring weight from one foot to another, both sides.
- Standing on one leg oscillating the other in front of the body.

- Stand on one foot at a time, for at least 30 seconds.

The movement centre, flow

- Make oscillating (waving) movements with the arms, lift the arms towards the ceiling and straighten them, let the arms fall bent.
- Rhythmic knee-bends, swing the arms simultaneously back and forwards (to the same rhythm).
- Stretch and bend knees, extend up and down along the body's centre line.

Centre-line, flow, centring

- Standing with the feet shoulder-wide, turn from side to side.
- Rhythmic knee-bends, reciprocal oscillations with both arms.
- Reciprocal tapping, left hand on right knee, right hand on left knee.

Centre-line, transferring of bodyweight

- Standing astride, legs far apart and bent, transferring weight from one foot to another.
- Step standing, bent legs, transferring weight from one foot to another, both sides.

Movement control in front of a mirror

- Lift one stretched arm straight forward, hold it for a while (approximately 5 seconds), lower the arm and change sides.
- Lift one stretched arm out to the side, hold it for a while, lower the arm, change sides.
- Lift both arms straight forward, hold them for a while, lower the arms.

Meeting, personal space

- The person and the therapist change places from each short side of the room, twice.

Chair and stability

- Sit on a chair (Comment: Are you sitting comfortably like that?).

- Sit on the edge of the chair (without the back support), lift one stretched arm straight ahead, hold it for a while, lower the arm, and change arms x 1.
- Lift one arm stretched to the side, hold it for a while, lower the arm, and change arms x 1.
- Lift both arms straight ahead, hold them for a while, and lower the arms x 1.
- Lift one knee (bent leg), hold it for a while, lower the leg, and change legs x 1.

On the floor

- Lie down on the floor, turn on to the stomach, and stay there for a while.
- Put the legs together, and let go.
- Stretch the whole left side, arms, body, legs, and then repeat on the right side.
- Stretch arms and legs and the whole body.
- Lie with bent legs, feet on the floor, and make contractions around the body centre.
- Lie for a while and watch your breathing.

Walk

- Walk as usual for a while.

References

Roxendal G. Body awareness therapy and the body awareness scale : treatment and evaluation in psychiatric physiotherapy. [Ph.D. thesis]. Gothenburg: University of Gothenburg; 1985.

Gyllensten AL, Hansson L, Ekdahl CH. Outcome of basic body awareness therapy : a randomized controlled study of patients in psychiatric outpatient care. *Advances in Physiotherapy*. 2003;5(4):179-190.

Mattsson M, Mattsson B. Physiotherapeutic treatment in out-patient psychiatric care. *Scand J Caring Sci*. 1994;8:119-26.

Working with interpreters

HEALTHCARE ASSISTANT

Key signs

- If the client and healthcare assistant do not speak the same language, an interpreter should always be used. If not, important information may be lost and unnecessary misunderstandings may arise. There are some fundamental principles which should be considered and which are a precondition for an intervention to have a good outcome:
- All interpreting is based on a relationship of trust. The interpreter should therefore respect a pledge of secrecy and discretion, a fact which should be made clear to all parties, including the client, at the beginning of an intervention.
- The interpreters must be aware of their responsibility. They should feel empathy for the person's situation but this should not lead to their intervening in the treatment without the consent of the healthcare workers.
- The interpreter should translate everything that is said, preferably with the linguistic nuances. It is not the interpreter's task to judge that something is not worth translating!
- To secure dynamic communication, statements should be limited to a few sentences at a time. A direct translation of what is said, supported by a more detailed explanation, may turn out to be the best way of conveying the true meaning of what has been said.
- The interpreter should know about torture methods, in order not to overexert the person by asking for detailed, elaborate explanations.

Action

Ensure that the interpreter does not have any conflicts of interest (political, religious or social). One problem may be that the interpreter speaks the language used by the upper or middle class people very well but not that of the lower class and ethnic groups.

Note

It is most inappropriate to use the children of clients as interpreters. Children, acting as interpreters, may not tell the client what the healthcare worker is actually saying. They may also filter what they tell the healthcare worker for various reasons, such as embarrassment or not believing the pain is as severe as the parent says it is. Cultures vary in their willingness to disclose a diagnosis.

HEALTHCARE PROFESSIONAL

Characteristic

See above.

In rehabilitation work the interpreter should master the general terminology of anatomy (physiology and pathology) and psychology.

References

Pentz-Møller V, Hermansen A, Bentsen E, Knudsen I.H. Interpretation in the rehabilitation of torture victims. In: Health situation of refugees and victims of organized violence : proceedings of a meeting of the advisory group on the health situation of refugees and victims of organized violence. Rijswijk: Ministry of Welfare, Health and Cultural Affairs; 1992. p. 75-84.

Tribe R, Raval H, editors. Working with interpreters in mental health. New York: Brunner-Routledge; 2003.

Van der Veer G. Counselling and therapy with refugees and victims of trauma. 2nd ed. Chichester: John Wiley & Sons; 1998. p. 76-84.

4. ANNEX I: INTERNATIONAL CLASSIFICATION OF FUNCTIONING AND DISABILITY (ICF).

1. BACK-GROUND

This addendum* explains the principles of the International Classification of Functioning, Disability and Health, known as ICF.³ The overall aim of the ICF classification is to provide a unified and standard language and framework for the description of health and health-related states. It defines components of health and some health-related components of well-being (such as education and labour).

The domains contained in ICF can, therefore, be seen as health domains and health-related domains. These domains are described from the perspective of the body, the individual and society in two basic lists: (1) Body Functions and Structures; and (2) Activities and Participation⁴. As a classification, ICF systematically groups different domains⁵ for a person in a given health condition (e.g. what a person with a disease or disorder does do or can do). Functioning is an umbrella term

*From the International Classification of Functioning, Disability and Health, WHO, Geneva 2001, pp. 3 – 20 (with permission)

³ The text represents a revision of the International Classification of Impairments, Disabilities, and Handicaps (ICIDH), which was first published by the World Health Organization for trial purposes in 1980. Developed after systematic field trials and international consultation over the past five years, it was endorsed by the Fifty-fourth World Health Assembly for international use on 22 May 2001 (resolution WHA54.21).

⁴ These terms, which replace the formerly used terms “impairment”, “disability” and “handicap”, extend the scope of the classification to allow positive experiences to be described. The new terms are further defined in this Introduction and are detailed within the classification. It should be noted that these terms are used with specific meanings that may differ from their everyday usage.

⁵ A domain is a practical and meaningful set of related physiological functions, anatomical structures, actions, tasks, or areas of life

encompassing all body functions, activities and participation; similarly, disability serves as an umbrella term for impairments, activity limitations or participation restrictions. ICF also lists environmental factors that interact with all these constructs. In this way, it enables the user to record useful profiles of individuals' functioning, disability and health in various domains.

ICF belongs to the “family” of international classifications developed by the World Health Organization (WHO) for application to various aspects of health. The WHO family of international classifications provides a framework to code a wide range of information about health (e.g. diagnosis, functioning and disability, reasons for contact with health services) and uses a standardized common language permitting communication about health and health care⁷ across the world in various disciplines and sciences.

In WHO's international classifications, health conditions (diseases, disorders, injuries, etc.) are classified primarily in ICD-10 (shorthand for the International Classification of Diseases, Tenth Revision)⁶, which provides an etiological framework. Functioning and disability associated with health conditions are classified in ICF. ICD-10 and ICF are therefore complementary⁷, and users are encouraged to utilize these two members of the WHO family of international classifications together. ICD-10 provides a “diagnosis” of diseases, disorders or other health conditions, and this information is enriched by the additional information given by ICF on functioning⁸. Together, information on diagnosis plus functioning provides a broader and more meaningful picture of the health of people or populations, which can then be used for decision-making purposes.

⁶ International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Vols. 1-3. Geneva, World Health Organization, 1992-1994.

⁷ It is also important to recognize the overlap between ICD-10 and ICF. Both classifications begin with the body systems. Impairments refer to body structures and functions, which are usually parts of the “disease process” and are therefore also used in the ICD-10. Nevertheless, ICD-10 uses impairments (as signs and symptoms) as parts of a constellation that forms a “disease”, or sometimes as reasons for contact with health services, whereas the ICF system uses impairments as problems of body functions and structures associated with health conditions.

⁸ Two persons with the same disease can have different levels of functioning, and two persons with the same level of functioning do not necessarily have the same health condition. Hence, joint use enhances data quality for medical purposes. Use of ICF should not bypass regular diagnostic procedures. In other uses, ICF may be used alone.

The WHO family of international classifications provides a valuable tool to describe and compare the health of populations in an international context. The information on mortality (provided by ICD-10) and on health outcomes (provided by ICF) may be combined in summary measures of population health for monitoring the health of populations and its distribution, and also for assessing the contributions of different causes of mortality and morbidity.

ICF has moved away from being a “consequences of disease” classification (1980 version) to become a “components of health” classification.

“Components of health” identifies the constituents of health, whereas “consequences” focuses on the impacts of diseases or other health conditions that may follow as a result.

Thus, ICF takes a neutral stand with regard to etiology so that researchers can draw causal inferences using appropriate scientific methods. Similarly, this approach is also different from a “determinants of health” or “risk factors” approach. To facilitate the study of determinants or risk factors, ICF includes a list of environmental factors that describe the context in which individuals live.

2. AIMS OF ICF

ICF is a multipurpose classification designed to serve various disciplines and different sectors. Its specific aims can be summarized as follows:

- to provide a scientific basis for understanding and studying health and health-related states, outcomes and determinants;
- to establish a common language for describing health and health-related states in order to improve communication between different users, such as health care workers, researchers, policy-makers and the public, including people with disabilities;
- to permit comparison of data across countries, health care disciplines, services and time;
- to provide a systematic coding scheme for health information systems.

These aims are interrelated, since the need for and uses of ICF require the construction of a meaningful and practical system that can be used by various consumers for health policy, quality assurance and outcome evaluation in different cultures.

2.1 Applications of ICF

Since its publication as a trial version in 1980, ICIDH has been used for various purposes, for example:

- as a statistical tool – in the collection and recording of data (e.g. in population studies and surveys or in management information systems);
- as a research tool – to measure outcomes, quality of life or environmental factors;
- as a clinical tool – in needs assessment, matching treatments with specific conditions, vocational assessment, rehabilitation and outcome evaluation;
- as a social policy tool – in social security planning, compensation systems and policy design and implementation;
- as an educational tool – in curriculum design and to raise awareness and undertake social action.

Since ICF is inherently a health and health-related classification it is also used by sectors such as insurance, social security, labour, education, economics, social policy and general legislation development, and environmental modification. It has been accepted as one of the United Nations social classifications and is referred to in and incorporates *The Standard Rules on the Equalization of Opportunities for Persons with Disabilities*⁹. Thus ICF provides an appropriate instrument for the implementation of stated international human rights mandates as well as national legislation. ICF is useful for a broad spectrum of different applications, for example social security, evaluation in managed health care, and population surveys at

⁹ The Standard Rules on the Equalization of Opportunities for Persons with Disabilities. Adopted by the United Nations General Assembly at its 48th session on 20 December 1993 (resolution 48/96). New York, NY, United Nations Department of Public Information, 1994.

local, national and international levels. It offers a conceptual framework for information that is applicable to personal health care, including prevention, health promotion, and the improvement of participation by removing or mitigating societal hindrances and encouraging the provision of social supports and facilitators. It is also useful for the study of health care systems, in terms of both evaluation and policy formulation.

3. PROPERTIES OF ICF

A classification should be clear about what it classifies: its universe, its scope, its units of classification, its organisation, and how these elements are structured in terms of their relation to each other. The following sections explain these basic properties of ICF.

3.1 Universe of ICF

ICF encompasses all aspects of human health and some health-relevant components of well-being and describes them in terms of *health domains* and *health-related domains*¹⁰. The classification remains in the broad context of health and does not cover circumstances that are not health-related, such as those brought about by socioeconomic factors. For example, because of their race, gender, religion or other socioeconomic characteristics people may be restricted

in their execution of a task in their current environment, but these are not health related restrictions of participation as classified in ICF.

There is a widely held misunderstanding that ICF is only about people with disabilities; in fact, it is about *all people*. The health and health-related states associated with all health conditions can be described using ICF. In other words,

ICF has universal application¹¹.

¹⁰ Examples of health domains include seeing, hearing, walking, learning and remembering, while examples of health-related domains include transportation, education and social interactions.

¹¹ Bickenbach JE, Chatterji S, Badley EM, Üstün TB. Models of disablement, universalism and the ICIDH, *Social Science and Medicine*, 1999, 48:1173-1187.

3.2 Scope of ICF

ICF provides a description of situations with regard to human functioning and its restrictions and serves as a framework to organize this information. It structures the information in a meaningful, interrelated and easily accessible way.

ICF organizes information in two parts. Part 1 deals with Functioning and Disability, while Part 2 covers Contextual Factors. Each part has two components:

1. Components of Functioning and Disability

The **Body** component comprises two classifications, one for functions of body systems, and one for body structures. The chapters in both classifications are organized according to the body systems.

The **Activities and Participation** component covers the complete range of domains denoting aspects of functioning from both an individual and a societal perspective.

2. Components of Contextual Factors

A list of **Environmental Factors** is the first component of Contextual Factors.

Environmental factors have an impact on all components of functioning and disability and are organized in sequence from the individual's most immediate environment to the general environment.

Personal Factors is also a component of Contextual Factors but they are not classified in ICF because of the large social and cultural variance associated with them.

The components of Functioning and Disability in Part 1 of ICF can be expressed in two ways. On the one hand, they can be used to indicate problems (e.g. impairment, activity limitation or participation restriction summarized under the umbrella term *disability*); on the other hand they can indicate nonproblematic (i.e. neutral) aspects of health and health-related states summarized under the umbrella term *functioning*).

These components of functioning and disability are interpreted by means of four separate but related *constructs*. These constructs are operationalized by using *qualifiers*. Body functions and structures can be interpreted by means of changes in physiological systems or in anatomical structures. For the Activities and Participation component, two constructs are available: *capacity* and *performance* (see section 4.2).

A person's functioning and disability is conceived as a dynamic interaction¹² between health conditions (diseases, disorders, injuries, traumas, etc.) and contextual factors. As indicated above, Contextual Factors include both personal and environmental factors. ICF includes a comprehensive list of environmental factors as an essential component of the classification. Environmental factors interact with all the components of functioning and disability. The basic construct of the Environmental Factors component is the facilitating or hindering impact of features of the physical, social and attitudinal world.

3.3 Unit of classification

ICF classifies health and health-related states. The unit of classification is, therefore, *categories* within health and health-related domains. It is important to note, therefore, that in ICF persons are not the units of classification; that is, ICF does not classify people, but describes the situation of each person within an array of health or health-related domains. Moreover, the description is always made within the context of environmental and personal factors.

3.4 Presentation of ICF

ICF is presented in two versions in order to meet the needs of different users for varying levels of detail.

The *full version* of ICF, as contained in this volume, provides classification at four levels of detail. These four levels can be aggregated into a higher-level classification system that includes all the domains at the second level. The two-level system is also available as a *short version* of ICF.

¹² This interaction can be viewed as a *process* or a *result* depending on the user.

4. OVER-VIEW OF ICF COMPONENTS

Definitions

In the context of health:

Body functions are the physiological functions of body systems (including psychological functions).

Body structures are anatomical parts of the body such as organs, limbs and their components.

Impairments are problems in body function or structure such as a significant deviation or loss.

Activity is the execution of a task or action by an individual.

Participation is involvement in a life situation.

Activity limitations are difficulties an individual may have in executing activities.

Participation restrictions are problems an individual may experience in involvement in life situations.

Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives.

An overview of these concepts is given in Table 1; they are explained further in operational terms in section 5.1. As the table indicates:

ICF has two *parts*, each with two *components*:

Part 1. Functioning and Disability

- (a) Body Functions and Structures
- (b) Activities and Participation

Part 2. Contextual Factors

- (c) Environmental Factors
- (d) Personal Factors

- Each component can be expressed in both *positive* and *negative* terms.

- Each component consists of various domains and, within each domain, categories, which are the units of classification. Health and health-related states of an individual may be recorded by selecting the appropriate category code or codes and then adding *qualifiers*, which are numeric codes that specify the extent or the magnitude of the functioning or disability in that category, or the extent to which an environmental factor is a facilitator or barrier.

Table 1. An overview of ICF

	Part 1: Functioning and Disability		Part 2: Contextual Factors	
Components	Body Functions and Structures	Activities and Participation	Environmental Factors	Personal Factors
Domains	Body functions Body structures	Life areas (tasks, actions)	External influences on functioning and disability	Internal influences on functioning and disability
Constructs	Change in body functions (physiological) Change in body structures (anatomical)	Capacity Executing tasks in a standard environment Performance Executing tasks in the current environment	Facilitating or hindering impact of features of the physical, social, and attitudinal world	Impact of attributes of the person
Positive aspect	Functional and structural integrity	Activities Participation	Facilitators	not applicable
	Functioning			
Negative aspect	Impairment	Activity limitation Participation restriction	Barriers / hindrances	not applicable
	Disability			

4.1 Body Functions and Structures and impairments

Body functions *are the physiological functions of body systems (including psychological functions).*

Body structures *are anatomical parts of the body such as organs, limbs and their components.*

Impairments *are problems in body function or structure as a significant deviation or loss.*

(1) Body functions and body structures are classified in two different sections.

These two classifications are designed for use in parallel. For example, body functions include basic human senses such as “seeing functions” and their structural correlates exist in the form of “eye and related structures”.

(2) “Body” refers to the human organism as a whole; hence it includes the brain and its functions, i.e. the mind. Mental (or psychological) functions are therefore subsumed under body functions.

(3) Body functions and structures are classified according to body systems; consequently, body structures are not considered as organs¹³.

(4) Impairments of structure can involve an anomaly, defect, loss or other significant deviation in body structures. Impairments have been conceptualized in congruence with biological knowledge at the level of tissues or cells and at the subcellular or molecular level. For practical reasons, however, these levels are not listed¹⁴. The biological foundations of impairments have guided the classification and there may be room for expanding the classification at the cellular or molecular levels. For medical users, it should be noted that impairments are not the same as the underlying pathology, but are the manifestations of that pathology.

(5) Impairments represent a deviation from certain generally accepted population standards in the biomedical status of the body and its functions,

¹³ Although organ level was mentioned in the 1980 version of ICF, the definition of an “organ” is not clear. The eye and ear are traditionally considered as organs; however, it is difficult to identify and define their boundaries, and the same is true of extremities and internal organs. Instead of an approach by “organ”, which implies the existence of an entity or unit within the body, ICF replaces this term with “body structure”.

¹⁴ Thus impairments coded using the full version of ICF should be detectable or noticeable by others or the person concerned by direct observation or by inference from observation.

and definition of their constituents is undertaken primarily by those qualified to judge physical and mental functioning according to these standards.

(6) Impairments can be temporary or permanent; progressive, regressive or static; intermittent or continuous. The deviation from the population norm may be slight or severe and may fluctuate over time. These characteristics are captured in further descriptions, mainly in the codes, by means of qualifiers after the point.

(7) Impairments are not contingent on etiology or how they are developed; for example, loss of vision or a limb may arise from a genetic abnormality or an injury. The presence of an impairment necessarily implies a cause; however, the cause may not be sufficient to explain the resulting impairment. Also, when there is an impairment, there is a dysfunction in body functions or structures, but this may be related to any of the various diseases, disorders or physiological states.

(8) Impairments may be part or an expression of a health condition, but do not necessarily indicate that a disease is present or that the individual should be regarded as sick.

(9) Impairments are broader and more inclusive in scope than disorders or diseases; for example, the loss of a leg is an impairment of body structure, but not a disorder or a disease.

(10) Impairments may result in other impairments; for example, a lack of muscle power may impair movement functions, heart functions may relate to deficit in respiratory functions, and impaired perception may relate to thought functions.

(11) Some categories of the Body Functions and Structures component and the ICD-10 categories seem to overlap, particularly with regard to symptoms and signs. However, the purposes of the two classifications are different. ICD-10 classifies symptoms in special chapters to document morbidity or service utilization, whereas ICF shows them as part of the body functions, which may be used for prevention or identifying patients' needs. Most importantly, in ICF the Body Functions and Structures classification is intended to be used along with the Activities and Participation categories.

(12) Impairments are classified in the appropriate categories using defined identification criteria (e.g. as present or absent according to a threshold level). These criteria are the same for body functions and structures. They are: (a) loss or lack; (b) reduction; (c) addition or excess; and (d) deviation. Once an impairment is present, it may be scaled in terms of its severity using the generic qualifier in the ICF.

(13) Environmental factors interact with body functions, as in the interactions between air quality and breathing, light and seeing, sounds and hearing, distracting stimuli and attention, ground texture and balance, and ambient temperature and body temperature regulation.

4.2 Activities and Participation / activity limitations and participation restrictions

Activity *is the execution of a task or action by an individual.*

Participation *is involvement in a life situation.*

Activity limitations *are difficulties an individual may have in executing activities.*

Participation restrictions *are problems an individual may experience in involvement in life situations.*

(1) The domains for the Activities and Participation component are given in a *single list* that covers the full range of life areas (from basic learning or watching to composite areas such as interpersonal interactions or employment). The component can be used to denote activities (a) or participation (p) or both. The domains of this component are qualified by the two qualifiers of *performance* and *capacity*. Hence the information gathered from the list provides a data matrix that has no overlap or redundancy.

(2) The *performance* qualifier describes what an individual does in his or her current environment. Because the current environment includes a societal context, performance can also be understood as "involvement in a life situation" or "the lived experience" of people in the actual context in which

they live¹⁵. This context includes the environmental factors – all aspects of the physical, social and attitudinal world which can be coded using the Environmental Factors component.

(3) The *capacity* qualifier describes an individual’s ability to execute a task or an action. This construct aims to indicate the highest probable level of functioning that a person may reach in a given domain at a given moment. To assess the full ability of the individual, one would need to have a “standardized” environment to neutralize the varying impact of different environments on the ability of the individual. This standardized environment may be: (a) an actual environment commonly used for capacity assessment in test settings; or (b) in cases where this is not possible, an assumed environment which can be thought to have a uniform impact. This environment can be called a “uniform” or “standard” environment. Thus, capacity reflects the environmentally adjusted ability of the individual. This adjustment has to be the same for all persons in all countries to allow for international comparisons. The features of the uniform or standard environment can be coded using the Environmental Factors classification.

The gap between capacity and performance reflects the difference between the impacts of current and uniform environments, and thus provides a useful guide as to what can be done to the environment of the individual to improve performance.

(4) Both capacity and performance qualifiers can further be used with and without assistive devices or personal assistance. While neither devices nor personal assistance eliminate the impairments, they may remove limitations on functioning in specific domains. This type of coding is particularly useful to identify how much the functioning of the individual would be limited without the assistive devices (see coding guidelines in Annex 2)

¹⁵ The definition of “participation” brings in the concept of involvement. Some proposed definitions of “involvement” incorporate taking part, being included or engaged in an area of life, being accepted, or having access to needed resources. Within the information matrix in Table 2 the only possible indicator of participation is coding through performance. This does not mean that participation is automatically equated with performance. The concept of involvement should also be distinguished from the subjective experience of involvement (the sense of “belonging”). Users who wish to code involvement separately should refer to the coding guidelines in Annex 2.

(5) Difficulties or problems in these domains can arise when there is a qualitative or quantitative alteration in the way in which an individual carries out these domain functions. *Limitations* or *restrictions* are assessed against a generally accepted population standard. The standard or norm against which an individual's capacity and performance is compared is that of an individual without a similar health condition (disease, disorder or injury, etc.). The limitation or restriction records the discordance between the observed and the expected performance. The expected performance is the population norm, which represents the experience of people without the specific health condition. The same norm is used in the capacity qualifier so that one can infer what can be done to the environment of the individual to enhance performance.

(6) A problem with performance can result directly from the social environment, even when the individual has no impairment. For example, an individual who is HIV-positive without any symptoms or disease, or someone with a genetic predisposition to a certain disease, may exhibit no impairments or may have sufficient capacity to work, yet may not do so because of the denial of access to services, discrimination or stigma.

(7) It is difficult to distinguish between "Activities" and "Participation" on the basis of the domains in the Activities and Participation component. Similarly, differentiating between "individual" and "societal" perspectives on the basis of domains has not been possible given international variation and differences in the approaches of professionals and theoretical frameworks.

Therefore, ICF provides a single list that can be used, if users so wish, to differentiate activities and participation in their own operational ways. This is further explained in Annex 3. There are four possible ways of doing so:

(a) to designate some domains as activities and others as participation, not allowing any overlap; (b) same as (a) above, but allowing partial overlap; (c) to designate all detailed domains as activities and the broad category headings as participation; (d) to use all domains as both activities and participation.

4.3 Contextual Factors

Contextual Factors represent the complete background of an individual's life and living. They include two components: Environmental Factors and Personal Factors – which may have an impact on the individual with a health condition and that individual's health and health-related states.

Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives. These factors are external to individuals and can have a positive or negative influence on the individual's performance as a member of society, on the individual's capacity to execute actions or tasks, or on the individual's body function or structure.

(1) Environmental factors are organized in the classification to focus on two different levels:

(a) *Individual* – in the immediate environment of the individual, including settings such as home, workplace and school. Included at this level are the physical and material features of the environment that an individual comes face to face with, as well as direct contact with others such as family, acquaintances, peers and strangers.

(b) *Societal* – formal and informal social structures, services and overarching approaches or systems in the community or society that have an impact on individuals. This level includes organisations and services related to the work environment, community activities, government agencies, communication and transportation services, and informal social networks as well as laws, regulations, formal and informal rules, attitudes and ideologies.

(2) Environmental factors interact with the components of Body Functions and Structures and Activities and Participation. For each component, the nature and extent of that interaction may be elaborated by future scientific work.

Disability is characterized as the outcome or result of a complex relationship between an individual's health condition and personal factors, and of the external factors that represent the circumstances in which the

individual lives. Because of this relationship, different environments may have a very different impact on the same individual with a given health condition. An environment with barriers, or without facilitators, will restrict the individual's performance; other environments that are more facilitating may increase that performance. Society may hinder an individual's performance because either it creates barriers (e.g. inaccessible buildings) or it does not provide facilitators (e.g. unavailability of assistive devices).

Personal factors are the particular background of an individual's life and living, and comprise features of the individual that are not part of a health condition or health states. These factors may include gender, race, age, other health conditions, fitness, lifestyle, habits, upbringing, coping styles, social background, education, profession, past and current experience (past life events and concurrent events), overall behaviour pattern and character style, individual psychological assets and other characteristics, all or any of which may play a role in disability at any level. Personal factors are not classified in ICF. However, they are included in Fig. 1 to show their contribution, which may have an impact on the outcome of various interventions.

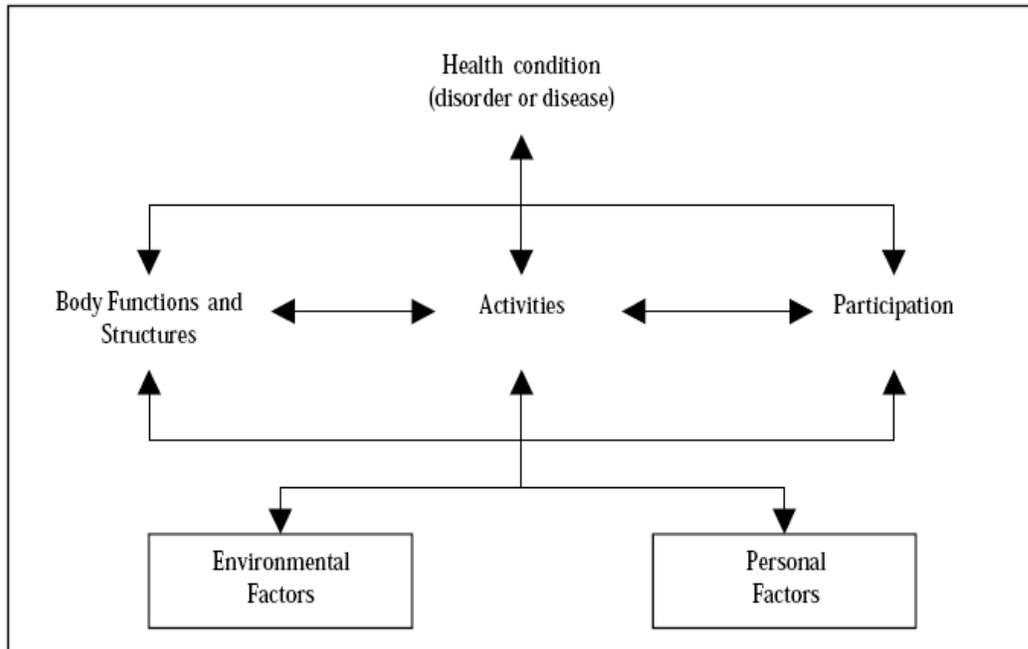
5. MODEL OF FUNCTIONING AND DISABILITY

5.1 Process of functioning and disability

As a classification, ICF does not model the “process” of functioning and disability. It can be used, however, to describe the process by providing the means to map the different constructs and domains. It provides a multiperspective approach to the classification of functioning and disability as an interactive and evolutionary process. It provides the building blocks for users who wish to create models and study different aspects of this process. In this sense, ICF can be seen as a language: the texts that can be created with it depend on the users, their creativity and their scientific

orientation. In order to visualize the current understanding of interaction of various components, the diagram presented in Fig. 1 may be helpful¹⁶

Fig.1. Interactions between the components of ICF



In this diagram, an individual's functioning in a specific domain is an interaction or complex relationship between the health condition and contextual factors (i.e. environmental and personal factors). There is a dynamic interaction among these entities: interventions in one entity have the potential to modify one or more of the other entities. These interactions are specific and not always in a predictable one-to-one relationship. The interaction works in two directions; the presence of disability may even

¹⁶ ICF differs substantially from the 1980 version of ICIDH in the depiction of the interrelations between functioning and disability. It should be noted that any diagram is likely to be incomplete and prone to misrepresentation because of the complexity of interactions in a multidimensional model.

The model is drawn to illustrate multiple interactions. Other depictions indicating other important foci in the process are certainly possible. Interpretations of interactions between different components and constructs may also vary (for example, the impact of environmental factors on body functions certainly differs from their impact on participation).

modify the health condition itself. To infer a limitation in capacity from one or more impairments, or a restriction of performance from one or more limitations, may often seem reasonable. It is important, however, to collect data on these constructs independently and thereafter explore associations and causal links between them. If the full health experience is to be described, all components are useful. For example, one may:

- have impairments without having capacity limitations (e.g. a disfigurement in leprosy may have no effect on a person's capacity);
- have performance problems and capacity limitations without evident impairments (e.g. reduced performance in daily activities associated with many diseases);
- have performance problems without impairments or capacity limitations (e.g. an HIV-positive individual, or an ex-patient recovered from mental illness, facing stigmatization or discrimination in interpersonal relations or work);
- have capacity limitations without assistance, and no performance problems in the current environment (e.g. an individual with mobility limitations may be provided by society with assistive technology to move around);
- experience a degree of influence in a reverse direction (e.g. lack of use of limbs can cause muscle atrophy; institutionalization may result in loss of social skills).

The scheme shown in Fig. 1 demonstrates the role that contextual factors (i.e. environmental and personal factors) play in the process. These factors interact with the individual with a health condition and determine the level and extent of the individual's functioning. Environmental factors are extrinsic to the individual (e.g. the attitudes of the society, architectural characteristics, the legal system) and are classified in the Environmental Factors classification. Personal Factors, on the other hand, are not classified in the current version of ICF. They include gender, race, age, fitness,

lifestyle, habits, coping styles and other such factors. Their assessment is left to the user, if needed.

5.2 Medical and social models

A variety of conceptual models¹⁷ has been proposed to understand and explain disability and functioning. These may be expressed in a dialectic of “medical model” versus “social model”. The *medical model* views disability as a problem of the person, directly caused by disease, trauma or other health condition, which requires medical care provided in the form of individual treatment by professionals. Management of the disability is aimed at cure or the individual’s adjustment and behaviour change. Medical care is viewed as the main issue, and at the political level the principal response is that of modifying or reforming health care policy. The *social model* of disability, on the other hand, sees the issue mainly as a socially created problem, and basically as a matter of the full integration of individuals into society. Disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the social environment. Hence the management of the problem requires social action, and it is the collective responsibility of society at large to make the environmental modifications necessary for the full participation of people with disabilities in all areas of social life. The issue is therefore an attitudinal or ideological one requiring social change, which at the political level becomes a question of human rights. For this model disability is a political issue.

ICF is based on an integration of these two opposing models. In order to capture the integration of the various perspectives of functioning, a “biopsychosocial” approach is used. Thus, ICF attempts to achieve a synthesis, in order to provide a coherent view of different perspectives of health from a biological, individual and social perspective¹⁸

¹⁷ The term "model" here means construct or paradigm, which differs from the use of the term in the previous section.

¹⁸ See also Annex 5 - “ICF and people with disabilities”.

5. INDEX

- Abdominal pain 14;40;88;89;164
- ACTIVITIES AND PARTICIPATION
..... 169
- Acute pain..... 102
- Aggressive outbursts
..... 16;147;169;170;172;252
- Alienation..... 57;172;198;263
- Anger .. 16;54;112;218;219;226;303;305;322
- Antisocial behaviour 172;225
- Anxiety
.14;16;17;18;21;28;32;34;35;38;46;49;50;
71;73;75;76;77;84;87;103;105;108;110;1
12;116;130;131;139;141;144;146;147;15
6;174;175;177;180;181;189;194;195;203;
206;207;208;211;212;213;221;224;228;2
29;230;233;234;237;238;239;240;241;24
5;259;272;275;300;303;305;308;322;324;
326;329;333;334;335;338;339;344;350;3
53;377;378;384;386;388;391
- Arm pain 22;68
- Armed conflict
.....241;247;257;260;262;268;279
- Assessment of torture survivors
21;49;67;87;102;126;133;172;208;240;27
7;293;319
- Autogenic training..... 308;367;368;369;391
- Avoidance behaviour
..... 173;175;180;181;212;220;224;309
- Back pain.....24;83;103;235;236;268;364
- Basic needs not satisfied244;279
- BAT 391
- Bed wetting..... 176
- Bereavement..... 179
- Bleeding from orifice 26;27
- Body awareness therapy (BAT)..... 391
- BODY FUNCTIONS.....14
- Breakdown of infrastructure
..... 246;247;260;261
- Breathing difficulties28
- Burning30
- Burning sensation..... 30;62;109
- CAM.....314;315;316
- Care for caregivers303;318;323
- CBT**
21;49;102;108;121;126;178;212;230;231;
233;277;308;309;310;321;324;325;345;3
56;377;386
- Chest pain 19;28;31;32;317
- Chronic pain..... 105
- Cognitive Behavioural Therapy..... 308
- Cognitive problems.....33;35;46;148
- Cognitive-Behavioural Therapy (CBT)
.....308;324;377
- Coldness..... 37;38
- Community Approach..... 310
- Community life, participation in
..... 182;193;194;214
- Complementary and Alternative Medicine
(CAM) 314
- Constipation 14;39;50
- CONTEXT 241
- Coping and preoccupation with pain
..... 91;107;167;168;183;335;349;350
- Coughing 41;42
- Counselling
27;28;29;30;31;36;48;50;58;59;66;75;85;

87;88;89;92;96;99;100;101;107;114;115; 121;124;126;129;132;147;148;149;150;1 55;168;171;178;189;191;192;193;194;19 8;202;212;213;217;219;224;228;229;231; 232;234;237;239;243;251;255;256;257;2 63;267;270;276;280;281;304;317;319;32 0;321;322;323;342;355;396	Family life, participation in 57;193;194;199;218;229
Depersonalisation..... 44;45;54;57	Family separation 241;257
Depression 34;35;46;47;66;67;71;84;86;87;102;105;1 07;108;110;111;112;116;125;126;132;13 3;141;144;156;180;181;188;189;190;191; 194;195;199;203;213;218;219;220;221;2 24;227;228;229;237;238;239;240;241;24 5;259;275;277;300;307;345;350;356;377	Flashback..... 56;59;61
DESNOS 53;121;288	Foot pain 62;235;236
Diarrhoea 15;50;150	Forced displacement, including refugees 257;263
Disability .187;188;203;229;337;349;350;363;397;4 02;404;411;412;415	Friendship breakdown..... 194
Disfiguration 51	Gainful activities.....194;202;203
Disorders of Extreme Stress Not Otherwise Specified (DESNOS) 53	Guilt feelings 46;64;269
Dissociation..... 55;57;61;81;172	Hand Pain.....67
Dizziness..... 19;34;35;58;59;97;149	Headache 17;60;61;69;97;103;145;306;338;349
Domestic Violence..... 248	Health services244;246;248;252;259;260;357
Dressing problems 190	Hearing difficulties..... 60;72
Eating problems..... 191;192	Heart palpitation..... 17;73;272;308
Education .34;183;245;246;250;253;254;260;263;27 1;279;283;288;294;302;365	Human Rights.....267;279;282;283;289
EMDR..... 121;325;332;345	Hyper-vigilance..... 75;76;100
Exclusion from participation in social and political activities 193	ICF 11;188;292;363;365;366;397;398;399;40 0;401;402;403;404;406;407;408;410;412; 413;414;415
Exposure Therapy 324;386	Identity problems 195;197
Facial Pain..... 60	Incontinence 77;78;90;160;161
Family breakdown 255	Indigestion..... 79;80
Family disappearance 256	Information and psycho-education321;333;354
	INTERNATIONAL CLASSIFICATION OF FUNCTIONING AND DISABILITY (ICF)..... 397; <i>chapter 4</i>
	Interventions with traumatised children 20;35;48;71;87;101;125;126;146;191;208 ;213;214;217;231;232;233;257;265;338
	Intimate relations.....124;129;199
	INTRODUCTION <i>chapter 1</i>
	Intrusive memories 81;117;305
	Isolation 46;86;130;165;199;204;252;268;278;317

Job - acquiring, keeping and terminating one	262	Pain, psychogenic	111;349;350
Leg pain.....	25;63;82;235;236;347	Paranoia	45;76;112;175;204;205
Lifting and carrying objects	201	Parenting.....	213;229
Local community breakdown	241;244;246;259;262;265;312	Paresis	78;114;161
Local physical therapy (joint mobilization, stretching, heat/cold).....	346	Pelvic pain	115;116
Loss of appetite.....	84;345	Performing household work.....	214
Loss of energy	86	Persistent thoughts.....	117
Loss of interest.....	46;86;156;204	Phantom pain.....	110;117;118;185
Maintaining a dwelling.....	202	Population at risk	248;261;263;265
Meditation.....	200;367;374;377;384	Post conflict society	265
Menstruation problems	88;123;124	Posttraumatic Stress Disorder (PTSD)	119
Micturition	90;110;115;118	Posture and balance problems	121
Mistrust .	112;113;114;182;193;204;255;321	Practising religion and spirituality.....	265
Muscle power	99;100;114	Problem solving 34;36;86;139;183;215;220;221;224;238;2 43;322;336;351;363	
Muscle weakness.....	92	PROBLEMS	<i>chapter 2</i>
Muscle, joint and bone pain.....	83;90;235	Psycho-education 15;17;23;107;148;153;168;169;176;182;1 89;191;193;195;212;214;219;225;232;23 4;255;256;277;321;322;335;337;353;354	
Nausea.....	50;95;96;164;165;315;330	Psychogenic pain	111
Neck pain.....	22;68;96;135	Psychotherapy 20;130;155;212;280;308;355	
Neuropathic pain	108	PTSD 18;21;49;53;55;56;57;58;81;87;102;114;1 19;121;125;126;148;171;173;175;178;18 0;192;194;200;204;207;213;228;229;233; 234;241;270;271;273;275;276;277;285;2 86;290;305;326;332;344;386	
Night terror	209;210	Public Health Approach.....	356
Nightmare.....	139;205;209	Redress	215;216
Numbness.....	25;31;62;99;100;134	Regressive symptoms.216;217;231;273;275	
Obsessive-compulsive activities	211;212;213	Rehabilitation and Physical Medicine... 362	
Organised violence 46;64;77;113;130;171;197;198;204;205;2 13;234;265;278;279;341		Relating to environment and nature.... 266	
Over alertness	75;100	Relational problems	129;218;268
Pain management .	64;107;288;334;348;351	Relaxation exercises	154;367
Pain, Acute.....	102	Relaxation techniques	17;20;71;84;289
Pain, chronic 68;83;84;105;134;167;168;181;221;273;2 76;349;350;377		Reproduction difficulties.....	123
Pain, neuropathic 23;31;60;63;104;105;106;107;108;116;11 7;119;134;135;349		Re-traumatisation	255;256;266

- Risk-taking behaviour 218;219;345
- Rule of law problems and re-traumatisation 266
- SELECTED REFERENCES 285
- Self-efficacy problems..... 220
- Self-harm
..... 47;48;66;131;133;173;225;227;228
- Self-mutilation..... 228
- Sense of a limited future..... 125;341
- Sexual problems..... 123;124;127;199;271
- Sexual violence
..... 64;116;131;242;246;249;259;268;269
- Shame
.54;130;193;253;268;269;270;305;317;322
- Shoulder pain 22;68;133;135
- Skin infections..... 136;159
- Sleeping difficulties..... 107;138;189;208
- Somatisation 53;55;69;144;335
- Somatisation - children 145
- Stress
.14;16;19;21;27;28;32;34;35;36;37;40;50;53;55;59;73;74;75;77;79;80;84;86;87;88;89;98;101;106;107;111;119;121;123;134;135;138;145;146;147;153;155;156;160;167;168;171;192;199;206;207;208;210;213;221;224;229;246;248;259;263;265;266;272;274;276;281;286;304;306;307;320;322;331;335;339;341;342;344;347;351;367;375;377;384;391
- Stress management
.14;36;40;75;80;87;98;101;106;107;121;134;135;146;153;155;167;168;171;199;208;224;229;274;276;306;320;322;342;367;391
- Substance abuse
18;20;48;56;142;147;148;157;169;171;175;219;251;259;331
- Substance abuse (craving) 147
- Sweating..... 95;96;103;109;149;272;317
- Swelling..... 22;68;91;103;115;151;347
- Taking care of others 229
- Testimony therapy
..... 321;325;331;332;385;388
- THERAPIES 293;*chapter 3*
- Tics 153
- Tinnitus 154;156
- Tiredness
34;35;61;62;86;156;157;190;237;317;345
- Toileting problems 230
- Torture and Organised Violence
214;246;248;250;262;263;264;265;266;277;304;312;363
- Traumatic play 232
- Ulcer of skin..... 158
- Urge to urinate..... 160
- Urinating difficulties 160
- Using transport..... 233
- Values and attitudes 281
- Violations of human rights
..... 258;259;267;282
- Vision difficulties..... 162;188
- Visualisation exercises 367;391
- Vomiting..... 14;40;50;70;150;164
- Walking problems 63;83;235
- Washing problems..... 237
- Weight loss 25;41;46;84;85;88;89;165
- Whole body pain 14;167
- Whole body physical therapies
..... 17;22;24;63;70;75;84;106;168;389
- Working with interpreters..... 395;396
- Worrying about symptoms 168;238;276