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Case report

The epidemiology of torture: A case series of 58 survivors of torture

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ABSTRACT

Introduction/context: Torture is widely practiced throughout the world and, yet, the ways by which torture is perpetrated, its regional similarities and differences, is not well understood. Our goal for this cases series was to elucidate the methods of torture practiced within different countries to both add to and expand upon previous research. This knowledge is important since it can buttress efforts to assist with torture survivors' recovery—medically, psychologically, and legally.

Methods: Fifty-eight survivors of torture who presented to a single interviewer over a 15-year period (1990–2005) for purposes of assisting with their claim for political asylum in the U.S. were enrolled into the study. The survivors' legal affidavits were examined and both quantitative and qualitative data were extracted for analysis. This data included the following: (1) duration, condition, and frequency of imprisonment, (2) abductors' affiliation and dress, (3) torture type, method, and frequency (both physical and mental), and (4) qualitative description of above items.

Results: Twenty-three countries were represented in the sample covering six major world regions. Women appear to be at greater risk for sexual torture than men. Sub-Saharan Africans tend to have more abuse compared to other world regions. Furthermore, the length of confinement also appears to trend towards longer duration in those survivors from Sub-Saharan African countries. Certain types of torture were almost universal in their application such as threats of death and beatings, but the manner by which survivors were beaten varied considerably, with hitting/kicking and beating with a stick/baton being the most common. There was no correlation between types of torturous acts and religion.

Conclusion: This case series confirms some earlier findings about regional similarities and differences in torture methodology. Study results built upon previous studies as well as uncovered new findings suggesting that more work needs to be done. Further, our results will help survivors of torture with their recovery both through improved patient care outcomes and by impacting upon the way asylum cases are adjudicated.

1. Introduction

Currently, the United States welcomes almost 1 million immigrants annually, arriving from over 180 countries [1,2]. Many of these immigrants come to the U.S. in search of a better life for themselves and their families through opportunities for prosperity. Yet for a substantial number, the reason for coming to the U.S. is more about being forced to flee their homelands for fear of torture and possibly even death. It is this particular group of immigrants, namely torture survivors, who are the focus of this paper. While exact numbers are not known, it has been estimated that between 400,000 and 500,000 survivors of torture are living in the United States [3–6].

This paper evaluates and categorizes a series of cases from torture survivors who sought asylum in the United States over a 15-year period. To date, only two studies of a similar nature have looked at methods of torture as they are practiced within different countries [7,8]. Thus, there is still much to be learned from understanding the epidemiology of torture. Foremost amongst these benefits is the service to the survivors themselves. Since torture survivors rarely self-identify, physicians must be sensitized to the possibility of survivorship and, where prudent, assist with post-torture recovery care. Indeed, Eisenmann et al. [9] showed that no physicians ever inquired about torture survivorship despite its relatively high prevalence and accompanying mental health consequences in certain populations. Yet evidence has shown that many survivors will present to a primary care physician with both psychological and physical complaints stemming from their ordeal [10]. This fact highlights how important it is for physicians to be aware of torture survival and to be competent in addressing the needs of survivors. Where there is clearly an abundance of patient needs yet a paucity of physician recognition, there is an opportunity for improvement.

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Secondly, studies such as this may assist the professional teams that assemble around asylum seekers in their efforts to mount successful cases. Lawyers, mental health therapists, physicians, case managers, and social workers all work to establish the credibility of the survivor when they prepare for the asylum hearings. It is anticipated that deepening their understanding of how torture is commonly experienced in their clients' country of origin would lead to a greater ability to achieve successful outcomes. A recent ruling from the Seventh Circuit Court of Appeals gives credence to this point. In this ruling, the Appellate Court overturned the lower court's finding against an asylum seeker by citing evidence provided by the defense's country-condition experts, specifically citing evidence provided by the examining physician [11]. As this case exemplifies, physicians can often have a profound influence in the outcome of a torture survivor's asylum case. In cases where there is no ancillary evidence that might strengthen an applicant's case (such as warrants for arrest, newspaper accounts of past political activity or detention, medical records, photos, etc.), the applicant's personal credibility becomes the key issue upon which his or her court case hinges. A physician's interview, examination, and opinion of the merits of the applicant's claims provide the expert authority that the court desires when deciding a case [12].

2. Methods

A convenience sample of 58 affidavits prepared for the purposes of legal proceedings pertaining to the application for asylum was reviewed. All affidavits were written over a 15-year time period (1990–2005). The selected affidavits were all written in a similar manner, corresponding to national and international norms [13,14]. Common to all these affidavits was a set of details that thoroughly outlined the nature of the survivors' torture experiences: the location of confinement, the type of confinement, the duration of confinement, the various physical and mental torture methods used, the particulars of the language used or the behavior of the torturers themselves, and the presence of vicarious trauma through the abuse of family members or close friends. While the affidavits were written in a narrative manner, they were judged to be sufficiently structured so as to provide a framework by which data could be reliably and validly gained. After de-identification and review, all 58 affidavits were judged to have met selection criteria.

Both quantitative and qualitative data from the affidavits were abstracted and entered into a Microsoft Access database. This database included the following: (1) duration, condition, and frequency of imprisonment, (2) abductors' affiliation and dress, (3) torture type, method, and frequency (both physical and mental), and (4) qualitative description of above items. The above information was captured for up to three separate detention events for each individual survivor. The database was designed with 15 different domain fields associated with each separate detention event. Each domain field, in turn, had the capacity for multiple data inputs. The resulting data set had the potential to capture up to 142 discreet data points for each survivor. This database was validated by having two research assistants separately input data from the same 10 randomly chosen affidavits. The resulting data sets were then compared to each other. After establishing similarity between the two independently derived data sets, the data base was considered valid.

A retrospective analysis was completed on the 58 affidavits using the validated database. The de-identified affidavits were divided among a group of research assistants. The research assistants were all student volunteers recruited from the Medical College of Wisconsin whom received standardized training in bio-ethical conduct for human research studies and were oriented to the subject matter via a multi-staged process. In all, 16 research assistants completed pre-project training. Occasionally, during data extraction and entry, circumstances of the described torture experience were felt to be compelling enough for inclusion but sufficiently unique enough as to not be easily inputted into the quantitative collection tool. Text boxes within the data collection tool were designed to capture these outliers. Upon completion of the data input, the assistants also aided in the analysis and review of the data sets as well as in writing up the results.

This case series was approved by the Institutional Review Board of the Medical College of Wisconsin. SAS 8.2, from SAS Institute Inc., Cary, NC, was used to run the statistics including chi-squared analyses to detect statistical significance. Qualitative data was also analyzed using a paired associations approach.

3. Results

3.1. Geography

Twenty-three countries (autonomous regions such as Kosovo were counted as a separate country) were represented in our sample, which we categorized into six major world regions (North Africa, Sub-Saharan Africa, South Asia, Southern Europe, South America, and the Middle East). When assessing the frequency of survivors per country, Cameroon had the most, with 10 survivors, followed by Ethiopia and Uganda each with 6. The other 20 countries had 4 or less survivors each. Survivors from Sub-Saharan Africa accounted for 67% of the total survivors. The geographical distribution of the survivors including country, world region, and number of survivors is summarized in Table 1. Despite the lack of statistical power, there were a number of interesting trends uncovered.

3.2. Social and circumstantial information

The affidavits were from 41 male and 17 female survivors, indicating that men were represented substantially more than women in this sample by a factor of 2 (70.7% vs. 29.3%). The vast majority (83%) of the survivors were tortured as a result of their political involvement in their homelands. Other reasons given for persecution include: ethnic/racial (12%), religious (2%), and gender (2%) (Table 2). The majority of all abductions took place at the hands of uniformed agents of the country's security forces. Whether these were police, soldiers, or members of a governmental militia, over 85% of the survivors reported being detained by uniformed government representatives. Confinement duration varied widely ranging from less than 24 h to greater than 1 month. Some survivors were confined more than once. The type of confinement also varied widely. Following detainment, some survivors reported confinement conditions such as being forced to lie on cold or wet floors. However, this was neither reported universally, nor was any consistent trend seen by region or country (Box 1).

Table 1
Geographical data (country total = 23, survivor total = 58).

Region	Southern Europe (country, *N*)	Northern Africa (country, *N*)	Middle East (country, *N*)	South Asia (country, *N*)	South America (country, *N*)	Sub-Saharan Africa (country, *N*)
Country	Albania, 3 Bulgaria, 1 Kosovo, 2 Yugoslavia, 1	Eritrea, 2 Somalia, 2 Sudan, 2	Iraq, 1 Turkey, 2	Sri Lanka, 1	Ecuador, 1 Peru, 1	Angola, 2 Cameroon, 10 Congo, 2 DRC Congo, 2 Ethiopia, 6 Guinea, 2 Kenya, 1 Liberia,3 Sierra Leone, 1 Togo, 4 Uganda, 6
Total	7	6	3	1	2	39