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Psychotherapy for Victims of Torture

F. E. SOMNIER and I. K. GENEFKE

Three groups of torture victims were studied with the aim of establishing a concept of psychotherapy for such victims. Analysis of the first group, consisting of 200 case-reports made by Amnesty International medical groups, resulted in a general outline of the psychological methods of torture and their main impact on the victims. A second group of 24 torture victims was examined by the authors, and a quantitative assessment of long-term neuropsychological complaints and a qualitative insight into these symptoms achieved. In-depth interviews with victims in the third group which, consisted of the victims from the second group and six others, together with the results from the other two groups, formed the basis of a concept of psychotherapy for torture victims.

Exposure to extreme situations may cause physical and psychological sequelae. This has been abundantly documented for former concentration camp prisoners (Kral *et al*, 1967; Strom, 1968; Nefzger, 1970; Thygesen *et al*, 1970; Beebe, 1975) and naval personnel (Askewold, 1980) after the Second World War. Similar findings have been reported with hostages (Eitinger & Weisaeth, 1980).

Amnesty International medical groups have described many such complaints in torture victims from a number of countries (Amnesty International, 1977, 1978, 1980, 1981; Randall *et al*, 1986). The initial aim was to provide proof, from the point of view of forensic medicine, of the existence of torture. The same reports also provide evidence that the sequelae of the clandestine torture of today are of the same magnitude as those reported for concentration camp victims. Furthermore, it can be inferred that there is little or no tendency to spontaneous recovery. This topic is therefore a concern of the medical and psychological professions.

Different views upon the aetiology of the sequelae of concentration camp survivors are reflected in the different terminology of the various syndromes (Strom, 1968; Thygesen *et al*, 1970; Trautman, 1964; Lederer, 1965; Krystal, 1968; Niederland, 1968; Hoppe, 1971). The discrepancy between the American psychodynamic views and the European more organic oriented explanations may be due to the fact that highly selected but very different groups were investigated (Eitinger 1986).

As pointed out by Lederer (1965), classical German psychiatry stated that life experiences, no matter how severe provided they do not inflict organic brain damage, can never cause lasting symptoms or alteration of personality. A similar point of view was alleged by Wolff (1960) in his paper on the conduct of prisoners-of-war. The interpretation by laymen may be the same. Also, victims of torture may consider themselves responsible when mental disability results from the cruelty. According to this hypothesis, psychological sequelae arise from a constitutional susceptibility, and psychological complaints can be seen as wishful reactions with the aim of maximal gain. The admission of psychological sequelae may thus imply a stigma, and the symptoms may be denied for years without motivation for treatment. Klein (1974) described the same therapeutic paradox in his work with survivors of the concentration camps.

On the other hand, Trautman (1964) stated that human beings placed under extreme and prolonged existential stress, fear and anxiety undergo an extensive adaptive change of mental and biological functioning. This point of view is supported by Bettelheim (1943). Adaptive change in psychiatric patients submitted to an authoritarian institution is described by Goffman (1961). Trautman's conclusion was that psychological sequelae should be seen as meaningful conditioned reactions for a sound and forceful constitution that make survival possible in a very pathological situation.

In this study the various psychological methods of torture and the long-term neuropsychological symptoms are evaluated to assess the adaptation of torture victims and to establish a concept of psychotherapy for them.

Method

This study is based on an analysis of three different groups of torture victims. The term 'torture' is used in accordance

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with the definition of the World Medical Assembly (The Declaration of Tokyo, 1975): 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.

Group 1. Two hundred case reports from Amnesty International medical groups, based on semi-structured interviews and medical examination of torture victims, formed the background for a systematic outline of the psychological methods of torture. All reported methods of torture were analysed with the aim of obtaining a more general knowledge of the actual procedures and their main impact on the victims. Ninety-five percent of the victims were males, and most of them were exiles at the time of study. The group consisted of victims from Latin-America, Europe, Africa and Asia.

Group 2. Since 1981 a large number of torture victims have been examined thoroughly at the Department of Neurology, Rigshospitalet, Copenhagen. Among them were 24 victims from different Latin-American countries. Long-term neuropsychological complaints from this group were analysed with regard to time since first exposure to torture. Ten of the victims had previously been examined by the Amnesty International Danish Medical Group using the same semi-structured interview as in the present study; the complaints of these victims were used as the basis for a follow-up comparison. All victims were males and exiles. All were in perfect health before exposure to torture.

Group 3. This group consisted of the 24 victims from group 2 plus four European and two African victims. Twenty-nine of the victims were males, and most of them were exciles at the time of study. The method of psychotherapy has been worked out from observations and systematic notes made by the authors during 425 in-depth interviews with these 30 torture victims since 1981.

All of the victims in this study were selected, and no control group was included. The victims examined by Amnesty International medical groups volunteered for medical investigations within the scope of forensic medicine, epidemiology, and clinical nosography. The victims examined by the authors volunteered for an in-depth investigation of physical and psychological sequelae to torture with the aim of establishing rehabilitation programmes.

Results

Psychological methods of torture

Although an over-simplification, the procedures can be divided into two types: the weakening techniques and the personality-destroying techniques. Common to the methods of the former is teaching the victims to be helpless and creating exhaustion. The latter methods are characterised by the induction of guilt, fear and loss of self-esteem.

Deprivation

Deprivation is defined according to Schultz (1965). A variety of procedures have been used to reduce environmental stimulation, and as a rule the victim is submitted to different forms of deprivation at the same time. During deprivation the victim suffers from cognitive disturbances, disorientation in time and space, difficulty in concentration, poor memory, and in some cases psychotic reactions with hallucinations. Long-term sequelae may be weakening of identity and emotional instability.

Constraint techniques

These are defined as psychological techniques which force experiences and stimuli upon victims which are totally foreign and harmful to their personality and conduct. Victims are submitted to a detailed set of regulations and rules, resulting in close supervision where everything (including completely insignificant details) is controlled. Violation of the rules (either real or supposed) is used as an excuse to punish the 'offending' victim. The victims are exposed to all kinds of humiliations, which force them to see their dignity and identity completely destroyed.

Induction of incongruent actions, i.e. methods which bring the victims into situations of impossible choices and consequently to act or react against their ideology and ethics, seems central to all psychological torture. Included are methods with the classical aim of yielding information, but it should be emphasised that in many cases this is a sham-purpose, with the real goal being to destroy the personality of the victim. The technique may be slow and progressive, starting by letting the victim admit insignificant or diffuse items; gradually, more specific information is disclosed. When the victim eventually breaks down he enters a vicious circle of guilt followed by repentance, which cannot be expiated. Other methods are mock-executions and threats of torturing family or friends if the victim does not fulfil various demands. African victims have reported violation of taboos as a method of torture.

The effects of the constraint techniques are multiple and long-lasting. The methods represent deep attacks on the identity and dignity of the victim, and they are closely linked with guilt, fear, loss of self-esteem, and repentance. During torture and imprisonment the aggressions of the victim are by neccessity turned inwards, and there is no possibility of adequately expressing emotions. As time goes by the events may to an extent be repressed, leaving a feeling of discontinuity in the victim's personality. Some of the experiences are remembered as profound humiliations. Other experiences become an unconscious source of suffering due to a feeling of guilt.

Communication techniques

There are a variety of verbal and non-verbal communication techniques, with varying aims. Counter-effect techinque, for example, is defined as torture which seems meaningless to the victims and which continues whether or not the victim co-operates. Any response from the victim becomes the pretext for renewed or continuous torture. The victim's aggressiveness and ability to fight back gradually decrease, and thus the victim learns to be totally helpless.

Double-bind techniques are frequently abused as torture. The term 'double-bind' originates from Bateson's hypoth-

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esis about schizophrenia. Victims are exposed to many ambiguous situations and contradictory messages, which induce confusion. Seemingly nice suggestions by the torturers soon turn out to be false, and promises to victims are broken in the next moment. A well-known technique involves the use of a friendly and a unfriendly interrogator. After violent torture carried out by torturers of low rank, the victim is interrogated by an officer of high rank in an ambience of tranquillity and polite conversation. Simultaneously, the officer intimates that he would hate very much to have to hand over the victim for further violence. In a situation of deep distress it is difficult for the victim to resist and not to grasp a 'helping' hand.

Conditioning technique was first described by Pavlov in his experiments with dogs, and the principle is to induce desired reactions or behaviour by certain conditions. As torture, the conditioning techniques are abused to adapt the victims to various demands.

Abuse of pharmacology and psychiatric institutions

There are many examples of these kinds of abuses as methods of torture. Such methods imply the abuse of the medical and psychological professions. The goals are various: profound mental destruction, punishment, creation of anxiety and psychological disturbances, causation of pain, immobilising victims, and yielding information. The psychopharmacological drugs abused either blunt the senses (neuroleptics or sedatives) or are psychotropics, including hallucinogens. Neuromuscular blocking agents (curare compounds) are abused to paralyse fully-awake subjects, which induces total panic due to the impossibility of breathing, and the victims are not offered oxygen until the point of suffocation. If victims are defined as 'mentally ill' they can be admitted to psychiatric institutions and submitted to various 'treatments' against their will, including psychopharmacological drugs.

Physical methods

Physical methods of torture are administered by physical means, but their main impact is of a psychological nature. Because of the acute and chronic pain evoked by such torture, one of the sequelae may be a distortion of the body image.

Long-term neuropsychological symptoms

The investigation of the 24 torture victims in group 2 was carried out a median of 9.5 years (range:7.5–11.5) after the first exposure to torture. The median age of the victims was 38 years (range: 28–42). The previous examination of 10 of the victims had been performed a median of 3.9 years earlier (range: 2.5–5.5).

Table I shows the frequency of neuropsychological complaints, arranged in decreasing order. There are no obvious differences in symptoms at the two examinations; nor are there if the 10 victims previously examined are compared only with themselves (not shown in the table). The investigation thus provides evidence of a poor tendency to spontaneous recovery. The number of victims is inadequate for any statistical evaluation; the quantitative aspects of the symptoms will not be further described.

TABLE I
Neuro-psychological complaints

Complaints[1]	*Present study (n = 24)*		*Previous examination (n = 10)*	
	%	*n*	%	*n*
Sleep disturbances	83	20	60	6
Headache	79	19	80	8
Impaired memory	79	19	60	6
Impaired concentration	75	18	60	6
Fatigue	75	18	60	6
Nightmares	71	17	60	6
Fear/anxiety	50	12	40	4
Impaired hearing	38	9	40	4
Social withdrawal	38	9	50	5
Vertigo	33	8	20	2
Sexual disturbances	21	5	20	2
Tremor/shaking	13	3	20	3

1. Five (21%) of the victims investigated in our study suffered from guilt. This complaint was not systemically asked for.

The complaints have rather particular qualitative characteristics. Perhaps surprisingly, spontaneous hate, hostility, and aggression have not been a common feature. The victim's feelings about the torturers are reflected by the typical statement that the torturers should be prosecuted in acccordance with democratic laws. During interviews examiners can sense the victim's inward-turning aggression. In spite of all the suffering and sacrifice, victims often claim that the struggle for social justice will never cease. Much emphasis is laid upon the victim's further education and work and the welfare of the family. We have not in any single case observed that victims identify themselves with the aggressor (the 'Stockholm syndrome', Eitinger & Weisaeth, 1980).

Unlike neurosis, the anxiety of the victims is associated with conscious memories, tentatively but never really fully repressed. The anxiety is evoked by sensory, auditory or visual signals or experiences symbolising torture and persecution. The victims react immediately to the 'signal' and are overwhelmed by panic before they have had time to think. To the observer it is clear that these victims are living on an unconscious alert, as if the previous danger was still present. This panic reaction can be evoked by such things as an automobile door slamming, the sound of a siren, or the sight of a soldier or policeman in uniform. Evoking experiences may be such things as a visit to a small room or lift (the cell is recalled), admittance to hospital and confronation with equipment or investigations resembling the torture situations (blood samples, ECG, X-ray, etc.), or taking an examination (the interrogation centre is recalled). The same may be the case when a therapist, social worker, employer or any 'authority' addresses the victim in a somewhat unfriendly manner (the person is immediately identified with the torturer).

Sleep disturbances are frequent. One of the main reasons

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is a repetitive reliving of the same torture experiences during nightmares in which the subject is trying to escape but is helpless, without means of protecting himself and also without counter-aggression. In the conscious memories of the torture, the victim is aware that the aggression had by necessity to be repressed; in the nightmare, however, there is no attempt at defence, and this may be one of the reasons why these nightly experiences are so evocative of extreme anxiety.

Many victims allege imparied memory and difficulty in concentration. During in-depth interviews we have made no observations consistent with dementia, nor observed progression in the alleged cognitive malfunction. In some cases the behaviour may be marked by decreased vigilance and resistance to taking an interest in outside activities. In spite of the victim's 'poor' memory the experiences of torture are remembered to the smallest detail.

Depression is another common feature. Some victims are less anxious when more depressed and vice versa. Loss of self-esteem and a feeling of guilt are often linked, and during the in-depth interviews these complaints can be traced back to certain experiences during torture. Fatigue, emotional instability, and social withdrawal may be considered as consequences of the other symptoms. Sexual disturbances have not yet been studied in detail.

Psychosomatic complaints are frequent. Chronic diffuse headache, muscular tensions, fear of having heart disease, and dyspeptic symptoms are daily experiences for most victims.

Concept of psychotherapy

The course of psychotherapy for torture victims is divided into 3 phases. The first phase is mainly cognitive, with the aim of bringing about a detailed insight into what really happened and thereby generalising the personal suffering. The second phase is more emotive, with emphasis on a reconstruction of the most harmful experiences gradually bringing the victim in contact with repressed feelings. During the reliving of the feelings the victim has an opportunity to realise that his conduct was not unique, but predictable. In this context the victim must also work with feelings which were naturally present, but which could not be expressed at that time, especially the aggression. The third and final phase serves to re-establish reality by offering the victim a way out of the seemingly endless traumatic state induced by the torture. The principle is to interrupt different vicious circles and to transform much of the energy from the previous fixed role of a victim into creativity, enabling a more dynamic course of life.

To illustrate the method we present a case history. Certain details have been changed to avoid recognition.

Case History

The victim is a 27 year-old Latin-American male. He grew up in a safe and economically solid home together with four siblings. After school he soon qualified as a skilled worker. The victim was considered as a strong person by those who knew him, and he has always reacted against social injustice. There was no previous history of neuropsychological problems, and he was in perfect health before exposure to torture. His first imprisonment, at the age of 18, lasted 7 months. The second imprisonment took place 2 years later, and lasted 18 months. On no occasion was he under any charge or put on trial. The victim was exiled after release from the second imprisonment.

During the first imprisonment he was submitted to solitary confinement, placed in a small dark cell without a toilet and almost without food and drink. The warders were extremely brutal, and he was repeatedly beaten up, suspended, whipped and threatened. When he started bleeding, salt was poured on the wounds. His head was battered against the wall until he lost consciousness. This was repeated twice per day during the first 3 weeks. He was sexually abused twice.

During the second imprisonment he was placed in a small room in a cellar, without light or toilet, and with only a dirty blanket for cover. For one month he was exposed daily to electric torture. Current was applied to all parts of his body, but particularly to his testicles, teeth, tongue, and ear-lobes. Several times his head was held in a bucket with water containing vomit and urine until the point of suffocation. Three times he was exposed to mock-executions. Several times he was forced to see other prisoners being tortured, particularly by different kinds of sexual torture.

Five years after release the victim was still suffering from the same symptoms as immediately after torture. He was distrustful and despairing, showing severe depressive features with suicidal thoughts. Panic was evoked by abrupt sounds or when he was confronted with authorities. Chronic headache, impaired hearing in the left ear, poor memory and social withdrawal were other important features. Apathy and fatigue were the consequences of difficulty in falling asleep and interrupted sleep with frequent nightmares.

The victim was offered psychotherapy in combination with a simultaneous physical pain-relieving therapy. The cognitive phase took place during ten in-depth interviews, three per week. When mutual trust was established the therapy proceeded by cognitatively reconstructing the harmful experiences. If the victim resisted a thorough description of the experiences in prison, they were approached instead by way of his nightmares. The cognitive context was stressed, consisting of information about the most important goal of the torture: to destroy the personality of the victim. During the conversations, otherwise inexplicable humiliations were viewed within a meaningful relationship, rendering it possible to generalise the personal suffering. The victim felt relief after every interview. There were emotional fluctuations at the end of the first phase. The victim was joyful for some days, making subsequent dives into depression even more painful.

The emotive phase consisted of ten in-depth interviews during a 3-week period. The victim was still suffering from violent nightmares, which provoked intense fear and made the victim depressed for a long time. The most frequent nightmare concerned a mock-execution to which he had been submitted during the second imprisonment. The torturer had placed a bottle on his head, whereupon the

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bottle was shot to pieces. The victim awoke abruptly at the moment of dreaming of the shot, totally in panic and helpless. During the victim's detailed description of this nightmare he realised that the most panic-evoking part was his own lack of aggression. Three interviews later he related that the previous night he had experienced the same nightmare. This time, however, he had fixed the eyes of the torturer, who immediately looked at him with respect and was not laughing as usual. At that moment he felt a great strength. During the interview he remembered that for several days after the mock-execution he could hardly believe he was alive. He thus found himself in a situation where the following electric torture was a confirmation of life. Later he felt that he could no longer stand to be tortured constantly, and he begged the torturers to kill him. For some time great care was taken that the victim did not lose consciousness during torture. Thus he found himself in a situation where being forced to live was in itself torture. In subsequent in-depth interviews the method of impossible choices was thoroughly explained to him. It was a great relief for the victim to realise that no matter what he had done, he would have felt that he had made the wrong choice.

When the victim proceeded to the third phase, the re-establishment of reality, there were changing moods from almost euphoria one week to depression the next. On some occasions there were relapses of nightmares, which were evoked by bad news from his country. The interviews took place with intervals of 1–2 weeks. Gradually the victim developed insight into the various vicious circles, and was soon able to circumvent the mechanisms. The victim started helping friends and other victims. He was then, for the first time since release, able to deal constructively with the school problems of his children. Before the therapy his wife had justly accused him of being evasive when confronted with these problems. The victim started supplementary education. One result was that it was no longer necessary for his wife to shoulder a heavy burden, and she could then tell us that she was a torture victim herself with an urgent need for psychotherapy.

After 28 in-depth interviews over 4 months the therapy was stopped, with an agreement that the victim could apply again if he wanted further treatment. During a follow-up period of two years there has been no subjective need for resumption of psychotherapy. At the end of that period an in-depth interview confirmed that further treatment was unnecessary.

Other cases

The psychotherapy was performed according to the same principles in the other 29 cases. A median number of 22 in-depth interviews were needed (range: 10–52). The whole procedure was carried out during a median period of 12 weeks (range: 4–19). In our hands the method has been successful, with only a few relapses during a median follow-up period of 11 months (range: 6–36 months). When supplementary psychotherapy was needed, 2–3 sessions were generally sufficient. It must be emphasised that during the period of psychotherapy a pain-relieving physical therapy was simultaneously carried out.

Discussion

The psychological methods of torture listed above provide evidence that normal psychological mechanisms are distorted by torture and that torture is performed in a systematic and scientific way. Destruction of the personality of the individual victim is probably one of the most important goals of torture.

An important biological character of the brain is the great capacity for adaptation. One would expect the victims to adapt to the atrocious circumstances with the aim of preserving as much as possible of their personality, including norms, ideology and emotional reactions. There are two other 'possibilities': biological or psychological death—suicide or psychosis. Bettelheim (1943) observed the adaptation procedure of concentration camp prisoners, and Goffman (1961) described adaptation to an authoritarian institution. Between them they describe four coping strategies: intransigence, re-establishment, introversion, and conversion. Eitinger (1974) found during interviews with more than 2000 concentration camp survivors that one of the most important coping mechanisms was the conservation of the ability to make at least a few of one's own decisions. Those who were able to retain their system of values and personality more or less intact were the most fortunate, i.e. people who could practice and show interest in others (doctors, nurses, priests, social workers, etc.). Identification with the aggressor was used by some, but this mechanism led to deep pathological changes in the personality. A few had maintained an attitude of a detached observer, but this mechanism was unsuccessful due to the loss of contact with others and with reality. Eitinger's conclusion was that survivors who mobilised an active and more or less conscious coping mechanism had fewer psychiatric complications than survivors who were completely isolated, remained passive, or ascribed survival to mere luck.

Short-term neuropsychological complaints provide evidence that torture victims adapt to the inhuman conditions (Amnesty International, 1977, 1978, 1980, 1981). The 200 case reports from Amnesty International medical groups in the present study provide no evidence for the use of a strategy of conversion, and an intransigent attitude was rarely maintained for a significant time. This has been confirmed during the 425 in-depth interviews with the third group of torture victims studied, so presumably those mechanisms are rarely used by torture victims. On the other hand, the same two studies provide evidence for a frequent use of a strategy of introversion and re-establishment.

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The various physical sequelae reveal the applied physical torture (Genefke & Aalund, 1982). Perhaps more surprisingly, the long-term neuropsychological symptoms (Table I), and particularly the qualitative aspects, are evidence of a long-term adaptation to a victim's role, where previous danger is still experienced or easily evoked. There is thus an element of a faulty accordance with reality. Furthermore, the tendency to spontaneous recovery from the neuropsychological complaints seems poor.

Out of this concept of the psychological sequelae as a result of specific and systematic psychological methods of torture, adaptation to atrocious circumstances, vicious circles of anxiety, guilt, repentance, atonement, and loss of self-esteem, we propose a psychotherapeutical approach to bring the subject out of this victim's role, thus enabling him to restore reality and re-establish a valuable course of life. Forgetting is not the answer; nor is atonement through obsessive remembering.

Psychotherapy for victims of torture requires a thorough reconstruction of the harmful experiences during in-depth interviews, where the methods of torture and the conduct of the victim are evaluated as cause-and-effect situations, not as phenomena. In contrast to classical psychotherapy, the therapy of victims can start as soon as a mutual trust is established, and a preceding period of analysis is unnecessary. In the cognitive phase the victim realises how the torture distorted normal psychological mechanisms, and that the torture was systematic with very particular goals (often different from what the victim thought were the goals). When he realises that these goals were obtained, not because of an inborn weakness, but as a predictable result, the heavy burden of responsibility is justifiably transferred to the torturers.

The cognitive phase is followed by a phase where the most harmful experiences are reconstructed in a more emotional context, enabling the victim to see that there were no options. It is of the utmost importance that the therapist is never identified with the aggressors. The ambience must be characterised by mutual and complete trust. The therapy takes place in an atmosphere of humanity, but with directness and professionalism without unnecessary sentimentality. All procedures which may cause uncontrollable pain and memories are systematically avoided. Precise information about all aspects of the examination and therapy must be given, and the subject must fully understand and accept the procedures. Finally, the therapy must be carried out at a tempo adjusted to the immediate emotional reactions of the subject, and enough space must be allowed between the sessions that the subjects cognitive acceptance and emotional reactions correlate.

Implicitly, the victim realises during the first two phases of the therapy that there is no reason for a general mistrust, and when both a new cognitive and emotional context are achieved the re-establishment of reality is not troublesome.

If a victim has strong repressive mechanisms he is asked to tell his story in chronological order. The victim must describe precisely what he experienced during isolation and the time spent waiting for torture. If these topics (e.g. size of the cell, noises, light, food, toilet facilities, hallucinations) are not probed into, the victim will usually not tell much about them. The victim's reactive pattern often shows itself most clearly when these experiences are described, and this is thus a good starting point for a dialogue about a variety of the victim's psychological mechanisms. The principle of forcing a victim into a conduct totally opposed to his personality and thereby creating guilt and repentence is thoroughly expounded.

During discussions of the situations in which the victim was forced to make a choice, and feels that he made the wrong choice, it can often be proved that no matter what decision was taken the result would have been the same. As a rule the victim has not considered this, and it is a relief to understand how the method of impossible choices has been exploited. Furthermore, it is emphasised that a victim cannot have responsibility for what he did in a situation of utmost physical and psychological pain. The methods are elaborated with the purpose of creating a guilty conscience, and the responsibility lies completely with the repressive system. This principle should be recognised by international law.

By penetrating the most painful experiences the victim has an opportunity to work with them within a new context. During this kind of conversation the victim often realises that he has turned all aggression against himself, even though it should be directed at the torturers. Humiliations must be discussed point for point. Hereby the victim conceives that it is actually the torturers who are degraded by their inhuman conduct. The memories no longer cause the victim the same fear as before, when he eventually comes to understand what was done to him and that he was broken down in a predictable way by torture distorting normal psychological mechanisms.

There are many sources of guilt besides those already mentioned. Some victims consider that they did not help fellows enough during imprisonment, for example, the difficult situation of the family, the many years without education, the present social situation and the very fact of being alive are other examples. It is emphasised that it is the opposite of

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egoism and very valuable to mankind that people are willing work for a better society even under very difficult conditions.

The results of the psychotherapy obtained so far have been encouraging. The present study provides evidence that the long-term neuropsychological symptoms may be reversible provided psychotherapy is applied rather than supportive treatment or teaching the victims to cope better. The concept of psychotherapy will be further evolved and evaluated at the International Rehabilitation and Research Center for Torture Victims in Copenhagen.

Rehabilitation of torture victims has to include spouses and children, and indeed the whole social network of the victims must be taken into consideration. Psychological disability due to exile is also of great significance. However, all of these topics are outside the scope of this paper.

The rehabilitation of a torture victim cannot be considered to have succeeded until the term 'victim' no longer signifies the subject as adapted to this role and instead signifies only a historical event.

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*Finn E. Somnier, MD. *Senior Registrar, Department of Neurology, State University Hospital (Rigshospitalet), 2100 Copenhagen, Denmark*

Inge Kemp Genefke, MD, *Medical Director, International Rehabilitation and Research Center for Torture Victims, Copenhagen, Denmark*

*Correspondence

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