Women as victims of torture

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This is a retrospective study on the effects of torture on Latin American refugee women in Toronto. Thirty-six cases of female torture victims are reviewed. The cases are divided in 2 groups, according to whether they experienced physical and psychological torture or only psychological assaults. Both groups are compared in terms of demographic characteristics, social and/or political involvement prior to the traumatic experiences, symptoms for which they sought psychiatric intervention and recovery rates. The symptoms presented by all women are consistent with those described in the literature for torture victims, regardless of their sex. The main findings are that women who experienced direct physical and psychological violence more frequently had persistence of symptoms than women who experienced only psychological violence.

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According to Amnesty International, there are more than 1 million political prisoners in the world, and most of them are exposed to torture (1). Despite its prohibition under the Universal Declaration of Human Rights and the Geneva Conventions, torture remains as a common practice in at least 98 countries around the world, and in many of them, it is carried out systematically (1).

Each year a large number of torture victims emigrate to Canada from all parts of the world, many of them from Latin America. As a direct consequence of torture, they often suffer physical impairments and a wide variety of psychological symptoms. Sequelae of torture is a relatively new, tragic and emotionally demanding field within the mental health profession. Most patients meet all the criteria for the diagnosis of posttraumatic stress disorder, as described by DSM-III-R, especially in the period immediately after the torture experience.

Some of the victims develop a delayed and/or chronic state, which is not usually observed after major traumatic experiences other than torture (2).

In most studies in this field, the majority of torture victims are young males, and in some reports (3–5) women have been estimated to comprise only 20–25% of torture cases. However, in other studies, females appear to be detained and tortured as frequently as males (6) and sexual assault figures prominently among torture practices against women (7).

Even though some refugees do not suffer the effects of psychological and/or physical torture directed to themselves, they suffer the effects of the violence committed against their loved ones. Some refugees have been threatened by arrest or mock executions without physical violence, or they may have observed or suffered the violence being perpetrated against friends or family members. These individuals have been refer to as secondary victims of political repression (8, 9).

The aim of this study is to describe demographic data, psychological sequelae of torture, and recovery rates of a group of refugee women, comparing victims of physical and psychological torture with victims of only psychological torture.

Material and methods

We reviewed the records of all cases of women exiled from Latin America (n = 36) who had sought psychiatric intervention from 2 Latin American female therapists within a 2-year period. All of them had been subjected to state violence in their countries of origin. The records were reviewed using a data-structured research scheme.

These 36 women had all been exposed to traumatic experiences that had taken place from periods ranging from 12 years to a few months prior to the initial contact with the therapists. All patients came from Latin American countries, and all interviews and therapy sessions were conducted in Spanish. The 36 cases in this study were divided in 2 groups according to the presence or absence of physical abuse. The first group is formed by 23 women who experienced "direct" physical and psychological torture. The second group is comprised of 13 women who suffered "indirect" torture, which includes death threats to patients and/or family members, or detention, disappearance or death of close relatives. None of the women in group 2 experienced physical abuse.

Recovery rates were measured by looking at the patient's level of functioning and adaptation to the

new society and the presence or absence of the psychiatric symptoms for which they had consulted.

In order to document significant differences in the data obtained, the information was analyzed using two-way tables and chi-square statistics.

Results

Demographic data

The ages of the 36 women ranged from 18 to 66 years (mean 37). Most of the women were married (44%) and more than half (56%) of them came from working-class families. More than half of them (53%) had some kind of a postsecondary education.

An attempt was made to assess the political and/or social involvement that these women had prior to undergoing the traumatic experiences. We found that 69% had some type of involvement, whether it was only with community activities through churches or religious organizations (human rights organizations, solidarity vicariate, popular kitchens, etc.), or whether it was through more active political involvement or both. Thirty percent had never been involved in any of these types of activities.

Most patients came from Chile (33%) or Guatemala (22%). The rest came from Uruguay, El Salvador, Argentina and 1 came from Bolivia.

The symptoms these women presented can be classified as affective, cognitive, psychotic, somatic and others. The most frequent ones are anxiety, irritability, anguish and feelings of depression, sleep disturbances and weight and appetite changes. These symptoms were present in 70–100% of all cases.

The sample was divided into 2 groups: group 1, comprising 23 women who suffered physical and psychological torture, and group 2, formed by 13 women who underwent only psychological torture.

The women in group 1 were younger than in group 2, with a mean age of 33.3 ± 8.5 *vs* 42.5 ± 9.6 in group 2. In group 1, almost half were single (43%), as compared with only 8% in group 2. Sixty-one percent of women in group 1 came from working-class families, and 46% in group 2.

With regard to educational level, only 39% of the women in group I had postsecondary education *vs* 77% in group 2.

The social and/or political degree of involvement was different: it reached 78% of the patients in group I as compared with 54% in group 2.

Torture

Sixty-two percent of the women in group 1 were detained, most of them more than once for periods ranging from hours, days or weeks and in some cases, up to 1 year or more.

All women detained were apprehended violently, in most cases by the military, who burst into their homes, destroying their belongings and mistreating family members, including children. Victims were blindfolded and taken to detention places where they were kept in solitary confinement, many times without food or fluids. The reason most frequently given for detention was political involvement. All of the women in this group were subjected to some form of physical abuse that left demonstrable physical sequelae in 26% of the cases.

The most frequent types of torture methods used were beatings with hands, fists or kicks, or with wet clothes on naked bodies to minimize visible damages. Some women were hung naked from their wrists. Many underwent isolation, starvation and thirst; 8 women were raped by their torturers, 5 of them repeatedly. Three of these women became pregnant as a result of the sexual assault; 1 had the baby upon arrival in Canada, and 2 had abortions that were performed in their countries of origin. Other forms of psychological harassment included verbal abuse, death threats against the patient and/or their close relatives, house searches and house ransacking. A few women had to live underground for 2 weeks to 1 year, before leaving their country and going into exile. This happened more frequently among women in group 2. Four women underwent the experience of being banned from the high school or university where they had been studying.

In group 2, none of the women was exposed to detention, physical abuse or sexual abuse. A high percentage of them were subjected to verbal abuse, death threats against themselves or close relatives; 54% had their homes searched, 15% ransacked and 46% had had to go underground, usually because of their association with close relatives being sought by the regime.

When we looked at "indirect" traumatic experiences, which consisted of the loss and/or detention and physical abuse of a close family member or friend, we found that about 40% of women in both groups had close relatives that had either been executed or missing. Fifty-two percent of the women in group 1 had a close relative who had been physically abused as compared with 92% of the women in group 2.

When we looked at the loss of close friends, either by execution or because they had "disappeared" in the hands of military forces, this was the case in 78% of women in group 1, and 39% in group 2.

Symptoms

Even though several symptoms were found in most women in both groups, a cluster of symptoms was found to be present more frequently among women

in group 1: guilt, poor self-esteem, concentration difficulties, mistrust, fears of rejection and memory difficulties.

Vague suicidal ideation was found in 56% in group 1, and in 23% in group 2. Only one patient in group 1 was assessed as actively suicidal. Social withdrawal was found to be twice as frequent in group 1 than in group 2 (60% and 23% respectively). Somatic complaints such as headaches were found to be present with almost the same frequency in both groups (equal to 50% of cases).

Two patients in group 1 presented with recurrent episodes of acute psychosis characterized by paranoid delusions and abnormal perceptions (visual and auditory hallucinations) requiring maintenance treatment with antipsychotic medications. When the patients that experienced sexual assault while in detention centres were looked at separately, we found that again a cluster of symptoms was present in all 8 cases: anguish, anxiety; sadness, tearfulness, poor self-esteem; guilt, mistrust; irritability; insomnia, nightmares; changes in appetite and weight; fear of being alone, of rejection and of persecution; and feeling dirty. Half of them presented suicidal ideation.

An attempt was made to assess these women's recovery rates by looking at them in terms of presence of symptoms and levels of functioning and adaptation. After 1 year of follow-up, all patients were either working, studying or functioning well as housewives. When we looked at the presence or absence of the symptoms for which these women consulted, we found that 58% of them had almost complete alleviation of their symptoms, and 44% had only partial alleviation of symptoms after one year. When we compared both groups, we found that women in group 2 had the highest rates of almost complete alleviation of symptoms (85%) as compared with 44% in group 1 ($P < 0.05$).

Discussion

Our findings are consistent with data reported in the literature on torture victims in general, regardless of sex. Our population studied was relatively young, mainly of a working-class social background and had extensive social and/or political involvement in their countries of origin prior to undergoing the traumatic experiences. The methods of torture used in these women were not different from those reported in the literature on Latin American refugees or exiles (7). In our sample, rape was used in 8 cases (22%) and suicidal ideation was found in a high proportion of these women who underwent sexual assault.

Numerous observations from mental health workers worldwide reveal that sexual abuse is a frequent torture practice of women (7, 10). Rape and sexual abuse has been described among Cambodian, Laotian, Vietnamese, Chilean and Salvadoran women (7). Women with sexual abuse histories have been found to experience suicidal ideation among other symptoms, more frequently than their non-abused peers (11). Thus, sexual torture may cause significant emotional and physical injury among female survivors.

The symptoms our sample of women presented are consistent with those described in the literature for torture victims in general, mainly anxiety and affective-type symptoms, plus symptoms that match those of the current diagnostic criteria for post-traumatic stress disorder.

The high prevalence of anxiety symptoms among refugees has been documented in several clinical studies of various refugee populations (12–15) as well as high rates for posttraumatic stress disorder (16–19).

Depression has been identified as the most frequent mental health problem leading to psychiatric treatment in widely different refugee groups (14, 20, 21).

The symptoms of mistrust and suspiciousness were found to be present among our population in high rates (83% of group 1 and 69% in groups 2). Tyhurst (15) has reported suspiciousness and paranoid trends in refugee patients with all diagnoses.

Our data shows that the women who underwent direct physical and psychological violence more frequently experienced persistence of symptoms than women that did not experience physical violence. It would seem, then, that direct violence against the person is the most important factor accounting for the persistence of the symptoms of torture victims.

Krupinsky et al. (17) studied Second World War refugees in Australia and found that the refugees with the most severe persecution and war experiences had both a higher frequency and a higher intensity of neurotic symptoms. Similar symptoms are now being identified among survivors of Cambodian concentration camps (22, 23).

Previous involvement in social and/or political activities does not seem to protect the victims from the sequelae of torture, as we had hypothesized initially. Clinical observations led us to believe that we would find the highest levels of adaptation, functioning and symptom resolution in the women that had been actively involved in social and/or political activities in their countries prior to the traumatic experiences. We felt that strong political or religious ideals would in some way protect them from the psychological sequelae of torture. Our assumption was that these women would be more aware than those not politically or socially involved of the potential risks of detention and violence to which they were exposed.

However, our results do not support this assumption.

We are aware that our ratings on recovery rates for these women were done very subjectively. Nevertheless, our results show that the women who did not suffer direct types of torture had the highest frequency of good recovery rates, even though they were less committed or uncommitted to the situation leading to their traumatic experiences. It is likely that other factors may also play a role in the development and persistence of symptoms in this population, such as the person's ego strength, specific personal experiences prior to the torture situation, their social network and difficulties in adapting to a new country.

Conclusion

Torture causes significant emotional and physical injury to its victims. Among women, sexual torture is frequent. Health professionals dealing with torture victims should be aware of the different clinical presentations of this population to be able to help victims effectively. Future research in this field should explore the prevalence and complications of sexual assault among victims of torture.

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