By Kathleen McCullough-Zander, MA, RN, CTN, and Sharyn Larson, BS, RN, PHN

‘The Fear Is Still in Me’: Caring for Survivors of Torture

How to identify, assess, and treat those who have endured this extreme trauma.

Editor’s note: The three cases that begin this article are composite characters based on real survivors of torture. The fourth case, that of the Cambodian woman, is real, but details have been changed to protect her anonymity.

While visiting the home of a 34-year-old immigrant from Cameroon who recently delivered her second child, a public health nurse notices that the woman’s husband seems overly vigilant. During the visit, the couple’s three-year-old son makes a loud noise by hitting a plastic toy against a wooden table. The husband jumps up at the sound, then yells at his son for making noise. After her husband leaves the room, the woman explains that he doesn’t sleep well and that “he hasn’t been the same” since his imprisonment in Cameroon for organizing a public demonstration critical of the government’s human rights abuses. Weeping, she explains that her husband used to be a happy person who enjoyed life. She says she doesn’t know what was done to him during his imprisonment because he won’t discuss it with her, and now she doesn’t know how to help him.

A 26-year-old Iraqi man comes to the ED of a county hospital complaining of chest pain. The man speaks limited English. While waiting for the Arabic interpreter, the nurse checks his blood pressure and pulse, which are 150/98 mmHg and 110 beats per minute, respectively. Using gestures, she indicates that the man should remove his shirt and lie down; he seems nervous but complies. As she places cardiac monitor electrodes on his chest and begins connecting the monitor...
cables, she notices dime-size scars on his chest. The man sits up suddenly and pulls off the electrodes, shouting, “No! No!” He grabs his shirt and walks out of the ED.

A 24-year-old Ethiopian Oromo woman has an appointment at a neighborhood clinic. Upon reviewing the patient’s chart, the clinic nurse notices that the patient has visited the clinic four times in three months with abdominal and lower-back pain. Twice this woman was hospitalized for testing; all results were normal. When the nurse asks how she feels today, the patient places her hand over her lower abdomen and says, “Please, you must help me. I have terrible pain.”

Although you may not realize it, if your patient population includes refugees, you are probably caring for survivors of torture. The cases described above represent just three of an estimated 400,000 to 500,000 survivors of torture now living in the United States.1 Amnesty International’s most recent

1 Torture Victim in a Spider’s Web, Anonymous, watercolor on paper, 8.27” × 11.69”, early 1980s. The artist, who wishes to remain anonymous, is a survivor of torture.
Torture and Its Effect on Survivors

AN OVERVIEW

Torture defined. The Geneva Conventions that were written in 1949 and ratified by the United States in 1955 constitute the main source of international humanitarian laws today, according to Human Rights Watch. The conventions explicitly forbade “physical or mental coercion” and made the use of torture a war crime; they were a basis for the 1984 United Nations convention mentioned above. In 1975 the World Medical Association defined torture as “the deliberate, systematic, or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.” In its 1998 position statement on nurses and torture, the International Council of Nurses stated that “nurses have the duty to provide the highest possible level of care to victims of cruel, degrading, and inhumane treatment. The nurse shall not voluntarily participate in any deliberate infliction of physical or mental suffering.” (See Working Against Torture: The Importance of Education, page 60.)

Why people torture. While the media usually portray torture being used to extract information from someone, this is just one aspect; in fact, information so obtained is notoriously unreliable because most people subjected to torture will admit to anything. The primary goal of torturers is to gain power over others and to silence opposition. Individuals, communities, and even entire countries have been controlled through the use of torture. For example, from 1973 to 1990 Chile was governed by a military regime led by Augusto Pinochet, on whose orders thousands of people were put to death, tortured, or kidnapped (the “disappeared”) for supporting the previous regime and for protesting the Pinochet government’s human rights abuses. The fear engendered silenced countless people. Considered by experts to be at epidemic levels worldwide, torture has been used for as long as humans have sought power over one another. As Conroy noted, “Torture was routine in ancient Greece and Rome, and although methods have changed in the intervening centuries, the goals of the torturer—to punish, to force an individual to change his beliefs or loyalties, to intimidate a community—have not changed at all.”

The rise of the use of torture worldwide in recent years appears related to greater political instability, economic inequality, and war, which have displaced huge numbers of people, many of whom become refugees. In 1980 the U.S. Congress passed the Refugee Act, adopting the international definition of refugee, as put forth in the United Nations’ Convention and Protocol Relating to the Status of Refugees: a person who, because of “well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion,” has left his home country and is unable or unwilling to return. Today the federal Office of Refugee Resettlement recognizes that “many members of groups residing in the United States, including refugees, asylees, immigrants, other displaced persons, and U.S. citizens, may have experienced torture.”

TORTURE AND ITS EFFECT ON SURVIVORS

There has been some debate among mental health professionals as to whether a distinct “torture syndrome” exists. Regardless, it’s possible to identify survivors of torture.

The physical effects of torture depend on the methods used and may involve structural damage, disturbed function, or both. Because victims are often subjected to many forms of torture—severe beatings to the soles of the feet (falanga) or other parts of the body, prolonged immobilization, electric shock, and rape—estimating etiology for a particular injury is difficult. It’s rare for U.S. clinicians to see refugees with recently acquired physical injuries because travel takes time. Chronic sequelae such as untreated fractures, mutilation of genitalia, or paraplegia may be present. Over the long term, survivors of torture are at increased risk for “infectious disease, malignancies, cerebrovascular acci-
dents, and heart disease,” as compared with nontortured, culturally matched controls, according to Goldman and Goldston (as cited by Basoglu and colleagues in *The Mental Health Consequences of Torture*).12 The reasons for the differences in risk are unknown. Survivors may also have illnesses such as tuberculosis or parasitic infection acquired in prison, in a refugee camp, or by fleeing.

**Psychological effects.** At the CVT, survivors say that psychological torture is harder to endure than physical torture and that its effects are more difficult to live with. Forms of psychological torture include prolonged interrogation, sensory deprivation, mock execution, and being forced to watch loved ones being tortured.

*Posttraumatic stress disorder (PTSD) and depression* are the most common psychological disorders in people who’ve survived torture. Symptoms of PTSD commonly seen in this population include “reexperiencing phenomena” (such as flashbacks, intrusive thoughts, and nightmares), the avoidance of stimuli associated with being tortured (such as other people from one’s cultural group, people in uniforms, windowless rooms), and physiologic symptoms of increased arousal and reactivity of the sympathetic nervous system (such as hypertension, sleep disturbances, and a heightened startle response).12, 13 Survivors may find themselves caught in a cycle of trying to move on with their lives as vivid reminders of the past encroach. Though it may seem paradoxical, severely depressed survivors can have physiologic symptoms of increased arousal and reactivity; clinicians should look for symptoms of both depression and PTSD. Other possible symptoms include social isolation, impaired memory and concentration (which may or may not be a result of head injury), fatigue, sexual dysfunction (especially if sexual trauma has occurred), and personality changes.12 (See “PTSD in the World War II Combat Veteran,” November 2003.)

Although PTSD appears to be a common response to severe stress, the interpretation and expression of symptoms differs among cultural groups.14 For example, a 49-year-old Cambodian woman who survived the “killing fields” of the Khmer Rouge and emigrated to the United States several years ago reported that for more than 25 years she has experienced chronic headaches, abdominal pain, nightmares, and difficulty sleeping. Her U.S. providers attributed these symptoms to the extreme trauma she had endured, which included being starved, beaten, raped, and forced to witness the torture and execution of family members and friends. But the woman believed that her symptoms were caused by the spirit of her dead mother, who “shook” her feet at night because her daughter hadn’t buried her properly. Some survivors view their suffering as punishment for bad behavior in this or a previous life.

*Somatization* refers to the physical expression of psychological needs. Most cultures regard mental health in absolute terms—one is either sane or crazy—and thus physical symptoms are more socially acceptable than psychological ones. For example, one person might express emotional pain as a gastrointestinal disorder; another might say that his head is “too hot.” Survivors frequently complain of head, shoulder, back, or abdominal pain, yet in many cases no physical cause can be found on examination.11 With time, as the emotional issues are addressed, the physical pain diminishes or disappears.

**Variations in symptoms** can be tremendous among survivors. In our experience, risk factors for a greater severity of symptoms include longer duration and greater intensity of torture, a history of abuse during childhood (before the torture), an absence of social support after the torture, young age at the time of torture (children are particularly vulnerable), and any history of mental illness.
Another risk factor is having family members who were tortured or killed in retribution for the survivor's political activities. However, as Basoglu and Aker note, “some torture survivors never develop psychological problems . . . others recover from the trauma spontaneously.” Many survivors would agree with Dianna Ortiz, an American nun who was tortured in Guatemala, who writes, “Considerably more attention must be given to our resilience and less to what others may consider to be our weakness, our pathological behavior.”

Ortiz also notes that survivors often “try to cope with the aftermath of [their] trauma by searching for ways to numb the pain,” such as through alcohol or drug abuse, high-risk sexual behavior, excessive sleeping, and even self-injury or suicidal thoughts. It’s important for clinicians to realize that though injurious in the long run, these behaviors may have short-term survival value for torture survivors. Ortiz cautions, “Hearing the behaviors that have allowed us to survive described as deviant or pathological only reinforces our sense that we are misunderstood [and] alone.”

The rate of suicide among torture survivors is unknown.

According to Amnesty International (as cited by Basoglu in the Journal of the American Medical Association), torture occurs more often in the context of other severe stressors such as war and other forms of armed conflict. Symptoms are more pronounced in refugees than in those who remain in their homelands, because of the added stress associated with the loss of one’s family, community, and country and having to adapt to a new culture.

The families and communities surrounding survivors of torture are also profoundly affected. A study of 85 children whose parents had been tortured showed that 68% had emotional disorders, physical symptoms, or both. Specifically, 34 children had insomnia and nightmares, 34 suffered from anxiety, 12 had chronic stomachaches, 13 had frequent headaches, 15 wet their beds, 13 had anorexia, four had impaired memories, and 16 demonstrated unspecified “behavioral difficulties.” Conroy reports that “studies of Nazi Holocaust survivors have found that their children and even grandchildren have higher rates of clinical depression and suicide than the population at large.”

Some of the current social problems within the African-American and Native-American communities (for example, these groups have higher rates of domestic violence, alcoholism, and drug abuse than most other groups) may be the result of intergenerational transmission of the effects of torture. With intergenerational transmission, symptoms such as depression and low self-esteem are often seen not only in the survivors but also in their descendants for generations. Maria Yellow Horse Brave Heart, associate professor of social work at the University of Denver, in Colorado, has labeled this phenomenon “historical trauma.” According to Brave Heart, symptoms in a community affected by historical trauma include elevated rates of suicide, depression, self-destructive behavior, substance abuse, obsessive thoughts about past trauma, somatization, anxiety, guilt, and chronic grief. Many of the symptoms of historical trauma are the same as those seen in survivors of torture.

**TREATMENT**

The treatment of torture survivors is a relatively new field, and much is still unknown. Although some psychologists and psychiatrists had worked with Holocaust survivors, it wasn’t until the 1970s that torture treatment began to be viewed as an area deserving of focus. The world’s first torture treatment center, the Rehabilitation and Research Centre for Torture Victims, opened in 1982 in Copenhagen, Denmark. In 1985 the CVT became the first such center in the United States. Currently, there are 30 centers in the United States, with more planned or in development, and more than 200 worldwide.

There is no published nursing research on torture survivors; what little research exists has been done in the fields of medicine and psychology. There is little information on the treatment of torture survivors and thus little consensus on which interventions are best. Many survivors of torture are unaware that their current symptoms are the result of having been tortured.

In Europe and the United States, the primary treatment modality has been psychotherapy using cognitive–behavioral and insight-oriented approaches. Cognitive–behavioral therapy emphasizes the role of thinking in how patients feel and act. The underlying premise is that thoughts, not external situations, cause feelings and behaviors; thus, learning to think differently will result in desired change. Insight-oriented therapies ("talk")
therapies) focus on a patient’s current or past experiences, thoughts, and feelings. The underlying assumption is that gaining insight into one’s feelings and actions can bring about desired change.

Psychotropic medications, especially selective serotonin reuptake inhibitors that have been approved by the Food and Drug Administration for the treatment of PTSD, such as paroxetine (Paxil) and sertraline (Zoloft), are also used frequently in the treatment of torture survivors. Although no research on their use in treating torture survivors has yet been done, the efficacy of these drugs in treating anxiety and depression associated with PTSD is well established.

Many survivors now living in the United States have difficulty obtaining access to health care that is affordable and culturally appropriate. In our experience, cultural differences in beliefs about health, illness, and care create the most formidable barriers to their getting that care. Western-based psychological treatment isn’t acceptable to all survivors, and as Ortiz has noted, “Talk therapy is not the only form of treatment that has proved useful.” She points out that treatment by traditional or “folk” healers and interventions considered alternative or complementary in Western health care, such as herbal remedies, massage therapy, aromatherapy, and breathing and relaxation exercises, may also be valuable. For example, a British nurse and Reiki practitioner reported that Reiki treatments helped reduce the frequency and severity of nightmares, abdominal pain, headaches, and stress in two Bosnian torture survivors.23

NURSING CARE FOR TORTURE SURVIVORS

Torture assessment. If a nurse suspects that a patient may have been tortured, an assessment for this should be done. A good opening question is “Can you tell me a little about what happened in your country that made you come to the United States?” Based on the patient’s response and apparent comfort level, the nurse might follow with more specific questions, such as “I know that in your country many people have been beaten or arrested by soldiers or rebels. Have you ever been attacked like that?” We find that it’s best to avoid the word “torture” as the word encompasses different things in different cultures. For example, not all cultures consider rape to be a form of torture.

We have found that it can be very therapeutic for survivors to tell their stories. As nurses, we are often so busy with more concrete tasks that we sometimes forget the tremendous healing power of presence and empathy. Indeed, in the July 1 issue of the New England Journal of Medicine, Mollica noted that “despite routine exposure to the suffering of victims of human brutality, health care professionals tend to shy away from confronting this reality . . . . they believe they won’t have the tools or the time to help torture survivors once they’ve elicited their history.” Clinicians may also fear that asking the survivor to retell his story will retraumatize him. However, survivors frequently tell us that although telling their stories is difficult, having someone believe them and show concern for them outweighs the difficulty.

It’s important to let the survivor proceed at his own pace and to tell as much or as little of his story as he’s comfortable with. Many survivors have said that simply being listened to is beneficial; some have never told friends or family members what happened to them. Some survivors may be very reluctant to relate their experiences; others may tell a story without any apparent emotion. (The suppression of emotion is one sign of PTSD and can be a reaction to torture.) Assurances of confidentiality are essential, as survivors often feel great shame.

The Center for Victims of Torture

The first in this country.

The Center for Victims of Torture, founded in Minneapolis in 1985, was the first treatment center for torture survivors in the United States. An independent nonprofit organization, it offers free treatment services to survivors living in the Minneapolis–St. Paul area, as well as in Guinea and Sierra Leone, West Africa. In Minnesota survivors work with a team of care providers, including doctors, nurses, psychologists, social workers, massage therapists, and physical therapists. The Minneapolis and St. Paul treatment programs serve approximately 200 to 300 people a year. In addition, the center provides education in working effectively with survivors of torture and war trauma for health care providers, students, educators, and social workers, training about 5,000 professionals annually. Basic and advanced nursing curricula have been developed, and the center’s nurse trainer makes educational presentations in health care facilities, public health agencies, and nursing schools statewide. In West Africa similar programs offer refugees group therapy and education on the effects of war trauma. They provide education for African health care providers in how to care for survivors effectively; in some cases they also train refugees, who then serve as paraprofessional caregivers. In Guinea, for example, some Liberian refugees given training in the areas of communication, counseling, and conflict resolution have gone on to work with other refugees.
Working Against Torture: The Importance of Education

**INTERNATIONAL DECLARATIONS**

**The United Nations.** As of June 2004, 136 states (out of 194 possible) had ratified the United Nations’ Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (1984); the United States ratified it in October 1994. (For the complete text, see www.unhchr.ch/html/menu3/b/h_cat39.htm). These states stand committed to condemning torture and refraining from its use under any circumstances. (Ratifying the convention has not eliminated the use of torture by these states, as recent news of the torture of Iraqi prisoners by American and British troops at Abu Ghraib prison indicates.)

Although the convention is not directly aimed at nurses and doctors, much of it is relevant to health care professionals. Two articles are of particular importance. Article 2 emphasizes that torture is never permissible or acceptable; it states that “no exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency” can justify the use of torture; neither can “an order from a superior officer or other authority.” Article 10 makes “education and information regarding the prohibition against torture” mandatory components in the training of medical personnel, including nurses.

The International Council of Nurses (ICN) adopted its first position statement against torture in 1989. Revised in 1998, it’s now known as the ICN’s Position Statement on Torture, Death Penalty, and Participatory Politics. The statement reads, in part:

> The nurse’s primary responsibility is to those people who require nursing care. Nurses have the duty to provide the highest possible level of care to victims of cruel, degrading, and inhumane treatment. The nurse shall not voluntarily participate in any deliberate infliction of physical or mental suffering.

The ICN also advocates the inclusion at all levels of nursing curricula the recognition of human rights issues and violations, including the use of torture. Nurses will meet torture survivors among their patients. Survivors are often very reluctant to talk about or even mention what they have experienced, but the effects of torture will be evident if the nurse knows what to look for.

**TEACHING NURSES: THE DANISH PERSPECTIVE**

The Rehabilitation and Research Centre for Torture Victims in Copenhagen (RCT), the first center of its kind worldwide, was founded in 1982. In keeping with the importance placed on education by the aforementioned UN convention (Denmark ratified it in 1987) and the ICN position statement, one of the RCT’s long-standing goals has been to offer targeted training about torture and torture survivors to nurse teachers at Danish schools of nursing. Ultimately the goal is to make such training compulsory in nursing education programs.

In the autumn of 1992 the RCT planned its first seminar for nurse teachers. The goal was to provide them with basic knowledge of torture, including the various methods and effects of torture, as well as rehabilitation, treatment, and services that they could then pass on to their students. Instruction also focused on nurses’ responsibilities as outlined in the ICN position statement. The long-term objective was to teach students and nurses how to identify likely torture survivors and to plan care and treatment programs that would meet their specific needs.

The RCT has continued to offer the two-day seminars every other year since 1992. As of this writing, 136 nurse teachers have participated, and 35 are teaching these subjects to nursing students at several of Denmark’s 22 nursing schools. The nursing schools cover the RCT staff’s travel expenses and teaching fees; the RCT covers venue and food costs.

Nurse teachers who have taken the RCT seminar have expressed a need to share subsequent teaching experiences with colleagues at other nursing schools and to continue learning about torture and the treatment of torture survivors. They’ve also sought further discussion of practical matters, such as when during a nursing student’s overall course of study the subject of torture should be taught and what course materials should be used. To meet these goals, the RCT now offers a follow-up seminar every two years. For more about the RCT and its work, go to www.rct.dk/.userid=RTIG-4L5JTTU.

Nurse teachers are enthusiastic about passing on what they learn about caring for torture survivors, not only to nursing students, but to RNs and other health care students and professionals. They have become a new and vocal group in opposing the use of torture.—Lone Jacobsen, MA Health, RN (specialist in management, teaching, and systemic therapy), chief nurse and psychotherapist, Rehabilitation and Research Centre for Torture Victims, Copenhagen, Denmark, and member, ICN’s Data Bank of Experts in Ethics.
about the torture they experienced and may fear what others will think. This may be especially true if an interpreter must be present. Thus, under no circumstances should a family member or friend be used to interpret when asking a patient whether she has been tortured.

Nurses should be aware that survivors who tell their story will need continuing care once the trauma is revealed. Survivors’ trust in other human beings has been deliberately damaged. Nurses will need patience and commitment in forming therapeutic relationships with torture survivors. Supporting their autonomy and allowing them as much control as possible in a given situation will help. For example, questions such as “Where would you like to sit?” and statements such as “Tell me when you’d like to take a break” can be useful.24

Beyond the assessment. Assisting survivors with whatever they feel is most important at that moment may be the best way to support them. Often social service and economic issues are paramount, especially for recent immigrants. Survivors may need help obtaining basic necessities such as food, clothing, and housing before they can begin to deal with the effects of torture. Teaching them relevant survival skills—such as how to access and navigate the health care system or how to use mass transit, enroll a child in school, or use a bank—also helps them gain some control of their situation and rebuilds confidence.

Survivors generally need help in understanding the link between the torture and its physical and psychological effects. There is some controversy about whether a survivor of extreme trauma who has PTSD or depression can be considered to have a mental illness; it’s argued that these are normal responses to horrific experiences. Regardless, it seems clear that clinicians must be sensitive to what survivors have endured. Ortiz, speaking on behalf of survivors, writes, “We readily acknowledge that the trauma we have endured has altered our lives. . . . We want to be recognized as normal beings has been deliberately damaged. Nurses will need patience and commitment in forming therapeutic relationships with torture survivors. Supporting their autonomy and allowing them as much control as possible in a given situation will help. For example, questions such as “Where would you like to sit?” and statements such as “Tell me when you’d like to take a break” can be useful.24

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Common Methods of Torture

- Beatings with hands or objects (such as rifle butts or clubs)
- Electric shocks to sensitive body parts
- Hanging by the arms, legs, or shoulders
- Sexual humiliation and rape
- Burning with cigarettes, hot water, or acid
- Exposure to environmental extremes (such as very high or low temperature)
- Being forced to stand for extended periods of time
- Being forced to stare at the sun
- Having one’s head submerged in water or excrement
- Mock execution (for example, having an empty gun fired at one’s head)
- Threats of violence to loved ones
- Being forced to watch or participate in the torture or death of others, including loved ones
- Forced nakedness
- Not being allowed the use of a toilet
- Solitary confinement or overcrowding
- Exposure to continuous noise
- Sleep deprivation
- Being forced to remain with dead bodies
- Repeated interrogations conducted at random and unpredictable times

Giving Light
A book of short stories offers hope of redemption.

In her 2004 book The Dew Breaker, a collection of related stories, Edwidge Danticat looks at the life of a “choukèt laroze,” a man who tortured others during Haiti’s Duvalier dictatorships. The term “dew breaker” is Danticat’s own translation of the Creole phrase and could easily have been the dew shaker or the dew stomper, a reference to the way the torturers would often abduct their victims at first light, disrupting the morning dew. The book presents the dew breaker through the eyes of those around him—wife, daughter, and former victims.

Set primarily in the United States, the stories offer insight into how those who have suffered torture survive and the form that survival takes. The characters in Danticat’s book manage their pasts with greater and lesser degrees of success: for some, the threat of encountering a former torturer is very real; he is the barber in the shop on your street. For others, he exists only in the imagination, the result of “chasing fragments of themselves long lost to others.” There is a palpable sense that the torture has not ended—in one story, the dew breaker’s wife (who had also suffered loss at his hands), having just arrived in America, listens to the radio and hears callers talking “about a Haitian American man named Patrick Dorsimond who had been killed. He had been shot by a police officer in a place called Manhattan.” One has the sense that the place names have changed, but the dangers remain.

In a book that swings between “regret and forgiveness,” Danticat gives hope. In an e-mail interview, she stated that she believes “silence is a very big part of suffering and sometimes an obstacle to healing.” In the story “Night Talkers” Danticat writes of “palannit,” night talkers, “those who spoke their nightmares out loud to themselves.” With the character of Claude, a Haiti-born son of immigrants who was raised in America but sent “home” after committing patricide, Danticat offers the hope of some redemption—for the afflicted and the afflictors alike.

Claude, a palannit, is both a victim and a perpetrator and is “even luckier than he realized, for he was able to speak his nightmares to himself as well as others, in the nighttime as well as in the hours past dawn, when the moon had completely vanished from the sky.” Danticat believes telling one’s story helps in healing. She noted, “Sometimes just to have people acknowledge what happened to you can be a great help.” Perhaps The Dew Breaker serves as some acknowledgment for the torture survivors of Haiti, with stories that speak truths, told in the light of day.—Lisa Melhado, associate editor
longer believe that . . . God, I believe, has united our voices . . . [in] calling for an end to torture.”

Nurses must have in-depth knowledge of trans-cultural issues with regard to responses to torture. It’s also important for nurses to have some understanding of what life is like for most people in economically poor countries, what refugees have gone through in their home countries, and what adjusting to life in the United States entails. (One excellent resource is The Middle of Everywhere: The World’s Refugees Come to Our Town, by Mary Pipher, a family therapist in Lincoln, Nebraska, who writes perceptively about the lives of refugees, including torture survivors, from Bosnia, Vietnam, and Sierra Leone, among others.)

In keeping with the United Nations Convention Against Torture, U.S. nursing schools must begin to incorporate education on caring for torture survivors into their curricula. In 2001 the American Academy of Nursing issued Policy Recommendations for Nurses Caring for Victims of Torture, which include the following (quoted verbatim)29:

- Fund and administer educational training and support for nurses who will develop nursing care plans to assist victims of torture to find hope and healing.
- Include torture and treatment of its sequelae in nursing’s research agenda.
- Develop linkages with current centers of treatment to add nursing expertise.
- Support a conference or institute on the topic of torture and survivors of torture.
- Consider a . . . conference to develop a white paper on torture.
- Augment nursing educational training to add expertise in treatment of victims of torture in psychiatric mental health nursing programs.
- Extend the Academy’s support of [these] recommendations to the ANA, ICN, and Sigma Theta Tau to ensure that the profession of nursing contributes to healing victims of torture.

As of this writing, these recommendations had not been acted on.

The impact on nurses. The prospect of working with survivors of torture can raise several concerns. First, nurses may fear that they’ll inadvertently do something that exacerbates a survivor’s suffering. It’s true that survivors are vulnerable; their vulnerability stems from a susceptibility to having trauma symptoms triggered by everyday events and, like other refugees, to a general lack of knowledge about U.S. culture. But most torture survivors are also strong and resilient people.

It’s also true that many nurses don’t have specialized knowledge or skills for helping people who have been tortured. Years ago nurses were in a similar situation with regard to suspected cases of domestic violence. Nurses often didn’t ask whether domestic violence was occurring, either because they didn’t know how to respond if it was or because they assumed the matter was someone else’s responsibility; far too often, therefore, domestic violence was ignored. Nurses need to learn to work with survivors of torture and extreme trauma. Information on caring for survivors must be included in nursing schools and through continuing education courses.

For caregivers, hearing about the deliberate infliction of severe pain and suffering may be especially troubling. Nurses may worry that they too will begin to feel hopelessness and despair. Secondary trauma is prevalent throughout nursing, yet nurses aren’t taught much about how to prevent or address it. Caring for oneself is more than simply finding time to relax; it requires having a deliberate plan for balancing all aspects of one’s life. Each nurse must determine what this means for her. (For more on this subject, see “Understanding Secondary Traumatic Stress,” July 2001.) ▼

REFERENCES

General Purpose: To provide registered professional nurses with information on the care of torture survivors.

Learning Objectives: After reading this article and taking the test on the next page, you will be able to:

- outline background information on the prevalence and effects of torture.
- discuss the care of patients who have survived torture.

To earn continuing education (CE) credit, follow these instructions:

1. After reading this article, darken the appropriate boxes (numbers 1–15) on the answer card between pages 64 and 65 (or a photocopy). Each question has only one correct answer.
2. Complete the registration information (Box A) and help us evaluate this offering (Box C).*
3. Send the card with your registration fee to: Continuing Education Department, Lippincott Williams & Wilkins, 333 Seventh Avenue, 19th Floor, New York, NY 10001.
4. Your registration fee for this offering is $13.95. If you take two or more tests in any nursing journal published by Lippincott Williams & Wilkins and send in your answers to all tests together, you may deduct $0.75 from the price of each test. Within six weeks after Lippincott Williams & Wilkins receives your answer card, you’ll be notified of your test results. A passing score for this test is 11 correct answers (73%). If you pass, Lippincott Williams & Wilkins will send you a CE certificate indicating the number of contact hours you’ve earned. If you fail, Lippincott Williams & Wilkins gives you the option of taking the test again at no additional cost. All answer cards for this test on “The Fear Is Still in Me*: Caring for Survivors of Torture must be received by October 31, 2006.

This continuing education activity for 2 contact hours is provided by Lippincott Williams & Wilkins, which is accredited as a provider of continuing nursing education (CNE) by the American Nurses Credentialing Center’s Commission on Accreditation and by the American Association of Critical-Care Nurses (AACN 00012278, category A). This activity is also provider approved by the California Board of Registered Nursing, provider number CEP117459 for 2 contact hours. Lippincott Williams & Wilkins is also an approved provider of CNE in Alabama, Florida, and Iowa, and holds the following provider numbers: AL #ABNP0114, FL #FBN2454, IA #75. All of its home study activities are classified for Texas nursing continuing education requirements as Type 1.

*In accordance with Iowa Board of Nursing administrative rules governing grievances, a copy of your evaluation of this CNE offering may be submitted to the Iowa Board of Nursing.