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REPORT of the Medical Subcommittee/THE GOVERNOR'S TASK FORCE ON THE FEASIBILITY OF A MINNESOTA CENTER FOR VICTIMS OF TORTURE

I. Introduction

The Medical Subcommittee was charged with delineating the requisite elements of an optimal treatment program for the victims of political torture.

The subcommittee was chaired by Dr. Michael Popkin, and included Dr. Thomas Briggs, Dr. Neal Holtan, Commissioner Linda Johnson, Ms. Ann McLaughlin, Mr. Josip Temali, and Dr. Neal Vanselow.

The subcommittee held three meetings.

II. Recommendations

The subcommittee listed five theoretical issues which require further consideration before the center is established.

1. the need to determine whether an organic brain syndrome is present in an individual victim;

2. the need for a holistic approach to evaluation and treatment;

3. the need for medical care to provide the credibility and trust which permits psychological intervention;

4. the choice of a conceptual framework to guide pyschological and psychiatric intervention; and,

5. the recognition that assessment and treatment will evoke a degree of discomfort in the torture victim.

The subcommittee made the following recommendations:

1. An outpatient, free-standing urban facility with proximity and ties to medical institutions, such as University Hospitals or St. Paul Ramsey Hospital, is most desirable.

2. First-line treatment personnel should include a physician, a social worker, a psychiatrist or psychologist, interpreters, and a network of clergy. Second line treatment members should include a physiotherapist, a neurologist and a PMR physician. Treatment should be provided by professionally trained personnel.

3. The treatment program should be restricted to proven victims of torture.

4. Determination of eligibility should be performed at a site and with personnel not associated with the treatment program.

5. A comprehensive approach to evaluation and treatment of the individual and his or her family is very important.

6. Design of the program must incorporate from the outset systematic evaluation of program effectiveness.

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Report of the Medical Subcommittee
Governor's Task Force on the Feasibility of a Minnesota Center for the Treatment of Victims of Political Torture

The medical subcommittee was charged with the task of delineating the requisite elements of an optimal treatment program for victims of political torture. Toward this objective, members first reviewed pertinent medical-psychiatric literature, principally from four spheres: 1) studies of concentration camp survivors conducted in the 1950's and 1960's; 2) accounts of "post-traumatic stress disorders," encompassing sequelae of service in the war in Viet Nam; 3) reports concerning the broad category of "victimization"; and 4) reports emerging from the ongoing Danish, Canadian, and other experiences with assessment, treatment and rehabilitation of victims of political torture. This last group represents work effected in conjunction with Amnesty International. (A representative bibliography for these areas is attached at the conclusion of this report.) This reading of the literature was complemented by input and observations of the team which, together with Governor Perpich, site-visited the Danish treatment program in Copenhagen in February, 1985. In addition, the medical subcommittee gained a modest perspective regarding the Toronto treatment program, although a planned site visit has not yet been achieved due to "internal difficulties" in the Canadian center. Finally, members of the medical subcommittee visited the International Clinic at St. Paul Ramsey Hospital. This clinic, directed by Dr. N. Holtan, has been in operation since 1980 and sees approximately 20-25 individuals weekly. It utilizes a staff of four interpreters, a social worker, two physicians (an internist and a psychiatrist), a nurse-clinician, and a medical psychologist. The majority of the clinic's clientele have to date come from Southeast Asia. There is considerable similarity between at least some of the clientele which the International Clinic serves and the torture victims which the Center might treat. The International Clinic serves refugees; many are diagnosed as suffering from post-traumatic stress conditions. The International Clinic also deals with individuals who have suffered loss of homeland, family members, status, etc. In addition to comprehensive medical care, they receive ongoing social and emotional support via the clinic for variable periods of time.

This combination of steps served to guide the subcommittee in its determinations. However, at the outset, it is apparent that there is no universally recognized approach to treating victims of political torture; moreover, such approaches as have been utilized to date have yet to undergo systematic assessment of their effectiveness in follow-up studies. Hence, the "science" of optimal treatment of victims of political torture remains to be established. In this context, the subcommittee underscores the preliminary nature of its recommendations.

Theoretical Considerations

From review of the medical-psychiatric literature, certain theoretical considerations emerge which appear integral to formulation of an approach to treatment. The subcommittee wishes to preface its discussion of these theoretical considerations by stating that the overall goal of the treatment center ought to be to restore victims to a maximal degree of functioning consistent with the situation of the individual.

The subcommittee raised five theoretical considerations: the first deals with assessment; the remainder concern treatment. The theoretical considerations are:

1) the need to determine whether an organic brain syndrome is present in an individual victim;

2) the need for a holistic approach to evaluation and treatment;

3) the need for medical care to provide the credibility and trust which permits psychological intervention;

4) the choice of a conceptual framework to guide pyschological and psychiatric intervention; and,

5) the recognition that assessment and treatment will evoke a degree of discomfort in the torture victim.

First, both the studies from the Second World War and the more recent Danish-Canadian reports indicate that head trauma (e.g., closed head injury) is prevalent in captives/political prisoners who are the victims of torture. In concentration camp survivors, a chronic brain syndrome has been demonstrated in upwards of 80% of subjects studied 15 years after the close of the war (Eitinger, 1967). A comparable clinical picture has been described by those in Denmark studying recent victims of political torture (Rasmussen and Lunde, 1980). In the concentration camp victims, malnutrition was undoubtedly a second major etiological variable regarding organic brain syndrome (OBS). This apparently has not been a factor in the clinical presentations of today's torture victims, who have been studied at relatively short intervals after torture. Irrespective of the question of malnutrition, the subcommittee notes that priority must be assigned to the effort to determine whether or not OBS is an element of the symptom complex seen in an individual victim of political torture. The subsequent approach to treatment should vary if it is determined that the individual victim has sustained brain dysfunction. Clearly, individuals with organic brain syndromes will require specific rehabilitative and treatment programs directed to the cognitive and motor deficits associated with their brain injury. (This would be akin to the treatment and rehabilitation of patients with stroke,

closed head injury associated with auto accidents, and degenerative neurological disorders.) For those victims free from brain injury and dysfunction, a more general approach to the somatic and psychological sequelae of torture should suffice. The nature of the trauma to those who did not suffer brain injury may suggest particular sorts of treatment -- particularly for physical symptoms.

A second theoretical consideration is the need for a holistic approach to treatment. The subcommittee is firmly committed to the proposition that treatment must proceed with coordinated attention to physical, psychological, and social parameters. A holistic approach must treat the individual as embedded in a familial, cultural and social matrix as well. Victims of political torture and their families require attention for a full range of needs if they are to be restored to an optimal level of functioning.

Provision of comprehensive medical care is seen as facilitating credibility and trust necessary for psychiatric intervention. It is recognized that the somatic disorders resulting from torture may vary widely in duration. Concentration camp studies indicate that victims of torture (and malnutrition) suffered long term somatic disorders. The more recent Canadian-Danish studies depict numerous if variable somatic sequelae of torture, but suggest that they are often resolved in relatively short time periods. Accordingly, the opportunity for psychiatric intervention is a function of the extent of medical care.

A fourth theoretical consideration is the choice of a conceptual model or framework to guide psychiatric/psychological interventions. Here the subcommittee recognizes that a range of options exist and at presently only a few can be enumerated. For example, as an outgrowth of the Viet Nam experience, there is a steadily growing literature concerning post-traumatic stress disorders and "coping." Major conceptual models in these areas are Horowitz's "Stress Response Syndromes" (1976) and Lazarus' work regarding coping; both carry treatment implications as well. Ochberg and Fojtik's review of victimization (1984) offers another perspective with particular emphasis on a Rogerian treatment approach. From the Danish experience with victims of political torture comes a conceptual model emphasizing abreaction (allowing people to discuss their feelings and responses), understanding and reassurance. Though the subcommittee regarded closure in this area as beyond its immediate objectives, it strongly recommends outcome or follow-up studies on the existing conceptual frameworks or methodologies currently guiding treatment.

A fifth theoretical consideration is that physical and psychological treatment may remind patients of their torture experience and may not always be comfortable for the patient. Some effort must be given to explaining treatment to the victim and the family, so as to minimize the unpleasantness.

Elements of an Optimal Treatment Program

Setting:

An outpatient treatment program was regarded as most appropriate, and following detailed discussion, the subcommittee concluded that a freestanding urban facility with proximity and ties to medical institutions, such as University Hospitals or St. Paul Ramsey Hospital, would be most desirable. In this plan, the medical centers including specific resources such as SPR's International Clinic, could provide needed medical consultation and support. In a minority of cases, they could also provide sites for hospitalization. Much of the preference for a freestanding facility was predicated upon the observation that victims of political torture are reluctant/loathe to be treated in "institutional settings." The literature emphasizes that in as many as half of cases of recent political torture, physicians have been active participants. Thus, the free-standing facility, without formal trappings, might help to minimize apprehensions based on the nature and circumstances of the torture experience. Such a free-standing, outpatient facility in a non-institutional setting may make medical evaluation and treatment more difficult, but a compromise may be that the center would assign a staff person to accompany the patient in visiting necessary medical facilities. Also, the evaluation procedure might be fully explained to the patient, and the family and clergy of the patient. Hospital rooms might be designed to appear less institutional. An additional issue is that a free-standing outpatient facility may be more expensive to run than a center incorporated into an existing hospital.

Linked to the question of choice of treatment setting are additional issues including: the process of self-selection for treatment, concerns regarding confidentiality, and the nature of an initial treatment contract. The choice of a treatment setting also served to identify an inherent tension in the design of an optimal treatment program -- the need for initial systematic evaluation and careful followup measures versus the need for a more humanistic, less formal paradigm.

Staff:

Selection of the optimal configuration of staff for the treatment program is, of course, dependent on the extent of available funding. It was agreed that first-line treatment personnel should ideally include: a physician (a non-psychiatrist) with responsibility for addressing physical issues in the victims; a social worker; a psychiatrist or psychologist; interpreters; and a network of clergy. Additional or second line treatment members should include: a physiotherapist; a neurologist; and a PMR physician. Also the

following should be available for consultative activities: a dentist, an otolaryngologist, an ophthalmologist, and an orthopedist. The subcommittee concludes at this time that treatment should be provided by professionally trained personnel.

In order to begin the program, the subcommittee concluded that it would be necessary to have a social worker and a secretary in full time roles; other treatment team members could hopefully serve on a part time or volunteer basis in the early stages of program development. The subcommittee did not require that the primary physician be a specialist, although it noted that the Danish program has utilitzed a neurologist in this role. Selection of all personnel should be predicated on strong interest in and dedication to working in this area. It is also important that some staff are committed to research.

The subcommittee emphasizes the important role that clergy may serve in the treatment program. This takes note of victims apparent willingness to engage clergy more readily than other mental health professionals. The subcommttee also notes that clergy are already involved in a range of human rights activities in the community and that any new treatment program must be sensitive to these existing activites.

Clients:

It was agreed that the treatment program be restricted to proven victims of torture. It was further concluded that determination of eligibility (e.g., evaluation to establish that an individual has been the victim of torture) should be performed at a site and with personnel not associated with the treatment program. This step was deemed necessary to permit the program to focus its energies and resources on treatment itself. The center might accept patients only on the referral of a professional. The subcommittee's discussion focused on a tenative treatment propulation approaching 100 victims annually.

The subcommittee also recognized the probable need to provide temporary housing for some of the victims during the period of treatment - which may be expected to range on the order of 6 months. In addition, the program will also have to address the psychological/emotional needs of the families of the victims.

While it appreciated the need for individual "adjustments," the subcommittee noted the importance of systematic evaluation of physical and psychological status at an early point following entry.

Outcome studies:

Due to the empiric nature of past and current treatment techniques, the subcommittee believes that careful measures of the effectiveness of the center's treatment program must be incorporated into its design. In short, outcome research should be an integral part of the center; only such data can place ongoing treatment on an objective, rational basis--capable of modification in response to results achieved. The subcommittee believes that the center can learn from the literature on victimization in general and hopes that it can contribute to knowledge about victimization.

Closing Comment:

Cognizant of the difficulties of developing further detailed recommendations without the full input from the other working committees and particularly without specifics regarding financing, the medical subcommittee concluded that it was best to limit itself to the present observations as of April 3, 1985. It also should be noted that many of the details of a psychiatric treatment approach would prove a function of the specific conceptual model selected by those actually administering treatment.