

TORTURE – new size – new concept

TORTURE Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture was launched in 1991 as a quarterly journal. The aim of the journal was to disseminate essential biomedical knowledge about torture and about the examination of torture sequelae.

In the following years, TORTURE Journal was developed into a format that had a main section for special and documentary articles and other sections mainly for special health professionals and human rights organisations.

TORTURE is presently distributed in close to 150 countries to health professionals; network organisations and professionals with a specific interest in human rights subjects; libraries; and educational institutions.

A number of the recipients of TORTURE live in countries in which torture and human rights violations are prevalent, and in which it may be dangerous to show an overt interest in the subject by subscribing to a journal dealing with torture. Such conditions often result in democratic and economic restrictions, which may render the subscription fee economically overwhelming. It has therefore been the editorial policy of the IRCT to finance and distribute the journal free of charge, and anonymously, to anyone interested. At the same time, it has also been editorial policy that this should not lead to confusion about the status of TORTURE in comparison to NGO information of a more general nature.

Previously, the publication of essential

documentation was prioritised over fine adjustment to meet submission requirements for international medical journals. After a moratorium with a reduced publication frequency, TORTURE has now been relaunched in a new format with a new typography, and adjusted so as to meet international standards for scientific publications. The intention is to invite a broader selection of scientific and documentation articles for publication in the journal. Articles which meet the high standards will be presented in the first section, "Scientific Articles", of the new TORTURE.

The future profile of the journal has been discussed for some time, and three new steps forward have been decided upon:

- to establish the journal as a medium in which health professionals working with torture victims and conducting research in this particular field will seek information and may publish relevant articles
- to make the new TORTURE available in printed copies to core target groups, and
- to make the new TORTURE available on the IRCT website (www.irct.org) for anyone else interested.

When justifying the launch of any kind of scientific journal, existing similar publications should be taken into account. To assess the justification for launching the new TORTURE, the IRCT Documentation Centre conducted a bibliometric analysis of articles published between 1973 and 2002 that were registered

in the Medline and PsycINFO databases and indexed under the descriptor "torture". The analysis highlighted the fact that, although applied research on torture has developed into an international discipline, torture-related articles and publications are spread across a large number of journals. The analysis confirmed the IRCT's belief that there

was a need for a scientific journal dedicated to the subject of torture, and this is the context in which the *TORTURE* has now been relaunched.

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Social transition, exclusion, shame and humiliation

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Abstract

Although social exclusion is a permanently present phenomenon in human history, only the philosophical approach originating from the nineteenth century perceived it as an “anomaly”. Today, the phenomenon of social exclusion is an important element of contemporary intellectual discourse.

Shame and humiliation are closely connected to social exclusion, and the interdisciplinary concept of humiliation might contribute to the understanding of some socio-psychological aspects of social traumatisatisation.

The process of Central and Eastern European social transformation contributed to the realisation of some important aspects of social traumatisatisation. For the understanding of these aspects, the concepts of social exclusion, humiliation and mental pain are very important, as the history of humiliation radically influences the social competency of individuals and groups, the generation of mental pain and, consequently, the rise of destructive and self-destructive behaviour.

In this article, the authors wish to discuss not only the humiliation-based mechanisms that radically influence the relation between perpetrators and victims, but also the scientific discourse of social traumatisatisation and social exclusion.

Key words: trauma, PTSD, victim, violence, humiliation, social competence, mental pain

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Introduction

The last decade of the twentieth century was also a decade of extreme political and interethnic violence that occurred in widely different social circumstances and almost worldwide. The horrible events of massive political and interethnic terror before the global eyes of the news media networks on one hand, and, on the other hand, the humanitarian work provided for the survivors turned the attention of the professional community towards the question of the short- and long-term consequences of extreme violence, torture, neglect and exclusionism.¹

From the perspective of more than a decade’s experience, it seems that the late modern times promoted the development of a broad, multi- and interdisciplinary psycho-traumatological discourse that contributed to the recognition of the individual, social and even the cultural consequences of political, military and/or home-based violence.

Particularly, the “fall of the Iron Curtain” at the beginning of the nineties in Central and Eastern Europe turned the attention of scientists towards totalitarianism-related psycho-traumatological phenomena.

According to these research findings and theoretical models, shame and humiliation are socio-cultural phenomena that emerge as consequences of violence, and are on the rise among individuals, groups, ethnicities and societies.

The authors are psychiatrists who are involved in the mental health and trauma-re-

lated issues of refugees, asylum seekers, former political prisoners and victims of sexual violence in Central Europe. During their conversations, they realised that many problems of the countries in which they live and work (Slovenia, Hungary, Vojvodina in Serbia, and Montenegro) are closely related to the traumatic experiences of the population during the totalitarian regimes of the last century.

It is possible that the short-term and, even more, the long-term consequences of political and interethnic violence may influence the quality of life and the cultural well-being of the entire population or some of its segments for a long time.

During more than a decade of therapeutic work with various populations of traumatised and victimised individuals and groups, the authors were often confronted with characteristic statements and behavioural patterns of trauma survivors, depending on how they perceived their trauma and victimhood.

It became evident to the authors that seriously wounded people often try to make themselves invisible or to hide behind various kinds of fronts.

A few years ago a television reporter asked the permission of a psychiatrist at a refugee camp to conduct interviews with raped women. The psychiatrist told her that she had been working in the camp for only half a year and had no information about raped women, and even if she had, she should not disclose such information. The reporter did not accept the psychiatrist's statement and still came to visit the camp, since she was certain to be able to find subjects for her interview. In the evening, the psychiatrist and the reporter met at the gate of the camp. After spending the day at the camp, the reporter was exhausted and disappointed, "They are hiding", she said and was very upset with the psychiatrist.

The psychiatrist explained to her that victims of extreme violence were often humiliated, and they suffered from feelings of deep shame. Usually a long therapeutic contact was needed to break their silence, a silence caused by feelings of shame. Half a year was not enough to break the silence. The psychiatrist and her team needed nearly a year of regular work at the acceptance station to build a really open therapeutic contact with the applicants. They had to put down the foundations of a newly built "basic trust" in order to open the box with the most humiliating secrets.

During the therapeutic process, victims of violence often describe themselves as feeling socially "unacceptable, filthy and stinky". They are also often unable to separate themselves from their perpetrators or to turn against them.

For survivors of violence, it is sometimes very difficult to recognise their legitimate social rights and/or values, especially rights arising from their status as victims.

It becomes evident from the personal narratives told by the survivors that the process of traumatising, victimisation, and the subsequent secondary identity construction, is significantly connected to the phenomena of shame and humiliation.

Theoretical background

The existing theoretical literature on shame and humiliation generally uses the two terms as synonyms, and most authors distinguish only quantitative differences between them.

Therefore, an almost constant semantic vagueness is present in the literature regarding the meanings of "shame" and "humiliation".

In the opinion of the authors, this above-mentioned indiscriminate originates from a theoretical tradition that does not aim to

clarify and/or separate these two terms. In approaching the recent outcomes of extreme violence, however, it seems very relevant to describe the effect of humiliation also by distinguishing it from the effect of shame.

A theoretical model that serves the clarification of this conceptual vagueness could meaningfully contribute to a better understanding of the psychosocial consequences of violence.

With this paper, which emphasises their experiences with refugees and survivors of torture and/or sexual violence, the authors intend to contribute to the development of a shame- and humiliation-related psychotraumatological discourse.

Cultural anthropology and shame

The phenomenon of shame was traditionally connected to the scientific discourse in the field of cultural anthropology. Pitt-Rivers² provided an early description when he analysed Mediterranean societies. He pointed out the connection between honour and shame. He mentioned the classical situation in which the incorrect behaviour of a woman reflects on the males (husbands, fathers and brothers) she belongs to. When the female's honour is compromised, the male(s) should bear the shame. Pastner³ also supports this description after conducting fieldwork in Pakistani Baluchistan.

Other anthropological categories (Benedict⁴, Lebra⁵, Fung⁶) divide cultures based on their application of shame and guilt. In monotheistic cultures, the basic phenomenon is guilt and its reciprocity. In the so-called socio-cultic cultures, e.g. in Japan or China, shame is a fundamental phenomenon. Shame is considered as the basic element in child rearing and socialisation by which adults demonstrate to the child his/her social incompetence. In the individualistic Judeo-Christian culture, however, guilt is the fundamental

element. In Japanese society, guilt is defined more by situational ethics⁷; therefore a social action may be either good or bad, depending on the situation. In traditional Japan, the boundaries of the "self" were considered as non-individual, since they also included the context of relevant social relationships. Keeler⁸ demonstrated the same for Javanese society, in which children from about the age of six should acquire the skill of talking at different hierarchic speech levels, otherwise they would meet parental disapproval and the expression of *isin* (a Javanese term for shaming). It is important to mention that many scholars criticised the original concept of Benedict for its possible ethnocentric interpretations and its irrelevance to contemporary Japanese society.

Psychology, philosophy and shame

The issue of shame became a key concept of psychological, psychiatric and philosophical discussion only a few years ago. Kaufman⁹ wrote that the recognition of the scientific importance of shame is connected to a shift in the theoretical understanding of neuroses. The phenomenon of shame came into the spotlight through the appearance of some newly introduced psychopathological entities, syndromes and disorders, and it is connected to several psychopathological phenomena, the so-called "shame-based syndromes".⁹

Otherwise, in contemporary philosophy, the issue of shame has been addressed by analysing its application and interpretation in Central and East European totalitarian systems.¹⁰

From this overview of the scientific discourse on shame, the authors suggest that contemporary psychological concepts of shame focus on different aspects (or meanings) than those traditionally used by ethnologists and anthropologists. It is plausible that the different scientific meanings of

shame are connected to different phenomenological aspects.

Heller¹⁰ points out the difference between the “physical manifestation of shame” (blushing) and “deep shame” in native cultures in which the intensity of shame depends on the nature of the violated rule. In contemporary societies, the intensity of this feeling is also determined by the individual relationships of the person who has violated the rule. The plurality of rules (or moral norms) and their appearance in specific situations in contemporary societies is probably the key element in distinguishing the shame perception of native and contemporary cultures.

This suggests that today shame manifests itself in different ways than it did in native or ancient societies.

Wurmser¹¹ points out three different psychological aspects of shame:

- Shame – as a particular type of anxiety in a situation of threatened exposure or humiliation.
- Shame – as an emotion or a cognitive/emotional reaction.
- Shame – as a reactive formation (characterological trait).

The word “shame” originates from the Teutonic root word “skem” and means “to cover oneself”.¹² Schultz¹³ states, “The parts of ourselves we wish to hide are the shameful parts, and we also wish to hide the fact that we are ashamed.”

Jamieson¹⁴ analyses the usage of the expression of shame in an East-Nicaraguan community. There, shame is primarily an intrapsychic emotion that, in a certain context, reflects a distinct inter-gender communicative interaction and is not connected to taboo values imposed on a person by other members of the community.

Psychological and behavioural approaches

to shame recognise it as a phenomenon of basic affect. But shame is also an emotion in the sense of “involvement with something”.¹⁰ Summarising Heller’s theoretical contributions, it should be pointed out that the “involvement of a human” means emotions, and the arbitrations made by human authorities value the emotion that is produced in the process of human involvement.

Based on the fact that authorities of human behaviour are normative authorities, “involvement” in this sense is strongly connected to the sphere of morality. Shame, on a behavioural level, is connected to particular social situations and determined by the presence of an authority of human behaviour.

Kaufman⁹ describes two activators as developmental sources of shame, from a psychological point of view.

First, the *innate activator* is the “incomplete reduction of interest or joy”.⁹

By referring to Tomkins¹⁵, Kaufman states, “shame is an affect auxiliary because it operates only after the positive affects, interest or enjoyment, have been activated. Shame functions as a specific inhibitor of continuing interest and enjoyment.”

Kaufman⁹ also states that “whenever an individual’s fundamental expectations (imagined positive scenes or desired outcomes in relation to people, events, or accomplishment) are suddenly exposed as wrong, shame is activated. Whenever expectations are thwarted or disappointed, shame is also activated. These are all instances of the innate activation of shame, triggered by the partial or incomplete reduction of positive affect or of the imagined scenes thereof”.

Second, the *interpersonal activator* of shame, as Kaufman⁹ describes it, is “breaking the interpersonal bridge”. She provides an insight into the interpersonal genesis of shame through the presentation of the bonding process between a mother and an infant.

She emphasises the role of eye contact (gazing in their relationship): “The eyes are indeed windows of soul”.

Identification is the central term in understanding the bonding process. The merit of bonding is “the infant’s feeling of oceanic oneness or union” with the mother that he/she recognises as “basic security”.

Heller¹⁰ also points out the role of eyes which she observed while examining the linguistic expression of shame-related events. She related the role of gazing to the specific relations of the individual and the authorities of human behaviour. As she stated, shame is connected to the presence of external authorities.

M. Weber¹⁶ describes *domination* (“authority”) as “the probability that specific commands (or all commands) will be obeyed by a given group of persons.” From this follows that authority is a legitimate relation of domination (those who exercise authority) and subjection (those who are excluded from the exercise of authority).

It seems that eye control over the violation of the rules is necessary for the activation of shame. Therefore, the role of an external authority is connected to the role of an observer. The internalisation of external authorities is connected to the internalisation of moral values. An individual evaluates his/her own behaviour based on the values represented by moral authorities. Violation of external or internalised values leads to exclusion or the alienation of the individual or group and/or to the experience of shame or humiliation.

Therapists working with victims of political violence often observe that tortured clients avoid eye contact at the beginning of the therapy. “I face the earth”, as one of our young clients said after suffering for four years in Chechnyan underground prison-like cells,

“not to be dominated by the enemy”. Eye contact is a very special form of human contact. Our environment can be controlled by identifying whether objects are friendly or hostile towards us. Children look down if they feel ashamed; parents can humiliate the disobedient child by looking at him/her with rage or anger. This means control over the child who tries to avoid the strict glance of the adult.

The young client’s only means of defence was to avoid eye contact with his torturers. He felt he could neither be influenced nor humiliated by them if he did not give them his eyes, the only part of his body that preserved his past identity. “They could beat me, they could keep me without light, food and water, but they could not get my eyes and my soul,” he said.

One of the results of the therapeutic process was that he looked into the eyes of the therapist, gaining back his trust in her and in the others around him.

Heller, in her ethical philosophical theory¹⁰, points out the regulative (authoritarian) aspects of shame production and their relation to the development of moral values. According to her theoretical approach, the basic social role of an external authority is a socio-cultural reality construction via the process of social meaning production and selection.

By her understanding, an external authority is able to maintain control over human behaviour if:

- The behavioural norms are homogenous.
- The community is small.
- The different generations living in the same community don’t experience social changes.¹⁰

In other settings, it is necessary to activate an internal authority. Therefore, shaming is

often connected to the process of authority internalisation.

In the surrealistic world of the torture chamber, the victim's only means of survival is to accept the rules and the roles offered by the perpetrator (the torturer). He/she identifies with the torturer by internalising him as an internal object. This is the only way to feel safe in a tormented world and to gain protection from further torture. Some torture victims are also inclined to become torturers themselves. They feel they "belong to the other party", to the "strong adults" who "teach the weak, the child, obedience". In Second World War concentration camps, some captives became the servants of the officers and treated their fellow captives even more cruelly than they did.

When evaluating the developmental dimensions of bonding, Kaufman stated, "An interpersonal bridge forms out of reciprocal interest and shared experiences of trust. Trusting must be matched by the parent behaving in a trustworthy fashion." Kaufman⁹ identified *consistency* and *predictability* as decisive factors in building an interpersonal bridge.

The breaking of the interpersonal bridge happens either by an act of physical violence or by a language-based, performative act that will have an effect only under certain conditions in an authority relationship. For example, the expression "Shame on you!" produces feelings of shame only if the "shamed" person recognises and accepts the authority of the "shaming" person. The threat of rejection and possible abandonment seems to be the source of the behavioural change that is caused by shaming.

Therefore, the authority relationship is an important, but not the only, condition for shaming. In other words, an interpersonal

bridge has to exist first in order to be broken in the process of shaming.

Shame can be expressed by a serious paranoid attitude towards the therapist working with the refugees in a camp. As time passes and they realise that the therapist arrives reliably on the promised day and time, the fundamentals of trust and reliable relationships are rebuilt. After several therapeutic sessions, shame fades and disappears as a result of the reliable therapeutic attachment, and the clients are able to speak about their previous trauma.

The therapeutic team, led by one of the authors (Lilla Hárđi), wished to develop a new method of group therapy in a Hungarian refugee camp for male torture survivors from Iraq. The level of paranoia was so heightened that when the therapists showed a symbolic object and asked the clients for their associations with the object, nobody answered. The refugees mentioned spies in the refugee camp and talked about the presence of the Iraqi Secret Service. No one answered the therapist's questions. After several sessions, the group prepared a meal for the therapeutic team. They served fish for the therapists as a symbolic object! This was their gift for taking care of their problems. The paranoid attitude disappeared perfectly and, as an acceptance of the therapeutic situation, they themselves offered the meal as a sacral, symbolic object. After this session, there were no longer problems with their associations and their trust.

Tracing possible shame-producing events, Kaufman⁹ emphasised:

- The role of early parental expressions of anger.
- The connection between shame and the fear of abandonment.

- The shame-producing mechanism of the utterance “Shame on you”.

Cloke¹² states, “Shame wounds that occur as a result of child abuse whether from neglect, violence, sexual abuse, humiliation, betrayal or abandonment are often subsumed into a child’s self image. These experiences produce ‘bad self’ feelings and are felt as self-loathing, inadequacy, powerlessness, weakness, and worthlessness.” Although Cloke here describes the phenomenon of shaming as it is caused by violent events, his description seems to be closer to the definition of humiliation. In the opinion of the authors, a general impact on the Self is the key notion that separates the phenomenon of shame from that of humiliation.

The overwhelming and devastating effect of abuse and neglect is easily imaginable.

A young refugee boy – 17 years old – asked for help from a therapist in a refugee camp.

The young client finished his schooling at the age of fourteen in Afghanistan. Then he was taken to the army, where he became his father’s assistant and carried the guns in the battles. After he witnessed his father being shot and killed, he himself was also maltreated by the Taliban. He was humiliated on a regular basis, beaten with a leash, he suffered from hunger, and could eat only once a day. He was also forced to bear arms and shoot at the enemy. Later he succeeded in escaping from Afghanistan, leaving his mother, brothers and sisters behind, in danger. After arriving in Hungary, he behaved “rather strangely”. He started to walk the streets, abused nicotine and alcohol, and even “didn’t tell the truth” to his uncle, who lived in Hungary at the time. His behavioural problems were also present at school and at work. He was “bad and aggressive”, identifying unconsciously with the enemy

that destroyed his family and home. He found an escape in daydreaming and tried to avoid reality by creating fantasies about “bad and aggressive people” who dominate the world. It became clear during the therapeutic process that this was the only way he could defeat his shameful feelings that originated from the regular humiliation and maltreatment he suffered during the war.

Shultz¹³ explains the effect of humiliation as “... it so disrupts our function that the ego is temporarily dissolved and dead. Shame comes with consciousness, particularly self consciousness – self consciousness that is the awareness of our constitutional inadequacy, our essential inferiority, worthlessness and evil. It is the affect of knowing the shadow. It comes with dismemberment, in the sense of being cut off from an essential source of survival, be it mother, clan, community, self, God, or other, and it comes with dismemberment also in the sense of splitting off or repressing the shameful part.”

The violent implementation of social rules set by an external authority causes feelings of impotence, suppression and/or numbness. In clinical practice, however, humiliation is rarely observable as a separate phenomenon.

Shame and humiliation

Based on the modalities of shame production, observed in therapeutic and cultural anthropological work, the authors recognised that the mechanisms of shame production are heterogeneous and produce a wide spectrum of psychosocial consequences.

The main components of shame production could be described in a two-dimensional model (see Figure 1).

The first, vertical axis represents the social consequences of shame production, with social inclusion (assimilation, socialisation) on one side and social exclusion on the other.

The second, horizontal axis represents the implementation of social values versus the subordination of an individual to an authority.

The shame producing events and mechanisms can be represented according to these two axis.

Social values – inclusion

The traditional use of shaming, as described by anthropologists, might have a positive cultural role, since it serves the implementation of moral values during the process of individual psychosocial development. In such cases, the primary motive of shaming is not the implementation of an authority, rather the internalisation of certain community-based rules and values by an individual.

The fact that refugee children from Afghanistan become the best students at school in their host country may be interpreted as the result of overcompensation of their minority feelings on the one hand and, on the other hand, as a sign that they want to achieve a stable position as part of the process of their integration and assimilation.

A traditional way of working through shame may be the Italian *vendetta*, taking revenge for the shame one suffers after the murder of a family member. The respect of the community may be preserved by an aggressive action that is proof against the feeling of weakness and submissiveness.

The presence of an authority and the existence of an interpersonal bridge are just the necessary conditions for the implementation of moral values, and the effect of shaming is not the exclusion or the elimination of an individual from the social space; on the contrary, it is his/her assimilation into the community.

Social values – exclusion

In contrast to the culturally positive role of shame production, described above, it appears that shaming also has an important role to play in implementing subordinate relations in contemporary societies.

According to the observations of the authors during their therapeutic work, authorities may break interpersonal bridges in order

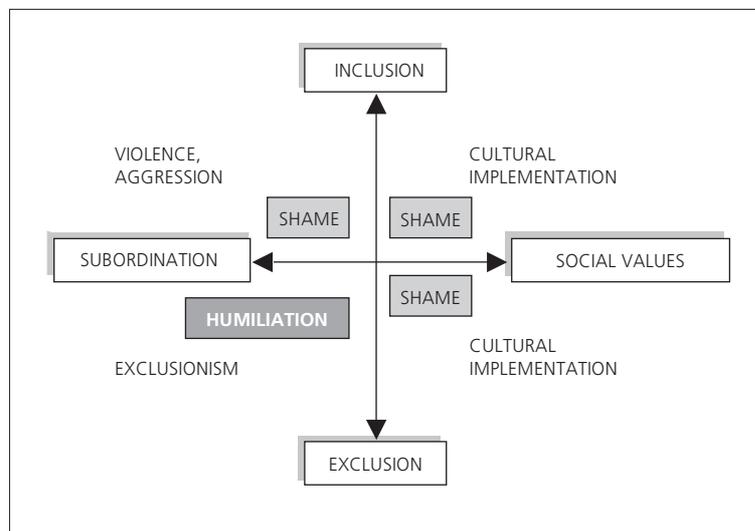


Figure 1. The main components of shame production.

to evoke culturally incoherent shame-based feelings in other individuals or just in order to subordinate them. This is also the aim of the perpetrators during interrogations.

Inclusion – subordination

It is well known in the field of addictology that individuals addicted to alcohol often apply shame-related techniques in order to subordinate their family members. They, as well as perpetrators, isolate their victim, inhibit their reality-constructing attempts that would be supported by the relatives and the outside world, with the intention of destroying their victim's will. In these cases, shaming routinely serves as a method to eliminate divergent voices from the social arena, but without the intention of excluding the carriers of these voices.

Shame-producing mechanisms are also very common in the process of transgenerational trauma transfer, when a traumatised individual (or a perpetrator) is in a role of authority and tries to implement values, rules and other elements of reality that were constructed under the influence of a different set of facts or events that existed in a former social reality. This kind of shaming may also result in the implementation of values, but sometimes subordination of an individual is the only reason for shaming.

A psychotherapeutic client of one of the authors is the daughter of a Holocaust survivor. The father was sent to the concentration camp in Dachau during the Second World War because of his "partisan activity".

When he returned from the camp, he became an armed officer of the communist regime. At home he tried to develop a special regime for his family, isolated the family members from the neighbourhood and forbade any social activity that was usual in the community. During the therapy, the client

often used the expression that she lived "behind the Iron Curtain". Periodically, the father woke up the family at night, forced them to form a line and give account of their work or present their homework.

Based on the stories presented by the client, the authors concluded that the father had constructed a "mini" concentration camp for his family. By this he intended to implement the "out-of-normal" norms and values of a concentration camp. The client completely internalised this reality created by the father. Even today, she is not able to take care of her own interests, represent her values or assume a role of authority.

Humiliation

Based on the two-dimensional model above, it was found that humiliation is a distinct phenomenon that significantly differs from the other modalities of shaming, and is instead related to subordination, violent reality construction and social exclusion.

Another client was a survivor of a concentration camp in the years of the Bosnian crisis. As he remembered, they were locked up in large buildings, such as barns, without any toilet facilities, and suffered from cold, hunger and thirst. "I felt like an animal when they – the soldiers – came for us and forced us to go in front of the barn and watch how they burned women and children. I saw babies burning on an open fire, I smelt the odour of their flesh, I saw women like my mother and sisters burning in the flames."

Leaving his country, he wasn't the same person as before. He became extremely hostile to the members of his family, regularly abused alcohol and showed symptoms of antisocial behaviour in the refugee camp. He beat his wife and children regularly, destroyed the furniture of their room and threw it out of the window. His family was

broken, and so were his social contacts. As the result of a long therapeutic process – both individual and group psychotherapy – he could work through his experience of humiliation. Today he is a valuable member of the community in another country to which he could emigrate in good health.

As the result of torture or humiliation, trauma-related reality is transformed into the surrealistic reality of the torture chamber, in which the subordinator/perpetrator is the absolute authority in implementing reality. This “irrational” reality causes the victim to become disoriented under “normal” circumstances and excludes him from social relationships.

An eligibility officer of the Hungarian Ministry of the Interior asked the therapist to submit the medical report of an applicant for refugee status, since he was convinced that “he was telling a lie because his story had contradictions”. The refugee came from a Middle Eastern country, where he was severely tortured in a prison for a year, nearly on a daily basis. He was isolated in a cell for months without any light. Then he was taken to the yard of the prison, forced to kneel and look into the strong sunlight until he felt he had lost his vision forever. He was hooded while interrogated and tortured. Palestinian hanging, falanga and electrical torture were also applied.

During the therapeutic sessions, the client wore a cap over his eyes. “The light disturbs me,” he stated. He was close to psychosis and suffered from permanent flashbacks and nightmares during his short and unrestful sleep at night. Due to his paranoid perception of reality, he was not able to talk about his traumatic experiences to the therapeutic team. He was convinced that should he begin any conversation, the Secret Service of

his home country would take him back to prison again.

This vignette represents well that breaking the will, by defeating, violent and repeated beating of, or sexual abuse of an individual (especially an infant), causes feelings of severe humiliation, along with thoughts like “I don’t belong, I don’t deserve to be here, I am no good”.

The same applies to raped women in a Muslim society in which they live lonely and invisible, even in big families, and express their gratefulness, “though I am so bad they accept me”.

Invisibility can preserve the painful impact of lowered self-esteem. Therefore, in such societies, as some experts suggest,¹⁷ the issue of violence should be addressed (e.g. by health care authorities) in order to raise awareness of public interest and turn it from a personal burden into a political issue.

Some authors¹² define the feelings caused by violent events as: “It can best be described as an emotional wound to the self for which one blames oneself as if one’s person is the reason”. They also state, “These experiences produce ‘bad self’ feelings and are felt as self-loathing, inadequacy, powerlessness, weakness, and worthlessness”.

According to the theoretical concepts presented above, humiliation shows some important differences in comparison to other shame-based phenomena:

- First, humiliation is usually not a result of a performative act that is intended to produce feelings of shame. Hence, the performative expression “Shame on you” usually is appropriate in order to evoke a feeling of shame. (Alternatively: First, humiliation is not the result of a performative act, as it is in the case of shame, where the performative expression “Shame on

you” is usually sufficient to evoke a feeling of shame.)

- Second, humiliation is not conditioned upon the existence of a previous positive relationship, or of an interpersonal bridge between the perpetrator and the victim, whereas these are necessary for the development of shame. The Hungarian expression: *megalázás* or the Slovenian *poniž anje* clearly reflect the event or process that violently subordinates an individual to an authority by ways of making him inadequate, incompetent or powerless. The direct, literal meaning of these expressions used for “humiliation” is “degradation” or “putting someone lower”.
- Therefore, humiliation is almost always a result of violent events, a demonstration of authority over an individual or a group, and governed by the intention to eliminate the individual or the group.

During their professional careers, the authors met several former political prisoners who maintained an unusual body posture (head down, hands behind, eyes down, gazing at the floor) in the presence of individuals whom they recognised as authorities.

This body posture expresses the acceptance of subordination, powerlessness and inadequacy. As they recalled, prison authorities forced prisoners to take on such a posture as the expression of their subordination. It seems that once imprinted, the posture becomes a life-long behavioural trait in front of anyone who is recognised as an authority.

A young Russian boy, mentioned previously, was kept in an underground prison by Chechnyan troops for four years, where he was seriously tortured and intimidated. During his therapy, he did not have eye contact with the therapist for a long time and maintained a peculiar body posture right un-

til the very end of the therapeutic process. He sat on his chair with his head bowed, not moving his hands and gazing at the floor, as if he were trying to hide under the earth, like a little bug, and remain invisible. His self-esteem was entirely lost, he wanted to present himself as an object, lying on the floor, submitting himself to anyone entering his personal space.

As the first result of the therapy, the therapist gained a glance from him; this was the symbol of trust in her, somebody who did not treat him as a subordinate but as a human partner. By the time he had finished psychotherapy, he could leave the consultation room walking straight, just as any other young boy of his age.

Facts, distinguishing shame and humiliation

- While shame is an emotion, humiliation is an inner psychosocial effect of violence.
- While shame affects an individual only partially, humiliation hits the entire psychosocial self of a person.
- Humiliation results in two permanent wounds on the human self. Self-destructiveness is one, and inability to take charge of one’s own life and destiny is the other.

Therefore, humiliation affects the individual through the destruction of his/her social competence.

- Humiliation, a result of psychophysical torture or abuse, gives a long-lasting advantage to the perpetrator/torturer.

The lack of the victim’s social competence, coupled with the negative feelings toward one’s self (caused by the humiliation of human dignity) and the mental pain from which the victim suffers, makes it easy for the perpetrator to implement or to maintain rule and

order, and to eliminate the divergent voices in the community/society.

During the application procedure, the eligibility officer at the Ministry of the Interior requested the psychiatrist's evaluation of whether the applicant had been tortured in his native country or not.

The client had been imprisoned for ten years, but after being released from prison, he did not leave his country immediately, but half a year later. What happened? Perhaps he was not telling the truth, he had not been tortured, and even the "prison story" was a fabrication?

During the therapeutic interview, he revealed his story: He tried to carry on his life in silence after the imprisonment and torture, but he was unable to rebuild even his basic contacts with his family members. His wife divorced him, and his relatives did not accept him as a member of the family. He suffered from total isolation, and so he decided to leave the country. In Hungary, during his interview with the officer, he told "his story" with some "contradictions", i.e. he was not able to speak about his traumatisation in a consistent way. This type of behaviour was only accepted in his psychotherapeutic relationship, where, in his relationship to the therapist, he was able to find the lost trust. As a result of the therapeutic process, his dissolved ego boundaries were solidified, and he was granted refugee status after being able to present his life history in a coherent way and showing "healthy emotions".

Effects of humiliation and social transition

At the end of the article, the authors wish to point out that the phenomenon of humiliation is of special interest during times of social transition and transformation.

The process of social transition and transformation that presently is taking place in Central and East Europe is an all-embracing and time-dimensioned process connecting the past, present and also the future.

One of the most important phenomena of the Central European transition is the destruction of totalitarian authority. The symbolical "loss of the father" could be interpreted as a loss of meaning-coherence, and, consequently, as damage caused by a diffuse reality. The process of transition implements many different or opposing values and ideologies, all competing to influence "mainstream" social discourse.

Thus, if the process of social transition contributes to a developing *incoherence* of social reality, then the outcome of this process is a decreasing relevance of meanings in their connection to socio-cultural and ideological issues.

This often contributes to the feeling of meaning uncertainty and/or meaning unpredictability.

Considering meaning uncertainty, the Central European transition process activates many shame- or humiliation-based feelings that are connected to the violent authority implementation of the past, the practice of the former totalitarian regime(s).

Of course, these feelings arise not only on the side of victims, but also on the side of former representatives of authority and their informers.

Meaning incoherence is increasing during this transition process. The fragmentation of ideology often changes the socio-historical position of the victims of (former, mainly political) humiliation, but the act of liberation generally is not sufficient to transform the belief systems of the victims.

On the one hand, despite the changing socio-cultural conditions, the effect of abuse and humiliation is often sustained by the

victims' inability to express the pain they have suffered during the process of humiliation.

The feeling of social incompetence and the subsequent psychological pain of the humiliated usually preserves the original relationship between victims and perpetrators, despite the transformation of the macro- and micro-social system.

The inability of the victim population to change the flow of social discourse often contributes to the preservation of a hidden reality which is conducive to the persistence of victim-blaming. This can be seen as evidence of the power which former perpetrators still have over the victims.

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Case presentation of a tattoo-mutilated, Bosnian torture survivor

Utilising a community-based, multidisciplinary treatment network model

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Abstract

Torture is used to create fear, destroy individuals and communities, and to suppress unwanted political or religious views. The survivor of torture often endures significant physical and psychological trauma. The basis for treating this trauma varies according to individual needs, community resources, programme designs and cultural acceptance. The case presented here focuses on torture occurring during the Bosnian conflict of 1992 and demonstrates how the utilisation of a community-based, multidisciplinary network model can be effective in helping survivors through the recovery process. The unique circumstances of the study identify factors of imprisonment, rape, deprivation, physical violence and, particularly, body mutilation through tattooing.

Key words: torture, Muslim, rape, mutilation, multidisciplinary treatment, EMDR (Eye Movement Desensitization and Reprocessing), plastic surgery

Introduction

Many countries today continue to practise torture on their own citizens.¹ Since the Second World War, there has been an increased awareness of the physical and psychological effects of torture, resulting in the development of treatment centres utilising an array

of treatment modalities to assist survivors in the healing process. Eitinger and Weisaeth² concluded after the establishment of the first Rehabilitation and Research Centre for Torture Victims (RCT), in Copenhagen, that “the therapeutic approach must be all encompassing and include somatic and psychological therapy”. Many torture treatment centres around the world recognise the need for multidisciplinary approaches to treatment and recovery. Bojholm & Vesti³ stated that to treat survivors, staff should have a comprehensive knowledge base concerning torture and its effects, as well as programmes designed specifically to serve torture survivors.

In recent years, there has been a notable expansion in the number of torture treatment centres in the United States. Made possible by an annual appropriation from the US Congress of USD 10 million via the US Office of Refugee Resettlement, and funding from the United Nations Voluntary Fund for Victims of Torture, there are now 33 such centres in the United States.

The Florida Center for Survivors of Torture, a programme of Gulf Coast Jewish Family Services in the Tampa Bay, Florida, region, is the only such treatment centre in the very populous state of Florida. Unlike most other centres around the world, it utilises a community-based network model that focuses on the delivery of multidisciplinary services and network training. The Florida Center is a programme “without walls,” of-

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fering services in the communities in which survivors live through a network of partner resettlement agencies providing assessment and case management, and a cadre of volunteer and low-cost mental health professionals, psychiatrists, psychologists, physicians, attorneys, interpreters and other providers. As of February 2004, the Florida Center was actively providing treatment services to 200 survivors from 15 countries. With a large Bosnian refugee population in the Tampa Bay area, the Florida Center has received a number of referrals and has assisted survivors with medical, psychological, legal, transportation, housing and social services support. The programme demonstrates how the utilisation of a community-based holistic network model can be effective in helping the survivor through the recovery process. The unique circumstances surrounding the case presented here identify factors of body mutilation through tattooing, imprisonment, rape and physical violence.

The high occurrence of rape during the Bosnian conflict has been well documented. Because of enormous discrepancies among reports, it is difficult to say how many individuals were raped. The Bosnian government originally stated in 1993 that there had been 50,000 to 60,000 Muslim women raped,⁴ however, other sources state this number has been inflated by the European and American media.⁵⁻⁶ While Muslim women and girls were the most common targets, most sources agree that victims of rape during the Bosnian war included all ethnic groups.⁷ Helsinki Watch⁸ asserts that, "Each of the parties to the conflict in Bosnia-Herzegovina have used rape as a weapon of war" (p. 21). Rape was even used as a weapon of war within an ethnic group, such as Serb on Serb or Muslim on Muslim.⁹ Ethnic groups became blurred when households consisted of two ethnic groups because of mixed marriages between Serbs and Muslims.

Women were raped in a number of different contexts during this war. Soldiers raped women and girls in their homes, in front of their community members and families, and took them to converted camps, where they were systematically and repeatedly raped by multiple soldiers, sometimes resulting in pregnancy. In rare cases, body mutilations through tattooing and scarring, in conjunction with physical and sexual violence, have been documented.⁸ According to Helsinki Watch, the perpetrators use rape to humiliate the victim and insert fear into the community, such that the victim and others from the same ethnic group would flee the area.⁸

Because of personal feelings of shame, and the survival mode that people living in wartime must adopt, many women did not tell their family or others about their rape victimisation. The women who were raped and impregnated by perpetrators were especially stigmatised and blamed for their victimisation.¹⁰ As the soldiers or civilians committing the rapes were not held accountable, victims did not report the violence.⁸ However, the women who did admit to being raped often were used by a government to enrage their ethnic members to retaliate against the perpetrators as an ethnic group.^{6,10} Further, the victims of rape were left on their own to deal with psychological and physical scars, mostly without the assistance of treatment.

Women who were raped during the Balkan conflicts had to deal with the symptoms that often result from sexual violence, along with the added trauma of living in a war-stricken area. Nikolic Ristanovic¹¹ quotes a victim of war, stating, "Violence against women in war involves rape, their children being killed, their families destroyed, struggling for survival, suffering mental damage, harassment and extortion as refugees, irrespective of their religion" (p. 32). The chronic exposure to torture often carries with it deep-

rooted physical and psychological scars.¹²⁻¹³ It is with this emotional and physical pain that some of these individuals become refugees and flee to a place of safety.

Case study

Fatima is a 44-year-old Bosnian female. She had arrived in the United States with refugee status after living in Germany for eight years with her husband and children. She presented with multiple physical and psychological symptoms. While in Bosnia, she was targeted as a Muslim woman by Muslim soldiers, due to her marriage to a Serbian. Fatima explained that her town had been subjected to several surprise visits by soldiers, and that her neighbours had been taken, beaten, raped and imprisoned for days at a time. Individuals living in mixed marriages, Muslim and Serbian, were targeted repeatedly, she explained. This caused a heightened arousal and fear among those individuals living within her community.

One night, Fatima and her husband were awakened by soldiers who ordered them at gun-point to get dressed and follow them. The soldiers separated the couple. She explained that after her abduction, she was plagued with concern for her family's safety. She was taken to a school gymnasium that had been converted into a temporary camp that housed many other women of varying ages. She was held captive for 20 days, during which time her concern for her family grew. She was given very little food or water and reported being beaten repeatedly. While imprisoned, she witnessed nearly every woman being dragged into areas of the room, and repeatedly raped and beaten by groups of soldiers. She painfully explained that she, too, had been victimised by five to six groups of men repeatedly during her imprisonment. The effects of violence were heightened as she felt betrayed by her own religious brothers.

She stated that she was being punished for the person whom she had fallen in love with.

It was very difficult for Fatima to discuss her past trauma. She became overwhelmed with emotion as she described the most horrific violation that she had experienced. One night, a group of soldiers randomly selected her as their victim and began their sexual assault. During this violation, she became aware that something was different about this night. The circumstances of the assault quickly began to change. The soldiers who were attacking her began to hold her down and a new pain was introduced. As she looked down, the soldiers had begun tattooing and scarring parts of her body. She felt that these soldiers had decided that the pain and humiliation of rape alone would not be enough, and they wanted her to suffer as much indignity as possible by placing a physical reminder of this ordeal on her body. By placing their Muslim names on her body, they scarred and marked her, proving to her community that this could happen to anyone. They continued to beat, rape and tattoo her throughout that night. In the morning, when she looked at her breasts, arms and shoulders, she saw the names of the soldiers who had attacked her, forever embedded in her skin.

After almost three weeks of imprisonment, the soldiers released her. They had inflicted not only psychological and physical torture, but had left her with a daily reminder of the torture she survived. The reflection of her own image now brought haunting memories of her imprisonment. She painfully explained that after the day of her tattooing, she felt her life had ended and she merely existed day to day.

Upon her release, Fatima reunited with her husband and family to find them safe. Her husband had been detained for several days, then released. She revealed her ordeal only to her husband and took great pains to

hide the tattoos from her children. At this point, the family realised that for their survival, they had to leave their life, their loved ones and their country. Shortly afterwards they fled to Germany.

Fatima discussed her time in Germany very little, but explained that she did receive medical and psychiatric assistance while there. She visited her psychiatrist one time per week for six years and received tranquilliser injections two times per week during the three years preceding her arrival in the United States. She explained that her family was safe, but the constant reminder of her torture caused her significant psychological pain. The depressive symptoms she endured while in Germany became unbearable as she lost hope for recovery. She had twice attempted suicide while in Germany by overdosing on medication but had been found in time by her husband both times.

Soon after arriving in the United States, Fatima was referred to Gulf Coast Jewish Family Services' Florida Center for Survivors of Torture by the agency that had assisted with her family's resettlement process. The primary reason for referral was for psychological assistance. Fatima also presented with medical concerns at the point of initial referral. She was willing to participate in the intake process and disclosed background information to the intake worker and female interpreter in the absence of her family members. Inquiries into Fatima's emotional stability were made during intake; however, detailed questioning of past trauma was not made as she was not yet ready for this ordeal. She had no current suicidal ideation, but depressive symptoms were observed. The recent move to the United States, paired with her traumatic past, increased her psychological symptoms. She reported weight loss, no appetite, body pains, difficulty concentrating, memory problems, fatigue, loss of in-

terest in activities including sex, difficulty feeling safe, sensitivity to stimuli and nightmares. She was able to provide brief background information, but past torture was not easily disclosed until later sessions. Fatima was able to disclose that she had been raped and tattooed by her assailants but was initially unable to give more concrete details. Physically, she appeared withdrawn and ashamed. She failed to make eye contact, exhibited declined posture and spoke in a quiet tone.

Fatima's case was then assigned to a case manager who had previously been a physician in the former Yugoslavia. She quickly appeared at ease with this staff member, was able to disclose more detailed information regarding her past torture and openly discussed her medical needs with him, although she continued to become upset during discussions. She explained that she still cried every day, that her husband and children recognised when she was not feeling well and that they allowed her time alone to cry. She felt very fortunate that her husband did not apply pressure on her to disclose past memories and allowed her personal time.

Fatima initially expressed concerns over her medical conditions and stated she had not seen a physician for her pre-existing medical conditions since arriving in the United States, which included being treated for "heart problems" in Germany for five years and an ulcer for six years. She minimised her heart condition and stated she had taken medication in the past for chronic bronchitis, high blood pressure, anxiety, depression, heart irregularities and ulcers. She had also undergone surgery five years prior to arrival, in which her uterus had been removed owing to a large tumour.

With rapport well-established with staff from the Florida Center for Survivors of Torture, a master service plan that encom-

passed all services to be delivered was quickly developed. Mental health needs, as well as medical and social service needs, were clearly defined as target areas to focus on during the treatment period. The Florida Center immediately began making community linkages to needed medical facilities to address areas of concern. The Centre was able to locate area physicians to provide appropriate screening and diagnosis, and medication for her heart, blood pressure and ulcer conditions. Consistent interpretation was provided at each appointment. During medical treatment, Fatima's trust level grew, and discussions began concerning other needs.

She continued to exhibit severe Depression, Post Traumatic Stress Disorder (PTSD) and Generalized Anxiety symptoms. Mental health treatment had been ongoing for many years prior to her arrival, but she explained that the treatment had merely allowed her to maintain her daily functioning. Staff began discussing treatment strategies that were available within her community. Fatima expressed that her mind had psychological scars while her body housed physical scars. The bruises and soreness had long healed, but the tattoos remained forever. These scars were her daily reminder, her flashback triggers that kept her grounded in the past.

Fatima was, nevertheless, open to receiving mental health services. Her case manager utilised another Gulf Coast Jewish Family Services programme funded by the US Office of Refugee Resettlement, the Refugee Mental Health Training and Consultation Program, which trained mental health professionals in refugee mental health issues and linked clients to needed community mental health services. The programme arranged for Fatima to be seen by a trained staff member at a local community mental health centre that would provide medication and individual therapy. She was immediately

placed on antidepressant/anti-anxiety medication. Individual therapy sessions through an interpreter were then provided weekly, which used conventional talk therapy with a cognitive-behavioural focus. Fatima completed each scheduled session for six months.

Prior to beginning her mental health treatment, the Florida Center for Survivors of Torture began to consider ways to reduce her flashbacks. Staff discussion turned to removal of her tattoos by plastic surgery. Staff discussed Fatima's case with a local plastic surgeon, and a plan was formulated to possibly remove the tattoos. The plastic surgeon provided free consultation to Fatima and discussed the number of procedures that would be necessary to remove the tattoos. Fatima discussed her past abuse with much ease and was willing to have photographs taken as part of her record. The plastic surgeon was very moved by the circumstances surrounding the case and offered his services, staff and facility for free. Considerable time was spent in the preparation for all aspects of the surgery. Discussions took place with Fatima concerning the exact details of each procedure and that laser surgery was to be utilized as the primary method for tattoo removal. The laser had to be tested on Fatima to assure it would be successful. (Laser treatment for the removal of tattoos has varying degrees of success depending on the laser wavelength used, the colour of the tattoo and the composition of the ink.)¹⁴

This was completed and the first session was scheduled. Fatima showed few signs of apprehension concerning the tools used to remove the tattoos and was comfortable in the hospital setting. She completed the first laser surgery, and upon awakening, became overcome with joy as several of the images were either completely removed or had faded significantly.

Surgery proved to be a turning point

in her mental health treatment and her depressive symptoms began slowly to subside. Laser surgery was paired with continued psychotropic medication, and individual therapy further improved her level of functioning at home and in her community. She began to discuss employment possibilities and going out of her home more often. Two more laser surgeries followed over the next three months. After the third laser surgery, all tattoos were either removed or unrecognisable. A fourth laser surgery was completed with attempts to remove the more embedded blurs of grey. Fatima began wearing shorter sleeves and expressed more freedom with her body image. She was not afraid to let her children see her arms. She continued to express gratitude to the surgeon and was pleased with the physical results, yet continued to have nightmares and flashbacks concerning her torture.

Fatima explained that the emotions surrounding the memories had improved, but recurrent episodes were still present. This led staff and clinical consultants to advise an additional approach, Eye Movement Desensitization and Reprocessing (EMDR), which had proven helpful in other traumatised individuals. (Numerous studies, including controlled studies, have shown the effectiveness of EMDR for PTSD. Additionally, practice guidelines of the International Society for Traumatic Stress Studies assess EMDR as an effective treatment for PTSD.)¹⁵⁻¹⁹

The originator of EMDR, Francine Shapiro, describes it as “a time-efficient, comprehensive methodology – backed by positive controlled research – for the treatment of the disturbing experiences that underlie many pathologies. An eight-phase treatment approach that includes using eye movements or other left-right stimulation, EMDR helps victims of trauma reprocess disturbing thoughts and memories”.²⁰ This treatment

approach was described to Fatima, and an appointment was scheduled with a trained and certified clinician. The first session was scheduled approximately three months after the first laser surgery and mental health appointments.

After two EMDR sessions, Fatima described that her nightmares and anxiety had lessened, as had her preoccupation with torture memories. After three more EMDR sessions, which concluded the treatment, she reported a significant reduction in recurrent thoughts and trauma symptoms, while still continuing with her other cognitive-behavioural mental health appointments. Counselling sessions now were focused more on adjustment issues surrounding life in the United States. Her scheduled appointments became less frequent, with individual therapy being scheduled one time per month, then eventually as needed.

At this time in Fatima’s treatment, she now wished to focus on employment, and asked for assistance in finding a job that matched her skill level. Staff assisted with advocacy and linkages to appropriate services, and Fatima soon began working for a large hotel chain. She enjoyed her work, took great pride in accomplishing her tasks and, as evidence of her success, desired to work more hours than originally scheduled. Further social service needs were met during the first six months of services that included helping with landlord disputes, housing advocacy, cultural training on housing issues, transportation arrangement and training, medication compliance and advocacy, food bank assistance, interpretation needs, and family support assistance. Fatima also was enrolled in a unique programme that assisted refugees in matching money saved toward large purchases such as a home, car or computer. Her enrollment in the programme, paired with her future planning, further ex-

emphified a regaining of hope and a continued decrease in psychological symptoms.

After eight months of treatment and services coordinated by the Florida Center for Survivors of Torture, Fatima was able to significantly decrease her need for mental health and social services, but continued the monitoring of her medical conditions. Fatima also had been discussing the possibility of removing the faded tattoos that were too deep to be removed by laser surgery. This procedure would entail actually cutting out the tattooed areas. Fatima is currently debating whether or not to follow through with this procedure.

Discussion

There were a number of individual variables that increased the likelihood of Fatima reducing her depressive, anxiety and PTSD symptoms. The Florida Center was able to provide her with a case manager who was a former physician who spoke Serbo-Croatian. Because he was a physician, Fatima felt more comfortable in his presence. He also was able to help prepare her for her medical procedures. Extra effort was taken in preparing her for the tattoo removal surgeries, with the knowledge that the removal itself could trigger her back to the traumatic event. Also, consistent interpreting with the many different service provider agencies throughout her treatment resulted in an improved comfort level treatment. The relationship between Fatima and the case manager played an integral role in the healing process, as rapport had been easily established and maintained.

After the first tattoo removal surgery, Fatima reported a decrease in depressive symptoms and an increase in her self-esteem, stating, "I feel that my life is now beginning again." Removing the physical reminder of the horrific event was a definitive way for Fatima to gain more control over her life.

This was evident in her willingness to expose her arms more frequently and her feeling more open to her family members.

Fatima continued to report PTSD symptoms even after receiving antidepressant medications, attending traditional talk therapy, completing further tattoo removal procedures and cognitive-behavioural therapy. It was not until a volunteer therapist provided EMDR therapy that the client reported a significant decrease in PTSD symptoms. The combination of psychotropic medication, traditional talk and EMDR therapies provided a holistic approach to mental health treatment that gave Fatima coping skills to reduce her PTSD and depressive symptoms to functional levels.

There often are many barriers to accessing mental health treatment for torture survivors, including stigma, cost, transportation and available providers.²¹ Utilising a holistic, multidisciplinary medical, psychological and social approach, and with considerable preparatory work, Fatima was willing to become able to participate in an array of services. With patient, supportive and culturally sensitive assistance, Fatima became eager to engage in services that others within her culture often see as outside societal norms.

We encourage those treating torture survivors to look at all dimensions of a person's well-being in order to assist them in achieving their maximum level of functioning. A holistic approach utilising existing community resources was essential in Fatima's successful treatment. Through community networking and advocacy, treatment professionals may be able to identify and recruit low-cost, pro bono and additional services that are enormously helpful to clients served. The authors have found that area network providers typically are eager to receive training on dealing with survivor issues and techniques, and often are willing to accept new

referrals, given the support from staff from a torture treatment centre.

Conclusion

Fatima's case particularly illustrates the impact that torture-induced disfiguring through tattooing can have on self-esteem and social, psychological and interpersonal function. Further, EMDR, as a technique to reduce psychological symptoms of PTSD, proved effective. Through the support provided by a community-based multidisciplinary network model for treating torture survivors, treatment was able to successfully meet the varying needs of the client, addressing both the physical and psychological sequelae of torture. Through consistent service delivery, the training of network providers on torture treatment issues, comprehensive and specialised mental health treatment and medical interventions to remove disfiguring tattoos, the client was able to significantly reduce symptoms and increase her level of functioning. Finally, given the paucity of literature related to the sequelae of tattooing as a torture method and subsequent treatment, additional descriptive and other research is needed in this area.

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Introduction

For the past fifteen years, Northern Uganda has been engulfed in an atrocious and violent conflict between government forces – Uganda People's Defence Force (UPDF) – and rebels of the Lord's Resistance Army (LRA). This conflict has resulted in large-scale internal displacement of people, abductions of over 14,000 children (Table 1), deaths and the destruction of homes, basic infrastructure and services such as education and health.¹ Subsequently, the very core and fabric of the society have broken down, and the people affected have lost hope and suffer from a range of psychological problems.² This large-scale abduction of children is the most tragic aspect of this conflict, forcing the vulnerable and innocent to become part of the conflict as child soldiers, human shields, hostages or as coerced sexual slaves of rebel commanders. Children as young as seven have been abducted; however, the majority are between 10 and 18 years of age. Many of them have either escaped from rebel captivity or were rescued from battles with the rebels. This has attracted the attention of international non-governmental organisations (NGOs), which help provide psychosocial services and reintegrate them into their communities.

World Vision is a Christian-based NGO operating in many parts of the world, including Uganda. Their areas of operation, among others, include: education, micro credit, pov-

erty alleviation and psychosocial support. The World Vision Trauma Centre (WVTC), in Gulu, Northern Uganda, was set up in 1990 to help rehabilitate and eventually reintegrate formerly abducted children who were rescued or had escaped from rebel captivity back to their families and the community. Rehabilitation at the centre ranges from six to twelve weeks, depending on the degree of severity of the psychological reactions they manifest. After rehabilitation, the children are reunited with their parents and reintegrated into the community with a possible follow-up. The therapies employed by the centre include: tension-relieving games and dances, art therapy and individual and group counselling.

Upon admission to the centre, the children showed a variety of traumatic reactions such as withdrawal, fear, anxiety, affect and conduct disorders, aggression, intrusive thoughts and a hoard of other posttraumatic stress disorder (PTSD) symptoms such as nightmares, lack of concentration, hypervigilance, sleep disorders, depression, deep sadness, abnormal reactions to situations, as well as attachment disorder (AD), attention deficit hyperactive disorder (ADHD) and apathy. This study initially aimed at providing social workers, counsellors, health workers and teachers at the centre, to facilitate the rehabilitation process, with a handbook and guide to assess the signs of traumatic reactions severity of traumatic reactions and the children's perception of the current situation. This was subsequently intended to provide focused and appropriate measures of intervention and rehabilitation to generate healing, development and subsequent reintegration of the children into their families and community.

Trauma

Trauma has a broad definition. In this case, it could be understood to mean the conse-

Table 1. Persons abducted by district in Northern Uganda (N = 14585).

	APAC (n)	Gulu (n)	KITGUM (n)	LIRA (n)
Not returned	597	2610	3161	131
Returned	1442	1842	4631	171
District total	2039	4452	7792	302

Source: UNICEF, 1998.

quences of traumatic events that overwhelm a person's sense of control, connection and meaning in life; or events that cause a person to experience overwhelming fear, helplessness and isolation. These events are the kinds that threaten the person or relatives in the sense of their existence, or by causing the destruction of things that are essential to their lives, such as the killing of their parents or relatives, burning of their houses and destruction of their property. Such traumatic events include: war, natural catastrophes, accidents, deaths and exposure to violence. The consequences of these traumatic events include: nightmares, extreme fears of objects that remind them of the traumatic events, intrusive thoughts, anxiety, isolation and withdrawal. In Northern Uganda, children were abducted and coerced into guerrilla warfare, and one of the strategies was to "burn the bridges", that is, to completely cut, alienate, detach and destroy the bond between the children and their families and communities as a means of keeping the children in the rebel ranks and preventing them from escaping from rebel captivity. One way of doing this was to force the children to be part of a group that attacked and looted their own villages and possibly killed their own families. Another strategy was to tell the children that their parents and all their relatives, whom they had left behind, had already been killed and their homes destroyed. In addition, while in captivity, the children were also informed that if they came back to their homes, they too would be killed and that even those who were admitted to hospitals were injected with poison.³ They were brutalised and sometimes forced to kill or be killed. They wielded life-and-death powers over adults, often in their local communities, and sometimes over fellow children who disobeyed the orders of their older rebel mentors. The children who tried to escape and were caught were tortured

and often killed by fellow children as an example to those with intentions to escape. They were highly traumatised and dehumanised as a consequence of widespread exposure to violence through this strategy.^{2,4}

Methodology

Sample

The sample in this study consisted of 74 children: 21 girls (28.3%, mean age 13.4) and 53 boys (71.7%, mean age 14.2) out of 168 children aged 8-18, residents at WVRC Centre, selected in a stratified random sampling to ensure that the proportion of boys to girls in the study was the same as in the target population.

Procedure

Permission was obtained from the centre and the children's parents to conduct the study, and an initial period of two weeks was allowed for familiarisation with the children to build rapport. Each child was assigned a number, which was subsequently placed in a box and shuffled, and the required number of children drawn from the box. The participants were grouped according to gender and a one-on-one interview was conducted. For in-depth interviews, two or more research assistants interviewed the participants. In all the cases, the questions in the questionnaires and interview schedules were read out aloud to them. Female and male research assistants led the female and male groups respectively. To ensure anonymity and confidentiality, the names of the participants were not recorded.

Measures and analysis

Two sets of questionnaires were used. The questionnaires were crosschecked by various NGOs working in related fields, pilot-tested and found to be reliable. The first questionnaire, an 18-item War Experiences Checklist, made for the purpose of this study, dealt

with general information about life in rebel captivity and the kind of traumatic events they experienced, and was rated on a scale of 0 (no) and 1 (yes). A sum score was obtained by adding up all the positive endorsements of events a child experienced while in rebel captivity and descriptive statistics was used to analyse the results. The second was a DSM-IV-based 30-item self-rated traumatic reactions questionnaire rated on a scale of 0 (not at all), 1 (a little bit), 2 (moderately), 3 (quite a bit) and 4 (extremely) of what their reactions were concerning their traumatic experience.⁵⁻⁶ This questionnaire was aimed at recording the severity of traumatic reactions among the children. Scores were classified as: 0-12 = almost normal; 13-48 = mild traumatic reaction; 49-80 = moderate traumatic reaction; and 81+ = severe traumatic reaction. The overall score is indicative of the severity of traumatic reactions of the participant. The semi-structured interview was used to obtain information concerning the children's perception of the current situation as well as life in captivity.

Data was also obtained from the records and files of the children at the centre documenting the physical, emotional, cognitive and behavioural signs of psychological distress manifested by the children. This was tabulated and presented as signs of psychological distress. Social workers and counsellors at the centre made these records. Case stories were obtained through the semi-structured interview that dealt with the children's perception of the current situation and life in captivity. Records of responses from the structured interviews with the children and data from the records at the centre were carefully analysed and transformed into meaningful broader content categories in order to analyse the intensity of traumatic reactions among the children through group discussion and analysis by the counsellors, health

workers and social workers at the centre. The records were again cross-examined by different research assistants, the principal investigator and the counsellors at the centre for cross-validation of the interpretative thematic analysis; a careful multistage analysis was used in which information collected was transformed into meaningful broader content categories, and later discussed and analysed until particular themes emerged. All the recordings by the different research assistants were later compared, and a common position arrived at. In analysing the perception of the current situation, records of interviews by the different research assistants were compared, discussed and carefully analysed and transformed into meaningful content categories to arrive at the perceptions of the children on the current situation.

Results

Signs of traumatic reactions among the children

The children showed an array of signs of traumatic reactions and symptoms as a result of exposure to a broad spectrum of violent activities and experiences. Table 2 shows the affirmative endorsements of the 18 items on the War Experiences Checklist specifically made for this study. The mean total score on the War Experiences Checklist for the whole sample was 10.8 (SD = 2.8, range = 4-6). Among the experiences highly endorsed by all the participants were long-distance treks, death threats and thinking that they would be killed. Other experiences, such as seeing dead bodies and body parts, were witnessed by 90% of the children, while 47% participated in killings and 20% saw family members or close relatives being killed. To corroborate these findings, records from the files of the children at the centre were studied and found to be consistent with the war experiences.

Table 2.
War experiences
checklist (N = 74).

Events	Yes (%)	No (%)
Walked very long distances without rest to avoid rebels	100	0
Saw other people being abducted	100	0
Slept in the bushes to avoid abduction by rebels	100	0
Witnessed people being flogged	100	0
Thought that you would be killed	100	0
Threatened with death	100	0
Had to hide sometimes to protect oneself	100	0
Saw dead bodies or parts	94	6
Saw killings and injuries with machetes, pangas or knives	90	10
Saw someone shot	87	13
Heard people shouting or screaming for help	80	20
Escaped narrowly from rebel abduction	78	22
Escaped narrowly from battles	78	22
Witnessed village raids	70	30
Saw someone blown up in a landmine blast	55	45
Participated in killing their own relatives	47	53
Participated in beating or killing a fellow child who tried to escape	40	60
Saw your family members or close relatives being killed	20	80

The signs and symptoms were categorised as follows: a) physical, b) emotional, c) cognitive and d) behavioural signs, and are listed in Box 1. All the children showed at least one of these signs and symptoms. The majority of the children were malnourished, emaciated and had numerous dermatological complaints, such as rashes, scars and wounds. They also had eye problems, muscle aches, sores, pains and diseases such as cataract and conjunctivitis. Many of the girls who had reached menarche were having irregular menstrual cycles. Three of the girls who had already reached puberty, and had started having their menstrual periods, had stayed for over a year without menstruating. They were severely depressed and expressed fears that they would not have children in the future because of their condition. The common emotional signs were sadness, fears, irritability and numerous phobias, especially those associated with their experiences while in rebel captivity. A few, especially the younger ones, were prone to crying. The common cognitive signs included: lack of concentra-

tion, confusion, intrusive thoughts, absent-mindedness and incoherent speech patterns. Bedwetting, nail biting, thumb sucking, sleep disturbances, repetitive play and failure to comply with rules and regulations were also common among the children. Many of the children (29, 39.1%) had nightmares quite often and others were withdrawn and engaged in reckless and self-destructive activities. Many were also very suspicious and found it difficult to stay in one place for a long time.

Severity of traumatic reactions among the children at the centre

Overall, 11 children (15%) were found to be almost normal, 34 (46%) were found in the mild reaction range, 26 (35%) in the moderate range and 3 (4%) in the severe range. It was observed that many of the children who had stayed for a shorter time in rebel captivity had mild traumatic reactions. The majority of those who were in the mild and moderate categories were in the age group 13-18 years old, and those categorised as almost

normal were in the age group 8-12. The three children who were categorised as having severe traumatic reaction were girls. They very rarely verbally communicated and were withdrawn and extremely suspicious, often had nightmares and messed themselves whenever they answered the call of nature (Box 2). The classifications of the traumatic reactions were consistent with the records on the physical, cognitive, emotional and behavioural signs manifested by the children. Children in the category “almost normal” presented with very few, if any, of the symptoms required to make the assessment. Poor hygiene and a few dermatological signs were present. Among the children in the category “mild reaction”, there were symptoms that could be used to make the assessment, and there was one or two minor impairments in social functioning, such as difficulty in com-

plying with rules or regulations, repetitive play and social withdrawal. There were clearly many signs and symptoms (physical, emotional, cognitive and behavioural) that could be used in the assessment of the category “moderate reaction”. The functional impairment in this category included: difficulty in complying with rules, extreme suspicion, aggression, repetitive play, social withdrawal and enuresis. Among the children in the “severe” category, there were numerous signs and symptoms in excess of those required for assessment. There were marked impairments such as depressive withdrawal, nightmares and sleep disturbances, daydreaming, aggression, crying, difficulty in staying in one place and reckless and sometimes self-destructive activities (Box 1). Excerpts from some of the outstanding cases are described in Box 2.

Physical signs	Emotional signs	Cognitive signs	Behavioural signs
<ul style="list-style-type: none"> • Malnourished and emaciated • Dry lips • Poor hygiene: long and dirty nails, dirty, smelly and untidy • Chest infections and bad coughs • Fevers • Amenorrhoea • Dermatological signs: rashes, scars, wounds, etc. • Ear, nose and throat problems • Excessive sweating • Pain related to the muscular-skeletal system • Twitching eyes • Pelvic pains (mainly girls) • Reduced muscular endurance or general fatigue 	<ul style="list-style-type: none"> • Sadness • Anxiety • Fears and worries • Stress • Depression • Irritability • Bitterness • Disillusionment • Hopelessness • Crying, screaming and groaning • Phobias related to experiences in rebel captivity • Pains and body aches without an apparent cause 	<ul style="list-style-type: none"> • Intrusive thoughts • Confusion • Lack of concentration • Absent-mindedness • Incoherent speech pattern 	<ul style="list-style-type: none"> • Crying • Nightmares and other sleep disturbances • Aggression • Lack of body care • Daydreaming • Thumb sucking • Enuresis • Biting • Depressive withdrawal • Difficulty in complying with the rules at the centre • Repetitive play • Extreme suspicion • Reckless and sometimes self-destructive activities • Loss of interest in play/games • Social withdrawal • Difficulty in staying in one place for a long time

Box 1. Summary of the signs and symptoms from records and observations at WVRC Rehabilitation Centre.

Perception of the current situation among the children

The perception of the children of the current situation was mainly based on their experiences during their abduction from the community and in rebel captivity and at the

time of rescue or during their escape from rebel captivity (Table 2). Many expressed hopelessness, lack of trust in the adult community and a bleak future. Some of the children had no knowledge of where their parents were, others had committed atrocities

J, girl, 12 years old, was abducted when she was 11 and was in rebel captivity for a year. She and her friend made a daring escape from rebel captivity during a battle when her captors were overpowered and scattered in disarray. While in the bush with the rebels, she was allocated to one of the rebel leaders and was responsible for domestic chores: collecting firewood, fetching water, cooking and cleaning. She was beaten and abused by the wives of the rebel commander. She witnessed her fellow captives severely beaten and on many occasions was made to participate in the beating. In one incident, three of the children who tried to escape were killed. They were cut by machetes and beaten with huge sticks. J participated in burying them and it utterly revolted and shattered her. She says the scene keeps coming back to her. She is withdrawn, depressed and sad. She is also very suspicious and nervous. She fears being abducted again, as the rebels are still operating in the area. She feels that she has to undergo traditional rituals to cleanse her.

D, boy, is 15 years old and was abducted together with his sister on the way to school one morning. His sister was badly injured in a battle during which government soldiers intercepted the rebels as they were taking their captives across the border. He learnt that she later died. D confessed that he is sad and does not have any hope for a bright future for himself because he learnt that the rebels beat his father to death, and there is no one to pay his school fees. He does not have the same feeling he used to have for his mother. When asked why, he kept quiet as he looked down. He has problems with his sleep and finds it hard to concentrate on anything for a long time. He fears he might be abducted again because the rebels are still active in his home village to which he loathes to go back. D is sometimes very aggressive and plays repetitively. He says he participated in many battles and was forced to kill his friends who tried to escape. He also believes that he might have killed many during the battles. He actually confessed that his commander loved him because he was daring during battles. He feels a deep sense of insecurity and guilt and fears he might be abducted again. Like J, D feels that he has to undergo traditional rituals to cleanse him.

K is a 17-year-old boy who was brought to the centre by government soldiers who rescued him from the battlefield where many of his colleagues with whom he was abducted three years ago were killed. He lives in great fear and is always suspicious and cannot stay in one place for a long time. He washes his feet several times a day. When asked why he keeps quiet. When pressed to explain this behaviour, he becomes very nervous and begins to stammer. Later on, he hinted that he was forced to repeatedly kick a friend to death after he tried to escape. K is usually withdrawn but easily irritable and aggressive. He does not want to go back home after the counselling and fears that he might be abducted and killed by the rebels. He frequently has nightmares and wets his bed every night, a situation he describes as humiliating and degrading because his friends laugh at him and he fears his wife will not tolerate this kind of situation.

B, girl, 16 years old, was abducted when she was 14 years old and had already started her menarche. She has not had her menstrual period for the last four months and yet she is not pregnant. She was diagnosed with gonorrhoea and syphilis upon admission at the centre. She fears she might not have children in the future. Her tasks while in rebel captivity were to do domestic chores: walk long distances to fetch firewood and water, cook and clean. Sometimes the commander would come to the hut in which she slept and ask her to come out. When she remembers this, she cries all night long. She does not feel safe at the centre and says she does not want to go back home. Loud noise frightens her and makes her tense.

S, a 14-year-old boy, cannot follow what he is told to do. He is always very angry and irritable and quarrels a lot with his peers. Sometimes he wakes up shouting in the night. He was abducted one night from his home village. He participated in raiding villages, looting foodstuff and brutal killings and was made to amputate the legs of villagers who did not follow rebel rules and regulations. He feels very guilty about all this. He is hyperactive and unable to concentrate on any activity, and is unable to stay in one place for long.

Box 2. Excerpts from cases showing the degree of traumatic reactions among the children at the time of the study.

against their communities, including torching their houses, looting their foods and sometimes killing their relatives. For fear of retribution, they did not want to go back to their communities. Many of the children were very suspicious of the communities and facilities they were indoctrinated against while in rebel captivity. For instance, they avoided accessing health facilities for fear of being poisoned, and those who had not yet met their parents feared that they may be dead. Another source of great fear among the children was the possibility of reabduction by the rebels who are still operating in some of the areas from which the children came and into which they are to be reintegrated. The grinding poverty in the communities made it uncondusive for the children to want to go back. Many of the children had also lost their parents, either as a result of the war or natural causes, leaving the children without any support. The majority of children of school-going age expressed the desire to go back to school or be trained in some skill that would be a source of livelihood for them in the future. Also very prominent was the worry about when the war will end.

Discussion and conclusion

Exposure to wartime events is generally associated with a variety of traumatic reactions. This can take the form of physical, emotional, cognitive or behavioural signs and different levels or degrees of trauma. The present study sought to examine the signs and severity of traumatic reactions, in addition to the children's perceptions of the current situations, with the aim of finding an assessment tool and an insight into the intervention needs of the children at the rehabilitation centre.

The children at the centre manifested a wide range of traumatic reactions. Most of them were exposed to very gruesome activities, such as raids on villages, participating in

killing their relatives and fellow children who attempted to escape, etc. Many were threatened with death and thought they would be killed. Signs of traumatic reactions were clearly evident in the majority of the children studied. Previous studies recorded similar findings in populations exposed to violence in which life in captivity consisted of activities and scenes involving very strong mental imprints such as in this study.⁷⁻⁸ The majority of the children showed signs of physical, emotional, cognitive and behavioural psychological distress associated with exposure to traumatic events and a range of other mental health problems, including PTSD symptomatology (Box 1). These findings are consistent with previous studies conducted in Palestine, Sierra Leone and Rwanda.^{7,9-12} In Sierra Leone and Rwanda, 99% and 79% of the children reported clinically significant levels of PTSD respectively. The limitations here, as in the Sierra Leonean and Rwandan cases, are that the number of experiences depended on self-reports and records at the rehabilitation centre, that the environment at the time of the study is still fraught with war and that there was no psychiatric assessment. In a climate fraught with war, fear of retribution, shame or guilt, the children may have underreported their experiences. Sometimes, health and social workers, if not sufficiently trained in dealing with traumatised children, may fail to recognise and record signs. However, in spite of these limitations, this study clearly shows that the children had a high degree of psychological distress.

The adolescents continue to live in surroundings resonant with wanton violence and amidst a variety of traumatic reminders in addition to communities traumatised by the same war. The "unspeakable viciousness" of the rebels has created anxiety, fear and despair in the population. Loss, grief, hatred, vendettas, societal dislocation, lack of trust,

dysfunctional families, material deprivation, interruption of schooling and social networks, and scarce resources resulting from the war, in addition to the uncertainty about when the war will end, are possible sources of new traumas for the adolescents, catching them between reminders of life in rebel captivity and an uncertain and bleak future. These additive factors might have influenced their perception of the current situation. They do not understand why it happened to them, they distrust society in general and have enormous fear of possible retribution, reabduction and when the war will end, in addition to worrying about their future in such a society. This is in line with previous findings in which additive factors such as these may further exacerbate the situation, influence perception, make it difficult to come to terms with what has happened and delay healing.⁷⁻¹³ Health workers, social workers and counsellors have to appreciate these additive factors in order to make any intervention meaningful. Alternately, the revulsion and the sickening level of brutality and cruelty associated with this war can only be compared to others with great caution, and statistical computations can never fully characterise the consequences of the war on the adolescents. Considering the limitations of the cross-sectional design of the study, and that the children were exposed to war situations and were aged between 8-18 years, the results of this study will need to be interpreted with caution, and generalising the findings beyond the sample would be possible after several replications with other similar samples and populations.

Implications for interventions

As underscored in this and many previous studies, the severity of traumatic signs and reactions shown in the War Experiences Checklist – the physical, emotional, cognitive

and behavioural signs and the perceptions of the current situations – may make the children less prone to process the trauma, and they may develop psychopathology.¹⁴ Rational Emotive Behaviour Therapy, in which the adolescents are taught how to identify their irrational beliefs and behaviours, question them and replace them with rational ones, can be very useful in this regard.¹⁵

However, it is imperative to note that several factors affect how children exposed to organised violence react. Knowledge of such factors as immediacy, effectiveness and appropriateness of interventions, intensity and length of time of exposure, nature and history of the violence, context in which it occurs, those involved and how adolescents and their parents are likely to react, individual differences, and gender dynamics in the society are very crucial in planning appropriate interventions. Children's needs are holistic: attention to physical and survival needs must be complemented by equal attention to psychosocial, emotional and developmental needs. Likewise, parents, with whom the children are going to live, need the same if not more attention in all the above needs. Awareness of the community into which the children are going to be reintegrated is also paramount.^{8,16-18} For any intervention to be meaningful, the following additive factors consequent to experiencing traumatic events should all be adequately addressed in the context of the local culture: low self-esteem and morale, failure to openly discuss what happened, the dehumanising consequences of the war, restoring the severed bonds between individuals and communities, and strengthening the family systems by improving psychosocial support to parents to manage their stress effectively and enhancing community resources that the adolescents will be reintegrated back into, improving the material well being.^{11,12}

Social workers and counsellors at the centre should implement a combination of modalities. Such modalities would include family counselling, cognitive-behavioural therapy and other psychosocial interventions such as community reintegration programmes. The length of psychotherapy should depend on the complexity and severity of the problems of each child and should often be informed by the local culture.¹⁹ In Mozambique, for instance, silence about the past has become a way of coping after decades of cruel and horrendous civil war. Therefore, the assumption that verbalisation of emotions is an integral part of reducing psychological distress may not hold for all cultures.²⁰ If the school and community functioning are affected, appropriate interventions in these areas are needed, too. Problem solving and learning self-soothing, anger management, communication of feelings and social skills are of enormous importance. Organised and appropriate tension-relieving activities, such as games and sports, dances, culturally appropriate counselling and therapy (such as cleansing rituals) are recommended in addition to the establishment of community support networks and an education system cognisant of their special needs.

Above all, what is crucial to the needs of the children is what the future holds for them. The different therapies alone will not restore any hope in the children, who already see the future as bleak and hopeless and the community into which they are to be reintegrated as awash with poverty. Many of the children would like to go back to school, others need training in technical or entrepreneurial skills that would give them a means of livelihood. Therefore, training and micro-credit facilities should form part of the intervention offered to the children.

More research, especially case studies, needs to be conducted on individual children

to determine the degree of severity of their reactions, how to help individual children cope with their experiences, and the treatment regimes within a clearly defined cultural context.

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Suicide in custody

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Abstract

Hanging is an asphyxial death caused by a ligature around the neck and the suspension of the body, either partially or completely. It is one of the most common causes of death in cases of suicide. It always causes suspicion among relatives and the investigating officers, as well as – at times – on the part of the autopsy surgeon. Controversy arises in those cases in which the noose is too tight, has too many turns or uses an atypical slipknot. Controversy also arises with regard to complete ligature marks, when the hanging is not possible from a sitting or kneeling position, or when there is no dribbling of saliva from the corner of the mouth, especially when there is suspicion of postmortem hanging.

At times, it can be very difficult to determine whether the death was suicidal, homicidal or accidental in nature. The latter can often be differentiated on the basis of evidence at the scene of the crime, but problems arise in cases of suicidal/homicidal hanging, and in differentiating between antemortem and postmortem hanging.

Two cases of suicidal deaths are presented in this article, one in a central jail and another in a police station lock-up room.

Introduction

Various questions arise when death occurs in custody. It often raises the question whether

a person has committing suicide in custody because he/she has been unable to bear being tortured by interrogators. Yet, on the other hand, the deceased may have suffered from psychological problems and have ended his/her life for this reason.

Torture is defined by the United Nations Convention against Torture¹. *Suicide* has been defined as an act of self-inflicted, self-intended taking of one's own life, in a culturally non-acceptable manner². *Hanging* is the most common way of committing suicide in our country. It is one of the causes of death which always leads to suspicion of homicidal death. Sometimes suicidal death is very difficult to differentiate from accidental death, the abetment of suicide or homicidal death. This is especially true when the scene has been disturbed intentionally by the person who reported the death. For fear of police interrogation, relative may change the position of articles or the body. Other interventions may be caused by a physician, especially if there has been signs of life.

The average prevalence³ of deaths due to suicide in India is estimated at 150-200 deaths per day. It is much more common for males than females, with a male/female ratio of 50:1.

Material and methods

Both of the hangings described in this article occurred in bathrooms. In the case of the death in the central jail, the investigating officers explained that the deceased was discovered by the police officer on night duty, while in the case of the death in the lock-up room, the deceased was discovered by an-

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other detainee, who was in the same room overnight. In both cases, the doors were bolted from the inside.

Case no. 1

At 10.45 a.m. on 29 June 1997, a dead body was brought for postmortem examination by the investigating officer, who related that the deceased had been found in a partially hanging position in one of the bathrooms of a district jail. A waistcloth was used for this purpose. The postmortem examination was conducted by two doctors between 10.48 a.m. and 12.30 p.m.

Upon external examination, the 23-year-old male was of average build, was averagely nourished, and was wearing a full-sleeved self-printed shirt. At the corner of the mouth, a brownish fluid mixed with digested food particles was present, and at the right nostril a dried fluid was present. The tongue was inside the oral cavity, and there was a bluish discolouration of the fingernails.

An interrupted ligature mark was present on the neck, above the thyroid cartilage, oblique in size, 39.5×2.3 cm. There was an abrasion over the right submandibular area, 4.0×2.2 cm, and red in colour. There was no evidence of marginal contusions and ecchymosis, nor evidence of other external injuries. Stool and semen were present at the anus and at the glands.

Upon internal examination, the organs were observed as being congested, the hyoid and thyroid bones were intact, and there were haemorrhages in the right submandibular gland. On opening the oesophagus, a piece of razor blade, 1.5×0.7 cm, was found in the oesophageal mucosal lining, along with haemorrhage in the surrounding tissue at the level of the lower part of the larynx. The other organs were congested. No abnormal smells in the stomach contents were detected.

The viscera were preserved for chemical,

histopathological, biochemical and microbiological examinations. Reports revealed congestion in the organs, but no other abnormalities in the samples.

The cause of death was recorded as asphyxia as a result of hanging.

Case no. 2

At 4.20 p.m. on 4 July 2001, another dead body was brought for postmortem examination by an investigating officer, who related that the deceased was found in a hanging position in the bathroom of the lock-up room of a police station. A thin cloth towel was used for this purpose. The deceased had been arrested on the suspicion of involvement in murder and dacoity.

The postmortem examination was conducted by two doctors between 4.30 p.m. and 6.45 p.m. on 4 July 2001. Upon external examination, the deceased was a 25-year-old male who was well-built and well-nourished. Urine had passed into the clothing. Rigor mortis was present in the body, and postmortem lividity was present in both lower limbs up to the thigh and in both hands and forearms. Multiple haemorrhagic spots were present over both lower limbs.

The tip of the tongue was protruding from the mouth and caught between the teeth. There was a bluish discolouration of the lips and fingernails, and a ligature mark, 28×2.5 cm, was present on the neck, which was oblique, interrupted, above the thyroid prominence and red-brown in colour. There were no visible and palpable fractures.

Upon internal examination, all organs were congested, and the stomach contained a brownish fluid that did not emit any abnormal smells. Neck tissues showed a congestion below the ligature mark. There was no evidence of fracture of the hyoid or thyroid bone.

The cause of death was given as asphyxia

due to hanging. However, viscera were preserved for chemical and histopathological examination.

The histopathological examination report revealed congestion in all organs and interstitial haemorrhages in the lungs. The chemical examination report did not show any trace of poison in the tissues.

The final cause of death was given as asphyxia due to hanging.

Discussion

Both autopsies were videotaped according to the directions of the National Human Rights Commission (NHRC), in New Delhi. It is mandatory for all authorities to report all cases of custodial death to the NHRC, New Delhi, within 24 hours of occurrence or from the time the officers were made aware of such an occurrence⁴. In the two cases, the exact cause of suicide could not be determined. Suspicion still remained with regard to the investigative agencies, although there was no

evidence of physical injury on the bodies. However, the deceased may have been tortured in order to coerce them into providing information relevant to the investigation. By performing a meticulous postmortem examination and a thorough documentation of the facts, the forensic expert may play a constructive role in society, not only by treating the sick, but also by acting as a health professional social healer⁵.

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Secondary trauma in treating refugee survivors of torture:

Assessing and responding to secondary traumatisation in the survivors' families

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Abstract

The paper deals with the exploration of the theoretical basis of different kinds of secondary traumatisation in general and specifically in torture. The analysis is focused on the effect of torture on the survivors' families. This presented analysis with the author's clinical and personal experience is basis for developing a framework for assessing secondary traumatization in torture survivors' families. A family typology of six types, in which each may need different approach in intervention, is proposed. Clinical case studies that represent some of these typologies are reported. The goal intends to provide a holistic and multidimensional wraparound approach to torture trauma in order to ensure a truly effective intervention towards the full recovery of the survivors.

Key words: torture survivors, secondary traumatisation, family dynamics

Introduction

In this paper I explore the theoretical basis of different kinds of secondary traumatisation in general and specifically in torture. After this, I will focus my analysis on the effects of torture on the survivors' families. Based on

the presented analysis and on my clinical and personal experience, I develop a framework for assessing secondary traumatisation in torture survivors' families. I propose a family typology of six types in which each may need a different approach in intervention. Finally, I provide clinical case studies that represent some of these typologies. The goal is to provide a holistic and multidimensional wrap-around approach to torture trauma in order to ensure a truly effective intervention toward the full recovery of the survivors.

The theoretical basis of secondary traumatisation

Figley^{1,2} and others, by introducing the concept of secondary trauma, started a revolution in trauma theory and research. Traumas can have similar or different effects on persons in relationships, or within a strong collective identity, even if they did not suffer the trauma themselves. The concept of secondary trauma in model I is based on few assumptions. The *first assumption* is that a human individual does not exist alone. He or she is part of a network that is structured and connected through different ties and mechanisms. He or she is part of a course of activities and systems that continuously moves in space and time, and that is governed by the systems' dynamics. Any significant event, negative or positive, that affects him/her can

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have equal or different effects on the system and networks, their activities and the dynamics that he/she is part of, and the other individuals who are members of this system or group. The *second assumption* is that the degree of closeness in one's relationship to others, within these systems, will determine the mechanism of such transmission and its effects. The *third assumption* is that the transmitted effects can have systemic and ripple effects that go through space and time, beyond the initial impact. This systemic perspective presents one level of analysis. Individuals co-exist in a system or a network of interlocking relationships that transmit the effects of different significant events horizontally and vertically within time and space. The other level of analysis, which is the trauma-focused perspective that negatively defines the significance of events, concentrates on which kind of traumatic events happen: is it personal, interpersonal or collective. This moves us from the abstract system thinking level to the concrete clinical experiencing level. The individual exists in relationships, interpersonal relationships, families, groups and communities. He or she belongs and develops affiliations, attachments, feelings of belonging, and personal and group identities. What affects him/her significantly, negatively or positively, can affect those who are in a relationship or those with whom she or he identifies. Moreover, whatever affects negatively the group members he identifies with, e.g. in an ethnic or national group, may secondarily traumatise him.

Trauma is transmitted to those in relationships, and in some instances across generations or different levels, and through different mechanisms of transmission. Examples of such mechanisms that channel transmission of trauma are symbiosis, empathy, attachment, enmeshment, personal or collective identification, projective identification,

introjection, dependency and codependency and interdependency. An extreme example that gives validity to this assumption is shared psychotic disorder (Folie a Deux). In this disorder, a delusion develops in an individual in the context of a close relationship with another person(s) who has an already established delusion (DSM IV, 297.3). In this context, secondary trauma can happen not only to one person, but also to a family, to a primary or secondary social group, to a community, or sometimes, to a whole nation or ethnic group, e.g. genocide, September 11.³ However, the transmission of trauma does not always occur. Moreover, the mere experience of the most extreme traumatic event does not necessarily result in a disorder.⁴

We can find two main kinds of transmission:

- A. *One step transmission of trauma:* The transmission can happen from one person to another or from an individual or individuals to a connected group or vice versa. For example, domestic violence is a direct trauma to the parent, and indirect trauma to the child or children. Sexual abuse of the child is a direct trauma to the child and an indirect trauma to the parents.
- B. *Multiple steps of transmission:* In this case trauma is transmitted cross-generationally. This kind of secondary traumatising may be sub-divided into two categories:
 - a. *Cross-generational family trauma transmission:* In this kind, traumatic practices and their effects are transmitted within a family system across generations. Examples are the vicious cycles of violence, physical abuse and incest that go from one generation to the next in some families.
 - b. *Cross-generational collective identity trauma transmission:* There are at least

two kinds of collective identity traumas: 1. *The historical trauma*, for example the slavery of black Americans, the Armenian genocide in Turkey, the Jewish Holocaust, the Palestinian trauma and the American Indian experience of genocide. September 11 is a historical collective trauma. This type of trauma is rather a collective complex trauma, as it is inflicted on a group of people that has a specific group identity or affiliation to ethnicity, colour, nationality or religion. 2. The second kind is the *social structural trauma*: Multigenerational transmission of structural violence constitutes extreme social disparities.⁵ The effects of the chronic and pervasive condition of societal structure or social violence, created by generating extremely deprived social classes, are traumatic to the parents and their children. Recognition of such extreme discrepancy in social power results in a sense of relative deprivation.⁶ Differential status identity (DSI) that is generated by the critical differences in social standing from the ordinate group, as suggested by Fouad et al.,⁷ may demonstrate the case of such collective identity trauma and its transmission. The effects of deprivation by poverty and demoralisation are passed on from parents to their children and may cause collective terror that contributes to the kinds of conduct problems, violence and drugs that are more prevalent in some inner-city communities.

Table 1 summarises this classification of secondary trauma.

Torture trauma and its transmission

Torture is any systematic act by which severe

pain or suffering, whether physical, emotional or mental, is intentionally inflicted on a person for any reason, by or at the instigation of, or with the consent or acquiescence of, public officials or another person acting in an official capacity (cf. The Declaration of Tokyo of the World Medical Association, 1975). It can potentially yield cumulative trauma disorders. Severe physical pain, a type of bodily trauma in torture, is overwhelming and obliterating, and can produce lasting mutilation and disfigurement, and serious physical, mental and emotional impairment. Torture is a multilateral trauma and has multilateral transmission channels. While it affects one person directly, it is transmitted multilaterally to his/her family and to his/her social group or community. Torture can lead to family traumas that can cause different forms of family dysfunctions and disruptions in the course of family development.⁸⁻⁹ The effects of the torture of one parent on the other spouse and their children are well documented.¹⁰⁻¹¹ On the other hand, the torture of a son or daughter may traumatise his/her parents and his/her siblings. Children of tortured parents reveal more psychosomatic symptoms, headaches, depression, learning difficulties and aggressive behaviour. They manifest more severe ADHD, enuresis and trauma congruent or incongruent psychotic symptoms, developmental arrest or delays.¹²⁻¹⁴ Family assessment is one of the missing parts in most torture assessments. Assessing the effects of torture on the survivor's family members and family dynamics is an important part of torture assessment.^{15,16}

We conducted two studies on the effects of torture, one among Iraqi refugees,¹⁴ which is a population study, the other one was conducted on clinic clients.¹⁷ We found in the population study that tortured persons present significantly fewer symptoms and are

Table 1. *Classification of secondary trauma.*

Person to person Person to system System to person	Kind of trauma	Mechanism of transmission	One- step	Multi-step	Possible outcome	System response/ corrective dynamics
Therapist/client Worker/co-worker	Any kind	Empathy	***	NA	Compassion fatigue	Supervision
Member to pre-established family	Personal Inter- personal	Attachment – projective identification	***	Family cross- generation transmission	Triangulation, switching symptoms, reversing roles	Individual and family therapy, Models of intervention
Member to a group or group to member	Collective	Identity	***	Family and social cross- generation transmission	Social/structural dysfunction, gangs, underground group terrorism	Socio-political activism and action, group dynamics, interventions

more adjusted than other refugees who had been cumulatively traumatised but not tortured. However, in the clinic study, we found that those who had been tortured present significantly more symptoms. Tortured persons are more resilient, probably because they have suffered for a cause, however, when they collapse, they present the worst effects of cumulative trauma.¹⁷ In either case, the traumatised family is probably more affected. Another fact that supports our argument is that, in our clinic, we have more spouses and children of tortured refugees than those of regular refugees.

Assessing and treating the effects of torture on the family

Family therapists dealing with traumatised families presented cogent arguments about the effects of such trauma on the interpersonal system of the survivors and the family dynamics that tend to perpetuate the symptoms.^{8,9,18} Classical exposition of the family dynamics and structural models alert to the potential shift of attention to the spouse, or one of the children, as the presenting prob-

lem defocuses attention from the patient (e.g. the survivor) and refocuses on another component in the larger system.

The family system should be looked at from at least three different perspectives:

- Family, either as a part of the support system of the survivor, or as another added stressor.
- Family as a traumatised system by the torture of one of its members.
- Family dynamics as perpetuating the symptoms of the survivor, or shifting the symptoms around.

Family therapy is a missing part of torture treatment. Torture treatment will not be effective if it ignores family dynamics and the long- and short-term effects of the transmission of torture effects to the spouse and children. Family therapy should be part of a multi-systemic, multi-modal approach to torture treatment.

The effects of torture on families present themselves in different typologies that are observed in our clinical practice:

1. *First typology:* The tortured person has survived the torture without presenting significant symptomatology; however, family members are affected more and present different symptoms. The transmission mechanism in this model is mostly attachment. The focus of treatment will be more on the members affected.
2. *Second typology:* The tortured person has been presenting symptoms, but he is either in the state of denial, has projected them, is coping by withdrawal, gets over-involved obsessively in religion or self-medicates by using drugs. In this example, we encountered family dynamics similar to alcoholic families. The dominant mechanism in this model is projective identification and codependency. In this case, family therapy will help diffuse codependency, and individual therapy and other modalities with affected individuals are warranted.
3. *Third typology:* The tortured person has completely collapsed, and the wife or another member of the family takes over responsibility, while presenting different kinds of symptoms with different family dynamics for the children and spouse. In this case intensive work with the survivor is crucial, as well as providing more supportive interventions for the spouse and affected family members.
4. *Fourth typology:* The tortured person is a single parent, either by divorce, death of the spouse, or the spouse has run away with another man or woman, leaving him or her to handle him/herself and the children alone. The tortured person can be in any of the previous three categories, but ends up having and taking responsibility for the survival of his/her family. Supportive interventions are helpful, as well as other needed services.
5. *Fifth typology:* The tortured person gets married after the torture has taken place. This marriage may be his choice or an arranged marriage by his family or his tribe or another group who care about him. Marital problems can erupt. A diagnosis of relational dynamics will determine the treatment strategy.
6. *Sixth typology:* In this case, the tortured person is a son or a daughter. The dynamics in this typology may be significantly different. The loss of a son to torture can cause debilitating depression of the parents. It may affect their decisions and ability to function and to attend properly to their other children. It may terrorise other children with varying response.

In the first three or four typologies, the extent to which he/she has been tortured, the resiliency of the family members and the damage caused to the tortured person will contribute to the outcome. However, in the fifth typology, the dynamics will vary depending on the tortured person's damaged condition upon marriage alone, not on how much he/she has been tortured. Each case presents different dynamics and outcomes and requires different interventions on both the individual and the system dynamic level. While typology is helpful, there are cases that present themselves in a more complicated manner and present overlaps and different dynamics. Within each typology there are different sub-typologies.

Whether the therapist works with a tortured person, his spouse or one of his children, he or she should conduct a comprehensive family assessment and determine the family dynamics related to torture. Comprehensive family assessment is needed to appraise the effects of torture on the spouse and children, to determine the affected family dynamics, to address them in therapy, and to provide the children

and spouses with the necessary services. The goal of family therapy is to diffuse dysfunctional dynamics and return the family to being supportive to its members, including the tortured person.

Case example 1: This case is an example of a *sub-type of the second typology* in the previous classification. The identified client is a daughter of a torture survivor. Her school, her family physician and the mother's therapist have referred her. Her mother brought her to therapy. The client is an eight-year-old girl who has been diagnosed as having PTSD with psychotic features, ADHD and R/O atypical psychosis; on top of that, she suffers from partial complex seizure. She receives Tri-leptal for the seizures, as well as Ritalin and Respridal. She has an average IQ. The mother herself is a client diagnosed with PTSD and the psychotic disorder NOS; she is on Xanax, Zoloft and Zyprexa. Nevertheless, she is the one who takes care of the family and drives the child to her appointments. The client has seven siblings. In the family assessment, mother has indicated that the father had been severely tortured. He is withdrawn (spending most of his time at home reading his religious books), does not participate in family life, is very obsessed with religion, and does not work, since the torture resulted in a serious back injury. He thinks he does not have any problems. He refuses to ask for help. The child was very resistant, refused to open up, and was very difficult to establish rapport with. With all the medication, she was not very responsive to treatment. When the therapist asked the mother to bring the father as part of family therapy, she said that he did not get out of their home, and refused to drive them or to go anywhere. After five sessions with no progress, I asked the mother to tell the father that the therapist wanted to learn more about his religion. During the next ses-

sion, the father came with a few books in his hand, and in this way we started an interesting dialogue that lasted a few sessions. He was looking forward to every session. Every session was scheduled for two hours. He started driving his family, not only to therapy but also to various places, and started to be open to talking about his experiences in life, including the torture and his political beliefs and anger. At a certain point, he asked for help for himself, and was referred to another therapist. This intervention was a breakthrough for his daughter, she started to open up and bonded with the therapist, and her symptoms significantly reduced. In this case, once the father started to be more active, taking upon him his role as a parent and asking for help, the role of the patient shifted back and the identified patient was released from her role.

Case example 2: This case is an example of *the first typology* in the proposed classification. The identified client is a 15-year-old daughter of a torture survivor. The court had referred her and her family for evaluation and treatment. Her story started by her running away, after which she contacted the police and alleged that her father tried to lead her to a sexual act. After a few days of foster care, she denied the whole story and alleged lying. The judge, unable to decide on the case, ordered the father out of the home for at least 90 days, only being allowed back home after written permission from the therapist. The whole family, including the parents and seven children: 17-year-old daughter, 13- and 12-year-old sons, and four other younger daughters, and the client underwent a thorough psychosocial evaluation. The father and the client went through a thorough psychiatric evaluation as well. The father was evaluated separately by three therapists and by a psychiatrist, and the consensus was that he was

a symptom-free, caring and fully functioning father whom torture did not significantly harm. The mother was determined as suffering from mild to moderate symptoms of depression. Assessing the client, she agreed to having been depressed for a few years, and also to having severe nightmares related to war and to being afraid of sleeping alone. She stated that she sometimes sees or hears voices. She felt a lot of guilt. When she was six years old, the client had begun hearing voices and seeing things that did not exist, after her father had returned from jail, and after one incident in the Iran-Iraq war when she returned from a bomb shelter to find their home demolished by a rocket. The family's history revealed that the father fled from Iraq for his life, to Saudi Arabia and then to the USA, and had been separated from his family for over six years when they joined him four years ago. Because of the stigma of mental illness, the family did not ask for help for their daughter. The other children displayed some symptoms of depression and academic problems, but not as severe as the client. The client was diagnosed with PTSD and major depression with psychotic features, ADHD inattentive type, and R/O psychotic disorder NOS. The client was repeating her grade and had clear behavioural difficulties in school. After intensive individual and family therapy and medication (Zyprexa 2.5 mg twice daily, Concerta 18 mg, and Paxil CR 25 mg), the client became an A-student and was able to move up two grades at once. In this case, the torture and other cumulative trauma did not affect seriously any of the parents, but the children suffered in varying degrees.

Case example 3: This case is an example of the *fifth category* in the proposed typology. The family was referred by the child protective services as the father, who was a torture survivor and currently had serious marital

problems, had the habit when he got angry with his wife to grab his baby and severely hit him or push him against the wall. The client (55 years old) was 30 years older than his wife. After he had been sentenced to death for being part of the political opposition, it was decided that death was less of a punishment. Instead, he was tortured to the extent that damaged his sexual ability and caused serious damage to his spinal cord, after which he was released. His tribe wanted to compensate him by arranging for him to marry his young cousin. When he came to the USA, his wife was not satisfied sexually, was involved with other men and gave birth to a black baby. Whenever his anger towards his wife escalated, he hit and abused the baby, who he realised was not his. The marital problems after the torture were not directly related to the torture, but to the incompatibility of the arranged marriage. The intervention focused on several goals, including creating a better supportive system for him and even divorce.

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Medical, physical examination in connection with torture

Section I

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In three short sections we will focus on the medical, physical examination in connection with torture and other related human rights violations.

The major content theme is divided into different organ systems that will be described with regard to the acute and somatic consequences of torture here and in the following two issues.

The examination can have two purposes: in order to treat health problems and in order to document torture allegations. But physical examination for health problems cannot stand alone. It is not possible to look at a human being as a machine and limit ourselves to detection of physical machinery problems. Examination of torture survivors must look at the person from a holistic point of view, including physical, mental and social functioning. Other facts indirectly caused by torture may be taken into consideration: Torture survival is often followed by refugee status. To be a refugee in itself has an influence on one's health, and mental problems have somatic consequences.

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When dealing with torture, the definition of the UN Convention against Torture is used.

Section I contains:

- Literature review
- Pitfalls
- Skin lesions

Literature review

In early medical work against torture, the focus was very much on the documentation of torture. In 1990, a study was published based on the medical records of the first 200 torture victims examined by the Danish Medical Group.¹ When it was discovered that so many of the torture survivors had serious health problems and were in need of treatment, the focus changed to treatment. The first Rehabilitation and Research Centre for Torture Victims was established in Copenhagen in 1982. The literature on the health-related problems of torture victims has increased since then, both concerning somatic and mental problems.

The first manual on examining torture survivors was published in 1992.² Since then three books have been published (Forrest in 2000³, Physicians for Human Rights in 2001⁴, and Peel & Iacopino in 2002⁵), and a very important and impressive desk study was carried out by Gurr and Quiroga⁶ in 1997 and 1998.

Medical documentation of torture has

been an ongoing activity in the medical work against torture.⁷ This will be further elaborated in the relevant sections of this chapter.

A very important achievement took place in 1999 when the “Istanbul Protocol”, *Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* was produced.⁸

The principles are so important because they oblige the state to conduct an in-depth medical examination of torture allegations. The principles outline minimum standards for state adherence to ensure the effective documentation of torture.

According to these principles the investigating authority has the power and obligation to obtain all the information necessary to the inquiry.

When doctors write a certificate after the medical examination of a person who alleges having been tortured, it is extremely important that the doctor states the degree of consistency with the history of torture. A conclusion indicating the degree of support to the alleged history of torture should be based on a discussion of possible differential diagnoses (non-torture-related injuries – including self-inflicted injuries – and diseases).

The degree of support should be indicated as follows:

- 1) A high degree of support.
- 2) Consistent with the alleged torture, moderate degree of support.
- 3) Consistent with the alleged torture, slight degree of support.
- 4) The changes cannot support the history of torture.

In order to prevent torture, the medical profession desperately needs education in documenting torture. However, only if the legal profession is involved will it have the neces-

sary impact to erase impunity effectively and give the victim redress, compensation and rehabilitation. The ongoing rehabilitation of torture survivors should include these areas in its work.

Different physical torture methods leave different physical sequelae. Therefore, it is a very important part of the physical examination to obtain a detailed account of the alleged torture methods to which the person has been subjected.

It is also important to take into account that mental problems can have serious health implications. Prolonged stress conditions have in many studies shown to have somatic consequences via neuro-humeral and other mechanisms.

Somatisation among refugees has been found to be associated with psychiatric symptoms and disorders, but not with objective evidence of a medical disorder.⁹ Therefore one is seldomly presented with many somatic complaints, which of course have to be investigated, but may be a sign of more psychiatric illness.¹⁰

Many refugees have, prior to their flight, been imprisoned, often under very inhuman and degrading conditions, which is a serious health hazard. During imprisonment they may have contracted contagious diseases such as tuberculosis, hepatitis, etc. It lies, however, outside the scope of this chapter to cover the examination of those diseases. Likewise, we will not enter into a discussion of tropical diseases.

Pitfalls

As has already been highlighted at the beginning of this chapter, writing down the history is a crucial element in the medical evaluation of a refugee who alleges to have been tortured. In this connection, there are three major possible pitfalls: They do not tell you what they have been through, what they tell you

is not the truth, and lastly they may not have been aware of the time of the appearance of a non-torture-related disease, and hence they may wrongly suggest its relation to torture.

The following case story by Jakobsson¹¹ very well illustrates the first possibility:

“A 20-year-old woman from a Middle Eastern country walked in the street without a veil, and with lipstick and painted nails. She was taken by the ‘chastity-police’. At the station she was raped by policemen, and her right hand was put into a meat chopper. She received surgical treatment after some time, but lost 3 fingers.

She arrived in Sweden with her right hand hidden in her sleeve, and did not show her injuries to the police, nor to the lawyer. She was refused asylum. After showing the evidence, she was granted asylum a short time after her appeal.”

This case shows that it is difficult to have one’s words taken seriously, and to show and talk about one’s injuries.

To bring persons from poor countries to rich countries is a growing business in which the “travel agent” can earn a lot of money. Of course some of the asylum seekers will be provided with instructions on what to tell the authorities, including torture allegations, in order to obtain asylum. It can indeed be difficult to prove that a person is presenting a fabricated story, in cases in which no physical sequelae can be evaluated. The situation becomes even more complicated considering that many “real” torture victims may have problems recalling the exact details of their torture, and even in therapy sessions give conflicting stories during repeated interviews.

There is no easy solution. The examiner will have to follow the guidelines already given for comparing the history of torture with the description of the acute symptoms,

their development and the symptoms and signs that are present at the time of examination. On this basis, a conclusion has to be drawn concerning the degree of consistency.

Skin lesions

(by Lis Danielsen)

The significance of skin lesions is mostly related to the documentation of the history of torture. Acute lesions may lead to health problems, e.g. pain and secondary infections, including problems with healing, especially when located in an area with venous or arterial insufficiency. Scars located close to a joint may induce contracture, decreased mobility of the joint, and pain during activity. Apart from that, scars seldom inconvenience the patient, although they can sometimes be of cosmetic importance since they may be a reminder of the torture and add to the changed sense of identity induced by the torture.

A detailed history of the alleged torture and of the related symptoms it induced is important in order to evaluate the significance of the observed lesions on the skin. In cases with no or uncharacteristic lesions, a characteristic history may be the only support to the allegation of torture, as e.g. in some cases of electrical torture. Also a history of skin diseases and non-torture-related lesions is of importance.

The examination should include the entire body surface to detect signs of:

- 1) Skin diseases
- 2) Non-torture-related lesions
- 3) Torture-related lesions.

Torture sequelae related to the skin may be:

- 1) Lesions resulting from direct physical injuries.
- 2) The occurrence of new, or aggravation of

existent, skin diseases, provoked by physical or psychological trauma.

Acute lesions are often characteristic since they show a pattern of inflicted injuries that differs from non-inflicted injuries, e.g. by their shape and distribution on the body. Since most lesions heal within a short period of time leaving no or non-specific scars, a characteristic history of the acute lesions is important. A history of the development until healing is also of importance. Torture lesions should be described by their location, symmetry, shape, size, colour and surface (e.g. scaly, crusty, ulcerating), as well as by their demarcation and level in relation to the surrounding skin. Photography is essential whenever this is possible.

Blunt trauma

Blunt trauma may leave contusions or lacerations with extravasation of blood, in some cases reflecting the shape of the instrument used, e.g. from beating with a stick.¹ Severe beating on the soles of the feet, “Falanga”, may leave contusions in the arch of the feet and swelling of the feet extending from the arch to the medial aspects of the feet and ankles.¹ Blunt trauma often leaves no or uncharacteristic scars. Flogging or beating with canes or truncheons may, however, leave characteristic scars, e.g. asymmetric, linear, straight or curved or “tramline”-shaped scars, showing a pattern of external infliction.^{7,12-13} The scars may be hypertrophic with a narrow, regular, hyperpigmented area in the periphery, representing the inflammatory zone appearing around necrotic tissue in the acute phase (Figure 1)¹². A differential diagnosis could be plant dermatitis, usually dominated, however, by shorter scars, with a narrow zone of hyperpigmentation in the periphery. In one case, the alleged torture was beating and scalding on the back. Symmetrical, atrophic,



Figure 1. Long, straight or curved, linear scars in an asymmetric pattern on the back (Danielsen, 1992).

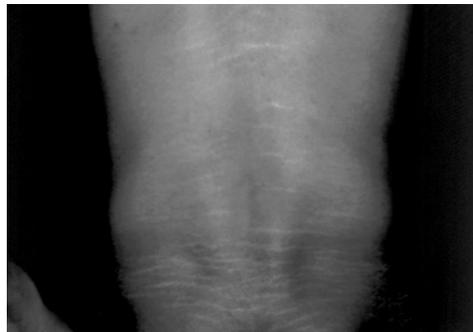


Figure 2. Symmetrical, atrophic, depigmented, linear changes on the back typical for striae distensae (Danielsen, 1992).

depigmented, linear changes typical for striae distensae were observed on the back and in both axillary regions (Figure 2).¹² The skin changes could not support the history of tor-

ture. The patient, however, may have been unaware of the changes on the back before the torture. Prolonged application of tight ligatures may leave a linear zone extending circularly around the arm or leg, in one case with lack of hair indicating cicatricial alopecia.¹² No differential diagnosis in the form of a spontaneous skin disease exists because of the location of the scar.

Sharp trauma

Sharp trauma, e.g. through the use of a razor blade, knife or bayonet, gives characteristic ulcers and usually leaves recognisable scars. In some cases, self-infliction should be considered, particularly when located on a wrist.⁷ If pepper is applied to the open wounds, the scars may become hypertrophic.¹² A differential diagnosis could be traditional healers or African ritual scar-tattoos. In one case in which the deepness of a scar, allegedly following the use of a sword, was doubted, the use of a high-frequency ultrasound could demonstrate a considerably deep scar.¹⁴ Afterwards, the patient was granted refugee status.

Thermal injuries

Burning with cigarettes, hot instruments or hot fluids leaves acute burns of varying degrees. Burning is the form of torture that most frequently leaves scars, often of diagnostic value. Cigarette burns often leave 5-10 mm large, circular and macular scars with a depigmented centre and a hyperpigmented, relatively indistinct periphery.¹ Dermatological conditions, e.g. sequels to pustules, might be a differential diagnosis. Burning via the transfer of larger amounts of energy to the skin than those transferred when stubbing a cigarette on the skin often produces markedly atrophic scars. They present a narrow, regular, hyperpigmented or hypertrophic periphery, originating from the inflammatory zone, which surrounds the necrotic tissue in the

acute phase. While their shape reflects the shape of the instrument used, their size relates to the amount of energy transferred to the skin. Following alleged torture from burning on several areas of the skin with a heated, circular metal rod the size of a cigarette, mostly circular scars with an atrophic centre and a regular, narrow, hyperpigmented or hypertrophic zone in the periphery were observed. Their diameter varied from below 1 cm to around 2 cm, and the patient had 35 scars distributed on several areas of the skin.¹² A differential diagnosis could be sequels to abscesses, but such scars usually do not show the typical, narrow zone in the periphery.⁷ Burning material from a rubber tyre, placed above the head of a woman, running down on her head and body, left keloid changes on the central area of her chest (the medial areas of her breasts not included). The periphery of the scar was irregular and demarcated via a narrow, well-defined zone of hyperpigmentation, and its shape corresponded to damage caused by material running down the body.¹ A scar following alleged torture from burning with a glowing metal rod placed across the broad area of the calf was primarily suggested to represent changes induced by venous insufficiency. The scar was shaped like a boat, and was placed across the broad part of the calf; it had an atrophic centre and a regular, narrow zone of hyperpigmentation in the periphery (Figure 3).¹⁵ The shape of the scar thus corresponds to a lesion induced by a rod pressed against the soft calf, and the appearance of the scar corresponds to a third-degree burn because of its atrophic centre and the narrow hyperpigmented zone in its periphery. In contrast, venous insufficiency leaves indistinctly limited hyperpigmentation and scars from ulcers located distally on the lower leg (Figure 4).¹⁵ Afterwards, the patient was granted refugee status. When the nail matrix



Figure 3. A scar shaped like a boat, placed across the calf with an atrophic centre and a narrow, regular zone of hyperpigmentation in the periphery (Danielsen, 1995). Published with kind permission from the Danish journal *Sår* (www.saar.dk).



Figure 4. Venous insufficiency with indistinctly limited hyperpigmentation distally on the lower leg (Danielsen, 1995). Published with kind permission from the Danish journal *Sår* (www.saar.dk).

is burnt, subsequent growth produces striped, thin, deformed nails, sometimes broken up in longitudinal segments. If the nail is also pulled off, an overgrowth of tissue may occur from the proximal nail fold.¹² Changes caused by lichen planus may be a relevant differential diagnosis, while fungus infection is characterised by thickened, yellowish, crumbling nails, different from those mentioned above.

Corrosive injuries

Corrosive injuries, caused by acid thrown against a victim, caused linear scars, a few cm wide, with a depigmented centre and a

regular, narrow, hyperpigmented zone in the periphery, located on the thighs and buttocks.² They were arranged in an asymmetric pattern, mostly obliquely directed down the legs. They showed signs of external infliction in agreement with a liquid running down the legs, and they indicated sequels to necrotic areas as expected following a corrosive injury.

Electrical injuries

Electric current follows the shortest route between two electrodes through tissue with the lowest resistance, i.e. blood vessels, nerves and muscles. When using high-voltage stun weapons, the current flow cannot, however, be limited to the pathway between the electrodes.¹⁶ In some of the cases, electrical torture leaves acute lesions on the skin. Unlike burn lesions, these lesions usually do not reflect the shape of the instrument used, but appear in segments within the influenced areas, since the current selects areas with low resistance. Electrical torture via electrodes shaped like a knitting needle, “Picana”, leaves clusters and linear arrangements of 1-5 mm wide lesions, covered by red-brown crusts, sometimes surrounded by a 1-2 mm broad, erythematous zone with irregular and indistinct edges. Lesions in lines following a linear application of the electrodes may also be seen.¹ The crusts probably correspond to an electrical injury and may contain deposits of metal from the electrodes.¹⁷⁻¹⁸ The concomitant heat development has not been sufficient to induce a regular inflammation in the periphery. A differential diagnosis may be insect bites or scratching. Well-demarcated, serpiginous lesions, measuring 1-2 cm across, with an irregular, narrow, elevated, peripheral zone and a central area containing several black spots, each measuring 1-2 mm, have been observed shortly after electrical injuries on the left side of the chest and on the left arm.¹⁹

The lesions show indication of electrical injury because of their appearance in 1-2 mm large segments and because of the involvement of blood vessels. Vasculitis or haemorrhagic herpes zoster might constitute a differential diagnosis. The location might be helpful since vasculitis is chiefly located on the lower extremities, is symmetrical, and sometimes more diffusely located, while herpes zoster is located in an area innervated by a single ganglion, and is unilateral. Clusters of round red macular scars, about 1 mm in diameter, have been observed four weeks after "Picana".¹² Eight weeks later many of the scars had disappeared. The remaining scars were small, white or red-brown spots. Among the skin diseases leaving pigmented scars is lichen planus, leaving about 2 mm large scars. Electrical torture has been reported to induce 6-8 mm large, irregular, red-brown, keloid scars on the helix of both ears.²⁰ A differential diagnosis might be a chondrodermatitis helicis, but this is usually covered by a scale and is pale and painful. Six months after the use of a 45-cm-long stun gun, delivering 150,000 V, with a screw 4 mm in diameter at its end and 12 small places where electricity is also discharged from the lower part of its side, a sharply demarcated bluish line 1 mm across, forming a complete circle 5 mm in diameter and a second mark of similar characteristics completing only two-thirds of a circle, were observed.²¹ Similar fractions of a narrow red ring appearing in segments have been seen in the days after defibrillation using 2736 V along the periphery of the pad.²²

Histological changes

If a victim agrees, a 3-4 mm punch biopsy in local anaesthesia, might be helpful in supporting an allegation of electrical torture.^{17,23} Previously, only few cases of electrical torture have been studied histologically.^{19,24-25} Only

in one case, in which lesions were excised seven days after the injury, alterations in the skin diagnostic of electrical injuries were observed (deposition of calcium salts on dermal fibres in viable tissue located around necrotic tissue and on collagen fibres deep in the dermis). Lesions excised a few days after alleged electrical torture showed segmental changes and deposits of calcium salts on cellular structures consistent with the influence of an electric current, but with only a moderate degree of support. A biopsy taken one month after the alleged electrical torture showed a conical scar, 1-2 mm broad, with an increased number of fibroblasts and tightly packed, thin collagen fibres arranged parallel to the surface, consistent with electrical injury, but with only a slight degree of support.

Even if an examination does not reveal any abnormal findings, the possible use of electrical torture cannot be excluded. The use of high-frequency ultrasound may be helpful to discover the location of calcium deposits in order to select an area for biopsy.²⁶

Skin diseases

An example of a skin disease being psychologically provoked by torture may be the concomitant occurrence of an urticarial eruption. Physically provoked skin diseases may be the development of psoriasis or lichen planus in the traumatised area, as a "Koebner-reaction".¹² However, such skin changes have little diagnostic significance in relation to torture.

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Torture survivors' perceptions of reparation

A survey published by the REDRESS organisation, 2001

Paul Dalton, BA, LLB*

The rights to reparation and to rehabilitation for survivors of torture are closely and intrinsically linked to each other. Both have their legal basis in article 14 of the UN Convention against Torture. Rehabilitation, in its broadest sense, could and does include many initiatives that would also be involved in a summary of activities associated with reparation. Similarly, the concept of reparation, as defined by Professor Van Boven in the leading UN study on the subject, "Draft Basic Principles and Guidelines on the Right to Reparation for Victims of Gross Violations of Human Rights and Humanitarian Law" (1997), includes rehabilitation as one of four main types of reparation.

It is important to acknowledge from the outset that torture survivors' perceptions of reparation – what they would like to receive, in what form and to what end(s) – vary widely. This presents particular difficulties in undertaking this type of research, and to the credit of Sarah Cullinan, the author of *Torture Survivors' Perceptions of Reparation – a Preliminary Survey*, published by REDRESS, 2001, does not attempt to disguise this fact.

Over the past decade, access to reparation has begun to be a more realistic possibility

for torture survivors. At the international level, the establishment of the ad hoc criminal tribunals for Yugoslavia and Rwanda and the adoption of the Statute of the International Criminal Tribunal, which specifically provides for reparation for victims of violations, create increased interest and attention. At the national level, the concept of universal jurisdiction for crimes of particularly gravity, including the crime of torture, has begun to take root. International justice is on the human rights agenda to stay, and an integral part of the delivery of justice is addressing the loss suffered by victims of human rights violations.

While it has been recognised many times that the attainment, or even the pursuit, of reparation can be a key element in the rehabilitation process, reparation can also be problematic for many survivors. The potential benefits of obtaining reparation may be dependent on the type of support, not least psychological support, and, where appropriate, counselling and debriefing, that the claimant receives during the process. Giving testimony in legal or quasi-legal forums does not necessarily help to restore the survivor's dignity or to achieve resolution. If the survivor believes that his story has not been believed, this can be psychologically damaging. For this reason, some have said that it could be better to encourage survivors to pursue civil remedies, where the burden of proof is lower, than to

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necessarily initiate criminal proceedings against the perpetrator, which will be more intrusive, and where the risks of failure are greater.

The survey considers, as one of a number of examples, the Truth and Reconciliation Commission in South Africa. The final report of the Commission postulates as one of its outcomes “the rehabilitation and the restoration of the human and civil dignity of victims”, yet no research has been done to see whether it was in fact the case that it had “a meaningful and substantial impact on victims’ lives”. Similarly, the report raises the point that many reparation programmes for survivors are based on what officials, or even, in the case of legal proceedings, the lawyers who are representing them, believe that their clients need, rather than what the survivors themselves want or need. While the programme may have as its goal a pre-defined outcome, the client’s emotional needs may be more focussed on a process rather than on any form of financial or non-financial compensation.

Sarah Cullinan’s survey examines the work that has been done to date in assessing torture survivors’ own perceptions of reparation, identifies the gaps that currently exist in the field, and then proposes a plan of action to address them. Cullinan believes that while a considerable amount of work has now been done to identify the medical and psychological effects of torture, the majority of studies to date have ignored the essential moral dimension and the need for moral, as well as physical, rehabilitation.

A particular difficulty in constructing a research model to assess survivors’ wants and needs is in obtaining a representative sample of people, even in the case of survivors from a particular country, on which to base the study. It has been said that people who pursue reparation are likely to be those victims

who are still capable, at least to a certain extent, of identifying and pursuing a particular course for their lives. The most brutalised of victims never pursue reparation, either because they do not become aware that it is a possibility, or, tragically, because they have lost the capacity for purposive action. Interestingly, this factor has also been identified as a problem in conducting research on the effects of rehabilitation programmes, although for the opposite reason: here, it has been said that those survivors receiving formal medical or psychological assistance may be “less healthy” than the total population of survivors.

There are many issues related to reparation on which no research has yet been undertaken. What are the likely effects on a survivor if pursuit of reparation is unsuccessful? Are there differences between the expectations and perceptions of “political” and “non-political” survivors, or between those seeking reparation in the context of a state in political transition and those doing so in a state in which torture continues to take place? Do men and women perceive reparation in different ways, and what about the needs of child victims?

The preliminary survey proposes a research programme to be conducted by REDRESS until 2005, with the goal of obtaining a more fundamental understanding of the wants and needs of torture survivors, with a view to identifying the particular form(s) of reparation that will be most beneficial for them. Two initial seminars will be held to gauge the opinions of both “gatekeepers”, i.e. those people engaged in providing medical, legal or social support to survivors of torture, and, crucially, of survivors themselves. The information gathered will be used in undertaking more extensive research, to result in the development of guidelines for providing advice and services to

victims and survivors, a “Torture Survivor’s Handbook”.

This kind of survey is an excellent overview of the current state of knowledge in this field. Significantly, it also provides a detailed road map on what needs to be done from here to improve our knowledge about survivors’ perceptions, and to develop guidelines that can be used to assist both survivors in their pursuit of reparation and those committed to providing them support and encouragement throughout their journey. The issues raised in the survey are of great interest and concern for all those involved in rehabilitation work.

By better understanding what survivors themselves see as a successful outcome to their pursuit of justice and the restoration of dignity, it should be possible to improve the quality of support and advice currently available. A survey or overview taking up problems and giving advice to their solution should be warmly recommended to all those who are involved in pursuing reparation or in providing assistance to those who are.

Copies of “Torture Survivors’ Perceptions of Reparation” by Sarah Cullinan can be obtained on request from The REDRESS Trust (redresstrust@gn.apc.org). □

A torture case presented in the UK Parliament on 21 January 2004

The debate in the UK Parliament on human rights in Saudi Arabia, referred here in extract, shows confidence at a high level in the decision to adopt knowledge used by health professionals when examining torture survivors.

Mr. John Lyons (Labour): "I am delighted that the subject of human rights in Saudi Arabia has been chosen for an adjournment debate. It is obviously a vast subject and I hope that hon. Members will feel free to contribute to the debate and make known their views. I want to draw attention to Sandy Mitchell – my constituent – Ron Jones and Bill Sampson, all of whom have faced abuse and torture in Saudi Arabia. (...)

A dark tale of torture has been unfolding since the release of Sandy Mitchell and the others last August. It seems that a new allegation would surface almost every month. New information and evidence would be produced by those who had been jailed. Sandy Mitchell was a senior anaesthetic technician at the security forces hospital in Riyadh. He was arrested on 17 December 2000 and was charged with the bombing and killing of Christopher Rodway. As I said, he was finally released on 6 August last year in response to a plea for clemency that was made to King Fahd. I thank the Foreign Secretary, the Prime Minister and other hon. Members who made representations to the Saudi Government for the release of the men. During his term of imprisonment, Sandy Mitchell had to face torture, solitary confinement, and physical and psychological torture. That was a con-

tinuing story for him when he was in prison in Riyadh. (...)

The case of Sandy Mitchell and his arrest is horrific. He turned up at the hospital on 17 December at 7 o'clock in the morning, only to be arrested by the Saudi secret police. He said that he was handcuffed, hooded and taken to a detention centre where he was accused of carrying out several bombings in Riyadh. He pleaded with them and told of his innocence, but without any response. He said that he was in no way party to any bombing campaign and that he was sure that the others who had been mentioned in the arrest were not party to it, either.

Mr Mitchell was immediately faced with a beating from the people who had arrested him. He could not defend himself because his wrists and ankles were cuffed. The beating continued for several hours. He was then taken down to the cells and was chained to a door, so that he could neither sit nor lie down. He was denied sleep and rest for a total of nine days. He said that at about 10 o'clock that evening he was taken back to his house in chains by the security officers who had beaten him. They ransacked his house, and all his personal items, including clothes, cameras and diplomas were confiscated. Most of the items taken have never been returned. His wife and son were, of course, terrified by his arrest and by the state he was in when he was taken back to his house. On his return to the detention centre he was punched, kicked and spat on, and was again chained to the door of his cell so that he could neither sit nor lie down.

As I said, he was kept awake for nine days and nine nights.

During Sandy Mitchell's imprisonment his beating consisted of the torturers striking the soles of his bare feet with axe-handles, with a Saudi sitting on his chest at the same time, making it difficult and frightening for him to breathe as his feet were being beaten. He was told that he would never be released if he did not confess to the bombings. He begged his captors to check his alibi for the evening on which they accused him of being involved in the bombing. He felt certain that friends and colleagues could easily convince the police that his alibi was strong and would clear him of any guilt. He demanded a polygraph test because, as a desperate man, he thought taking such a test would prove his innocence and he would be released. This was denied to him, and the torture continued. He said that, during the beating and torture, he was bleeding continually from inside his left ear, from his nose and his mouth, and that he lost some teeth.

I do not intend to go on all afternoon. I think what I have said about the torture is enough. That story can be repeated by Ron Jones, by Bill Sampson, and by any of the other prisoners held in Saudi Arabia. Having listened to one case, one can multiply it by seven to obtain an accurate picture of what went on for a very long time – as I say, these men were held for two and a half years.

In addition to the beatings and the psychological torture, we need to consider the solitary confinement in which these prisoners were held during this period – again, an attempt to break them and extract confessions to something in which they were not involved. We know all of them, and there is no question of that. (...)

Mr Mitchell said in his evidence that after about the fifth night he could not endure the beatings and the torture anymore.

He said he was prepared to sign a confession, no matter what it said. He was given a very sweet cup of tea and asked to sit down and sign a prepared statement of his confession. This was directed by Lieutenant Khalid al Sallah, the translator for Captain Ibrahim al Dali. These two seem to have been the two main torturers of Sandy Mitchell. I will refer to both of them again, as it is important that we identify the torturers and take the appropriate action when we can.

The interrogators also wanted to know, even after Mr Mitchell had signed his confession, who had been involved with him – not only the other prisoners, but which people from the British embassy had assisted him. He could not believe that this line of questioning was being put to him, that it was suggested that the embassy was somehow involved in a bombing in Riyadh. He continued to be beaten and tortured into the eighth night, even after the confession, because they wanted further information. They said that if he would not help them further, they would bring his wife into the interrogation, because she was Thai and they could do anything they wanted to her. He said that just hearing the screams of other detainees in the prison again put him under tremendous pressure to agree to anything they were saying in terms of the British embassy involvement and the devices for the bombings.

On 25 December 2000 Mr Mitchell was hooded and taken to what he later discovered was al-Hiar prison. The officer in charge of the prison, when he saw the state of him, had him cleaned up and examined by two doctors. He then had to sign a statement that his injuries when he arrived at the prison had been based on some previous interrogation at another location. The prison was not prepared to accept responsibility for the state of him. He did sign such a statement, which, quite properly, the prison wanted him to do. He

was then given some medical help, something for the pain, and he was allowed to sleep for three days. Being denied sleep for so long must have been torture in itself, as well as the interrogation and the beatings.

Mr Mitchell said that his interrogation and the torturing had sometimes lasted for an unbelievable 14 hours. That was normal for him. Even after he had been taken to the prison the beatings continued. He was hospitalised on three occasions, first for two days, then for 14 days and then for 15 days. Imagine the extent of the injuries, to be hospitalised for that length of time. He was allowed a visit from the British embassy after 46 days. Prior to that visit he was again warned not to complain to the embassy about his treatment or he would face even further beatings and torture. At least then he felt that the embassy had been involved, and would hopefully speak up for him and for the other prisoners and get things moving regarding his case.

Mr. Mitchell was then prepared – he says “drilled” – to make a video confession for television as part of his confession, which was rehearsed many times. At first he was told that it was nothing more than a video for the private files. All of us who saw the alleged confession on television were horrified because Sandy Mitchell was reading off an auto-cue in a very unconvincing manner – and no wonder, because it was the result of beatings and torture from previous days.

So a British citizen was shown all over the world confessing to the bombings in Riyadh, and that suited a lot of internal sources in Saudi at that time. They could claim that the bombings were not the work of domestic terrorists but were quite simply the work of British or other foreign nationals working in Saudi Arabia. (...)

Sandy Mitchell was finally taken to court in July, and before he entered the courtroom

he was warned again that if he tried to retract his statement, he would be taken back to the detention centre and the torture and the beatings would continue. That is what he was faced with at the so-called Department of Justice as he was being taken into court. It took about five months for a lawyer to come and speak to Sandy Mitchell and the other prisoners about the Saudis’ abuse of their human rights during their time in prison. It was then that he had found out that he had apparently been sentenced to partial beheading and crucifixion. His sentence had already been decided before he had even seen a lawyer. (...)

Since his release, Sandy Mitchell and the others have been referred for medical examination. Despite the fact that we have moved on and it is so long since the torture and beatings, they still want to prove medically that they were tortured and beaten in Saudi Arabia. I do not intend to go through the medical evidence produced by the Parker Institute in Denmark (1), which is the world centre of excellence to which people are referred when they think they are victims of torture and want to prove it. It is important that these reports should remain private, but I shall speak to the conclusion of that report, which states:

“There is an overall accordance between the presented torture history, the described symptoms and the results of today’s examination. The findings are consistent with alleged torture with a high degree of support.

That is not an allegation by any of the men. It comes from medical evidence to support their claims. There should be no question in anyone’s mind that everything points to the statements made by Sandy Mitchell, Ron Jones and others, being 200 per cent true. The report, from such a renowned institute, confirms that in everyone’s mind. (...)

We should ... make sure that those who

are responsible for torture and beatings are brought to court and that the victim has his day in court to accuse them. (...)"

The Parliamentary Under-Secretary of State for Foreign and Commonwealth Affairs, Mr Bill Rammell: "May I say to everyone who has participated in the debate this afternoon that we have had an exceedingly good debate on what is, undoubtedly, a very serious issue. In particular, I congratulate my hon. Friend the Member for Strathkelvin and Bearsden, Mr Lyons on securing this debate on human rights in Saudi Arabia. I have listened carefully to all the points. (...)"

We greatly welcomed the men's release on 8 August 2003. We were relieved at their return to the UK and to their families. Indeed, Ministers and officials had worked vigorously to secure that outcome. It is worth relating the efforts that we went to when they were released."

(1) The Oak Foundation-financed Parker Institute in Copenhagen, Denmark, is a medical scientific institute which specialises in rheumatological and rehabilitation studies on torture. The Parker Institute works in collaboration with the RCT and IRCT. □

Gathering seaweed: African prison writing

Mapanje J. *Gathering seaweed: African prison writing*. London: Heinemann African Writers' Series, 2002. 328 pages. ISBN 0435912119. Price: GBP 10.55.

Jack Mapanje, Malawi's best-known political detainee, who spent three and half years in detention without trial, introduces his book with a firm assertion that *Gathering seaweed* is not "another anthology calculated to negate Africa". In the current political atmosphere in Africa this is a highly debatable point. Prison writing is, after all, a yearning for the freedom taken away, the mere act of writing negates the "despot" who imposes the loss of freedom. Writing for oneself within prison can be a tool of mental survival, and later also be cathartic, therapeutic and reconciliative. This begs the questions about the ability to write: are prison texts therefore selective in favour of dissidents with literary talents? Does this anthology include writing by ordinary workers or citizens arrested for political reasons? From my knowledge of Southern Africa, I would have to say that it does not, a reflection of the marginalisation of incarcerated peasantry in literature. Most of Africa's political detainees are, as evidence from Zaire, South Africa, Malawi, Zambia, Zimbabwe and a host of other nations shows, ordinary citizens who may not be able to articulate their dehumanising suffering on paper.

Perhaps we are being prematurely unfair; *Gathering seaweed* is an anthology of prison writing conceived following a course that Mapanje taught at Leeds University entitled the

Literature of Incarceration. The texts are split into several periodised sections: origins (anti-colonial and nationalist); arrest, detention and trial; torture; survival; and release. The anthology does not pretend to be comprehensive; most of the material was "chosen by students" although we are not given the selection criteria.

The "Origins" section includes extracts by well-known nationalists such as Kenneth Kaunda, Augustinho Neto, Kwame Nkrumah, Jomo Kenyatta and Edison Zvobgo. But as we go through the subsequent sections, and decades, the number of politicians diminishes. A second problem arises: writing is about preserving experiences, memories, testimonies and thoughts in accessible and unalterable, rather than oral, forms. This preservation should facilitate learning and growth. One would – therefore – have liked to see the extracts of the politicians (then colonial victims) at the beginning balanced with their (own) present-day "victims" or their own post hoc reflections. What happened, for example, to Zvobgo's (Ian Smith's detainee who later became a powerful politician in Zimbabwe at the time of Mugabe's Matabele tyranny) "peace [and] gladness", Kenneth Kaunda's "my people should be treated with reasonable courtesy in their own country" (when he became responsible for detaining others) or indeed Sam Mpasu's (a present Malawi cabinet minister) "... if this cruel and beastly government could do that to its own cabinet minister, then how much more would it do to me, a humble civil servant?"? Included here, after all, are men who either served in govern-

ment and created (or helped to create) their own political prisoners or are now in power and at the centres of debates about future limitations on freedom, both physical and academic. One wonders why, for example, Mpasu, who for years fought Dr Banda's tyrannical regime, has remained silent as his present party, the United Democratic Front (UDF), attempts to return Malawi to another dictatorship. This attempted return comes complete with the resurgence of extra-judicial paramilitary "Young Democrats", who, as in the Banda era, dispense summary justice to political opponents of the ruling UDF party.

Then there is the irony about a book about prison writing arising from Leeds, where Mapanje settled, effectively in political exile, after leaving Malawi in 1991. The book, though in the Heinemann African Writers' Series, given current economic and, in cases, political strictures, will be hard to find in African universities. The editor concedes that the English students will find the study helpful in their careers, ranging from caring for asylum seekers to human rights and immigration work. Therefore, although meant as "an indelible record of the origins, growth and maturity of the struggle for the restitution of human dignity and integrity, justice and peace on the African continent", there is some ambiguity about its target audience. This is no mere academic question. The present generation of African politicians, many who are victims of previous despots, is fairly well acquainted with the writings of most African "prison graduates". It is, however, the current crop of African secondary school and university students who need to read books such as *Gathering seaweeds* if the culture of political violence, detentions and torture that characterise postcolonial Africa is to change. If the anthology is to be "waved as a warning banner to present and future African political leadership", it should have

been co-published in Africa with Heinemann's many sister publishing houses. Indeed, the New Partnership for African Development initiative should have emphasised the importance of a reading culture in promoting good governance. Otherwise these experiences will remain resource materials for those who enjoy freedoms rather than those whose educational systems need to address issues of basic civil freedoms.

Incidentally, although Mapanje hopes that "... more anthologies of this sort would eventually be compiled" to document events in the decade 1991-2001 (a decade politically dominated by some former prison writers included here and the "transitions to democracy"), outside of South Africa, few initiatives in this direction are apparent.

Having cleared these hurdles, we come to the texts themselves. We have already noted the fact that most of the texts are by "elite" political prisoners and literati. One would question the omission of criminal writers; one measure of the brutality of a society is how it treats its criminals. If freedoms and civil liberties are indivisible, the experiences of criminal prisoners, who often receive different treatments from their political counterparts, would be of interest. The selection for future anthologies will need to be revised to address this issue.

Critiquing prison texts can run the risk of devaluing, minimising or even justifying the prison experience of the text writer. This is not, for me, a problem here because most of the writers, as already stated, are – in their own genres – excellent writers: Kaunda, Neto, Ken Saro-Wiwa, Felix Mnthali, Denis Brutus, Wole Soyinka, Edison Mpina, Koigi wa Wamwere, Jack Mapanje himself, Nelson Mandela, Breyten Breytenbach, Jeremy Cronin, Ngugi wa Thiongo ...

Most people familiar with African literature will recognise the writing and medita-

tions of the imprisoned literary elite (Mapanje, Ngugi, Mnthali, Brutus, etc.), those of ordinary people, some famous in another artistic milieu, who are attempting to put their experiences in writing (Winnie Mandela, Fela Kuti), interviews (Pitika Ntuli), translations (Nawal el Sa'adawi) and so on. Each calls for a different standard of textual analysis. If all writing is to be judged on one level, writing itself becomes a prison tool, excluding and imprisoning those less gifted on the outside. Prison writing, as often occurs on the outside, includes the intellectual and the visceral. Here obviously these texts, interviews, prose and poetry are of different literary standards, varying from excellent to functional. They speak for themselves. But perhaps future anthologies should differentiate between "professional writers in prison" and the writings of ordinary people once incarcerated, as Fanon (*The wretched of the earth*. Penguin, 1963:179) put it:

"... great many men and women who up till then would never have thought of producing a literary work, now that they find themselves [in prison], or on the eve of their execution – feel the need to speak to their nation, to compose the sentence which expresses the heart of the people, and to become the mouth-piece of a new reality in action".

Thus, while the personal is often emphasised, there is an element in which prison writing is a discourse of national or communal aspirations; it can never be analysed outside the contexts of the socio-politico-economic circumstances placing the writer in prison. Fanon (181) adds:

"The artist who has decided to illustrate the truths of the nation turns paradoxically towards the past and away from actual events ... the native intellectual who wishes to cre-

ate an authentic work of art must realize that the truths of the nation are in the first place its realities".

Published prison writing, in one aspect, is a form of truthfully excavating painful realities. These painful realities infect our contemporary political culture, and, while a historical perspective is essential, it is the here and now that determines if in fact the anthology engages with its presumed target audience.

Like medical doctors, we can describe pain as mild, gnawing, severe, colic, horrendous or even exquisite; but this is a functional categorisation and classification: pain is pain. These painful testimonies speak for themselves, whether in Kofi Awoonor's:

"delirium was his refuge from pain"

or the chill of Soyinka's:

"The man died' he said"

And like the varieties of pain describable, the texts offer various intellectual and emotional challenges.

However, as in growing, from pain arises learning. For a reviewer familiar with the pain of despotism now current in Central and Southern Africa, I am disappointed at the lack of inclusion of contemporary, i.e. post-1994 texts, that would have counter-balanced some of the earlier nationalist "origins". These newer texts would also sensitise the younger generation to the brutalities within their "democratic" political cultures. Apart from Christine Anyanwu's 1998 testimony, there is nothing post-apartheid or post-multi-party. Even the closing poem by Mzwake Mbuli is from the early 1990s. Given Mbuli's current debatable incarceration in a South African prison, and the state of Africa in general, a more appropriate poem might have been one from his "Born free,

always in chains” album, for example the “Three Bs”. Large parts of Africa are currently gripped by forms of injustice, conflict and famine, leading to the most horrific human mental and physical torture. I would have liked more of this reflected in the anthology, especially one intended for future NGO (non-governmental organisation) policy makers.

Despite these reservations, this volume is a welcome addition to prison and freedom discourses.

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