Torture and spirituality:

Engaging the sacred in treatment

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Abstract

Torture by its very nature creates distress in part related to the intentionality of the trauma inflicted. Consequently, it is necessary for clinicians to address many of the existential concerns that arise in the course of treatment. Often in clinical training, issues of spirituality are deferred to spiritual caregivers. It is important when working with torture survivors to consider the myriad of ways in which the spiritual dimension is interfaced with. For some, efforts to address physical and emotional symptoms may fall short of that which is necessary for full recovery. Torture affects individuals on multiple domains simultaneously. Many survivors speak about the damage that has been inflicted to their souls. Furthermore, survivors may come from cultures where religion is a way of life and cannot be separated from one's daily life experiences. Helping people connect to communities of faith can be critical to not only decreasing the isolation that survivors may have, but also potentially helping in the process of restoring one's capacity to trust again. As clinicians, our own life views can impact on the work we do. It becomes important to take a personal inventory as to how we ourselves answer the question why such cruelty exists.

key words: torture, trauma, spirituality

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Introduction

Central to the practice of torture is the intention of cruelty and destruction.

It is perhaps best summarized by the Berber proverb: "Whoever wants to hurt never misses his target".[1] Torture has many goals: to get information, to destroy the individual, to destroy the family, to terrorize communities, and in more recent times, ethnic cleansing.[2] As with any traumatic event, our assumptions about the world as a benevolent and meaningful place and the self as worthy are challenged.[3] In countries where state-sponsored terrorism exists, the involvement of government further complicates the betrayal experienced by survivors and their families.

Torture influences four realms of human existence: the spiritual, emotional, social, and physical.[4] Hopelessness, alienation, and shattered trust in God, society, and oneself can arise out of the direct confrontation with evil. Furthermore, survivors may suffer from guilt and shame for surviving, for being a silent witness, or for being identified as one to be tortured.[5] The Istanbul Protocol was developed by human rights advocates and the United Nations in order to develop standards for the assessment of individuals claiming torture.[6] As summarized by the Istanbul Protocol, torture can result in multiple psychological responses:

- Posttraumatic Stress Disorder
- Somatic complaints such as pain and headache
- Depressive Disorders
- Substance Abuse
- Neuropsychological Impairment
- Bipolar Disorder
- Psychosis
- Enduring Personality Change
- Generalized Anxiety Disorder
- Panic Disorder
- Acute Stress Disorder
- Somatoform Disorders
- Phobias[6]

Torture can take many forms. Sham executions, sexual assault, prolonged arbitrary detention, disappearance of a loved one, threats against family members, and witnessing the torture of others are common approaches that have particularly noxious effects.[7] Further, one cannot easily escape the social consequences of torture on communities and families.[2] Survivors of trauma and torture are often rapidly thrust from the circumstances of their lives into facing the fundamental, existential questions of life, particularly questions such as "How can someone intentionally hurt another person?" and "How can God allow such evil to occur?".

We are reminded by the Istanbul Protocol to closely consider cultural issues relevant in treating diverse populations. What might be viewed as acceptable in one culture may not be viewed as acceptable in another. Cultures vary as to which behavioral and psychological reactions to torture are of concern. Moreover, Western cultures are known for medicalization of psychological symptoms. In non-Western cultures mental suffering may not be viewed as a disorder.[6] Further, religious beliefs may influence the presentation and understanding of torture and related traumatic events[6]. In this article, the interface of torture and spirituality is explored in an effort to illustrate its particular relevance to recovery from this form of traumatic experience.

Trauma and spirituality

Through spirituality and meaning making, trauma survivors can transform isolation and alienation by connecting to themselves, to others, and to communities.[8] Clinical work informs us of the importance of hope, defined by Post as "a subjective sense of having a meaningful future despite obstacles".[9] Torture can challenge spiritual constructs as its point of impact is upon the essence of human dignity. According to Frankl,[10] how one bears their suffering can be a genuine inner achievement: "It is this spiritual freedom which cannot be taken away that makes life meaningful and purposeful." Given the many polarities of human response and experience, identifying culturally appropriate ways for assessing the spiritual resources of the affected individual or group includes using innovative and alternative strategies[11]. Faith can both be increased and decreased in response to torture.[5] Developmental age at the onset of the traumatic experience, the use of religion or spirituality as a part of the actual abuse, and the role of religion in the family of the survivor are important considerations influencing the outcome of trauma for the individual.[8] One needs to also keep in mind where someone was in their faith journey at the time that they were exposed to torture.

Guidelines for therapists

Calhoun and Tedeschi[12] present important information on the assessment of torture on religious beliefs. They recommend an assessment of how spiritual beliefs have been shaken, shattered and modified in the wake of trauma. Specifically, one can ask:

"To what extent do you see yourself as a spiritual/religious person?"

"To what extent have you been thinking about spiritual or religious issues?"

Questions such as these open the possibility for dialogue on the role of religion in recovery from torture exposure. An alternative approach to spiritual inquiry has been suggested by Arandarajah and Hight[13] contained in their "Hope questions for spiritual assessment in medical interviews". They suggest that one ask questions regarding patients'/clients':

H – sources of hope
O – organized religion
P – personal spirituality practices
E – effects on medical care and end of life issues

Depending on the individual, different responses may be appropriate.

Yet a third approach to spiritual assessment is put forth by Puchalski[14] which goes by the acronym FICA:

F – faith or beliefs
What is your faith or belief?
Do you consider yourself spiritual or religious?
What things do you believe in that give meaning to your life?
I – importance or influence
Is it important in your life?
What influence does it have on how you take care of yourself?
How have your beliefs influenced your behavior during this illness?
What role do your beliefs play in regaining your health?
C – community
Are you part of a spiritual or religious community?
Is this support to you and how?
Is there a person or group of people you really love or who are really important to you?
A – address
How would you like me, your health care provider to address these issues in your health care?

Thought must be given to what approach is more appropriate given the particular circumstances, and cultural context.

For clinicians, Calhoun and Tedeschi[12] further recommend the importance of identifying one's own spiritual, religious, and existential perspectives as they may bias our work with clients by interfering with their possibility for posttraumatic growth. They advise that clinicians monitor closely their own responses as clients' talk enters the spiritual realm. Introspection can be attained by writing an autobiographical summary of one's own spiritual and existential history, giving consideration to difficulties and existential/spiritual issues that may have been central.[12] It can be very important to learn to listen for and respond to meaning making, spiritual, and religious material from clients, keeping in mind responses to practices that are different from our own backgrounds.[8]

The American Psychiatric Association clearly states that psychiatrists should not impose "their own religious, antireligious, or ideologic systems of beliefs on their patients, nor should they substitute such beliefs or ritual for accepted diagnostic concepts or therapeutic practice." At the same time, the Committee on Religion and Psychiatry encourage clinicians:

A. "To obtain information on the religious or ideologic orientation and beliefs of their patients so that they may properly attend to them in the course of treatment.

B. If an unexpected conflict arises in relation to such beliefs, it should be handled with a concern for the patient's vulnerability to the attitudes of the psychiatrist. Empathy for the patient's sensibilities and particular beliefs is essential.
C. Interpretations that concern a patient's beliefs should be made in the context of empathic respect for their value and meaning to the patient"[15].

Koenig and Pritchett[16] remind us that there is room for religious interventions in psychotherapy. They can include the validation of healthy forms of religious coping, providing religious scriptures for reading and consideration, and the challenging of maladaptive cognitions. They can also include using a patient's religious worldview to alter distorted cognitions and referral to religious leaders. Koenig and Pritchett further note that by addressing spiritual needs in treatment, one can have a better understanding of patients' psychological conflict. Interventions can be more congruent with someone's worldview. One can identify healthy religious resources that can bring comfort, and recognize psychological roadblocks to using spiritual resources. All of these, Koenig and Pritchett remind us, can result in the strengthening of the therapeutic relationship.[16]

Mediating role of religion

Religious coping may mediate positive health outcomes by encouraging health related behaviors, improving social support, and providing hope.[17] Pergament and Brant indicate that religious coping is more important than religious orientation. They identify helpful forms of coping as spiritual support and collaborative religious coping (perceptions of support, partnership with God, and guidance from God), congregational support, and reframing negative events as the will of God. Associated with poorer mental health status and mood, harmful forms of religious coping include discontent with the congregation and with God and the view that negative events are a punishment from God.[18]

When examining factors that protect against the development of PTSD among political activists tortured in Turkey, a strong commitment to a cause, prior knowledge/expectation of torture, immunization to traumatic stress, and social supports were identified as important.[19] In other empirical studies Buddhist spirituality was found to be protective against the adverse effects of torture. For example, when symptoms of 35 Tibetan nuns and lay people arrested and tortured in Tibet were compared with 35 controls not arrested or tortured, resilience seemed fostered by political commitment, social support in exile, prior knowledge and preparedness for confinement and torture, and Buddhist spirituality.[20] The following cases illustrate the centrality of spiritual issues to different aspects of patient/client presentation.

Case one – a source of persecution

He was a fighter during the war, and was viewed by many as a strong leader. He always fought against what he viewed was the occupation of his country. Whenever he had an opportunity, he encouraged others to join him in trying to eradicate the oppressor, which ruled his country. Due to the religious leanings of the ruling party, which was in opposition to his own, he reports multiple beatings at checkpoints, as well as imprisonments during which time he was tortured. He continuously prayed to a particular saint entrusting him with his life – living in fear.

Case two – a source of protection

She did not involve herself with politics. Her

husband worked for the government during the day, and she thinks spoke with the rebels at night. One night the soldiers came and killed her husband in front of the family, raped her and her daughter. They took her children and placed her in jail. There she was visited by a priest who advocated that she be allowed to get medical care. Once she was released to his care, he helped her to escape and be placed in safe hiding.

Case three – an excuse for persecution

She worked for women's rights in her country. Her sister died from complications related to female genital mutilation. She entered university and worked on behalf of women, talking about the ills of FGM, and the need for equal pay and opportunities for women in the workplace. She was arrested for being outspoken on behalf of human rights for women. After being tortured by women police, she was told that she needed to wash, cover her head, and be a "good Muslim" She replied that she was a better Muslim as she would never hurt anyone like they did. To no avail, she was not allowed to get medical attention. She was told that she must change.

Case four – a source of comfort

She was involved in educating, and ultimately organizing women who were illiterate. She used the opportunity to talk to them about democracy as she taught them skills. While speaking to a large group, she was arrested, and placed in jail. There she was beaten, and to her surprise raped. She prayed and prayed for strength and hope. Without God having been present during her torture, she does not think she would have survived.

Case five – a source of hope

More than fifteen members of his family were executed – many religious scholars. His father was tortured. Several years later, he was also. While imprisoned for some time, he speaks of the spiritual connection among his fellow prisoners ... an awareness that there was something more important, bigger than any of them. This unspoken connection helped him and his fellow prisoners to survive. Each day, they did not know if it would be their last. Today, his unspoken connection to other torture survivors gives him strength and his life purpose.

Case six – a source of anger

She was a gifted university student with much promise who held deeply onto her democratic ideals. She attended democratic political meetings. One day, she and her husband participated in a demonstration. They were both picked up, and threatened. After a period of non-involvement, she returned to her political activism. She started to prepare for national elections in her geographical area. She was picked up by the police, detained, tortured, and raped. She was able to escape. She was enraged with God that her life was destroyed, and that so many things were taken from her. It was impossible to pray.

Case seven – a source of pain

He was a priest who was actively teaching children about human rights. They used to meet each week. It was an opportunity for him to talk about issues of social justice, and the role of the church. As the children watched, he was arrested from his church. He and another family member were placed in prison. His brother died from his injuries. He was repeatedly tortured, and raped. He can't go near a church anymore, or hear religious music as it is a trigger for severe flashbacks, much tearfulness, and shame.

Case eight – a source of inspiration

Mr. A was interrogated about books related to the Dalai Lama and his possession of Tibetan flags, books, and cassettes. Chinese authorities wanted to confiscate them. Over a period of one week, he was tortured. After his release, he ultimately fled the country under very dangerous circumstances through the Himalayas. When he presented initially for an asylum evaluation, he identified his problem as a spiritual one. It was not about trauma or specifically torture, but rather about compassion. He was challenged by the effort to see the torturer as someone he could care about. He practiced trying to have the same feelings toward the torturer as someone who he loved deeply, and a neutral person. This was an effort to have greater empathy toward the torturer himself. He began to look at the background of the torturer and the impact of poverty on his life. To him, his understanding of the problem was not in the context of trauma. It was a purely spiritual problem. Namely, could he have enough discipline to relate to his torturer with full equanimity.

Case nine – a source of social support

She was a student leader, and very active in elections. She not only participated in demonstrations, but also solicited supporters, attended rallies, and passed out posters and flyers. At one of these demonstrations, officials rammed the crowd with a car causing multiple injuries. People were outright beaten. Army men pushed her onto the ground. A fellow student was killed in her dorm room at the university. They came to her house, but she escaped. She then began to get threatening phone calls. After arriving in the United States, she felt alone. It was not until she went to the mosque, that she found the support she needed to survive in this new and strange environment.

A therapist's perspective

Treating torture survivors requires that a therapist be keenly aware of the spiritual dimensions of the work. Part of this lies in the fact that torture, itself, brings one face to face with the extremes of human cruelty. In its intentionality, lies its power. As a treater, one needs to not only reflect on the dark side of human existence, but to serve as a beacon of hope that is transformative. It is the basic distrust of humanity itself that can result from torture. When it is sanctioned or allowed by a society, it moves beyond the realm of the dyadic relationship. It becomes related to the atmosphere of mistrust that is intentionally bred into the society.

The work sometimes allows for the unspeakable to be spoken, often for the first time. Creating safety, as in all psychotherapy, is tantamount. The role of therapist, however, moves beyond the traditional role, to encompass a more holistic view of the individual. By addressing clients' basic needs (food, shelter, and basic health care), the foundational stones of trust begin to be laid down. One often moves quickly beyond immediate needs to the familiarity of country conditions and their politics, cultural beliefs around health, community, and family, and often the role of faith. By opening the door to the spiritual, as in the view of many of the world's people, one's humanity is allowed to touch another: "obunto" – a South African word which means the essence of humanity.[21]

For some however, God died with them in a darkened cell. It becomes important to look at the ways in which their faith may have changed, as it too is a loss. Sometimes it requires looking at the circumstances under which someone was taken, or ways in which the divine may have been involved or absent. It may be necessary for someone to redefine how they acquire meaning inde-

pendent of a spiritual framework. It is necessary to accept how sometimes distance from God and time are needed to have a larger picture. Sometimes the antipathy for God originates in the belief that they were punished. Here, looking at who God is to the person, and his/her role in the universe, can be helpful. Sometimes religion is left behind, and other forms of activism or creative expression may become therapeutic. Here, more than ever, nonjudgmental treatment interwoven with kindness can be instrumental in someone's recovery.

The therapist must confront his or her own existential beliefs surrounding good and evil. It is only through self-reflection yielding the awareness that man, including oneself, is capable of all, that one is enabled to carry the pain and rage for the client, as well as the hope. Being actively present for the client is essential for healing. The more that one is able to engage the client in terms of their own view of healing and the sacred, the more the language of recovery is given form. One view of this work is that it is like entering into the sacred ... the place where recovery begins. By bearing witness, the therapist gives voice to the voiceless. This transaction diminishes the shame that can result from being tortured thereby resulting in that internal shift which allows empowerment to take hold.

Summary

Posttraumatic growth can exist in spiritual terms by increasing one's sense of purpose and the meaning in one's life, thereby strengthening freely chosen spiritual commitments[12]. Albert Schweitzer spoke about the "community of the suffering".[22] For many people throughout the world, spirituality is the source of recovery from adversity. It is important not to ignore spiritual issues, because for many these are the terms of survival. By recognizing the depths of despair in the most existential of terms, we also give validation to the depth of understanding of human existence that can only come about through personal suffering. For some torture and trauma survivors, spiritual understanding is the only possible pathway to recovery. Trauma by its very nature is isolating. For some, connecting with communities of faith can be the first step in restoring trust in humanity and alleviating the painful situation of isolation. In this diverse world, human experience and healing are described in a vast variety of ways. To fully "treat" survivors of trauma, and specifically the devastation secondary to war trauma and torture, it is necessary to reflect on our own understanding of causality with the implicit recognition that insight, wisdom, and psychological adjustment comes in many forms and from many different paths.

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The effectiveness of empowerment workshops with torture survivors

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Abstract

The article explores the effectiveness of the use of an empowerment workshop, called Free to Grow[1](FTG), in the treatment of a group of torture survivors who had shown great reluctance to enter into psychotherapeutic interventions.

Research into the effectiveness of the method is carried out using a series of tests measuring changes in empowerment, depression, anxiety and multiple operational definitions of health. Participants were also asked for feedback in an unstructured self-report upon completion of the workshop. In addition, an exit interview was conducted after follow-up, five months after the first workshop session.

Certain trends could be detected in spite of the small numbers of participants (11) and incomplete questionnaires. According to most of the measures used, the intervention proved to have a positive sustained impact.

At the exit interview all of the participants acknowledged experiencing increased levels of introspection and self-awareness, as well as having undergone a degree of growth and positive change. This resulted in many of them becoming more able to enter more mainstream psychotherapeutic interventions to deal with remaining psychological and interpersonal problems.

Key words: torture survivors, psychotherapy, PTSD.

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Introduction

The PEACE Centre in Namibia, a psychosocial healing centre for survivors of organized violence, offers a range of therapeutic interventions to its target groups of clients. These include torture survivors, ex-combatants, and refugees. It was noted that while many of the torture survivors familiar with the services offered by the Centre expressed a need for psychotherapeutic interventions to help them process their experiences and deal more effectively with its impact on their lives, most of them resisted entering into any therapeutic process.

It was decided to offer a self-empowerment programme, FTG[1], to a group of torture survivors, all of whom were experiencing problems in various areas of their lives, and who were resistant to enter into any type of psychotherapeutic process.

FTG is a life-skills programme, designed in South Africa, which focuses on improving inner and interpersonal effectiveness. It aims at enabling participants to strengthen their self-esteem and act with more confidence, take responsibility for their growth and development, develop their potential, improve the quality of their relationships inside as well as outside the workplace, and experience personal empowerment, productivity and success.

Facilitators of the FTG programme had

noted its effectiveness in not only bringing about aimed changes within participants, but also in helping them to achieve a degree of introspection into the problem areas in their lives. This led them to be able to effect positive changes in these areas, similar to the effects of psychotherapy.

In order to assess whether the programme was effective with this group of participants, and whether it brought about the envisaged changes, it was decided to couple their participation in the programme with participation into a research project to evaluate its effectiveness.

Participants selected for this project were all Namibian torture survivors who had been detained while in exile, participating in the struggle for the independence of Namibia. The group had been incarcerated together in "dungeons" under the ground, over a number of years, and were repeatedly tortured during their period of detention. The length of detention and torture varied from participant to participant.

The majority of the eleven participants who were included in the final analysis of data were female (63.6%), and most of them (73%) were over 40 years of age. All of the participants had completed high school and 27% of them were graduates.[2]

The research process

The FTG workshop is made up of a set of integrated modules focusing on personal and interpersonal empowerment. Issues such as self-esteem, locus of control, personal vision, and ownership are addressed in the personal empowerment modules, laying a foundation for proactive self-development. The interpersonal modules help participants identify and effectively address barriers in their communication and relationships. The training approach is holistic, encouraging participants to apply what they have learned to all areas of their lives, both private and in the workplace.

The workshop was designed using adult and accelerated learning principles. A blend of metaphor and experiential learning techniques help participants, even those with an educational backlog, to understand and integrate the concepts.

The FTG workshop was offered to the group in the period of November to December 2001 on four separate days. A follow-up session was given in May 2002. The break between the successive sessions is seen to be beneficial, as the participants have the opportunity to apply the knowledge they gain each session.

All subjects participated in the FTG workshop on a voluntary basis, on the understanding that they would participate in all the sessions of the workshop and would complete a series of questionnaires. Four questionnaires were used: the Empowerment Questionnaire,[3] the Beck Depression Inventory,[4-6] the State-Trait Anxiety Inventory[7] and the Health Status Questionnaire (SF-36). The SF-36 consists of eight scales which represent multiple operational definitions of health as well as two summary measures, a Physical Components Score and a Mental Components Score.

The questionnaires were given to the participants at three measurement points:

- prior to the first FTG workshop session (pre-workshop)
- on completion of the workshop (post-workshop)
- A follow-up to the FTG workshop session was given five months after the end of the first workshop. The same series of tests was given to the participants prior to the start of this workshop.

In addition, participants were asked to give

feedback in an unstructured self-report at the post-workshop point, and an exit interview was carried out at follow-up.

The small number of total participants (11) together with the fact that two participants did not attend all the sessions of the workshop, hampers meaningful statistical analysis of the data. Thus, the following is a report of the most noticeable findings and an examination of trends that emerged.

Results

Unstructured self-report

Participants were asked to evaluate the effectiveness of the workshop upon completion, at the post-workshop measurement point. They were asked to comment on changes that had taken place in their home life or private environment that they could attribute to the effects of the FTG workshop process. All ten workshop participants reported a positive improvement in areas ranging from:

- improved communication and listening skills ("Improved communication and understanding with people.")
- increased assertiveness and decreased aggression ("I have learned to be more assertive without hurting or subjecting the others to my way of doing things.")
- improved social interactive skills, especially in the relationship and parenting area ("I could assess my relationship at home and identify my faults and also openly admit where I was wrong, even with the approach of my children.")
- increased self-knowledge ("I have more knowledge and enlightenment how to handle my private environment." "I have discovered myself.")

Impowerment status of the group

The standardised questionnaire employed in this study conceptualises empowerment on three levels, namely the Micro-level, Interface level and Macro-level, based on the indicators or outcomes of empowerment.[3,8] The group appears to have gained the most on the Macro-level that refers to, amongst others, their awareness of their rights and their ability to think critically and to become involved in action to bring about change. There was also an improvement reflected in their interpersonal skills such as problem solving and mutual support. This was the area that they were weakest in before the workshop. There was a slight decrease on the Micro-level, relating to, amongst other things, their self-confidence, self-esteem and their ability to cope. This, however, had changed at the follow-up test, after five months, where it was found that they improved on this level, indicating a growth in their positive feelings about themselves as they gained skills and applied them in their everyday lives. There was therefore a sustained, long-term impact on the participants' empowerment on the Micro-level.[2]

Depression

It was expected that this group of torture survivors would record higher levels of depression than the general population, as some of the symptoms of PTSD (diminished interest or participation in significant activities; feelings of detachment or estrangement from others; restricted range of affect (e.g., unable to have loving feelings); difficulty falling or staying asleep; difficulty concentrating) are similarly symptoms of depression. This expectation was supported as ten of the 11 participants showed a pre-test measure of depression on the Beck's Depression Inventory[4] of at least 11, the level indicated as a cut-off score for the presence of depression by Gallagher et al.[9]

The one participant whose score was lower than 11 at pre-test did not complete

the BDI at follow-up, as well as one other participant. Of the remaining nine participants, five showed a decrease in scores over time at follow-up, compared with the pre-test measure, and three subjects showed an increase in scores at follow-up. At pre-test, four of the participants' scores fell in the severe or moderate/severe ranges of depression. At follow-up, eight of the nine participants recorded scores in the lower ranges of depression, ranging from the absence of depression to mild or moderate depression, and one participant scored in the severe range.

Trait Anxiety

This is a measure of anxiety as a personality trait, and should be stable over time unless a change in the trait has taken place within the person. A change is to be expected where the intervention has been successful in reducing the general, long-standing tendency to experience anxiety.

It was similarly expected that this group of torture survivors would record higher levels of trait anxiety than the general population, as some of the symptoms of PTSD are symptoms of anxiety (difficulty falling or staying asleep; irritability or outbursts of anger; difficulty concentrating; hyper vigilance; exaggerated startle response) and PTSD is in accordance with an anxiety disorder in DSM-IV.[10]

The results were in keeping with this expectation, with the majority of the group scoring above the average range of anxiety levels in the general population, that is above 44.08 for females and 44.01 for males,[7] at pre-test. At follow-up this level was reduced, indicating improved, lower levels of anxiety, with only four participants scoring above the standard deviation above the mean. However, five of the remaining participants' scores were still in the upper range of anxiety levels.

The Health Status Questionnaire (SF-36)

At pre-test, the group as a whole generally recorded levels indicating more physical and mental health problems and limitations than the general population.

Severe limitations are evident in the group's physical functioning. These results are not unexpected in a group of torture survivors. Physical torture produces a well-defined variety of physical symptoms that have been widely researched and documented. Most of the physical effects of torture resolve spontaneously, but a number of survivors continue to experience long-term or chronic symptoms, such as chronic pain, reduced mobility and chronic bronchitis. Torture survivors also often experience a negative or distorted body perception.

Similar severe limitations were recorded in the quality and quantity of the group's social interactions. Again, these results are not unusual in a group of torture survivors. As when survivors suffer psychological after-effects of torture, torture can be expected to impact on their social relationships as well. A cluster of symptoms commonly experienced include:

- avoiding activities, places or people that arouse recollections of the trauma
- markedly diminished interest or participation in significant activities
- feelings of detachment or estrangement from others
- restricted range of affect, such as the inability to experience loving feelings

Six of the participants showed an increase in their social functioning scores at follow-up, and two participants showed a decreased score.

While the results generally indicated physical problems and limitations, it appears that the majority of the group do not suffer

severe limitations to their work functions as a result of physical health problems. The group's work function does, however, appear to be severely limited as a result of emotional problems that they experience. The majority of the participants' scores are below the mean on at least one of the measuring points.

While the FTG intervention could be expected to have had some positive impact on the participants' emotional state, improving their work functioning as a result, six of the participants recorded a decreased score at follow-up, four had more than one standard deviation and one had more than two standard deviations. The large number and the degree of decreased scores recorded is unexpected.

The mental health of the group is generally slightly lower than that of the general population. The FTG intervention could be expected to have had the greatest positive impact on their mental health and emotional well-being scores. However, while follow-up scores greater than one standard deviation above the norm were recorded, indicating an above-average state of mental health for two participants, four participants recorded large decreases in mental health functioning following the FTG programme. The difference may be contributed to the fact that the FTG programme is aimed at increasing empowerment, including aspects such as feelings, attitudes and skills, beliefs, actions and interactions, while the Mental Health scale of the SF-36 records not only similar aspects such as behavioural and emotional control, but also aspects such as anxiety and depression.

The energy and vitality levels of the participants were also generally low, but here the intervention appears to have had some positive effect in increasing these levels. The majority of the group recorded an increase in their Energy/Vitality scores at follow-up, two of which are increases of more than one standard deviation.

Bodily pain is a common physical consequence of torture, and while this is apparently the case for a few of the participants, it clearly does not apply to the whole group. In general, FTG appears to have had little positive impact on the group's subjective experience of bodily pain. Four of the participants recorded a decreased score at follow-up, and four participants scores were unchanged. As Bodily Pain regards a physical experience, it was not expected that FTG would impact on this measure.

The group had a generally low perception of their physical health status. It can be expected that the group would suffer some long-term physical consequences of torture and that these would impact negatively on their physical health status. The majority of the group recorded an increase in their scores at follow-up, one of these an increase of more than two standard deviation units, and two of more than one standard deviation unit. In general, there appears to have been some improvement on the group's subjective experience of general health from the time of the pre-test to the time of follow-up, although it was not expected that the intervention would impact on the group's general health.

The many uncompleted items resulted in much missing data from the Physical and the Mental Component scores, rendering it irrelevant to look at the degree of individual improvement or decrease in these measures. While it can be said that the group as a whole recorded generally low scores on these measures, it is not possible to make any meaningful conclusions about the impact of FTG on this aspect.

Discussion

The FTG programme used in this interven-

tion is specifically aimed at increasing the levels of empowerment of the participants on the internal (Micro), interpersonal (Interface) and Macro levels. The intervention proved to have a positive, sustained impact on the levels of empowerment of this group of torture survivors, as three quarters recorded an average of 5.49% improved empowerment scores even five months after completion of the programme.[2]

An increase in levels of empowerment includes an increase of control over one's life as well as an improvement in relationships and interactions, and as such can be expected to have some positive impact on levels of anxiety and depression and the health status of participants. It is apparent that some positive change has been attained, but the fluctuation in scores can perhaps be explained by the fact that this intervention was not specifically aimed at affecting the levels of anxiety and depression or general health status of participants.

Where the aim of an intervention is to increase the levels of empowerment of such a group, the FTG intervention can be said to have a positive effect. Where the aim is to reduce psychological distress and limitations due to psychological problems and increase physical health and functioning, much variance was recorded on measures such as the work functions, emotional limitations, and mental health and emotional well-being. While FTG generally has had a positive effect, it appears that further interventions would be indicated.

Prior to participating in the FTG programme, this group of participants had shown much resistance to entering into psychotherapy. At the feedback interview all of the participants acknowledged experiencing increased levels of introspection and self-awareness, as well as having undergone a degree of growth and positive change. This resulted in many of them becoming more able to enter more mainstream psychotherapeutic interventions to deal with remaining issues such as anxiety and depression symptoms.

The exit interview proved to provide an opportunity for many of the participants to address painful issues from the past, or to look at ways of dealing with problems and issues in the present, with the therapist. This illustrates a major move forward for these participants, all of whom had avoided engaging in a therapeutic process with the therapist until this time.

In addition to becoming more motivated to enter therapy, participants were able to illustrate ways in which concrete, positive changes have taken place in their lives, which they attribute directly to having participated in the FTG workshop:

- Many of the participants reported an improvement in their physical self-care. Many have found themselves able to limit previous excessive use of alcohol.
- All participants reported improved relationships in at least one sphere of their lives. One participant described a dramatic improvement in the relationship with an ex-spouse.
- All participants described a greater degree of introspection. One participant has begun writing an autobiography covering the period of exile, detention and torture, an activity she had been considering for many years.
- Two participants described letting go of their hatred and anger towards the political group to which their torturers belonged. They experienced this as liberating, allowing them to move forwards.
- Most of the participants reported feeling better equipped to deal with problems in their lives at present.

The majority of the participants requested a continuation of this process in some form, such as follow-up workshops, or continuing to complete the series of questionnaires on a semi-annual basis for a further one or two years, so that they can continue to monitor their areas of growth and problem areas.

It is not known to what degree the results were influenced by the group process that was developed amongst these participants during their mutual incarceration, and developed and maintained by them and their fellow former-detainees in the ensuing years.

Further research on FTG with the population of torture survivors is recommended, examining whether and how the changes recorded are sustained and whether this process continues further in the future. An additional recommendation is looking at the impact of FTG on reducing or overcoming the resistance of many torture survivors to psychotherapeutic interventions.

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Police torture in Bangladesh – allegations by refugees in Sweden

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Abstract

Eighty-two refugees from Bangladesh were examined by specialists in forensic medicine and psychiatry at the Centre for Torture and Trauma Survivors in Stockholm from 1999 to 2004. The majority gave similar testimonies of political violence and torture during police interrogations. The aim of the present study was to describe general features and patterns of torture by the police in Bangladesh as well as medical and psychiatric sequelae in this group of alleged victims.

The majority was young men, mean age twenty-nine, who had been politically active in oppositional student organisations, arrested in the street during demonstrations, and accused of illegal possessions of arms or of murder. They were all kicked and beaten with police batons and fists. The most common torture methods were beatings on the soles with lathi, wooden canes or hot-water bottles, straight or upside-down suspension, electric shocks, and asphyxication by means of hot and/or polluted water poured into the nostrils. All the women and nearly a third of the men alleged that they had been raped. The victims were in most cases released within three days, many of them severely traumatised and in need of acute medical attention.

At the time of examination, all but a few subjects showed more than twenty scars, and over 80% were diagnosed with post-traumatic stress disorder. Many complained of chronic aches in the lower back joints and feet.

Key words: torture, Bangladesh, forensic medicine, human rights abuse, PTSD

Introduction

It is estimated that between 10 and 20% of all refugees and asylum-seekers who end up in Denmark,[1] and possibly also in Sweden and many other European countries, have been subjected to torture. Refugees who come to Sweden have since 1992 been examined at the Centre for Torture and Trauma Survivors (CTD, after 2001: Kris- och Traumacentrum, KTC) in Stockholm by a team of forensic and psychiatric specialists. To this date nearly 500 patients alleging torture have been examined, and their injuries have been documented. The data thus collected is also intended for use by the authorities investigating asylum applications. However, far less than 1% of all asylum-seekers who arrive in Sweden, about 20,000 a year, have so far been examined.

From 1999 and onwards, a considerable proportion of the refugees examined at the CTD had come from Bangladesh. It is esti-

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mated that about 5% of all Bangladeshi who arrive in Sweden will come to CTD for examination, which is more than for other nationalities. The reason for this is uncertain. Most refugees from Bangladesh have come to Sweden after 1995. In Bangladesh, a young nation founded in 1971, the social climate has long been characterized by political unrest and religious and ethnic conflicts. Political violence is common and police brutality has been documented by, among others, Amnesty International.[2] Two large political parties are struggling for dominance – the Awami League and the Bangladeshian National Party (BNP). Among the smaller parties represented in the political assemblies are the Jatya Party (JP), which was founded by the military dictator Ershad in 1986, and Jamaat-i-Islami, an Islamic party. The Awami League had been in power since 1996 until the election in 2001, when it was defeated by the BNP. Bangladesh is a Moslem society with numerous minority groups, mainly Hindus and Buddhists, many of whom also belong to ethnic minority groups, such as the Jumma nation and the Shanti bahini guerilla in the Chittagong Hills in the eastern part of the country.

Although Bangladesh today is a constitutional democracy with free elections, the testimonies of Bangladeshian political refugees reflect a different reality – that of an extremely violent society.

Methods

A total of 82 individuals, 79 men and three women, median age 29.4 years, were examined at the CTD and KTC between 1999 and 2004. The subjects were interviewed with the help of an interpreter. They were encouraged to speak freely without leading questions. Relevant information was registered in a standardised form (Appendix 1). Scars and other injuries were photographed and documented in a written protocol. After the forensic medical examination, psychiatric assessments were made in the form of a structured clinical interview for DSM-IV (SCID) that was videotaped. Post-traumatic stress disorder was also assessed by a number of self-rating instruments, e.g. the Harvard Trauma Questionnaire[3] and the Impact of Events Scale.[4]

The data were classified into six categories: 1) personal/social circumstances, 2) frequency of torture events, 3) type of violence and weapons, 4) torture methods, 5) acute injuries, and 6) scars, other objective findings, and persisting symptoms.

The data were processed in the Statview program for Macintosh (Abacus, SAS Institute Inc. NC, USA) and presented as frequency distributions and descriptive statistics.

Results

Personal and social circumstances

Forty-seven percent of the subjects were university students, and an additional 30% had gone to college. Only 2 (2.5%), both belonging to minority groups, lacked formal education. At the time of torture, 6% were younger than 18 years.

The majority, 89%, were Moslems, 2.5% Christians, 5% Hindus, and 3.5% Buddhists. Seventy-eight of the 82 (95%) described a history of political activity in their home country, where the majority had belonged to the BNP, Jatya or the Freedom Party. The Awami League activists were not seen before 2001.

Only 16% had a relative in Sweden, while 92.5% had arrived alone and without connections. The alleged reason for asylum was persecution because of political activity per se (36%) or in combination with false accusations of murder or possession of illegal weapons (56%). Religious or ethnic

persecution was alleged in 7% of the cases. At the time of examination, the asylum application had been rejected in 86.5% of the cases.

Frequency of torture events

Two applicants had not been tortured. One had been persecuted by political offenders and the other, a mere child, had escaped from slave labor. Eighty subjects had been tortured at least once, in mean 2.024 times, range of 1-8 times. Sixty-nine per cent had also been subjected to street violence during political demonstrations.

Type of violence and weapons used

All persons had been subjected to blunt force, i.e. been beaten with fists or weapons and kicked with boots, 79% had suffered sharp violence, and 78% had been burnt. The weapons used in the beatings were the pointed police batons called lathi (which also can be used for stabbing) (Figure 1), rifle butts, wooden canes, hot-water bottles, heavy wooden "rollers", and iron bars. Beating with land hockey clubs during interrogation were sometimes reported but many more described assaults with land hockey clubs during street demonstrations. When beaten with hot-water bottles it was most commonly under the feet.

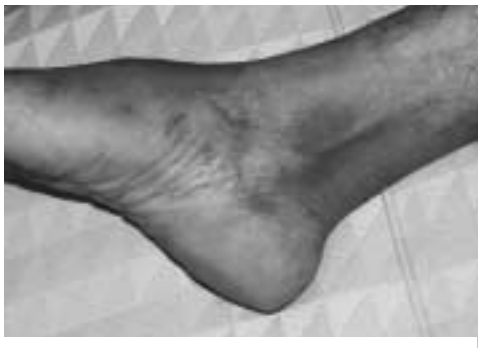

Figure 1. *Multiple scars on the ankle and foot after stabs with pointed police baton (lathi).*

The sharp violence was in most cases executed by means of knives in a few cases with an axe (Figure 2), razor blades, bayonets, swords, and with shards of broken glass. Needles had been used exclusively for nail torture.

Burning with cigarettes (Figure 3) was alleged by 70% of the subjects, with hot iron by 35%. Scalding with hot water was alleged by a few. For a summary see Table 1.

Torture methods

Sixteen different methods of torture were mentioned more than once. Most victims reported that they had been systematically beaten on the soles of the feet with batons, wooden canes, or hot-water bottles; many

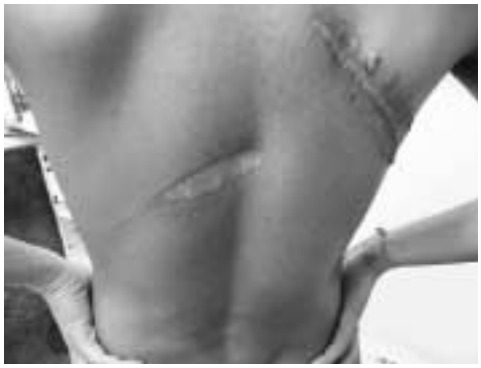

Figure 2. *Scar in the back after wound inflicted by a "Chinese axe". Scar in the right side after operation of subsequent pleural haemorrhage.*

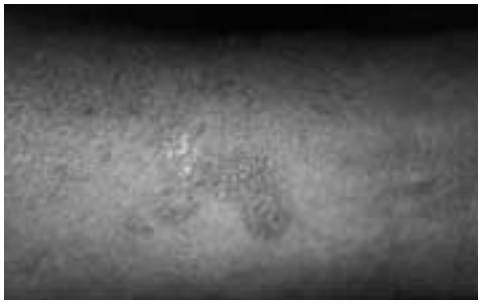

Figure 3. *Multiple cigarette burn marks on the arm.*

Table 1. *Type of force in 82 torture victims*

Type of force	Weapon	%
Blunt force		100
	police baton	91,5
	rifle butt	52,4
	wooden cane	42,7
	hot water bottle	21,2
	roller	20,7
	iron bar	19,5
	"knuckles"	16,8
	land hockey club	8,5
Sharp violence		79,3
	knife	56,1
	needle	18,3
	razor	17,1
	bayonet	9,6
	sword	8,5
	glass	6,1
Burning		78,1
	cigarette	69,5
	hot iron	35,4
	hot water	19,5
Gun shot		6,1

had been suspended for a longer period of time, either straight up or upside down. About two thirds had been given electric shocks with electrodes applied to the temples, genitals or digits. A majority had experienced "water treatment", whereby hot or cold, sometimes polluted, water was introduced into the nostrils with a piece of cloth in the mouth or over the face. Water treatment was often combined with upside down suspension. The use of hot peppers was reported by a few, either in wounds or in water squirted into the nostrils. Some of the victims had been subjected to strangulation by rope or hands. "Submarino", where the head is pushed under the water in a jar until near drowning, was described by a few patients. Some subjects had been forced to stare into strong light. Genital torture, such as beating of the genitals or having a heavy object hanging in a rope around the penis and/or scrotum, had allegedly occurred in nearly a third of the cases, and not a few had had objects such as batons or bottles pushed into the anus. Outright rape, anal or vaginal, was described by nearly a third, including all the women in the study group. Fake executions were alleged in some patients, all of whom described that a barrel of an unloaded gun or rifle was pressed against the temple. Not a few had been forced to drink urine or polluted water. Nail torture had most often involved needles pushed under the nails,and in a few cases nail extraction. Almost a third had been subjected to "finger torture" by having a pencil or something similar interlaced between the fingers while the hand was pressed against a hard surface. Some said that they had been treated with a "roller", which means that a heavy log is slowly rolled over the front of the legs of the victim lying in a supine position on the floor. Still other methods were mentioned once in 22.2% of all cases. A summary is given in Table 2.

Acute injuries

All subjects reported deep bleeding wounds after torture. Dental injuries were alleged by 34%. Injury to joints were described by 17% and fractures by 38%. The injured joints in-

Table 2. *Torture method in 82 victims.*

Torture method	%
Beating on the soles ("falaka")	79,3
Suspension	64,6
"Water treatment"	59,8
Electric shocks	58,5
Genital torture	31,7
Rape – anal or vaginal	30,5
Drinking urine or polluted water	26,8
Object into anus	25,6
Finger torture	24,4
Strong light	18,2
Nail torture	17,1
"Submarino"	16,7
Fake execution	14,6
Hot peppers	11,0
"Roller treatment"	9,8
Strangulation	9,8
Other methods (mentioned once)	31,7

cluded knees, shoulders, elbows, and wrists. The fractures were in fingers, toes and ribs. Acute eye injury was reported by 13.5% and bleeding from the ears and impaired hearing by 16%. Internal haemorrhage, manifested as bleeding from the anus, haematuria, and coughing or vomiting blood, was described by 16%. After release 16% had needed acute surgery, and 58.5% were hospitalised for medical and/or psychiatric care.

Objective findings and persisting symptoms

The whole group had a mean number of 19.5 +/- 8 scars (range 5-50), and 10% had visible or palpable healed fractures. The most common sequelae were joint- or foot pain, lower back pain, daily headaches, sensibility disturbances – mainly strange sensations and anaesthesia. Less common was neck pain. Rather common were symptoms from the gastro-intestinal tract, mainly gastritis and obstipation, and from the uro-genital tract in the form of dysuria or impotence. Ear, nose and throat (ENT) problems with hearing loss or tinnitus, chronic rhinitis and sinusitis were also rather common. A majority also complained of diffuse symptoms like pain in the whole body, palpitations, sweating, and tremor. They were categorised as vegetative symptoms. For a summary, see Table 3.

Table 3. *Subjective symptoms in 82 victims.*

Subjective symptoms	%
Foot pain	65,9
Vegetative symptoms	61,1
Lower back pain	54,9
Daily headaches	48,8
Gastro-intestinal symptoms	39,0
Sensibility disturbances	32,9
ENT symptoms	31,5
Uro-genital symptoms	17,1
Neck pain	14,6
Joint pain	14,6

Frequency of persisting symptoms ascribed to torture at the time of examination (%).

Psychiatric disease

Fifty-eight patients were examined by a psychiatrist and 84.5% fulfilled the criteria of post-traumatic stress disorder (PTSD). There were cases with co-morbidity, most commonly PTSD and depression. Active suicide plans or suicide attempts were reported in 31.3% cases. At the time of examination 15.7% were under psychiatric hospital care. More than 40% were on antipsychotic medication.

Discussion

The findings of this study are in concordance with a summary of torture methods used by the police in Bangladesh published in the Amnesty International Report 2001.[2] The Amnesty Report also stated that allegations of torture by the police have not led to any actions from the authorities or the major political parties. According to the latest Amnesty Report (2004) at least 13 persons died in police custody in 2003.[5] In the medical literature, as reflected by Medline, no scientific report of torture from Bangladesh is to be found. Patterns of abuse and torture methods vary between countries and cultures (6-10), but we lack systematic studies of such differences today.

The refugees from Bangladesh included in this study were examined during a relatively short period of time. The group was rather homogenous, mainly consisting of male college and university students between 20 and 35 years of age, who belonged to the major religious and ethnic category, i.e. Moslems, and had been active in established political organisations. It could be noted that not until 2001 had members of the Awami League appeared among the patients, which coincides with the change of government in Bangladesh after the election when BNP came into power after six years in opposition. Disproportionately large fractions al-

leged membership of the Freedom Party and the Sarbahara Party. The former have been systematically persecuted during the previous election period when the Awami League was in power. The Sarbahara Party is a forbidden party on the extreme left. Since the last election in 2001, the BNP in coalition with Islamic extremist parties, have increased the pressure on the Sarbahara party. In 2002 the persecution of political opponents escalated further as the government launched "Operation Clean Heart" officially a drive against the increasing criminality in Bangladesh. The army was called upon to work jointly with the police.

However, albeit differences in political affiliations, the testimonies were largely similar, but more or less detailed, possibly in part due to personality traits and psychic condition.

The typical history of police torture in Bangladesh (alleged by over 50% of the subjects) is thus that a university student is arrested during a violent political demonstration. He is beaten and kicked by the police on the way to the police station. He is accused of murder and/or illegal possessions of arms. During the interrogation carried out immediately or after a few hours in custody, he is beaten with batons (lathi) and rifle butts, especially over joints and the soles. He is often suspended straight or upside down and treated with water poured into his nostrils and/or electric shocks. He is also frequently burned with cigarettes, and often cut or stabbed with knives and the pointed end of lathi. The torture results in bleeding wounds and severe psychological derangement. The victim is usually released after three days or less. In many cases after a bribe from the victim's family or political party.

It is well known that Bangladesh is one of the most corrupt countries in the world. The police force is underpaid. The fact that the refugees from Bangladesh have political affiliations over the whole spectrum from left to right indicates that the motives for torture are not primarily political. Rather, it seems to be an expression of this extreme corruption and lack of government control. It is also suspected that political groups in power use the police unofficially to harass political opponents.[6]

The typical findings at the time of examination, most often one to three years after the torture event, are numerous scars, psychic symptoms consistent with PTSD, vegetative symptoms such as tremor, palpitations, and sweating, lower back pain, and chronic pain in the joints and feet.

The forensic statements are usually concluded with an opinion on the probability that torture has occurred on a scale from zero to three, where three is regarded as next to conclusive. This group of Bangladeshi scored high, with a mean of 2.58. The probability statements are based on the patient's story and the findings at the examination, i.e. the number of scars, the location and morphology of the scars, and other injuries and symptoms.

Firm validation of the statements registered in the forensic torture documentation is virtually impossible, however. Controlled studies of torture victims are scarse and difficult to execute.[7] One approach is to compare the results from two independent examinations.[8] It might also be possible to validate findings by statistical methods, using a large number of data[9]. Better specific knowledge of torture in different countries may provide useful tools for assessments. Though many features of torture vary little between countries and regions, others do.[10]

In this study of Bangladeshi refugees claiming to be torture victims, the agreement between the majority of statements

along with a few unique details (for example the water treatment that was reported by more than 60% and seems to be a regional speciality) can help to validate the allegations. The numerous scars and cigarette burn marks were objective findings that appear to be quite unique for Bangladeshian torture victims. Beating of the soles, which in other parts of the world is called falaka, falanga or bastinade, was the most common torture method in this study. It is also the "method of choice" in Turkey and the Middle East.[11,14]

The most common physical sequelae were lower back, foot and joint pains, which could be related to the beating of the joints and falaka. A previous study has shown correlations between specific methods of torture and physical sequelae.[3] Compared with other national groups, ENT symptoms i.e. chronic sinusitis, was far more common among the Bangladeshi and could possibly be attributed to the commonly used water treatment. However, the physical complaints of the patients were generally of a minor degree compared with their psychic injuries. A majority had some kind of medication, sedatives, analgesics, antidepressants or neuroleptic drugs, and 16.7% were hospitalised for psychotic symptoms at the time of examination. The prevalence of PTSD is generally very high among the torture victims examined at the CTD in Stockholm,[15] and the Bangladeshian group demonstrated no significant difference in this respect compared to other nationalities.

In conclusion, this study shows that Bangladeshi refugees in Sweden who allege to have been tortured by Bangladeshian police show many similarities in the details of their statements, in the findings at the physical examination, and in persistent symptoms. Research on torture needs to be focused on closer knowledge of differences between countries and cultures, which is crucial both for validation of the forensic and psychiatric statements and for the specific treatment of these victims.

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❑

Appendix 1

Informations registered in standardised protocol

- date
- name
- country
- age
- gender
- ethnicity/religion
- education
- profession
- co-applicants
- relatives in Sweden
- reason for asylum
- arrival in Sweden
- previous health

Circumstances

- arrest
- torture
- other violence
- trial
- imprisonment
- isolation
- food and hygiene
- naked when tortured
- blindfolded
- tied with ropes or handcuffs

Blunt force

- fists
- kicks
- box on the ears
- weapons
- other violence

Sharp force

- knife
- bayonet
- glass
- razor
- sword
- other sharp weapons

Flogging

- cable
- whip

Thermic

- cigarette
- hot iron
- hot water
- other

Torture methods

- falaka
- suspension
- stretching
- electric shocks
- asphyxia-submarino
- water treatment
- strangulation
- nail torture
- finger torture
- genital manipulation
- rape
- forced feeding(urine/feces etc.)
- forced positions
- fake executions
- other methods

Acute injuries

- wounds, abrasions and hematomas
- fractures
- injuries to joints
- injuries to teeth
- internal injuries

- loss of consciousness
- in need of acute surgery
- in need of acute surgery
- in need of acute medical attention

Chronic symptoms

- headache
- lower back pain
- joint pain
- foot pain
- loss of function
- eye symptoms
- ear-nose-throat symptoms
- respiratory symptoms
- cardiac symptoms
- gastro-intestinal symptoms
- uro-genital symptoms
- dermatological disease
- other symptoms/diseases

Observed injuries

- torture scars
- other scars
- head
- neck
- upper extremities
- hands
- trunk
- lower extremities
- feet
- back
- genitals
- fractures
- muscular atrophy
- loss of teeth
- other injuries

Present health status

- medications
- psychiatric diagnosis
- suicide attempts
- medical history in Sweden

Personality traits

- body type
- hygiene and dressing
- introverted (0)-extroverted (3)
- other traits

Forensic statement

Asylum application

Police custody deaths in Mauritius

A.K. Agnihotri, MD* & S.K. Gangadin, MD**

Abstract

People in police custody are more likely to die prematurely, especially from violent causes. This article presents data of a total of 28 police custody deaths in Mauritius from 1991 to April 2002. Twenty-two deaths were caused by suicide, three by natural causes, two by alcohol/drugs and one by unknown cause. Hanging was the most common means of committing suicide. Items of clothing were the most commonly used objects. Based on the findings, several measures for the prevention of deaths in police custody are discussed.

Key words: police, custody deaths, autopsy

Introduction

Any death in police custody is a serious matter causing public disquiet. People in custody are more likely to die prematurely, especially from violent causes, than similar people not in custody. Therefore, it is not only the lawful duty, but also the moral responsibility, of police to keep a person in their custody with necessary care and concern for his safety. This has become a major human rights issue worldwide.

We undertook this study to analyse causes of deaths in police custody in Mauritius and to compare these with the published reports from other countries, with the objective of identifying preventive measures.

Scenario in Mauritius

Mauritius is a small, pleasant island which serves as a popular tourist destination for wealthy Europeans. This island of volcanic origin covers an area of 1.865 square kilometers (720 square miles). The estimated residential population of the island of Mauritius on December 31, 2000 was 1,157,789, showing an average population growth rate (2000-2005) of about 0.8%. The nation claims to be prosperous and tranquil, offering stability and harmony for a racially mixed population.

From January 1991 to April 2002, a total of 28 deaths have occurred in police custody as shown in table 1.[1]

Analysis of the above mentioned data shows that the great majority of deaths in police custody are due to suicide – 22 (79%) – followed by deaths due to natural causes – 3 (11%) – and then two cases of poisoning (7%). In so far as suicides are concerned, the majority of deaths occurred due to hanging. Among all of these cases of custody

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Table 1. *Deaths in Police Custody.*

Causes of death	Number
Suicide	
Hanging	17
Self-inflicted injuries	2
Burns	3
Poisoning (alcohol/drugs)	2
Natural	3
Unknown	1
Total	28

deaths, Kaya's death brought into sharp focus an ongoing problem of police brutality, which included the use of torture to extract confessions and the use of excessive force during arrest. It has become very famous as described below.[2]

On 21 February 1999, the popular singer known as Kaya (Joseph Reginald Topize) died while in police custody, after being arrested for smoking marijuana during a protest for drug legalization. An autopsy obtained by his family revealed signs of beating, contradicting police claims that his injuries had been selfinflicted. Kaya's death provoked several days of rioting and protests such as the fire bombing of police stations, the closing of schools and stores, road-blocking and car-burning. The public accusations have suggested that Kaya's death resulted from skull fracture inflicted by police. Amnesty International wrote to the government expressing its concern about continuing police brutality and calling for the find-

ings of inquiries into the death of Kaya to be made public.

According to the 2002 Amnesty International Report,[3] there were at least four deaths in police custody as a result of torture or other cruel, inhumane or degrading treatment in the year 2001. Neither these cases nor the cases from previous years were investigated under open and thorough procedures. For example:

Josian Kersley Bayaram died on 21 July in prison in Pointe aux Cannoniers after his arrest for alleged drunkenness. An official autopsy concluded death by asphyxiation. His family disagreed with police statement that he had committed suicide by hanging, objecting that there was no trace of strangulation on his neck but there were deep wounds under his left eye and on his forearm. They filed a complaint to the Police Complaints Bureau and National Human Rights Commission but were not informed of any progress about the investigation. They had the body exhumed two months after burial for private autopsy.

In both of the cases, no evidence of foul play was suspected and the report was submitted to the Minister of Human Rights.

Discussion

Premature deaths of people in police custody are always tragic. At a moral level, it undoubtedly causes trauma among family members of the victim and at the same time sometimes gives rise to unfounded suspicion and rumours as to the conduct of police. Therefore, any such death needs to be explained in the first instance before the law, and then to the public and family members of the victim.

In South Africa, the Independent Complaints Directorate had recorded 2.174 custody related deaths in April 2000 since their inspections in 1994.[4] In Ontario, Canada, a total of 308 people died in custody during the period of 1990-1999.[5] In the Netherlands, 59 deaths were reported in Dutch police station in the period of 1983-1993.[6] The Institute of Legal Medicine in Bonn, Germany, reported 86 deaths in middle Rhine detention centers and custody from 1949 to 1990.[7] In Australia, 527 deaths are known to have occurred in police or prison custody in the period of 1980-1989.[8] In Denmark, 20 deaths (one homicide and 19 others) occurred in police custody during the period of 1981-1985[9]. In India, according to the NHRC report, the number of custodial deaths has doubled from 444 in 1995-1996 to 888 in 1996-1997, and this figure went to 1.012 in 1997-1998.[10] In India, as per NHRC, the facilities for the conduction of an autopsy in custodial deaths are inadequate and the procedure followed is unsatisfactory at most of the places.[11]

Case studies from other parts of the world show significant findings according to the suicidal behaviour of prisoners.[12]

These figures themselves speak of the magnitude of the problem in most of the countries. The United Nations has given guidelines on effective prevention and investigation of extra-legal, arbitrary and summary execution.[13]

The constitution of Mauritius contains human rights guarantees that prohibit arbitrary arrest and detention, torture and inhumane treatment. In 1999, the police established a Complaints Investigation Bureau that investigates allegations of abuses by officers. The National Human Rights Commission (NHRC) was set up in 2001 under the Protection of Human Rights Act 1998 enacted in December 1998. Under section 4(1) (b) of the act,[14] the NHRC may receive any complaint against police brutality either from physical violence or foul language. The Commission (NHRC) also recommended

the following views to the commissioner of police to be made known to each member of the police force:[15]

- The police officers are reminded that they are public servants paid for with public funds to provide a multitude of services to the public and they are expected to treat members of the public with patience, fairness and courtesy.
- The use of unnecessary violence and uncivil or improper language by police officers not only constitutes an offence against the discipline of the police force but can also entail criminal proceedings against the offender.

In this country, any reported case of death in police custody is automatically taken over by the NHRC. They enquire into the allegation, and if a crime is disclosed they refer the case to the Director of Public Prosecutions with their recommendation. They also visit police cells with a strict observance of the laws, rules and standing orders by the police in matters of care and custody of detainees in cells.

According to Amnesty International's recommendations to the Mauritius government[16] to ensure that investigations into allegations of torture or other human rights violations by the police are independent and impartial, the accused officers are to be suspended pending the result of investigations, and those responsible are to be subjected to disciplinary action or prosecution before the courts.

Studies conducted outside Mauritius[1-5] have shown that the majority of deaths in police custody have occurred as a result of suicide. Our analysis also supports this evidence. But in contrast to our study, Copeland,[17] in his study conducted in Metropolitan Date County (1956-1982), indicates that natural disease (predominantly cardio-cerebral vascular and alcohol-related) was most common, followed by suicides. Analysis of our data shows that most of these deaths may be preventable. Many of the deaths from natural causes seem to be unavoidable. Deaths due to poisoning appeared to be accidental and related to an overdose of drugs.

The deaths due to torture in custody are some of the most difficult cases for the forensic experts, which may sometimes require expertise and integrity of the highest order. The investigating agencies mostly try to conceal the circumstances surrounding the death. Keeping in view these shortcomings, the NHRC has suggested certain measures to improve the system, stressing mainly the examination of the body soon after death, before decomposition sets in, and early release of a postmortem report.[15] The relatives of a detainee found dead in police detention are entitled to know the cause of death and to require a counter autopsy if they wish to dispel any doubt they may have. Under section 110 (1) District and Intermediate Courts (Criminal Jurisdiction) Act,[18] the District Magistrate should be informed when a person has died in prison or while in police custody. They shall proceed, or order an officer to proceed, with the examination of the body and an investigation of the matter with the assistance of a medical practitioner. The investigating officer should be at least in the rank of Assistant Superintendent of police and the postmortem examination is to be carried out by the police medical officer. In our view, if the Magistrate would supervise the enquiry from the very start, there would be less suspicion. According to Hiss Jehuda and Kahana Tzipi,[19] the dorsal surface of the body should be examined by a modified elongated X-incision.

Recommendations & conclusion

To conclude, there should be responsibility on the part of the custodial authorities and the public to regularly review causes and rates of death among people in police custody and to look for ways to prevent such deaths. The following are some recommendations that can help in the prevention of such deaths:

- Since the majority of deaths in police custody were caused by the use of some kind of ligature made up of items of clothing, police officers should be authorized to withhold items of clothing and personal effects that may be likely to harm.
- Similarly, the presence of electrical fitting, door hinges, bolt holes, window bars, cell hatches, security grills, etc., all important parts of any building, constitute a source of danger to a determined detainee. The main aim should be to set up an ideal infrastructure for custody (suicide-proof cell). Most importantly, a metallic screen should be placed on all openings in police cells so that the bars are inaccessible to a detainee to hang himself. At the same time such a measure should not reduce the ventilation or penetration of light into the cell. The authorities also intended to set up special detention centers for suspects on remand with closed-circuit television to prevent any occurrence of death in police custody.[15]
- As far as alcohol-related deaths are concerned, promoting use and further development of simple tests to estimate blood alcohol concentration, chronic alcohol problems and suicide risks, before incarceration takes place, may save the lives of people in custody.[20] Some of these deaths could possibly be prevented by the timely application of drug rehabilitation and methadone programs.
- Deaths from natural causes appear to be non-preventable. However, the detainees of this group should have routine physical and medical check-ups with medical officers.
- According to McDonald and Thomson,[8] minimization of the number of people held in police and prison custody is an important measure to prevent such deaths. In our opinion, the legal authorities have to reduce the number of temporary detainees (temporary detainees means prior to the Director of public prosecution's decision), instead releasing them on heavy bail.

Considering the above mentioned points, it is concluded that custodial authorities should have clear responsibility to provide quality preventive and clinical health services to all people in custody. Close attention needs to be paid to ensure the safety of lock-ups and to the screening of people likely to have a suicidal tendency.

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Why survival is not enough:

Prevailing as a psychotherapeutic imperative for victims of torture

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Abstract

It is widely recognized that torture is among the most destructive and psychologically corrosive of acts. However, to date, the response from mental health professionals has generally focussed on notions of psychological survival and have largely ignored the effects of the fundamental intent of torture on the concept of self.

The paper will argue that if psychotherapy for victims of torture is going to be truly effective, it must begin to address issues of meaning and purpose, both in terms of the intent of torture and therefore, the goals of healing. If it is able to do that, it may allow victims of torture not just to survive the experience, but to prevail over it. Finally, it will introduce the concept of prevailing over the experience of torture as a psychological and spiritual state in which personal meaning, purpose and truths are integrated into a person's notion of self.

Key words: prevailing, survival, torture, therapy

Introduction

The descriptors of those who have been tortured are indicative of a framework around which the psychological and physical effects are constructed. It is common parlance to speak in terms of "victims" of abuse becoming, if they are fortunate, "survivors". However, it is proposed that there may be another state in which the experience is fully integrated into the conception of self and is seen to be able to reveal meaning, purpose and truths for the individual. This state may be called prevailing.

Each of the above states is seen to have certain characteristics. They all describe the individuals relationship to the experience of torture, its continuing effect on the individual's sense of self, the relationship with engagement with the outside world and, by implication, the extent to which any meaning and purpose can be found. Furthermore, these characteristics place distinct and important limitations on the nature of any therapeutic intervention.

Victims, survivors and prevailers

In victimhood a person is clearly still oppressed and invaded by the experience. The physical or psychological wounds have not healed and still handicap normal functioning to an intolerable degree. The physical damage aside, the person may still suffer from symptoms characterized by post-traumatic stress disorder. Furthermore, there may be additional factors such as shame and anger,

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grief over incalculable loss, and guilt over acts committed under coercion or even simply being still alive when so many others are dead.

In a state of victimhood a person's life remains shattered and inconsolable. The person is raw and exposed to the world and has no sense of self-mastery or control over the influences that dictate life's course. There is either no ability to properly protect the self from the outside world (no effective barrier to vicissitudes of fate) or there is a total inability to interact or engage with the world. In the latter case the person may well completely withdraw into severe depression and be unapproachable to reasoned cognitive treatments. The self is fragile and storm-tossed and in constant peril. The experience of torture is a mark of shame. Victims are in a state of anxiety with the experience and, in effect, perpetuate the oppression, perhaps even becoming their own oppressor.

It seems to be assumed that there is an almost linear relationship, as if on a continuum, between victimhood and becoming a survivor. It is as though if the experiences are carefully and gently explored, brought to full consciousness and eventually confronted, a kind of psychological reconciliation will occur. It is assumed that confrontation will itself engender this, although it make take a great deal of time, many, many visits to the same site of pain, and some terrifying and awful re-experiencing of the ordeal.

The survivor, by contrast to the victim, has learnt a degree of self-mastery but remains dominated by the events. The first degree symptoms of post-traumatic stress disorder may be under control, or non-intrusive, but the survivor is still in a self-definitional relationship with the trauma. The trauma has been conquered, or at least subdued. The language used betrays the underlying sympathies. The event is one to be survived, like a battle (which of course it may have been in many ways).

As a survivor, the protection of the sense of self may be strong, but it can be inflexible. The barriers erected to protect may also constrict growth. If a victim has no walls to protect him or her, a survivor may find that the walls not only keep the world at bay, and it can be a dangerous world as he or she may have discovered, they also keep the person locked firmly inside. The very things that protect the individual also constrict any future growth. What may be the greatest strength of a survivor can also be the greatest weakness. Survivors have great strength, but it may be brittle and inflexible. Furthermore, always seeing oneself as a survivor may lead to the torture becoming a perverse block to continuing psychological integration of experience, purpose and meaning. The survivor's sense of self wears the survival like a badge of honour, or at least a medal of valour. A survivor is in a state of intensity with the experience.

It is necessary to move beyond mere survival of the trauma to a state in which meaning can be ascertained. Being a survivor is a state in which a person is less oppressed by the trauma than in victimhood. They may be thankful, rather than guilty, over the fact that it did not actually kill them. But survival is not enough. It does seem that there is another, and as yet unexplored, reaction to the awful experience of torture. Can we postulate another state, that of prevailing?

There appear to be two aspects of reconstruction of the self in prevailing. First, a person may begin to find an appreciation of the trauma. There may be a realization that there are things that can be learnt from this experience that could not have been learnt in any other way. And although the circumstances in which they were learnt are regrettable, perhaps terrible to an unimaginable

degree, and would not be wished for again, they have allowed the person to realize something that would not have been possible in any other way. As Frankl[1, p.11] puts it, such things can "make sense out of ... apparently senseless suffering".

Prevailing may be when a person is able to fully and seamlessly incorporate and integrate the experiences and circumstances of the torture into a re-formed sense of self, and be able to see meaning in it, or draw meaning from it. Here a person, fully and with open consciousness, is able and willing to engage with the world, and often the world that damaged them so badly. The risks of engagement are taken in full awareness. When in a state of prevailing, people are able to recognize how they became who they are. They know and do not struggle against the circumstances of their life, including their torture, for the experiences made them who they are. An explanation which satisfies the person of why the events happened as they did may be found, but that does not necessarily mean that they were justified. The ability to hold this position is shown in prevailing.

Prevailers co-exist with a humility that knows they cannot alter or change the experience but they can use it in some way in their future interaction with the world to extract meaning from life and, importantly, a sense of purpose; and the two are always in a reciprocal relationship. Prevailing needs no external validation of identity, it is characterized by a certainty and serenity of purpose. Fundamentally it means engaging with an identified purpose, through which meaning may be gained. It can take many forms. There is no prescription of set expectation. Meaning and purpose can be found in being a good parent or great leader. The imperative is that people know who they are through the act of what they do.

Prevailing is demonstrated in a greater sense of self-awareness, a greater control of and mutual accessibility with the influences of the outside world, and a lived or articulated balance of protection and engagement. The prevailer has a secure and stable identity and sense of self, and is not in bondage to the torture or the torturer. The prevailer has not only reclaimed, but enhanced his or her own voice. The experience of the torture is neither minimized nor aggressively brandished, but is as much accepted a part of the make-up of the person as any other. It is not as though something is simply "tacked onto a person" but rather completely integrated and made into something more than it was before. The pain of the event has its place, and stays there. It does not inappropriately seep into or unwantedly invade areas of the person's life. When it is brought into consciousness, it is done so deliberately.

A state of prevailing also allows the developed realization that being human does not always mean being humane. The generosity of spirit recognizes that black and white thinking, with no degree of compromise, with no prospect of shades of grey in human behaviour or motives, is constricting rather than liberating. Although profoundly able to question and inquire into abominable behaviours, prevailers, unlike victims or survivors, are not threatened by the answers they find. It is not that they accept things without disagreement or opposition, but they are able to achieve balance and focus on their layered and deeply textured response.

Prevailing may not come easily, and may be enormously difficult for an individual, but can be seen as the full realization of a meaningfully informed sense of self in the world. There is a humbleness that puts aside the narcissism of the self-definitional relation-

ship with the trauma that, even when wholly understandable, still characterizes the world views of victims and survivors.

The goals of treatment

The psychological treatment of the effects of torture have most commonly been within the spectrum of those recommended for post-traumatic stress disorder and related concepts.[2] "Effective treatment involves helping the individual to systematically confront experiences, memories and situations associated with the traumatic event".[2, p.276] But to what purpose? Confrontation in itself is not enough. There must be a meaning to it. As Frankl argues, "facts will be significant only as far as they are part of a man's experiences".[1, p.24]

Most treatment and rehabilitation approaches have been multidisciplinary, recognizing that individuals who have been tortured often have a combination of medical, psychological, social and legal problems. Within these, many psychological treatments have been tried, although evaluation of their effectiveness is often limited.[3-5] Of course, the complex nature of the problems caused by torture can make controlled research very difficult, but it is pertinent to examine the therapeutic imperatives that drive some of the psychotherapies.

By and large, "services have utilized knowledge and skills developed in mainstream mental health services and assumed that they would be equally effective" in treating those who have been tortured.[3, p.17] However, in practical application they vary widely in duration and intensity. There are many approaches and all have their virtues but, as Elsass[6] notes, in general, Western psychotherapy is egocentric in orientation, being concerned with the "forces of the individual psyche", and do not emphasize social and cultural contexts to the same degree.

The present argument is not about therapeutic techniques, but about the inclusion of questions of meaning and purpose in the goals of treatment. If a state of prevailing is possible, what questions must be asked to facilitate a person reaching it? What drives the therapeutic imperative?

Good clinical and ethical guidelines and manuals for clinicians[2,7-9] are likely to consider strategies for the delicate and particular circumstances of those who have been tortured, and other traumatized refugees. Issues of cultural sensitivity and confidentiality, the fragility and fear of the client, are emphasized, but do not critically analyse the assumptions made which dictate the course of the therapeutic imperative. Perhaps for some, these matters seem too spiritual, and yet spirituality is what gives many people a fully realized sense of meaning. Perhaps they are too philosophical, yet we all have a profound, if sometimes unarticulated, philosophical construction of the world.

Little attention is paid to the way in which such traumatic events can, or should, change a person. It seems unrealistic to presume that the person will return to an individual state of status quo ante bellum and yet that often appears to be the aim of therapy. Denford describes it as a form of mourning, and speaks of being able to "bury [losses] as dead".[10, p.160] However, constructive mourning is the gateway to another life stage in which previous experiences are integrated and synthesized; it is not a full stop. Bamber[11] underlines freeing rather than curing the person as the principle of rehabilitation, yet does not explore the role of meaning in this (it is seen as more of an unyoking). As Frankl[1] has indicated, the search for meaning is a primary motivational force. Meaning is what sets you free. He paraphrases Nietzsche as saying that a person can bear anything so long as there is a why.

It would appear that revisiting the facts, even if done with the utmost care and with immense skill and gentleness, is not enough. Yet, prevailers would seem to ask themselves, whether overtly or not: "What happened to me and who is now in control, the torture or me? And if it is me, what am I going to do with this experience?" Although there may be an appreciation of the opportunity presented by the experience for meaning to be gained, advantage of the opportunity must be taken. There is a sense of hope, rather than hopelessness, and, as Seligman[12] has indicated, hope may well be a significant indicator of the way in which a person explains the world. Hope lightens the burden of despair. Meaning is further characterized by a sense of purpose through which the experiences can be used in such a way that the prevailer finds reason to engage with and actualize a place in the world.

Being a victim, survivor or prevailer should not be seen as fixed states of being or strictly linear. It is probable that individuals move between them frequently and rapidly. Nevertheless, the further towards a state of prevailing individuals may be, the less likely it is that they will slip into a state of oppression, and when they do the duration and severity will tend to be less. The state of prevailing may be a life goal.

Is it possible that we limit outcomes based on the goals set and the questions asked? Could it be that we not only limit our clients' expected outcomes, but also our own belief system of what can be achieved? The answers one gets are dependent upon the questions one asks.

Might it be argued that actively considering questions of meaning and purpose at such an intense period in ones life, when everything has been dismantled, when one has been stripped down to the most basic of fundamentals and beliefs, that these questions are the only ones which might offer satisfaction?

A search for meaning is a lengthy one. It might take place while in therapy. It might take place following therapy. It might even take place irrespective or in spite of therapy (and we have to consider and be prepared for that possibility as well). Neither victimhood nor survival are really sufficient for a fully congruent, integrated and stable psychological reconciliation of the effects of torture. Prevailing may be a state in which that insufficiency has been addressed.

It suggests that although the good intentions of current and conventional treatment programs and, in many respects, their outcomes should not in any way be minimized, there is the possibility of gaining something more from treatment than tools for survival. It may be possible to reach a state in which meaning and purpose can be taken from the most traumatic of experiences of torture in a way unachievable without that experience. It may be possible not just to enable victims to survive, but to be able to transcend that in a qualitatively significant way. This may be called prevailing. That is why survival is not enough.

Conclusion

The paper offers prevailing as a new perspective on the therapeutic imperative for those who have been tortured. It argues that current treatment modalities do not address ways in which people learn to integrate and re-form their experiences into a new sense of self, and so therapies may be enhanced by an orientation towards the realization of a sense of meaning and purpose that can be drawn from the experience.

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Medical physical examination in connection with torture

*Section II**

Ole V. Rasmussen, MD, DMSc, Stine Amris, MD, Margriet Blaauw, MD, MIH & Lis Danielsen, MD, DMSc**

The musculoskeletal system

by Stine Amris

Symptoms related to the musculoskeletal system are the most frequently reported physical complaints at the time of torture as well as in the later stages. The associated signs and symptoms in the acute phase are similar to those following other types of acute traumas causing lesions in soft tissues (muscles, joint capsules, tendons, ligaments, nerves and vessels), distortion/dislocation of joints and fractures.[1,13,18]

Pain is the dominating symptom related to the musculoskeletal system in the chronic phase. The clinical picture is one of localised or diffuse pain in muscles, joint pain, pain related to the spine and pelvic girdle, and neurological complaints mainly in the form of sensory disturbances and irradiating pain.[1,19,20]

Typical findings in the musculoskeletal system in the chronic phase are: increased muscle tone; tender and trigger points especially in the muscles of the neck and shoulder girdle, muscles in the low back and pelvic girdle, and muscles of the lower extremities; tendinitis around the shoulder joint, elbow, knee, and ankle joint; tenderness and restricted range of movement in peripheral joints, cervical and lumbar spine; and tenderness in the soles and a compensatory altered gait.[1,18,21]

The clinical examination of the musculoskeletal system can be done: 1) in order to document findings consistent with allegation of torture and/or 2) for the purpose of rehabilitation. In documenting torture, the focus will be a description of signs supporting the use of torture, whereas in assessment for the purpose of rehabilitation the focus should be on function and possibilities for intervention aiming at increasing function. In both instances, examination of the musculoskeletal system is time consuming. Most often torture victims present widespread symptoms necessitating a thorough examination of many structures guided by the medical history; and knowledge about torture and applied torture methods is a prerequisite for the examination.

Assessment of the musculoskeletal system should in general include:

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First section was published in TORTURE vol. 14, no. 1. The third and last section following in the next issue will give a short description of other somatic consequences of torture as well as references to all three sections.

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- Examination of muscles and tendons: inspection, palpation (tone, stretch range, tenderness, changes in tissue texture), and assessment of function (strength, endurance).
- Examination of peripheral joints and bones: inspection, palpation and assessment of joint function (range of movement and stability).
- Examination of the spine and pelvic girdle: inspection, palpation and range of movement in the cervical, thoracic and lumbar spine.
- Neurological examination: muscle strength, tendon reflexes, and sensibility.

Some symptoms/symptom constellations can be related to the use of specific torture methods e.g. pain in the feet and lower legs and impaired walking after falanga,[1] but symptoms and findings in the musculoskeletal system in the later stages are in general unspecific and can not, standing on their own, document exposure to torture.

Possible lesions in the musculoskeletal system after physical torture

Soft tissue injuries

An acute stretch of a muscle may cause a partial or even complete tear of the muscle-tendon unit. These injuries are usually designated as stretch-induced injuries or muscle strains. A direct, non-penetrating blow to the muscle belly is another common mechanism for muscle injuries. Such muscle contusions can cause significant damage to the structure and function of the muscle.

The initial pathology shows many similarities in strains and contusions. Immediately, following the injury there is disruption of the architecture because of ruptured muscle fibres, as well as injury to the connective tissue framework, and haematoma formation. Within two to three days an intense inflammatory response develops. Pain and disability in the acute phase are, at least in part, due to this inflammation and biomechanically the muscle is most impaired at this point. Within the first week, evidence of muscle regeneration can be found. Regenerating muscle cells and fibroblasts mounting a scar response are seen in the injured area. The combined regenerative and scar response results in a healed muscle that has fewer and smaller muscle fibres in the injured area as well as an increased amount of collagenous tissue between the fibres. In animal models the muscle is largely healed after approximately two weeks. It is not known whether the healing in human muscles is substantially different. It is possible that the healing process in human muscles takes longer, as suggested by the clinical symptoms that often last for several weeks.[22]

The majority of muscle lesions heal leaving no specific gross findings, but very often torture victims present with muscular dysfunction in the chronic phases. Typical, but unspecific findings are: increased muscle tone, restricted stretch range of movement, tender and trigger points, and musculotendinous inflammation.[21]

Muscle tone

With the application of digital pressure to a muscle, resistance in the tissue opposing deformation occurs. Variations in this resistance are referred to as muscle tone or muscle tension and are described in a continuum from high (hypertone) to low (hypotone). Several causes may lead to deviations in muscle tone and traditionally these are grouped in three main categories: 1) organically determined e.g. neurological disorder, 2) mechanically determined e.g. overload, 3) psychologically determined e.g. prolonged stress conditions.

Stretch range of movement

A normal muscle can be stretched to its full length with a springy, elastic resistance at the end of range. Stretching of a short, tight muscle evokes pain and causes, depending on the muscles involved, reduced range of movement in the corresponding joint. Restricted range of movement in muscles can be caused by: 1) sustained activation of the contractile mechanism of the muscle fibres e.g. painful trigger points or 2) reduced elasticity in the passive tissues components e.g. shortening due to fibrosis (muscle contracture).

Tender and trigger points

A tender point is a hyperirritable spot in a muscle that is painful on compression. Tender points are to be distinguished from trigger points, which are hyperirritable spots in a muscle or its fascia, that is painful on compression and give rise to a characteristic and well defined pattern of referred pain.

Musculotendinous inflammation

Inflammation represents the body's response to tissue injury caused by pressure, friction, repeated load or overload and external trauma. Whatever the nature of the underlying cause, the inflammatory response leads to impaired and painful mobility of the affected part. Inflammatory reactions in the musculoskeletal system may occur in joints, tendons, tendon and muscle attachments, bursae and the periosteum.

Inflammation of muscle-tendon attachment to bone (teno-periostitis) is clinically characterised by localised tenderness to pressure over the affected attachment and an increase in pain at the site of attachment, when the muscle group concerned is contracted against resistance (isometric testing).

Inflammation of tendons (tendinitis) and bursae (bursitis) is clinically characterised by tenderness, and in the acute phase swelling and crepitus may be present.

Ligaments injuries

Exceeding the normal range of movement in a joint or loading the joint by traction, as in suspension and other types of positional torture, may sprain the ligaments. An inflammatory response with swelling, pain and joint dysfunction will be present in the acute phase. In a first degree distortion the ligaments are sprained without macroscopic rupture and there will be no mechanical instability in the joint. In a second degree distortion there will be a partial macroscopic rupture of the ligaments leading to a slight mechanical instability in the joint, whereas in a third degree distortion the ligaments will be completely ruptured and the joint clearly, mechanically unstable. The healing process in ligaments and tendons is considerably slower than that of muscles. Full recovery with normalisation of strength and function takes months.

Pain and joint dysfunction are very frequent complaints in the chronic phase. At clinical examination reduced range of movement in peripheral joints as well as in the spine is the most typical finding, but various degrees of joint laxity/instability may also be found.[1,18,21] Specific clinical tests can be applied diagnosing instability and direction of instability in joints.

Bone injuries

Fractures produce a loss of bone integrity due to the effect of a blunt mechanical force on various vector planes. A direct fracture occurs at the site of impact or at the place where the force was applied. The location, contour, and other characteristics of a fracture reflect the nature and direction of the applied force.

In the acute phase local swelling, bony

deformity, tenderness and loss of function will be typical findings at the clinical examination. In the chronic phase various degrees of bone deformity, pain at activity and loss of function may be found.

Fractures related to alleged physical torture are reported with a frequency of 13% in a study by Rasmussen,[1] of 27% in a study by Allodi[23] and of 4% in a study by Randall, Lutz & Quiroga;[24] limb and rib fractures being predominant. Various types of spinal fractures and other lesions including lesions in intervertebral discs and disc herniation are likewise reported, but systematic radiodiagnostic studies are lacking.

Possible lesions and assessment of the musculoskeletal system following specific forms of physical torture

The following is not meant to be an exhaustive description of the numerous specific physical torture methods that carries a risk of injury to the musculoskeletal system. Suspension by the arms and falanga have been selected, since they are widely used torture methods that cause chronic disability and may serve as examples of the variety of lesions that may occur; all of which require special attention at clinical examination.

Suspension by the arms

There are many forms of positional torture, all of which are directed towards the musculoskeletal system producing injuries mainly in the soft tissues. Suspension by the limbs, prolonged forced squatting or standing, prolonged back loading positions with the spine being hyperextended or maximally flexed, restriction of movement during confinement in small cells or cages are all examples of such. Characteristically, these types of torture leave relatively few and unspecific findings, despite subsequent frequently severe, chronic physical disability.

Suspension by the arms, an often applied torture method, is practised either separately or in combination with other forms of torture such as beatings and electrical torture. The torture victim is most often tied up by the wrists and left hanging for a prolonged period of time in one or both arms. This form of torture is extremely painful and

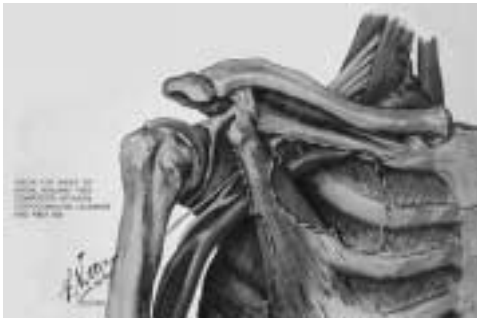

Figure 5. *Frontal view through the shoulder joint.*

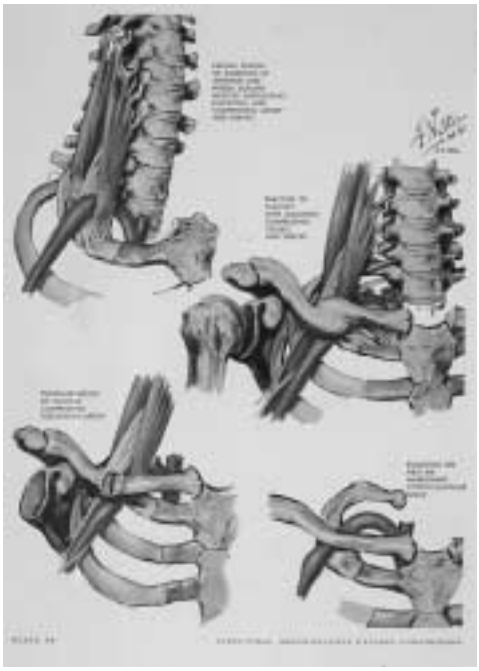

Figure 6. *The "scapula-thoracic" joint.*

Figure 7. *Suspension with the arms in forward flexion.*

Figure 8. *Palestinian hanging. The shoulder joint maximally extended, and inwards rotated.*

causes an immense overload of the shoulder joint and surrounding soft tissues.

The shoulder is a joint complex comprising four joints: the glenohumeral joint, the sterno-clavicular joint, the acromio-clavicular joint and the "scapula-thoracic" joint. Normal shoulder function requires an optimal co-ordination between these four joints. The bony anatomy of the glenohumeral joint (Figure 5) allows for the greatest possible range of movement found in any joint in the body, sacrificing joint stability for mobility. Additional stabilisation is therefore provided by: 1) static stabilisers: the glenoid labrum, joint capsule, and ligaments and 2) dynamic stabilisers: the muscles, in particular the rotator cuff, the deltoid and the long head of the biceps; the "scapula-thoracic" joint (Figure 6); and neuromuscular control ensuring a constant awareness of joint position and joint movement (proprioception).

During suspension with the arms in forward flexion (Figure 7) the shoulder joint is maximally flexed and slightly outward rotated. This "closed packed" position provides maximum bony contact between the articular head and the articular socket assisting joint stability. In Palestinian hanging (Figure 8) the shoulder joint is maximally extended, inward rotated and the entire body weight is loading the weak anterior aspect of the shoulder joint, placing traction on the brachial plexus. Typically the lower plexus and then the middle and the upper plexus fibres will be damaged, if the traction force is severe enough. If the suspension is of "cruci-

Figure 9. *Crucifixion. The shoulder joint in abduction.*

fixion" type, the shoulder joints being in abduction (Figure 9), the traction force will primarily be placed on the middle plexus fibres, which are likely to be the first ones damaged.[8]

Acute symptoms and signs

Symptoms in the acute phase are severe pain in the neck and shoulder girdle and in the shoulder joints, and loss of function in the upper extremity. Occasionally one or both shoulder joints may dislocate during the torture.[18]

Neurological complaints indicative of plexus lesion are frequent: irradiating pain and reduced muscle strength in the upper extremities accompanied by sensory disturbances, typically in the form of paraesthesia and reduced sensibility. At neurological examination, reduced muscle strength most prominently distally, loss/reduction of tendon reflexes, and sensory disturbances along the sensory nerve pathways are common findings[8].

Symptoms and signs in the chronic phase

Many torture victims who have been exposed to suspension by the arms, in particular Palestinian hanging, develop chronic disability with pain, reduced shoulder function and permanent neurological deficit indicative of partial lesion of the brachial plexus most often involving sensory modalities. Systematic studies including radiodiagnostic evaluation of possible lesions in the shoulder joint caused by suspension are, however, not available and the pathogenesis of the long lasting symptoms and shoulder dysfunction therefore not fully understood. Neurogenic pain due to plexus lesion may, however, play an important role.[20,26]

In the late stages, pain in the neck and shoulder girdle, deep pain in the shoulder joints at activity especially in connection with overhead movements (abduction, inward rotation) and lifting, reduced range of movements in the shoulder joints, feeling of instability in the shoulder joints or popping, and locking sensations on movement are typical complaints.

Neurological symptoms are likewise frequent: irradiating pain, muscle weakness with a feeling of heaviness in the upper extremities and various sensory disturbances including vasomotor and sudomotor changes.

At clinical examination most of the findings are unspecific and confined to the soft tissues: tender and trigger points in the neck and shoulder girdle, muscular imbalance with musculotendinous inflammation in dynamic shoulder stabilisers and shoulder impingement are typical findings. At joint

examination reduced range of active movement in the shoulder joint is common. Signs of habitual luxation/subluxation are rare, but at specific testing various degrees of instability may be present.

At neurological examination brachial plexus injury will manifest itself as sensory and motor deficit depending on the severity of the nerve lesion. Reduced muscle strength, which often is asymmetrical and most pronounced distally and reduction/loss of tendon reflexes, are signs of motor involvement. Sensory disturbances, which might involve different sensory modalities, are signs of sensory involvement.

Clinical examination

The clinical examination of torture victims submitted to suspension by the arms should include:

1) Examination of shoulder function: passive and active range of movement, joint stability, function of accessory shoulder joints including scapula function.
2) Examination of soft tissues: muscle relief, muscle tone and stretch range, tender and trigger points, tendinitis, shoulder impingement.
3) Neurological examination: muscle strength, tendon reflexes and a thorough examination of sensibility including vibration sensation, positional sensation, two-point discrimination, touch, pain, and thermosensation.

Falanga

Acute symptoms and signs

The immediate effect of falanga (repeated applications of blunt trauma to the soles) is bleeding and oedema in the soft tissues of the feet and severe pain. At clinical examination changes are also confined to the soft tissues. Swelling of the feet, discoloration of the soles due to haematoma formation and various degrees of skin lesions are typical and diagnostic findings[8,27]. Extensive ulcerations and gangrene of toes due to ischaemia have been described, but are not common. Fractures of tarsals, metatarsals and phalanxes are described to occur occasionally.[18] The acute changes disappear spontaneously within weeks as the oedema and extravasation of blood resolve, but the induced soft tissue lesions may be permanent.

Symptoms and signs in the chronic phase

The majority of torture victims submitted to falanga complain about pain and impaired walking.

The cardinal symptom is pain in the feet and calves and two types of pain are usually present:

- A deep, dull cramping pain in the feet, which intensifies with weight bearing and muscle activity spreading up the lower legs.
- A superficial burning, stinging pain in the soles often accompanied by sensory disturbances and frequently also a tendency for the feet to alternate between being hot and cold suggestive of autonomic instability.

Due to pain, walking is impaired in most falanga victims. Walking speed and walking distance are reduced. Typically the torture victim is only able to walk a limited distance, during which the pain will increase and make continued muscle activity impossible. At rest the pain subsides and the victim can resume walking.

Theories explaining the persistent pain and foot dysfunction after falanga

The aetiology and pathogenesis of the persistent pain and disability after falanga is not

fully understood. Several theories have been put forward[1,8,28-30] and most likely a combination of trauma mechanisms are responsible.

Reduced shock absorbency in the heel pads: The footpads are situated under the weight bearing bony structures, where in particular the heel pads act as the first in a series of shock absorbers. The heel pad is normally a firm elastic structure covering the calcaneus. It has a complex internal architecture consisting of closely packed fat cells surrounded by septa of connective tissue, which also contain the nerve and vessel supply to the tissues. Due to its structure the heel pad is under constant hydraulic pressure and maintains its shape during weight load in the standing position.

After falanga the heel pad may appear flat and wide, with displacement of the tissues laterally during weight loading. This is observed at inspection from behind, with the torture victim in the standing position. At palpation, the elasticity in the heel pad is reduced and the underlying bony structures are easily felt through the tissues. The pathophysiology of the reduced elasticity in the heelpad is thought to be the tearing of the connective tissue septa, leading to deprivation of blood supply and secondary atrophy of fat cells with loss of the shock absorbing ability.

Damaged foot pads are not pathognomonic of falanga, but are also described in connection with other conditions unrelated to torture e.g. lesions in long distance runners and patients with fractures of the heel bone. It should also be stressed that normal footpads at clinical examination do not rule out exposure to falanga.

Changes in the plantar fascia: The plantar fascia springs from the calcaneus and proceeds to the forefoot. It is tightened during foot of supporting the longitudinal arches of the foot, assisting the foot muscles during walking. Changes in the plantar fascia are present in some torture victims after falanga and are probably due to the repeated direct traumas to this superficial structure. After falanga the fascia may appear thickened with an uneven surface at palpation, and tenderness can be found throughout the whole length of the fascia from its spring to the insertion. Disruption of the plantar fascia has been reported, based on the finding of increased passive dorsiflexion in the toes at clinical examination.[18,21]

Closed compartment syndrome: The plantar muscles of the foot are arranged in tight compartments – an anatomical arrangement, which makes it possible for a closed compartment syndrome to develop. A closed compartment syndrome is defined as a painful ischaemic, circulatory disturbance in connection with an increase in pressure and volume inside a well-defined muscle compartment. In the acute form, with a rapidly increasing pressure e.g. caused by bleeding inside the compartment, the symptoms are alarming and the consequences severe with necrosis of involved tissues if left untreated. Chronic compartment syndromes can occur as a result of an increase in the muscle bulk and/or a narrowing of the compartment. Clinically this condition presents itself with pain that intensifies with load and which finally makes continued muscle activity impossible. The pain subsides after a short period of rest, but recurs if muscle activity is resumed – a picture not unlike that seen in impaired walking after falanga.

In an MRI study comparing torture victims exposed to falanga with healthy volunteers, significant thickening of the plantar fascia was found in all victims. Apart from

this, morphological changes were present in the fascia, possibly representing scar tissue formation. No signs of detachment of the plantar fascia, closed compartment syndrome or changes in the heel pads were shown in this study.[31]

Neurogenic pain: The skin of the soles in the normal foot is apart from the arch area, very thick and firmly tied to the underlying tissues. It is very rich in sensory nerve endings, which register touch and pressure. Peripheral nerve lesion affecting the small nerves of the soles is a very possible consequence of falanga. Neurogenic pain due to nerve lesion is therefore a possible contributing pain mechanism.

Impaired walking: Deviations from the normal gait pattern are very frequent after exposure to falanga. Many torture victims develop a compensatory altered gait with loading of the lateral border (supinating the foot) or loading of the medial border (pronating the foot) to avoid pain at heel strike. The unwinding of the foot is likewise abnormal. Maximal extension and weight loading of the first toe is typically avoided at take-off.

Stride and walking speed are reduced. The gait is broad, stiff and insecure as seen in patients with peripheral neuropathy of other causes. Postural reflexes are elicited from the soles and together with the ability to register distribution of pressure, these reflexes are essential for balance and walking. Nerve lesion influencing the proprioception may therefore also contribute to the overall picture.

As a consequence of the altered function of the foot, altered gait, and frequently concurrent exposure to other forms of torture involving the lower extremities, a chain reaction of muscular imbalance occurs. The various muscle groups of the lower legs are often painful due to increased muscle tone, tight muscles and fasciae, tender and trigger points, and musculo-tendinous inflammation.

Clinical examination

The clinical examination of torture victims exposed to falanga should include:

1) Inspection and palpation of the soft tissues of the feet: heel pads, plantar fascia, skin.
2) Assessment of foot function and gait.
3) Examination of soft tissues and joints in the lower extremities.
4) Neurological examination.

It should be stressed once more that none of the findings at clinical examination in the late phases after falanga are pathognomonic and that a normal examination of the feet does not rule out the use of this specific torture method. ❑

Knowledge and attitude on torture by medical students in Delhi

S.K. Verma, MD* & G. Biswas, MD**

Abstract

The custodial torture of detainees is a worldwide phenomenon which has inspired a number of declarations and conventions adopted by different world agencies. Medical professionals are under obligation to detect, treat and help in the rehabilitation of torture victims. During the last few years, much medical work has been initiated against the practice of torture. In order to assess the knowledge and attitude of medical students on the issue, a questionnaire survey study was designed and administered to 98 fourth year MBBS students in Delhi in November 2002.

The study shows that though the students posses positive attitudes for learning various aspects of torture and human rights issues, they still do not condemn custodial torture. The majority of students have a basic knowledge about torture and are desirous of the inclusion of torture medicine in the undergraduate curriculum for further detailed knowledge.

Key words: attitude, human rights, knowledge, medical students, torture

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Introduction

Custodial violence is considered to be a vital armory by law enforcing agencies to weaken the physical resistance and mental barrier of detainees.

In spite of the marked improvements in investigative techniques, law enforcers usually cut short the methods of scientific investigation and resort to the application of torture on the suspects and detainees in order to obtain a confession or information. Unfortunately, even today torture is globally present.

Medical work against the practice of torture started about three decades ago in 1973, when Amnesty International launched a campaign against torture and asked medical doctors to take part in the work of helping and diagnosing torture victims.[1] In the year 1975, the World Medical Association (WMA) adopted the "Declaration of Tokyo".[2] During the last quarter of the previous century, significant work has been done by various national and international agencies to curtail the menace of torture. However, the National Human Rights Commission in our country still receives more then 20,000 complaints regarding torture every year.

The obligations of this profession towards torture victims have been described in various declarations like the "Tokyo Declar-

ation", the "International Code of Medical Ethics", the "Declaration of Helsinki", the "Declaration on Protection of All Persons from Torture and other Cruel, Inhuman or Degrading Treatment or Punishment" etc.[3] Therefore, every member of the medical profession should be aware of the different issues related to torture medicine. In India, the University Grant Commission has also directed all universities and colleges across the country to incorporate lectures on torture and allied aspects in different undergraduate and postgraduate curriculums.[4] Now in India, the latest editions of books pertaining to the field of forensic medicine are including chapters on torture medicine.[5,6]

The knowledge and attitude of medical students on torture have been hardly studied and published in medical literature until now. Since the knowledge and attitude of medical students are bound to have an effect on their mindset once they become full-fledged doctors, it was thought pertinent to study this important aspect of medical education. Further, the "Delhi Declaration on Torture" had also urged for greater involvement of all components of civil society including health, legal and other professions, as well as non-governmental organizations and media in the fight against torture.[7] The result obtained in the study can be used to design the curriculum on torture and have a better understanding to develop a positive attitude in the detection and treatment of torture victims.

Methods

Ninety-eight medical students who have finished their 5th semester (4th year) course in 2nd professionals were provided each with a multiple-choice questionnaire during November 2002. The questionnaire had 9 MCQs to assess knowledge and attitude on torture. They were instructed to give their frank and free opinion anonymously to ensure privacy. No reminders were given to the students and they were asked to return the questionnaire after ticking off the response they thought correct on the spot, taking their own time. The results thus obtained were tabulated and analyzed.

Results

Ninety-five (97%) students responded by filling out the questionnaire. The age of the survey population varied 18-23 years with a mean of 20.25 years. The male/female ratio among the subjects was 6:1. The social and cultural background of all the students was almost similar.

A. Knowledge on Torture

In order to assess knowledge on torture the following multiple-choice questions were asked:

1. What do you mean by the term torture?
2. What are the objectives of torture?
3. Name the types of torture.
4. The commonest method of physical torture is?
5. The commonest form of sexual torture is?
6. National Human Rights Commission is situated at?

In response to question no. 1, 91(96%) students responded correctly while the remaining 4 (4.3%) gave an incorrect response. Regarding question no. 2, a maximum of 29 (31%) students opined that torture is aimed to destroy the mind without killing a person. This was followed closely by the second largest group of 26 (27%) students who were of the opinion that torture is committed to break the personality of an individual. Nineteen (20%) of them responded correctly by ticking off the choice that torture is

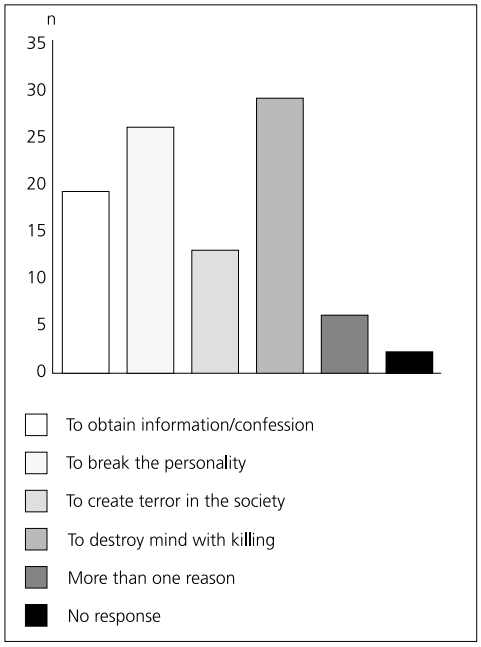

Figure 1. *Responses regarding aims of torture (N=95).*

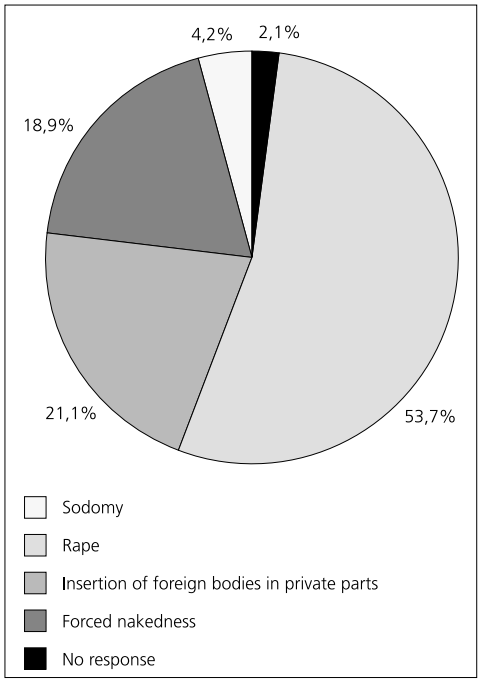

Figure 2. *Knowledge on sexual torture (N=95).*

done to obtain a confession or information (details are given in Figure 1).

Ninety (95%) students responded correctly by marking off physical, sexual and psychological as the types of torture, while five were of a different opinion. Again, 92 (97%) students answered correctly, the commonest method of physical torture as beating and kicking. Two ticked off electric shock and one falanga as the commonest method of physical torture.

Regarding the commonest form of sexual torture, more than half i.e. 51 (54%) students, ticked rape off correctly. Twenty marked off insertion of foreign bodies in private parts and 18 forced nakedness (details shown in Figure 2). For the question on the location of the National Human Rights Commission (NHRC) a little more than half, 53, responded correctly by marking off New Delhi. On the other hand, 32 ticked off other incorrect choices and ten did not respond to the question at all (details in Figure 3).

B. Attitude on Torture

Attitudes on torture were attempted to be assessed by designing the following questions:

1. Do you think that beating in police custody to get confession/information is proper?
2. Do you think that general medical practioners should be aware of torture medicine?
3. Should torture medicine be included in undergraduate curriculum?

In response to question no. 1, a little less then half 46 students were undetermined in their opinion and hence did not respond. Twenty-eight students opined that it is proper whereas 21 did not approve of this practice.

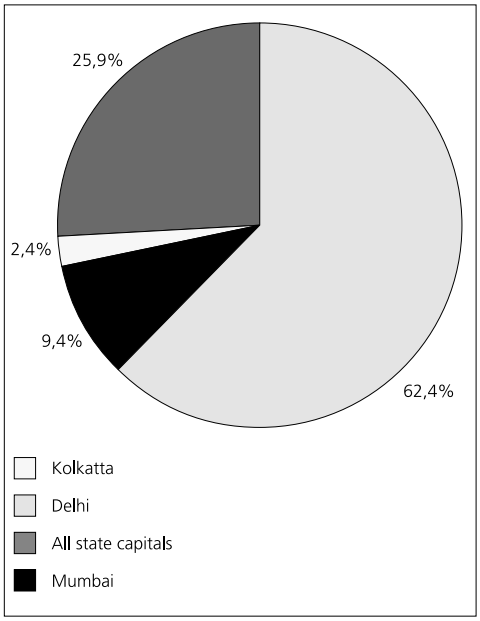

Figure 3. *Knowledge about situation of National Human Rights Commission (NHRC) (N=95).*

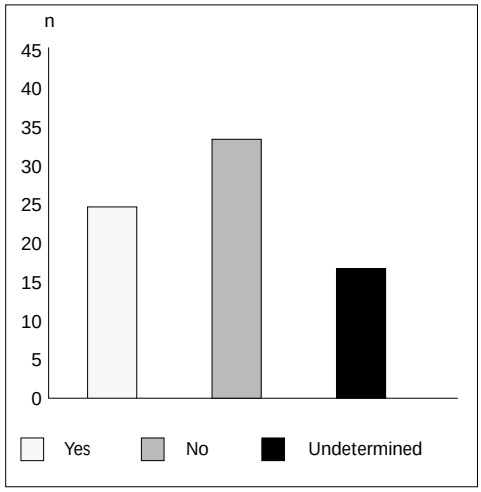

Figure 4. *Responses to question of inclusion of torture in undergraduate curriculum (N=95).*

Out of a total of 95 students, 87 (92%) were of the opinion that general medical practioners should be aware of torture medicine. Among the remaining 8,4 were against such awareness and four were not sure of their opinion. To a more direct question on inclusion of torture medicine in the undergraduate curriculum, 41 answered in the affirmative. Out of the remaining 54, 25 were not in favor and 29 were undetermined on this issue (Figure 4).

Discussion

Time and again knowledge, attitude and practices (KAP) studies are carried out in order to assess and modulate different subjects on various topics. However, on the subject of torture very few KAP studies related to doctors and medical students have been published.[4,8-10] The different governmental as well as statutory bodies in India, like the University Grants Commission and the National Human Rights Commission, have also emphasized the need for education related to torture and human rights. It is logical and sound to assess the knowledge and attitude of the medical students in order to select and design relevant and appropriate course content on the topic of torture and human rights.

Large percentages of the student were aware of the meaning of the term torture in a broader sense. However, they were not well acquainted with the reasons for torture. These findings are different then reported by Hussain[4]. This difference can be explained on the basis that the responses sought in Hussain's report were verbal. It is a well known fact that the response rate to a verbal question in a class is very low as compared to an anonymous MCQ questionnaire survey. The results in response to the first two

questions were similar to other published studies.[8,9]

The responses to other knowledge assessing questions were also found correct in more than half of the study population. But this can be increased to a much higher level by incorporating a knowledge component in the form of lecture discussions in the teaching of the students.

The more interesting aspect of this study was attitude assessment. Two other studies by Iacopino[8] and Sobti[9] also assessed this aspect among medical practitioners and found that most of them are complicit on the issue. A significant number of them even justified the use of coercive techniques and manhandling in dealing with detainees by law enforcing agencies. In the present study about half of the students were undetermined and did not either approve or disapprove of the practice of torture in custody. However, among the students who gave a clear opinion, a higher proportion of 29.5% approved this practice in comparison to 22% who were against it.

The study amply demonstrates that a fairly large percentage of the medical students of Delhi are not against the practice of torture and human rights violations. It is expected that students in other parts of the country will reflect similar sentiments on this issue. This attitude needs a review for all educationists. A very good percentage (92%) opined that even general medical practitioners should be aware of torture related issues. Again, only about one-fourth of the study population was against the inclusion of topics related to torture and human rights in the undergraduate curriculum, thereby showing a positive attitude on the subject.

Caveat

A large multicentre study should be planned and conducted to have more comprehensive and exhaustive data on the subject. Nevertheless, the present study may act as a trigger to initiate such work.

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The cost of coherence:

The case of EU-funding for rehabilitation of torture victims

Mette Hjorth-Madsen, BSc (politica science)*

Abstract

In 2003, a shift occurred in the European Union (EU) foreign policy moving funding from rehabilitation of torture victims to prevention of torture. The shift was explained with bureaucratic and technical arguments, rather than political priorities. However, the shift followed a large reform to obtain greater "coherence" among EU foreign policy instruments, in which trade, development and human rights policies were adjusted to "work in the same strategic direction". In spite of official statements that human rights are an "underlying principle", and thus the core of the identity of the EU, this article claims that human rights have been subordinated by trade and development objectives. These tendencies are not unique for the EU, but are contradictory to the EU's claim that the supranational position creates an "added value" in comparison to other political actors. This article argues that the EU is not any different from national states in pursuing strategic foreign policy objectives. If rehabilitation of torture victims is to survive where it is most needed, lobby efforts must take the strategic interest of the EU into account.

Introduction

In the EU's own words, human rights are an "underlying principle" of all policy areas of the EU. Human rights are supposedly at the very core of the self-understanding of the member states and thus the European Community. In 2003, however, the EU-Commission (hereafter the Commission) restructured the European Initiative for Democracy and Human Rights (EIDHR) in a "more strategic direction".[1] This resulted in the funding for rehabilitation of torture victims in third countries, after reaching a peak of euro 14 million in 2001, disappearing all together. Against the rhetoric of both Council and Commission stating that the EU sees rehabilitation as an important policy priority, and the emphasis on the "supranational value" in this particular sensitive area of human rights policy, the shift is bewildering. The EU has explicitly stated that the supranational support may have a protective effect for NGOs working in the area.[1]

This article explores how the shift was installed, and tries to identify the underlying reasons. The next paragraph will briefly account for the Commission's special features and characteristics as an object of political analysis; the following section introduces the article's perception of torture as a political phenomenon.

Supranationality: above, below and beyond nations

The Commission is the main focus of analysis in this article as executive of the EIDHR.

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It enjoys a unique position on the international policy stage, above, below and beyond the position of nations. How is this? The Commission is both a legislative (political) and executive (administrative) actor at the same time.[2] It therefore must satisfy a large number of diverse interests. Furthermore, the fact that members of the Commission are appointed, and not elected, places the Commission beyond the national state with no democratic legitimacy, where it depends on international NGOs for legitimacy and support.[3]

On the basis of the above, one could draw the following picture of the "political space of torture", in which the Commission must navigate to reconcile different interests in order to be successful:[4]

Figure 1 shows the different dimensions influencing the policy on torture. Each dimension represents different actors. The national dimension represents the national member states, whose primary interest is their own safety and promotion of their own political and strategic interests. The developmental dimension represents receiver states, whose primary objective is to obtain a larger piece of global wealth and advance their own position. The human rights dimension contains human rights activists/NGOs whose interests are the promotion of human rights and the funding of activities. Finally, the supranational dimension is the Commission's own interest: to gain credibility, legitimacy and "added value". How these dimensions intertwine is the subject of analysis in this paper. However, torture as a phenomenon creates special conditions for policy making. The next section will therefore briefly outline the paper's understanding of torture.

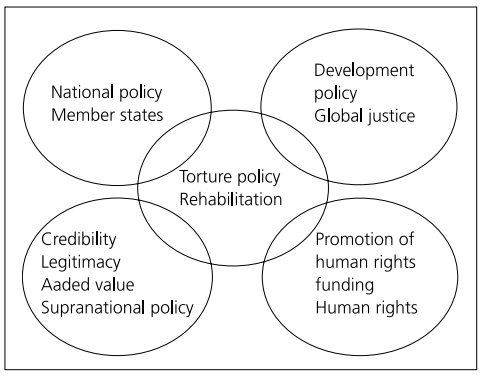

figure 1. *The different dimensions influencing the policy on torture.*

Torture in modern democratic states

Torture has always existed, but contrary to what could be expected, torture persists in modern democratic states. Thus, in 2002 Amnesty International could document incidences of torture in at least 151 countries all over the world[5].

In popular terms, torture is probably most often associated with authoritarian regimes such as Pinochet in Chile, Pol Pot in Cambodia and the regimes of the former Soviet Union. In these settings, torture was used openly to frighten and suppress political opponents and thus named "state terrorism".

The use of torture in modern democratic states is different in some important aspects. First of all, according to Crelinsten[6] the use of torture is an absolute taboo and is not discussed in any form other than complete condemnation. Where torture still occurs, it is often explained as "legacy" from past regimes or the result of "one rotten apple in the bowl". However, according to Kelman[7] torture is a "crime of obedience" rather than disobedience. Kelman's thesis is that torture is not used as opposition to the authorities, but rather in an environment where torture is, if not directly ordered, then at least tolerated by higher levels. On the individual level of the torturer, the use of torture is incorporated through a professional network with

its own routines, a high level of "esprit de corps" and targeted training. Any moral objection the individual might have is effectively removed through a "dehumanisation" of the victim.

Since the Second World War, the fight against torture has strengthened its position on the international human rights agenda. Since the UN Declaration of Human Rights in 1948, the fight against torture has gained an entire web of legislation, starting with the UN Convention Against Torture[8] and later followed by a number of regional and national instruments, such as the European Convention for the prevention of torture and the optional protocol to the US Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT). The juridical perception of the term uses the UN definition, in which torture is always intentionally inflicted, and the perpetrator is a state agent. These features are important for the understanding of torture as a political subject, and will be elaborated further below. The following paragraph will briefly outline the role of rehabilitation in the fight against torture.

Rehabilitation – a precondition for prevention?

The victims' right to rehabilitation is stated as article 14 in UNCAT, which in principle places the responsibility for providing medical, social, juridical and economic rehabilitation on the national (perpetrator) state. The juridical argument behind the right to rehabilitation seems thus to be of a pragmatic nature, as the actual use of torture is recognised, in spite of the intention of the Convention. Article 14 is thus the international society's recognition of the obligation to make up for its shortages.

The argument for rehabilitating victims originates with health professions and is based on the medical vow of alleviating human suffering,[9] but juridical redress is advancing on political agendas worldwide. Thus rehabilitation comprises health, economic, social and juridical aspects. In practice, rehabilitation is provided by a large number of rehabilitation centres around the world, which have in common that they are not run by the state. On the contrary, they perceive themselves as opposition to state authority. In a number of countries, the staff members of these centres endure harassment from paramilitaries, police forces or the government itself[10]. This means that the EU and UN (through the voluntary fund for victims of torture) de facto are the only donors, besides private funds, of rehabilitation in developing countries.

Practitioners of rehabilitation have widened their mandate in recent years. The argument is that a medical diagnosis of torture can be used as proof before the courts and thus effectively contribute to the fight against impunity. Furthermore, it is argued that accumulated and systematic knowledge of the symptoms of torture is a precondition for designing efficient prevention strategies. However, the EU policy shift seems to indicate that this argument has not gained much adherence on the political level. The concrete circumstances of the policy shift in EIDHR will be analysed below.

Analysis

Rehabilitation and coherence

The responsibility for achieving greater coherence among the EU's foreign policies is placed with the Commission of the Maastricht Treaty of 1996, which speaks of the need for "better coordination".[4] The EU's understanding of the term thus seems to neglect any conflict potential, as the creation of coherence is portrayed as a "managerial fix".

An administrative accident?

Overall, EU funding of rehabilitation peaked in 2001, with a total of euro 14 million.[11] At first glance it seems as if rehabilitation stood stronger than ever before as a political priority. However, the creation of budget line B5-813 was a result of a massive lobby campaign after rehabilitation was excluded from the budget as an activity all together in 2000, which was explained by the Commission as a mere "administrative failure".[9]

Where rehabilitation and prevention had previously been funded separately, the two branches of the fight against torture were to fight for the same funds in 2002. A single call for proposals targeted both rehabilitation and prevention projects with 25 million for the period 2002-2003. Of these funds, euro 5 million were spent inside the EU, and 12 million outside in 2002, leaving a total of euro 8 million for 2003. These funds were reserved for rehabilitation and prevention activities in the EU and candidate countries,[12] leaving no remaining funds for rehabilitation outside the EU in 2003. It is thus clear that the target group of the policy shift is rehabilitation in third countries only, but not rehabilitation as an activity per se, as funding for rehabilitation inside the EU even increased over the period. Rehabilitation and prevention have now become competing activities, rather than complementary, as 67% of the funds spent externally in 2002 were spent on prevention. Generally, the fight against torture is still high on the European political agenda, and the exclusion of rehabilitation in third countries appears as the result of a mere administrative "accident".

Rehabilitation disqualified on "objective" criteria

The Commission's administrative performance has been criticised heavily by the EU-parliament, the EU court of auditors and the Council. As the Commission often "implements" through funding of NGOs, the demand for greater efficiency, accountability and transparency "spills over" to the receiving organisations. The Commission therefore has an interest in narrowing the scope of projects and partner organisations in order to reduce complexity.[13]

The restructuring of EIDHR into a more strategic direction was done through the formulation of four thematic priorities:

1. Support to democratisation, good governance and strengthening of the rule of law.
2. Support for the abolition of the death penalty.
3. Support to the fight against torture and impunity, including international criminal courts and war crime tribunals.
4. The fight against racism, xenophobia and discrimination against minorities and indigenous people.

Activities under each headline are furthermore divided between three levels: global, regional and national, according to their scope. A better geographic focus is achieved through the identification of 29 "focus countries".

The thematic, geographic and instrumental dimensions do not individually exclude rehabilitation from funding. But in combination they do. As mentioned, rehabilitation's main contribution to the fight against torture consists of fighting impunity on the national level. But fighting impunity is now only a priority on the global level through supporting the international courts, and is not accepted as a project activity on the national level. Furthermore, when a project proposal is received by the Commission, it is assessed according to a series of relevance criteria concerning method, sustainability and efficiency. The relevance cri-

teria are formulated on the basis of the political priorities; visibility, multiplicator effects and distribution. Not least, the applicant must be able to document previous experience and technical knowledge of the field in question. This selection criteria meant that only 66 projects out of 530 were accepted in 2002, and 50 out of 580 in 2003.[14]

Formally, rehabilitation centres are still encouraged to apply for "core funding", but in reality, their activities fit badly with the relevance criteria, as the effects of rehabilitation fit badly with demands for visibility and multiplication, gender equality and environmental considerations. Thus, not formally but in fact, rehabilitation seems to have been disqualified on bureaucratic criteria. The important point is, however, that these criteria are political and not scientific in nature, and therefore not necessarily "objective", although they might be legitimate.

Prevention as the "magic stick"?

In December 2001, there was a sudden change of tone in the Commission's stance on rehabilitation of torture victims. The main purpose was now to "strengthen the institutional capacity of rehabilitation centres, including their preventive component" albeit "without jeopardizing the core activities of rehabilitation".[15] Without specifying the shortcomings of the centres, the Commission re-emphasised that long term funding should be directed towards prevention activities, which, the Commission claims, would be to the centres' own advantage in diminishing their dependence on EU-funding. The Commission justified the shift with a set of guidelines on the fight against torture formulated by the Council in 2001,[16] placing torture within the general human rights policy of the Union. The emphasis on prevention is based on the EU's desire to appear as an "agent of change". It thus seems clear that rehabilitation is no longer being assessed as a human rights priority, focusing on its humanitarian value, but rather according to a developmental logic in which the main argument is an expectation of benefits in the future. This argument is not easily matched by rehabilitation, having as its main justification the relief of human suffering today. Prevention seems to be the magic stick aimed at tomorrow's victim, rather than yesterday's. The idea of prevention is also not taken out of the blue. Prevention as supported by the Council of Europe has worked well in a European context.[17] How this argumentation fits with the overall strategic interests of the Commission is analysed further below.

The Commission's strategic interest: human rights or trade?

The primary aim of EU development policy is poverty alleviation. However, the selection of receivers is not based on indications of wealth/poverty, but on an overall assessment of the country's "strategic importance" to the EU. The Commission's strategy to alleviate poverty is by increasing trade, meaning strengthening competitiveness, the ability to participate in the WTO, and home markets in developing countries.[18] Eventually, a restructuring of the EU's Common Agricultural Policy (CAP) will also have to take place, but this issue is the cause of much disagreement internally between EU member states. It therefore seems plausible that developmental aid is distributed strategically in order to create positive alliances with developing countries on trade issues for as long as their main wish, an end to the CAP is not feasible.

The Commission repeatedly claims to possess comparative advantages due to its supranational position on human rights policy. It distinguishes between "classic" and

"developmental" policy tools. In the classic form, however, the EU's human rights policy consisting of public criticism and sanctions has had very limited reach.[19] On the other hand, the developmental tools are all framed in a positive way as "training" and "capacity building", thus avoiding any open criticism or confrontation with the receiving state regime. It is furthermore worth mentioning that the selection of countries under EIDHR[1] follows the same criteria as development aid recipients; rather than targeting the countries with the most severe problems, recipients are chosen according to overall strategic importance to the EU.

Finally, one could ask why rehabilitation of torture victims is not funded as a humanitarian policy, now that its self-understanding is based on humanitarian arguments rather than developmental? The answer is that humanitarian policy is exclusively targeted at emergency situations in non-strategic geographical areas where no other policy tool is applicable, thus claiming the traditional values of humanitarian action, impartiality and neutrality.[20] There are at least three reasons, why rehabilitation is not funded under the humanitarian policy: 1) The use of torture is not an acute crisis situation, but rather a symptom of a structural or institutional crisis. 2) When speaking of rehabilitation in humanitarian interventions, it is in the physical sense, in the shape of infrastructure, housing and income generating activities. 3) Rehabilitation of torture victims cannot be impartial, when the torturer necessarily is a state agent. 4) Incidences/use of torture is not restricted to non-strategic countries.

Conclusion

There are several explanations to why rehabilitation outside the EU has been excluded from funding. On the surface, the shift is simply a consequence, albeit unpleasant, of a necessary bureaucratic streamlining of activities. Moreover, on a deeper level, as the analysis shows, the shift is no "accident", but a direct effect of the strategic interests of the Commission as both a political and a bureaucratic actor. Shaming the receiving governments in developing countries, as the support for rehabilitation of torture victims might be perceived as doing, is not feasible, when the same governments are needed as strategic alliances in trade policy. When the argument of an "administrative accident" was no longer satisfactory, the Commission launched the need to strengthen the prevention component in the work of rehabilitation centres, which might be legitimate enough, but definitely turns prevention and rehabilitation into competitive activities rather than complementary human rights priorities. In the end, rehabilitation is no longer valued as a humanitarian priority, but rather is required to have an "all-in-one" function, targeting primarily the victim of tomorrow, rather than today. As the analysis shows, the Commission's perception of "coherence" as a matter of increased coordination or a managerial fix[4] whereby no policy priority will lose importance, is not feasible. Creating coherence entails conflict. Some priorities will lose, which in this case was rehabilitation of torture victims in third countries. Whether this is legitimate or not is not within the scope of this article to judge, but the fact that the Commission is no different from any other political actor in pursuing strategic interests on the international policy scene is important. Without assessing the EU's weight as a foreign policy actor in other ways (the EU might be a significant contributor to human rights policy through other measures), the conclusion here must be that the added value of supranationality in the fight against torture is null. There are no other significant donors of rehabilitation of torture

victims and the Commission has not acted differently than any national state might have done. Perspectives on the rehabilitation of torture victims are briefly discussed below.

Perspectives on the rehabilitation of torture victims: placing responsibility where it belongs

Chandler[21] argues that the interference of Western/developed countries in complex emergencies and humanitarian crisis all over the world is a sign of "ethical foreign policy" which provides Western political leaders with an opportunity to appear as "knights" in front of their voters without ever having to assume any responsibility towards the people affected by the policy in the "receiving" state. This might be part of the explanation why rehabilitation inside the EU not only has survived the financial shift, but even seems to gain still stronger support: The European rehabilitation centres treat mostly refugees, and once one has been accepted as a political refugee, the regime in the home country has de facto been declared illegitimate and thus deserves no protection. By treating victims of torture from other regimes in Europe, the EU preserves its humanitarian and "knightly" face without upsetting any strategic partner governments.

With regard to torture in general, another explanation might be that with the global shift away from authoritarian regimes to the establishment of democracies world wide, the "shaming" method whereby the crimes of illegitimate regimes are displayed to the world is no longer viable. The EU is also not the only donor to exclude rehabilitation of torture victims. The UN[22] as well has had to beg member countries to live up to their own promises of contributions every year and the very existence of the fund is threatened from various sides.

The perspectives on funding of rehabilitation of torture victims seem sombre, generally speaking. The argument for rehabilitation will likely lose further strength, if the victim can also be defined as a "terrorist". As the case with Guantanamo Bay has shown, even politicians at the core of government readily accept severe violations of basic freedom rights. And in the case of Abu Ghraib, not one of the 22 American reports on the matter has had a mandate to investigate all the way to the top. There seems to be implicit consensus in the West that torture is not a problem for "us", and without addressing the "splinter in your own eye" it is hardly legitimate to point to some one else's.

The question is thus what to do about it? The rehabilitation movement will surely not be completely successful in freeing itself from the demands of the developmental logic, but to some extent it must be recognised that rehabilitation per se holds a significant value, simply in relieving human suffering today for the people affected, besides its contribution to prevention, conflict resolution, etc. Rehabilitation professionals are already working hard in developing better measures of goal achievement, which should be maintained and upgraded. The link between rehabilitation and prevention through medical diagnosis of symptoms of torture should not be allowed to stand alone either. One idea could be to work for the inclusion of the responsibility to rehabilitate victims of torture in the human rights clause on EU cooperation agreements, so the state in question would assume its obligations according to UNCAT, article 14. This could be done in a "soft" way, linking the state's responsibility to EU funding.

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A prismatic Balint group in Kuwait

Alfred Drees, MD*

This report refers to a Balint group seminar in Kuwait. A prismatic group method with its concentration on sensual-metaphoric mood processes is particularly suited to the Arabic mentality by allowing individual depictions of certain experiences to unfold in their sociocultural context. The significance of prismatic conflict defocusing, sensual resonance and free fantasies is outlined in this report. This method of working appears to be particularly helpful in working through traumatic fixations resulting from violence.

Balint groups in the Muslim cultural region meet with particular difficulties if they are not able to adapt to the specific sociocultural characteristics of the respective country. I have been able to gather corresponding experience in Kuwait, Syria and Turkey. A specific method of working that has proved its value in institutional Balint groups, as well as in working through relational conflicts with psychotic and dying patients and those traumatised by violence, showed itself to be particularly useful in such cases. At the centre of this method of working are sensual-metaphoric mood processes with which subject-centred and group-dynamic processes can be transformed.

Below I describe my experiences in Kuwait. At the invitation of the Social Development Office of Kuwait I was able during the course of a six-day Balint group seminar, consisting of three two-hour sessions daily, to determine to what extent sensual-metaphoric methods of working are understood and accepted by the Kuwaiti group participants. The 15 participants were female psychologists, social workers and nurses. The aim was to work through the traumatic experiences of violence suffered by the patients and clients during the Gulf War and – something I did not expect – by the group members and their relatives. Here it is important to realise that approximately 70% of the families were affected by separation as a result of the Gulf War. Almost a third of the population fled to foreign countries. Those remaining suffered a multitude of threats, shootings, rapes and tortures, with the result that various forms of posttraumatic stress disorder (PTSD) were frequently found among the population.

In the group, English and Arabic were spoken with simultaneous translation. From the very beginning the "climate" within the group was trusting, warm, cordial and familiar in spite of the fact that some of the group members wore veils for religious reasons.

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Within the framework of the sensual-metaphoric work the male and female participants were also open to individual and family problems. Discussions on the function of faith and the significance of individual suras of the Koran (e.g. during the dying process) played an important role and confirmed the Muslim identity of the group participants. The reduction in critical questioning and the search for individual motivations in the group process were further important preconditions.

The Kuwaiti psychologist Allan Staer[1] describes the Arab mentality in terms of personal identity. He explains how it should be understood to a much greater extent than in our culture as a familial, national and group identity. Arabs grow up as a rule within a framework of unlimited love, with few structural requirements in the first years of their life, before being subsequently supported by authoritarian group structures which are accepted without question. Against this background, the feelings of fear and shame experienced by traumatised patients should be understood above all within their family and national context and approached accordingly from a psychological point of view. The interpretation of transference phenomena and the incorporation of analogies and fables must therefore seek a framework that encompasses the subject. In Kuwait I therefore kept more puristically than in our culture to a concept that allows sensual-metaphoric processing channels where subject and conflict fixations can be defocused and transformed. Some of the fundamental concepts of this prismatic group work with tortured patients in English are published by A. Drees.[2-4]

Prismatic conflict defocusing

In individual and group defocusing processes it can be shown how within the framework of changing mood processes, physical-sensual experiences, tension, and even painful physical symptoms can be aroused in the participants – seeking expression in the language of images – before melting away again. In a corresponding prismatic training group a symptom such as the stomach troubles of an ulcer patient who is not present, but thematised, can move through the bodies of individual group members. Here it is interesting that the symptoms of the patient who is not present do not have to be stated beforehand, and that the stomach troubles can be experienced by group members who otherwise never suffer from such symptoms. These results, some of which are amazing, can be achieved without anchoring in ritual-spiritual fantasising. The only requirements are to suspend logically construed search movements and targeted emotionality for a time and transform them into physical-sensory modes of experience and indirect figurative forms of communication.

For the Kuwaiti group members it was amazing to experience to what extent a physical-sensual resonance capability can unfold in an individual if he or she renounces customary patterns of thought and emotion which structurally limit his or her perceptions, actions and sensory horizon. Thure von Uexküll[5] describes the behaviour of medical students who are not familiar either with the scientific language of organic medicine or that of psychological medicine and who therefore in Balint groups may experience feelings of helplessness and perplexity, thus becoming more open and sensitive to the signals given off by psychosomatic patients. We call this method prismatic as we make the polychromy of fantasy-borne mood processes visible as an expression of the multiple layers of a background of experiences in the group process in the same way as white light is split up into its rainbow colours by a glass prism.

The individual's methods of experience,

which are understood and processed in a focusing Western setting as an expression of personality structure, individual history and a specific conflict processing method, can be understood in a defocusing setting as a resonance capability. The willingness to understand physical-sensual experience and the search for figurative-poetic expression as an individual ability to create the experiences and distress of the other individual opens up a view of the overall wealth of cultural experiences, as described by Winnicott[6] for the potential space. In the potential space, cultural dimensions gain psychotherapeutic relevance. In supervisions, fixed relational blocks can be removed with this orientation.

The alleviation of symptoms of a group member at the very beginning of the seminar in Kuwait serves as an example.

He reported that as a social worker he looked after numerous patients who since the war had suffered from marked depressive and anxiety symptoms, as well as sleep disturbances and lack of drive. He describes the anguish of a woman aged about 50 who witnessed her husband and her 16-year-old nephew being beaten to death with an axe. She could no longer remove from her mind the images of blood, the scene she had witnessed and her paralysing despair. At this point he begins to report hesitatingly in Arabic on his own suffering. For many months he had been suffering from intense stomach pains and sleep disturbances. In his case the reason was the loss of his mother during the war. However, he did not want to talk about this here. His concern was – and now he spoke in English again – to be fit enough to do his job. "My job is my life, you know," and he added energetically: "You have to know doctor."

The group reacts with consternation but quickly adjusts to the previously trained sensuous and imagination setting. Paralysing, apathetic and nauseating feelings and moods are awakened. A severed bleeding hand dances through a tangle of ships masts "like a dervish with a fluttering tail. The drops of blood dance in tune, colouring the sea". Headaches and stomach troubles appear. Then follow experiences and images of burning oil fields "which light up a marriage ceremony like candles". A crowd of people, dancing and convivial music. The mood now opens up to peaceful caravans of camels against the light of the setting sun. Dreamy sea moods and the gently rocking of a baby contrast with grey fields of fog. A huge mosque reaches up to the sky, into the clouds racing by, "like a sword or the bow of a ship". "On the trip in a nowhere land" laughs a female psychologist, who also works as a teacher of religion.

The social worker takes up the individual mood images and seeks to link them associatively with his own social and family fields of experience. Within the meaning of prismatic self-experience, in which individual utterances are neither dealt with more intensively by group-dynamic processes, nor analysed or interpreted, the group member succeeds in understanding the suffering borne reciprocally between his 50-year-old client and the burden of his own family background, while moderating it within the context of joint sociocultural and religious integration. In the final group session four days later the social worker reports that his stomach troubles disappeared some days before. ("They just flew away.") However, it was important for him to report that he had found a completely new basis of discussion with his client. He was now more relaxed and could speak to her about family and practical questions.

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This manuscript was received 13 April 2004, i.e. before the latest development in the government in Nepal and the subsequently changes in the democratic constitution.

Nepal make torture a crime

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By ratifying the UN Convention Against Torture, Nepal is obliged to submit progress reports periodically to the UN Committee Against Torture, constituted under Article 17 of the UN Convention Against Torture.

All acts of torture are to be made "punishable by appropriate penalties".

Nepal's initial report to the UN Committee Against Torture dates from 30 September 1993. In April 1994 Nepal appeared for the first time before the UN Committee Against Torture, the international body of experts monitoring the implementation of the UN Convention Against Torture. The government's initial two-page report of September 1993 on the implementation of the Committee was "scant on detail." It was supplemented at the time of the meeting by a six-page statement and a ten-page background note. The Committee recommended that a supplementary report be submitted within twelve months. The second periodic report was due on 12 June 1996 and the third was due on 12 June 2000. Neither of these has been submitted as of yet.

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The recognition of the rights against torture is also a feature of the new 1990 Constitution. The Constitution prohibits the practice of torture. According to Article 14, Section 4, it states: "no person who is detained during investigation or trial or for any other reason shall be subject to physical or mental torture, nor shall be given any cruel, inhuman or degrading treatment. Any person so treated shall be compensated in a manner as determined by law."

Unfortunately, torture is a common phenomenon in Nepal.

In Nepal torture is exercised through different physical and psychological methods used separately or in combination. Generally, public officials use systematic beating, which, also called falanga, is the most popular method in Nepal. In addition, electrical shock, burning, chepawa, and suffocation are commonly applied as tools of torture.

Other forms of torture specifically applied to destroy the victim psychologically include threats and deprivation techniques: social deprivation (isolation, confiscation of personal belongings), sensory deprivation (prolonged blindfolding, prolonged isolation in a small, dark and silent room), deprivation of basic needs (deprivation of food, water, toilet privileges and sleep)(Tables 1 and 2).

During the Maoists insurgency, the

Maoists were responsible for several incidents of physical and psychological assaults. Since the UN Convention Against Torture limits the definition of torture to covering severe physical and psychological suffering inflicted only by public officials or those working in official capacities, debate continues on whether or not the atrocities, including the infliction of severe physical and psychological suffering, committed by the Maoists, can be defined as torture.

The 1996 Torture Compensation Act has defined the term "torture" as physical or mental torture inflicted on a person who is in detention for investigation or waiting for any other reason, and this term includes cruel, inhuman or degrading treatment that person is subjected to.

The government has also failed in its duty under Articles 2 and 10 of the UN Convention Against Torture to take "effective legislative, administrative, judicial or other measures to prevent acts of torture" and "ensure education and information regarding the prohibition of torture are fully included in the training of law enforcement personal, medical personnel, public officials ..."

Civil societies are particularly unaware of the provisions of the 1996 Torture Compensation Act, which states: the concerned officer, at the time of detention and release of any person shall have the person's physical condition examined, as far as possible by a doctor, if not available by himself, and shall keep and maintain records thereof. One copy of the report concerning the examination of the physical or mental condition shall be submitted to the concerned district court.

Year	Male	Female	Unidentified	Juveniles	Total
1996	295	22	72	3	392
1997	877	68	623	N.A.	1568
1998	1665	417	583	N.A.	2665
1999	1037	102	–	N.A.	1139
2000	934	101	–	N.A.	1035
2001	2017	178	–	N.A.	2195
2002	2893	252	285	N.A.	3430

N.A.: Not available
Source: National Human Rights Commission. Human rights in Nepal: a status report 2003.

Table 1. *People arrested/tortured by state authorities.*

Perpetrator	1998	1999	2000	2001	2002
Police	260	247	714	335	678
Army	–	101	26	5	201
Maoist	–	32	23	37	180
Prison guard	5	7	2	3	31
Forest guard	1	8	55	20	9
Others*	14	12	61	12	192
Total	277	407	881	412	1291

*) 2002 figures under "others" include the number of victims who were tortured by more than one party: police, army and Maoist).
Source: National Human Rights Commission. Human rights in Nepal: a status report 2003

Table 2. *Categorise of perpetrators as reported by the torture survivors.*

Unfortunately, this provision is not adhered to. The police do not request doctors to examine prisoners at the time they are admitted into custody; judges do not ask for copies of the medical report when prisoners are produced before them. If this provision were to be fully implemented, it would serve as a significant measure to prevent torture from occurring, and would also serve as a significant piece of evidence in the event, prisoners later made allegations of torture during their trial or fielded complaints under the Torture Compensation Act.

Article 4 of the UN Convention Against Torture requires state parties to make torture an offence under criminal law, punishable by "appropriate penalties, which take into account their grave nature." However, under Nepalese law at present, torture is not defined as a special criminal offence. On occasion, Nepali government officials have commented that because the Treaty Act of 1990 provides that the provisions of international treaties prevail even if they contradict the provisions of national law, to the extent of such contradiction, the UN Convention Against Torture provisions are fully in force in Nepal.

The Torture Compensation Act enables victims of torture to obtain compensation of up to 100,000 Nepalese rupee. According to section 8 of the Torture Compensation Act, this amount is supposed to include any loss of earnings or, in the event of death due to torture, the expenses required for the livelihood of the dependents of the victim. It is clear that this ceiling is too low. The responsibility for paying the compensation should be shared by those involved in the crime. It should not rest with the government alone.

Conclusions

Hope for eradication of torture was highly expected when democracy was restored in Nepal in 1990. Several leading members of the political parties had been victims of torture under the "Phanchayat" system and had pledged their commitment to uphold human rights when they came to power in 1990. There are many factors that have contributed to the Constitution regarding torture. We know that our Constitution abolished death penalties and also provided rights to criminal justice. Nepal also has a tradition of torture and humiliation of criminals by police and local authorities.

Despite the political changes over the past years and the general prohibition of torture in the 1990 Constitution, torture has so far not been defined as a crime and it is still widely perceived as acceptable. So we can say that implementation and practice of the Constitution is very poor. Nepal ratified the UN Convention Against Torture on May 14, 1991. It entered no reservations to the treaty. However, many provisions of the Convention still wait for implementation. ❑

This comprehensive report has been written by Gretchen Borchelt, JD & Christian Pross, MD and with research assistance by others

Systematic use of psychological torture by US Forces*

Physicians for Human Rights**

Abstract

This report is the first to comprehensively examine the use of psychological torture by US personnel in the so-called "war on terror."[1] It reviews the techniques used on detainees, what clinical experience and studies reveal about the long-lasting and extremely devastating health consequences of psychological torture, how a regime of psychological torture came about and was perpetuated, and what the current status of psychological torture is in US policy. Although the evidence is far from complete, what is known warrants the inference that psychological torture was central to the interrogation process and reinforced through conditions of confinement. Evidence exists of its continued use in 2004 and some practices likely remain in place to this day. (...)

A regime of psychological torture

Much of what took place in the closed facilities where detainees were kept and interrogated remains secret. In particular, the policies and practices of the Central Intelligence Agency (CIA) are almost completely shielded from public scrutiny. Yet there is sufficient evidence available now to show a consistent pattern of the use of psychological torture as a key element in the interrogation of detainees by US personnel. Various techniques were often applied in combination, in order to amplify and heighten their effect.

Prolonged isolation

The use of prolonged isolation took place in all three theaters of operation throughout the "war on terror" and most likely is continuing today. There are reports from the US-run Bagram Air Force Base in Afghanistan that forces used solitary confinement at the base in 2002 and that the harshest treatment was directed at detainees held in isolation.[7] US personnel also used isolation as an interrogation tactic in Iraq. Based on visits to detention facilities throughout Iraq in 2003, the ICRC (International Committee of the Red Cross) found that detainees held at Baghdad International Airport were "held for nearly 23 hours a day in strict solitary confinement in small concrete cells devoid of daylight".[8]

An even more restrictive use of isolation was in place at Abu Ghraib prison in Iraq.

Sleep deprivation

The use of sleep deprivation appears to have been a common interrogation tactic in Afghanistan, Iraq, and Guantánamo.

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*) The following is an extract from the report

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Physicians for Human Rights (PHR) worked to stop torture, disappearances, and political killings by governments and opposition groups and to investigate and expose violations, including: deaths, injuries, and trauma inflicted on civilians as well as harsh methods of incarceration in prisons and detention centers.

Detainees held at various locations in Afghanistan in 2002 and 2003 describe being routinely deprived of sleep.[18] The spokesman for the American-led force in Afghanistan admitted in 2003 that sleep deprivation was "probably within the lexicon"[19] and that a "common technique" for keeping detainees awake was to keep bright lights on at all times or to wake detainees every fifteen minutes.[20] At Guantánamo, sleep deprivation also was regularly employed. Personnel familiar with conditions there described how sleep deprivation was implemented at the naval base in 2003:

An inmate was awakened, subjected to an interrogation in a facility known as the Gold Building, then returned to a different cell. As soon as the guards determined the inmate had fallen into a deep sleep, he was awakened again for interrogation after which he would be returned to yet a different cell. This could happen five or six times during a night.[21]

Its use continued in 2004, according to detainees held there during that time.[22]

Sleep deprivation occurred in detention facilities throughout Iraq as well. (...)

(...) At Guantánamo, detainees' accounts of forced nudity and sexual humiliation were confirmed by FBI reports. An FBI letter to an Army official states that during late 2002 an agent witnessed a female interrogator at Guantánamo rubbing lotion on a detainee's arms during Ramadan, when "physical contact with a woman would have been particularly offensive to a Moslem male."[33] News reports confirmed that the use of female interrogators violating Muslim taboos regarding sex and contact with women occurred at Guantánamo in 2003 as well.[34] These accounts were confirmed to PHR by a source familiar with conditions there. According to the source, in 2003 female interrogators used sexually provocative acts as part of interrogation. For example, female interrogators sat on detainees' laps and fondled themselves or detainees, opened their blouses and pushed their breasts in the faces of detainees, opened their skirts, kissed detainees and if rejected, accused them of liking men, and forced detainees to look at pornographic pictures or videos.[35] Although the use of female interrogators appeared to decline in 2004, a source told PHR that humiliation and violation of cultural and religious taboos, including forced shaving, persisted.[36] (...)

Use of threats and dogs to induce fear of death or injury

Interrogators in Afghanistan, Iraq, and Guantánamo cultivated the fear of injury and death through the use of military working dogs, the threat of beatings or electrocutions, and mock executions.

There is evidence that the use of dogs to instill fear and threaten detainees was used as an interrogation technique in all three theaters of operation, from the beginning of the "war on terror." (...)

Aside from the use of dogs, mock executions and death threats were prevalent in Afghanistan and Iraq. A detainee in Kandahar, Afghanistan says that in 2002, a 9 mm pistol was held to his temple.[47] A Criminal Investigation Command report describes a compact disc that contains digital images of American soldiers conducting mock executions on Afghan detainees beginning in early December 2003 at Fire Base Tycze, Dah Rah Wood, Afghanistan.[48]

Combination of techniques

The evidence points to a widespread and systematic application of these techniques, often in combination. (...)

(...) Detainees reported that at Guantánamo in late 2002, they observed techniques such as short-shackling, loud music playing in interrogation, forced shaving of beards and hair, putting people in cells naked, taking away people's comfort items, sleep deprivation, and the use of cold air.[54] (...)

Health consequences

Psychological torture and cruel, inhuman, and degrading treatment can have extremely destructive health consequences for individuals. Short- and long-term effects can include memory impairment, reduced capacity to concentrate, somatic complaints such as headache and back pain, hyperarousal, avoidance, irritability, severe depression with vegetative symptoms, nightmares, feelings of shame and humiliation, and post-traumatic stress disorder.[63] Sources with knowledge of interrogation at Guantánamo told PHR that some detainees there suffer from incoherent speech, disorientation, hallucination, irritability, anger, delusions, and sometimes paranoia.[64] Some detainees who have been released from US run detention facilities after being subjected to a combination of psychologically abusive interrogation techniques report that they suffer from depression, thoughts of suicide and nightmares, memory loss, emotional problems, and are quick to anger and have difficulties maintaining relationships and employment.[65] Based on past experience, post-traumatic stress disorder is likely to be common.

Prolonged isolation

In the 1950s and 1960s, studies demonstrated that short-term isolation caused an inability to think or concentrate, anxiety, somatic complaints, temporal and spatial disorientation, deficiencies in task performance, hallucinations, and loss of motor coordination.[66] The findings of contemporary research are consistent with the earlier findings of solitary confinement's harmful consequences. Effects include depression, anxiety, difficulty with concentration and memory, hypersensitivity to external stimuli, hallucinations and perceptual distortions, paranoia, and problems with impulse control.[67] People who are exposed to isolation for the first time develop "a predictable group of symptoms, which might almost be called a 'disease syndrome.'"[68] The symptoms include "bewilderment, anxiety, frustration, dejection, boredom, obsessive thoughts or ruminations, depression, and, in some cases, hallucination."[69]

Sleep deprivation

The most pronounced impact of total sleep deprivation is cognitive impairment[74],which can include "impairments in memory, learning, logical reasoning, arithmetic skills, complex verbal processing, and decision making."[75] Sleep-deprived individuals take longer to respond to stimuli, and sleep loss causes "attention deficits, decreases in short-term memory, speech impairments, perseveration, and inflexible thinking."[76] These symptoms may appear after one night of total sleep deprivation, after only a few nights of sleep restriction (five hours of sleep per night)[77]. (...)

Sexual humiliation

According to clinicians at the Minnesota-based Center for Victims of Torture (CVT), forced nakedness is intended to create a power differential between detainees and interrogators by stripping the victim of his/her identity, inducing immediate shame, and establishing an environment where the threat of sexual and physical assault is always present. By denying the victim the most basic forms of decency and privacy, forced nudity conveys the message that interrogators have

absolute control over the detainees' bodies and can do as they please. Implied in the context of forced nudity is the threat of other, more abusive violations, whether sexual or physical.[81]

There is evidence that US personnel directed sexual humiliation toward detainees because they knew that Arabs are particularly vulnerable to sexual humiliation and sought to exploit that vulnerability.[82] Clinicians at the Center for the Treatment of Torture Victims in Berlin, Germany (Berlin Center), who treat a large population of Muslims, have found that Muslim victims of sexual torture forever carry a stigma and will often be ostracized by the community. They have found that male victims often feel degraded in their manhood, especially if the perpetrator was a woman. (...)

Psychological torture

The use of psychological torture followed directly from decisions by the civilian leadership as well as high ranking military officers, including those in the executive branch, and their support of decisions to "take the gloves off" in interrogations and "break" prisoners by employing techniques of psychological torture including sensory deprivation, isolation, sleep deprivation, forced nudity, the use of military working dogs to instill fear, cultural and sexual humiliation, mock executions, and the threat of violence or death toward detainees or their loved ones. These kinds of techniques have extremely devastating consequences for individuals subjected to them and can be just as harmful and are often more long-lasting than physical torture.

The infamous pictures from Abu Ghraib prison in Iraq indelibly brought home how severe forms of psychological coercion – detainees terrorized by snarling dogs and wires dangling from their wrists, subjected to severe sexual humiliation, and disoriented by hooding – are indeed forms of torture. What the images do not show, but what this report reveals, is that psychological torture, even if not as graphic as the images, was at the center of the treatment and interrogation of detainees in US custody in Afghanistan, Guantánamo and Iraq since 2002.

Since the Abu Ghraib scandal broke a year ago, the physical abuse of detainees through beatings, use of stress positions, deprivation of food, and infliction of severely cold and hot temperatures, has understandably gained the most attention, and the United States Army has itself labeled the deaths of 26 detainees as homicides. The evidence now available from witness accounts, documents released under the Freedom of Information Act, official investigations, leaked reports from the International Committee of the Red Cross (ICRC), media reports, and inquiries by Physicians for Human Rights, shows that physical forms of torture and cruel, inhuman and degrading treatment served only to punctuate the pervasive use of psychological torture by US personnel against detainees.

The use of the psychologically abusive interrogation methods is immoral and is illegal under the Geneva Conventions and other sources of international law to which the United States is a party, civil domestic law and the Uniform Code of Military Justice. US courts, international treaty bodies, UN special rapporteurs on torture, and the US State Department have all identified these techniques as a form of torture or cruel, inhuman, or degrading treatment. Indeed, when Congress enacted a law to implement the requirement of the Convention against Torture to criminalize torture, it defined precisely what it meant by the criminal act of mental or psychological torture. The US Congress defined the severe mental pain

or suffering that constitutes an element of the crime of torture as including threats of death or injury and the administration or application or threatened administration or application of "procedures calculated to disrupt profoundly the senses or the personality."[2] This definition encompasses exactly the procedures that were used.

Psychological torture also violates longstanding instructions for military interrogations. Army Field Manual 34-52, the Army's guide on interrogations, currently being revised, allows psychological methods of interrogation, but draws a very sharp line at psychological coercion and efforts to break down detainees, which it considered both unlawful and ineffective:

[The] use of force, mental torture, threats, insults, or exposure to unpleasant or inhumane treatment of any kind is prohibited by law and is neither authorized nor condoned by the US Government. Experience dictates that the use of force is not necessary to gain the cooperation of sources for interrogation. Therefore, the use of force is a poor technique, as it yields unreliable results, may damage subsequent collection efforts, and can induce the source to say whatever he thinks the interrogator wants to hear.[3]

The Federal Bureau of Investigation agrees. After the Abu Ghraib scandal, it issued an electronic communication that said that FBI policy "has consistently provided that FBI personnel may not obtain statements during interrogations by the use of force, threats, physical abuse, threats of such abuse or severe physical conditions."[4] It reiterated, "It is the policy of the FBI that no interrogation of detainees, regardless of status, shall be conducted using methods which could be interpreted as inherently coercive, such as physical abuse or the threat of such abuse to the person being interrogated or to any third party, or imposing severe physical conditions."[5] This reiteration of policy came on the heels of a number of complaints from the FBI to the Department of Defense regarding their use of unacceptably aggressive interrogation tactics.[6]

Closing remarks

Based on a review of disclosed documents, comprising administration memorandums, government documents released pursuant to a Freedom of Information Act request, and leaked International Committee of the Red Cross reports, as well as PHR's own interviews, it is clear that US personnel have used these techniques systematically at detention facilities in Afghanistan, Guantánamo, and Iraq, from the beginning of the "war on terror" through 2004. Some techniques, like sleep deprivation and nakedness, were designed to part of interrogation plans and strategies for particular detainees; others, like long-term isolation, were part and parcel of the conditions of confinement for many detainees. Because of the close relationship between conditions of confinement and interrogation techniques, the victims could well number in the thousands. The evidence points to a system of consistent psychological torture and ill-treatment, accompanied by physical abuse that was central to the interrogation of detainees. There has been no accountability for the practice of psychological torture among officials responsible for putting the practices into place.

References

The numbers of references refer to their original placement in the PHR report.

The report called "Break Them Down" and its references can in full extension be accessed at www.phrusa.org/research/torture/news_2005-05-01.html