Foreword

One of the most significant events in the global movement against torture in recent years took place in Berlin on 9-10 December 2006, where the IRCT – with the generous support of numerous governments and foundations and in collaboration with the Berlin Center for the Treatment of Torture Victims (BZFO) – hosted a scientific symposium on torture. Nearly 400 health, legal and other professionals from 88 countries attended the two-day event, which was organised around the themes "Providing Reparation and Treatment, Preventing Impunity".

The symposium addressed important challenges and opportunities facing the movement in foremost the health and legal arenas. From a health perspective participants explored the relationship between medical/pharmacological treatment and classical psychological treatment, and considered ways to enhance standards of up-to-date evidence-based medical treatment for conflict and torture survivors suffering from anxiety disorders, depression or post traumatic disorders. The symposium also focused on the need to find better ways to deal with secondary trauma and burnout and to provide care for caregivers.

From a legal perspective, best practice examples and case law were discussed with regard to addressing impunity at the international and national level with a focus on obtaining reparations for victims.

This special issue of Torture journal has been assembled as a way to share information from the symposium with a wider audience. The IRCT believes that the synergy at the symposium between the medical, psychological, social and legal sciences holds great potential for the continued advancement of the prevention of torture and rehabilitation of torture victims.

I hope you will enjoy reading this special edition and that it will provide a useful insight into the main findings of the symposium.

Yours sincerely

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New treatment approaches: integrating new media in the treatment of war and torture victims*

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Abstract

The diagnostic process and treatment of victims of war and torture is associated with a number of difficulties. This article will provide an overview of three different approaches on how the new media may be integrated into the treatment of survivors of torture and war to face some of the challenges. Illiteracy is a common problem and makes it difficult to apply standardized psychological assessment procedures. Also, the majority of survivors of torture and war do not have access to any psychotherapeutic treatment due to geographical limitations or limitations concerning psychotherapeutic treatment capacity. Furthermore, chronic psychological disorders such as (complex) Posttraumatic Stress Disorder (PTSD) are often seen with comorbid chronic pain disorders, which present a therapeutic challenge. The Treatment Center for Torture Victims, Berlin, in cooperation with the University of Zurich, developed a number of approaches to address these challenges: 1) MultiCASI - to standardize the diagnostic process an audiovisual diagnostic tool was developed which allows illiterate individuals to answer standardized psychological questionnaires without the help of interpreters; 2) A virtual treatment center for posttraumatic stress disorder for traumatized patients in Iraq and other Arab speaking post-conflict countries; 3) Utility of Biofeedback (BF) in chronic (somatoform) pain and in traumatized patients: to address the chronic pain syndrome presented by most survivors, a biofeedback- supported cognitive-behavioral therapy approach was developed and successfully tested in a pilot study.

Key words: victims of torture and war, PTSD, pain, assessment, treatment, computer

Warfare and torture, occurring on a large scale around the world causes many victims to flee their countries. As reported by the International Organization for Migration[1] and UNHCR,[2] migrants and refugees comprise a large group worldwide with approximately 175 million and 19.2 million respectively at the end of 2004. Both voluntary and forced migration lead to excess risk of physical illness[3] and psychiatric morbidity,[4] particularly when associated with traumatic experiences and resettlement in unfamiliar environments. According to a recent meta-analysis,[5] about 10% of refugees in western countries suffer from Posttraumatic Stress Disorder (PTSD), 5% are diagnosed with major depression, and there is evidence for

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high psychiatric comorbidity. When diagnosing and treating survivors of war and torture, clinicians are frequently faced with a number of challenges. In this article, three approaches on how the integration of computer and the new communication pathways might help to overcome some of the problems occurring during diagnostics and treatment will be introduced: a multilingual computer-based diagnostic tool (MultiCASI), an internet-based treatment of PTSD in post-conflict countries and a biofeedback-based pain therapy.

1. MultiCASI

Illiteracy and limited reading and writing skills are common problems in many countries and are often observed in refugee populations. The application of standardized psychological assessment is therefore resource consuming, as interpreters are necessary, and poses methodological problems, as the validity of ad hoc translations of questionnaires during interviews is unclear. To face this challenge the Berlin Center for Torture Victims and the Outpatient Clinic for Victims of Torture and War, University of Zurich developed a computer based diagnostic tool (MultiCASI, multilingual computer assisted self-interview,[6]) to facilitate questionnaire-based standardized assessment of samples that consist of people who speak diverse languages and have limited reading or writing skills. MultiCASI consists of two separated surfaces. The interviewee works on a surface where single items of a given questionnaire are presented and read aloud in the interviewee's native language after being activated by touching them through a touch screen. Only one question is presented at a time on the screen (see Figure 1). After having completed the questionnaire, results are automatically exported into a statistics program. On the second surface any questionnaire can be entered in a wide range of different languages and fonts. The interview modalities (i.e. language, the selection and order of questionnaires, rules for skipping of items/questionnaires, audio on/off, single/multiple choice) can be individually adapted.

Figure 1. *Example of a Russian item with MultiCASI.*

The program eases the process of data collection considerably for therapists. In general, computer-assisted assessments offer a number of advantages such as data completeness and standardization, immediacy of data entry and elimination of transcription costs and errors.[7] Another possible advantage of this system is the anonymous interview setting. It has been argued that the use of computers reduces the tendency to respond in a socially desirable way. This is especially true for more sensitive or potentially stigmatizing information.[8] In previous studies with similar systems it was repeatedly shown that the under-report of sensitive behavior or pathological symptoms as a result of embarrassment, privacy concerns, or fear of negative reactions is a common problem. Furthermore, traditional paper-and-pencil self-report instruments can be easily transferred to computer-based administration. Ritter, Lorig, Laurent, and Matthews[9] compared the psychometric properties of internet-based versus paper-and-pencil questionnaires. They found that questionnaires

administered via the computer were reliable and answered as often as the paper-and-pencil questionnaire with less recruitment effort required. MultiCASI was developed in collaboration with psychologists, psychiatrists, ethnologists and computer specialists. The tool has been tested with migrants from different cultures and languages (including illiterates). Respondents so far have understood the program rapidly and have accepted it very well. An unexpected side effect was that several patients expressed their satisfaction and surprise that they were actually able to work on a computer given the fact that they were unable to read and write. Although this induction of self-efficacy was initially unintended we interpreted this as a further indication of acceptability of this diagnostic approach. Due to its simple operational structure, the program is also suited for surveys with children and is currently being applied in an epidemiological study in four West-African countries. Currently, the Berlin Center for Torture Victims and the Outpatient Clinic for Victims of Torture and War, University of Zurich are conducting a feasibility study where the acceptability and response patterns of MultiCASI are compared to traditional paper-and-pencil approaches.

Although we are well aware of the challenges and complexity cross-cultural diagnostic assessment implies, we intentionally omitted the discussion of whether a standardized assessment of DSM-criteria can and should be applied to individuals with a different cultural background. In addition, we chose not to focus on whether instruments used to assess the presence of psychological disorders may accurately reflect the given psychopathological condition within non-western cultures. This controversy has been discussed in great detail elsewhere[10,11] and will therefore not replicated here.

2. A virtual treatment center for post-traumatic stress disorder for traumatized patients in Iraq and other Arab speaking post-conflict countries

In 2002, the UN Commission on Human Rights pointed out "the systematic, widespread and extremely grave violations of human rights and of international humanitarian law by the Government of Iraq, resulting in an all-pervasive repression and oppression sustained by broad-based discrimination and widespread terror".[12]

A recent survey by Gallup showed that 6.6% of Baghdad's residents had experienced the execution of household members, a figure that projects to at least 60,000 executions in Baghdad alone.[13] This number agrees with estimates by Human Rights Watch and other human rights organizations that between 300,000 and 500,000 Iraqis were executed by the Ba'ath regime. In a recent survey of 2,000 Iraqi households in southern Iraq, conducted by Physicians for Human Rights, more than 1,000 incidents of severe human rights abuses by the Ba'ath regime were reported, including torture, killings, disappearance, beatings, kidnappings, forced amputation and rape.[14] In addition, the consequences of war dramatically increased the likelihood of being exposed to traumatic experiences, which implies the urgent need for immediate rehabilitation. Due to the highly critical security situation in Iraq only a very limited number of governmental and non-governmentalorganizations (NGOs) are present in this war-torn and conflicted region. This is in strong contrast to the actual need of the population in this country. Besides the lack of medical and infrastructural help, psychological support in this region is also sparse. There is a recognized urgency and priority to set up and strengthen processes in the Iraqi health sector.

These problems are confirmed by our own experiences in Iraq. In 2005 the Treatment Center for Torture Victims in Berlin, Germany, opened a treatment center for torture victims in Kirkuk, Iraq. The demand for psychological treatment was immense, and only a small percentage of people in need were able to receive treatment. In addition, more treatment facilities for patients located in the Northern part of Iraq and psychological support for those in other more unstable parts of the country are urgently needed.

As outlined previously, a major problem frequently found in survivors of torture and war is posttraumatic stress disorder. According to an estimate of prevalence by the Swiss Refugee Council, up to 50% of the Iraqi population suffers from various forms of posttraumatic stress.[15] This is in line with results from other high-risk populations, such as individuals originating from post-conflict areas and torture victims, where a high prevalence of PTSD (43-52%) was found.[16] As a recent study shows, these high prevalence rates are in large part due to the cumulative effect of traumatic experiences in conflict areas.[17]

2.1 Relevance of the project to Iraq and other Arabic post-conflict countries

Only a small percentage of victims of torture and war are able and have the resources to flee their country. The vast majority is forced to stay in the conflicted areas where there is usually no sufficient psychotherapeutic support structure. In addition to living with violence, many of these individuals are also living in poverty, and are often dependent on humanitarian aid. Therefore, any psychotherapeutic work that takes place must be brief given the large numbers of people and limited financial resources. Any broad-scale treatment program must be pragmatic and easy for local personnel to learn, even with little or no access to medical or psychological education or additional training. Consequently, the method must be easily implemented and adaptable to any environment regarding safety. The evolving communication technology offers new delivery channels for psychotherapeutic treatments, which provides a unique possibility to offer therapeutic treatment to areas without psychosocial infrastructure. Because therapist and patient are geographically independent, the approach is applicable even in high-risk areas, where no help systems exist due to the associated danger. Another advantage is the anonymity of the Internet, which offers new treatment possibilities in Iraq and other Arabic post-conflict countries.

2.2 Internet-based therapy for PTSD

Traumatic experiences are often associated with stigmatization and intense feelings of shame and guilt.[18] The Internet provides a protected environment where participants can easily control and regulate the degree of intimacy they want to share without the fear of real-life judgment, rejection, or devaluation. This way of communicating lessens social risks and inhibitions and encourages the disclosure of painful experiences or shameful thoughts.[19-21] In past years, a highly effective Internet-based treatment approach for posttraumatic stress disorder (Interapy) has been developed.[22-24] The treatment consists of structured writing assignments that take place through a database implemented on the Internet; it is delivered without any face-to-face contact and therefore is accessible all over the world. All studies repeatedly found substantial, significant and enduring improvements on posttraumatic stress symptoms and anxiety and depressed mood. Due to its high efficacy, Interapy is already integrated into the regular health care system in the Netherlands and is accessible nationwide. Interapy was evaluated cross-culturally

in numerous randomized controlled trials.[25-27] In cooperation with the Kirkuk Center for Torture Victims located in the Northern part of Iraq, a self-sustained virtual out-patient clinic for traumatized patients was initiated (www.ilajnafsy.org; www.virtual-trauma-center.org). This approach is based on the widely tested and proven protocol-based Interapy treatment approach and will be conducted in Arabic. Within this approach all contact between patient and therapist takes place exclusively via email and is based on a clinically evaluated treatment protocol. During the seven-week treatment patients communicate with their individual therapists. As the Internet allows geographical independence, the Arabic-speaking therapists can be located anywhere in the world.

2.3 Interapy

Potential patients browse through the website, which provides information about PTSD, the treatment, the therapists and other potential treatment alternatives. Potential participants can log in and fill out the screening questionnaires online. The screening is a set of standardized clinical questionnaires for all relevant disorders. As soon as those who pass the screening give written informed consent, they are admitted to treatment. The online therapy is accessible for anyone; patients, however, who are under 18, and/or who are too unstable (e.g. psychotic, suicidal, severely depressed) cannot be treated through the Internet. All therapists also participate in weekly supervision sessions and contribute to the Arabic Online Supervision Forum.

2.4 InterapyAID treatment protocol

Patients are set two weekly 45-minute writing assignments over a period of approximately five weeks, with the therapist and patient communicating exclusively by e-mail. After every second essay, patients receive feedback and further instructions from the therapist. These instructions (which are sent within one working day) are based on a cognitive-behavioral treatment protocol, but tailored to the individual patient's needs. At the beginning of each phase of treatment, patients receive psycho-education on the principles of the treatment module.

Subsequently, the three treatment phases, including examples of the therapists' writing instruction and an excerpt from the case illustration of a patient will be described. Each treatment phase includes an example of the therapists' writing instruction and an excerpt from the case illustration of a patient: The patient, Ms. N., is a 32-year-old Iraqi woman who was detained due to the human rights activities of her husband. During detainment Ms. N. was repeatedly raped by police officers. Until starting the InterapyAID she was unable to talk about her experiences in prison and the suffering that came in the years afterwards.

2.4.1. First phase – self-confrontation

First, patients are instructed to write two essays on the circumstances of the traumatic event or the death of a significant person. They are asked to express all their fears and thoughts about the event and to focus on sensory perceptions in as much detail as possible. Participants are asked to write their essays in the present tense, in the first person, and without worrying about grammar, style, or the logical chronology of events. The following is an example of the therapists' writing assignment set for essays 3 and 4:

> *Therapist instruction:* "For the next two texts, I would like to ask you to choose one moment of your traumatic event. One moment that you can hardly bear

to think about, but that keeps intruding on your thoughts. Write down the most painful memories and emotions you have when you think about it and describe everything that you experience – every feeling, every thought and physical reaction."
Example of the patient's text: "I wish I would not be a woman ... I am ready to reveal any information he demands but he does not want any information. He wants something different. He hits me in the face and starts to rip off my clothes. I smell and taste blood - the other guard is restraining my hands. I cannot move … I never hated myself as much as I do now. I never hated my body as much as I do now. I am scared; I am scared to die. My heart is racing – I am just pain – pain I cannot bear. I am worthless. I am not worth to be the mother of my son … I cannot live anymore. My head explodes, everywhere is blood, I cannot breathe, I cannot move. God, don't let them hurt my son …"

2.4.2. Second phase – cognitive reappraisal

In this cognitive restructuring phase, patients are instructed to write a supportive and encouraging letter to a hypothetical friend. They are asked to imagine that this friend had also experienced the same kind of traumatic experience and was now facing the same difficulties. The letter should reflect on guilt feelings, challenge dysfunctional automatic thinking and behaviour patterns, and correct unrealistic assumptions. The aim is to foster the development of new perspectives on the traumatic event and its circumstances. An example instruction of the therapist for the first two essays in this phase is as follows:

Therapist instruction: "Imagine you are writing a supportive letter to your friend Nailah, who experienced the same situation as you. Could she have foreseen what happened? Do you think she was responsible for this?"
Example of the patient's text: "I can understand that you feel that you can't go on living – but we are not the ones who determine that. Stop blaming yourself. Why do you double all what happened by thinking about it continuously and blame yourself for something that was out of control. It was not your fault. It was not your fault. I know I ask for a lot, but you know I do this to help you …. Why do you think these people (neighbours) invite you? Why do they look for your company? Because they see something inside of you that you cannot see anymore. Don't let your sadness and feelings of guilt and shame prevent those relationships. Don't let the monsters from the past win again over your heart and your body."

2.4.3. Third Phase – social sharing and farewell ritual

During the third phase, patients receive psycho-education about the positive effects of social sharing. In a final letter they then take symbolic leave of the traumatic event. Patients can address the letter either to themselves, to a close friend, or another significant person involved in the traumatic event. The letter did not ultimately have to be sent.

Therapist instruction: "You wrote that you would like to write the letter to yourself. First, I would like to ask you to describe the circumstances that happened. Which moments were so important that you would like to tell yourself about them? It

is important to give the past, the present and the future the same weight in this letter."

Example of the patient's text: "I can see that you feel better…you are stronger and your will seem stronger. Your sadness became less and you're thinking less about the past. What happened is part of your life and it does not have to be more than that. Try to live now! You bought yourself a new dress yesterday – how long ago has that been? Allow yourself to enjoy your life just as yesterday, get in touch with people you like and don't let your doubts and fears hinder you. You are a human being just as they are human beings and you have a right to take part in this life."

2.5 Limitations of this approach

As any other psychotherapeutic approach this internet-based treatment approach suits only a selected population. As indicated before, patients have to be psychologically stable enough, have to have sufficient reading and writing abilities and must have access to the Internet. Also, some patients might feel uncomfortable to share these intimate details though the Internet. However, for many this is the first approach, which provides an opportunity for treatment in areas where no psychosocial structure is available. Currently a randomized controlled trial is being conducted to test the efficacy of this approach in an Arabic speaking population. For more information and participation, readers are referred to www.ilajnafsy.org or www.virtual-traumacenter.org.

3. The Treatment of chronic pain in traumatized refugees

Chronic pain and "medically unexplained somatic symptoms" are frequent conditions in migrants[28] causing individual suffering and increased health care utilization. The International Association for the Study of Pain[29] defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage". The diagnosis Somatoform Pain Disorder (SPD) is made when pain has existed for at least six months, if there is strong evidence that psychological factors have caused or are maintaining the pain, and if the pain causes distress that is clinically significant or impairs work, social or personal functioning. The prevalence of chronic pain syndromes in North America's and Europe's general population is estimated to be between 7 and 44%.[30] Not surprisingly, SPD occurs particularly frequently after torture, and prevalence rates of 28-48% are reported.[31] One of the key features of SPD is a communication problem between patient and physician concerning the nature of the disease (organic/somatic vs. mental/psychic). This often results in fruitless and costly diagnostic activities, while at the same time effective treatment approaches, or at least reasonable clinical management strategies, are missed. Patients suffering from multiple somatoform disorders tend to focus on physical symptoms and catastrophising cognitive strategies related to those symptoms.

3.1 Interrelation of traumatic stress and chronic (somatoform) pain

The interrelation between SPD and PTSD [16,32] is well known. In individuals with a primary diagnosis of PTSD, chronic pain was one of the most commonly reported symptoms regardless of the nature of the trauma,[33] with a prevalence of 34-80%.[34] Also in refugees high rates of comorbidity between PTSD and SPD have been found.[35] Torture victims appear to be at particularly high risk for developing both PTSD and SPD, for they are not only se-

verely traumatized in terms of psychological impact, but have usually experienced severe physical damage. High rates of comorbidity between PTSD and SPD have lately been found in Bhutanese refugees (41% of the non-tortured and 62% of the tortured respectively,[35]). In a Swedish study of torture victims, chronic back pain was the most common complaint,[36] and the severity of physical torture correlated with PTSD symptom levels. Physical injury has also been identified as a PTSD risk factor in other trauma populations, such as combat veterans and accident survivors.[37,38]

The co-occurrence of SPD and PTSD suggests that the two disorders may have implications in terms of an individual's experience of both conditions and may interact in such a way as to negatively impact the course and outcome of treatment of either disorder.[39,40] Compared to non-affected individuals, lower pain thresholds have been observed among individuals with PTSD.[41] Theoretically it is assumed, that the experience and perception of pain after a traumatic event involving bodily harm is affected by the mental aspects of trauma, e.g. re-experience of trauma. On one hand, pain acts as a trigger that elicits re-experiencing symptoms; on the other hand, pain can also be precipitated "psychologically" by intrusive memories, thus assuming the role of a "somatic flashback".[42] This hypothesis is supported by the findings of increased PTSD re-experiencing symptoms being related to increased pain[43] and physical symptoms.[44] From a clinical perspective it is obvious that patients with SPD related to traumatic stress experience more intense pain and affective distress, higher levels of life interference and greater disability than SPD patients without trauma. Furthermore, persistent physical impairment may slow down remission of PTSD.[45]

3.2 Therapeutic interventions for posttraumatic chronic pain and PTSD - CBT-Biofeedback

Patients suffering from both PTSD and SPD tend to present a more complicated clinical picture and appear less responsive to treatment.[34] In their review Morley et al.[46] showed that CBT was found to be effective in the treatment of SPD. With co-occurring PTSD and/or transcultural problems, the available data get scarcer. This is comparable to PTSD - generally speaking, exposure based CBT is the method of choice for PTSD and associated problems.[47] In the case of comorbid PTSD and SPD, no clear treatment strategies exist so far. As demonstrated by the research of Richardson et al.[48] with Vietnam veterans, most professionals have difficulties dealing with multiple idiopathic physical symptoms in patients with psychological trauma. This frequently results in responsibility confusion, while mental health providers tend to view the veterans' physical symptoms as physical illness requiring medical therapies, physicians view the syndrome as a psychological illness requiring psychological treatment.

In their review, Otis et al.[34] found that only a few studies investigated treatments designed to address co-occurring SPD and PTSD, and results were inconsistent; the authors report no well-controlled studies investigating the efficacy of individually tailored treatments which might be needed in these cases. In two studies on patients suffering from headache after traumatic brain injury those with PTSD were found to need longer pain-focused treatment compared to those without PTSD.[49,50]

3.3 Utility of Biofeedback (BF) in chronic (somatoform) pain and in traumatized patients

For more than three decades Biofeedback (BF) has been widely utilized in the treatment of both chronic pain and anxiety disor-

ders. It is a technique in which a physiological signal is recorded and fed back to the patient while she/he is instructed to apply a strategy to alter the signal in a predefined direction. The aim of BF is to increase the patient's awareness of a specific physiological function and to improve his/her control over that function. BF is usually applied in combination with relaxation techniques such as Progressive Muscle Relaxation PMR, see[51] for review and CBT techniques.[52] BF showing correlations between psychophysiological processes and cognitive coping strategies functions as a bridge between body focused medical treatment and psychotherapy.[53]

The efficacy of various forms of BF such as EMG-BF, temperature BF, or heart rate BF has been well demonstrated for a variety of chronic pain syndromes such as tension headache, low back pain, or migraine.[51,54, 55] Tsushima and Stoddard[56] found no differences in EMG-BF efficacy between ethnic groups. In anxiety disorders, for example respiratory,[57] heart rate,[58] and EEG [electroencephalogram[59]], have been successfully used as BF modes. However, its suitability for the treatment of the latter, especially PTSD, has been discussed controversially.[60,61] In PTSD patients, two types of studies have been conducted: (1) studies utilizing BF to predominantly treat PTSD symptoms, where BF is regarded as a rather non-specific relaxation technique,[62],[63] and (2) studies addressing chronic pain in patients with comorbid PTSD.[49,50,64] In the first cluster of studies, rather low efficacy has been reported. The studies of the second cluster report poorer treatment efficacies for chronic pain sufferers with comorbid PTSD as compared to pain patients without PTSD.[65] Blanchard and associates[49,50,51] emphasized that PTSD symptoms in chronic pain patients need to be addressed in order to achieve sufficient pain improvement.

3.4 A pilot BF treatment study

The feasibility of a BF-approach was tested in a pilot study in three centers (Berlin Center for Torture Victims; Outpatient Clinic for Victims of Torture and War, University of Zurich; Charité Virchow-Clinic, Department of Anesthesiology and Critical Care Medicine) between December 2005 and February 2006. For the purpose of our study, manualized standard Biofeedback procedures[51,66] were slightly adapted to the needs of our population. The treatment protocol for this study consists of 10 sessions of CBT-BF, including psychoeducation about the interrelation between traumatization, stress and pain, as well as different relaxation strategies. The manual was especially expanded to the specific needs of patients with SPD secondary to traumatization (e.g. inclusion of vicious circle between pain and trauma-related symptoms). The treatment protocol consisted of 10 weekly sessions of 90 minutes within three months. Every session lasted 90 minutes each. In the initial sessions, the predominant physical and psychological problems as well as problems of the patient's current life situation were discussed. Furthermore, psychoeducation was delivered and an individual model of the patient's current complaints and possible ways to recovery was developed. In sessions three through nine, therapist and patient focused on the individual primary pain. Different relaxation strategies were introduced and trained with the help of CBT-BF. In addition, patients received daily homework to exercise progressive muscle relaxation PMR.[67] In session nine, pain-related problems such as dysfunctional cognitions and behavior, or inactivity were modified using standard CBT techniques. In session ten, the learned methods and strategies for coping with chronic pain were reviewed and evaluated regarding their use in future pain situations.

Farewell at termination of treatment was included. In general, the procedure was accepted very well. Some small apparent difficulties (e.g. frequency and duration of sessions) were adapted after the pilot study. Initially, 13 patients were included in the pilot treatment study. Eleven patients completed the protocol, while two patients (15%) dropped out of treatment. Overall, a significant improvement with regard to pain levels and coping behavior was found which was maintained during a 3-month follow-up period. A detailed description of the pilot study is given in Mueller et al.[68]

4. Conclusion

The aim of this paper was to introduce three different approaches on how new communication pathways and technology can be usefully integrated into the psychological care of traumatized refugees. As indicated before, these approaches are by no means panaceas but might provide new ways to overcome some of the challenges faced when working with this specific population.

References

1. World migration report 2005. International Organization for Migration, 2005. www.iom.int.
2. 2004 Global refugee trends: overview of refugee populations, new arrivals, durable solutions, asylum seekers and other persons of concern to UNHCR. UNHCR, 2005. www.unhcr.ch/statistics [cited 04.08.2005].
3. Gavagan T, Brodyaga L. Medical care for immigrants and refugees. Am Fam Physician 1998;57:1061-8.
4. Hollifield M, Warner TD, Lian N, Krakow B, Jenkins JH, Kesler J et al. Measuring trauma and health status in refugees: a critical review. JAMA 2002;288:611-21.
5. Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. Lancet 2005;365:1309-14.
6. Knaevelsrud C, Mueller J. Multilingual computer assisted self-interview (MultiCASI) System for psychiatric diagnostic of migrants. 1.0 ed. Heidelberg: Springer 2007 (in press).
7. Taylor CB, Luce HL. Computer- and internet-based psychotherapy interventions. Current Directions in Psychological Science 2003;12(1):18-22.
8. Turner CF, Ku L, Rogers SM, Lindberg LD, Pleck JH, Sonenstein FL. Adolescent sexual behavior, drug use, and violence: increased reporting with computer survey technology. Science 1998;280:867-73.
9. Ritter P, Lorig K, Laurent D, Matthews K. Internet versus mailed questionnaires: a randomized comparison. J Med Internet Res 2004;6(3):e29.
10. Bracken PJ, Giller JE, Summerfield D. Psychological responses to war and atrocity: the limitations of current concepts. Soc Sci Med (1982) 1995;40:1073-82.
11. Silove D. The psychosocial effects of torture, mass human rights violations, and refugee trauma: toward an integrated conceptual framework. J Nerv Ment Dis 1999;187:200-7.
12. Question of the violation of human rights and fundamental freedoms in any part of the world: report of the special rapporteur, Andreas Mavrommatis, on the situation of human rights in Iraq. UN Commission on Human Rights, 2002.
13. Gallup poll of Baghdad. The Gallup Organization, 2003.
14. Physicians for Human Rights report on Iraq. Physicians for Human Rights, 2003.
15. Kirschner M. Irak: Die Aktuelle Lage. In: Länderanalyse S, ed. SFH Länderanalyse, 2004.
16. Van Ommeren M, de Jong JT, Sharma B,

Komproe I, Thapa SB, Cardena E. Psychiatric disorders among tortured Bhutanese refugees in Nepal. Arch Gen Psychiatry 2001;58:475-82.
17. Neuner F, Schauer M, Karunakara U, Klaschik C, Robert C, Elbert T. Psychological trauma and evidence for enhanced vulnerability for posttraumatic stress disorder through previous trauma among West Nile refugees. BMC psychiatry 2004;4:34.
18. Kubany ES, Haynes SN, Abueg AFR, Brennan MFP. Development and validation of the Trauma-Related Guilt Inventory (TRGI). Psychol Assess 1996;8:428-44.
19. Suler J. Assessing a person's suitability for online therapy: the ISMHO clinical case study group. International Society for Mental Health Online. Cyberpsychol Behav 2001;4:675-9.
20. Hopps SL, Pepin M, Boisvert JM. The effectiveness of cognitive-behavioral group therapy for loneliness via inter relaychat among people with physical disabilities. Theor Res 2003;40:136-147.
21. Walter JB. Computer-mediated communication: Impersonal, interpersonal, and hyperpersonal interaction. Commun Res 1996; 23:3-43.
22. Lange A, van de Ven JP, Schrieken B. Interapy: treatment of post-traumatic stress via the internet. Cogn Behav Ther 2003;32:110-24.
23. Lange A, Rietdijk D, Hudcovicova M, van de Ven JP, Schrieken B, Emmelkamp PM. Interapy: a controlled randomized trial of the standardized treatment of posttraumatic stress through the internet. J Consult Clin Psychol 2003;71:901-9.
24. Lange A, van de Ven JP, Schrieken B, Emmelkamp PM. Interapy, treatment of posttraumatic stress through the Internet: a controlled trial. J Behav Ther Exp Psychiatry 2001;32:73-90.
25. Knaevelsrud C, Maercker A. Does the quality of the working alliance predict treatment outcome in online psychotherapy for traumatized patients? J Med Internet Res 2006;8(4):e31.
26. Wagner B, Knaevelsrud C, Maercker A. Internet-based cognitive-behavioral therapy for complicated grief: a randomized controlled trial. Death Studies 200;30:429-53.
27. Knaevelsrud C, Maercker A. Internet based treatment for PTSD reduces distress and facilitates the development of a strong therapeutic alliance: a randomized controlled trial. BMC Psychiatry (accepted).
28. Allison TR, Symmons DPM, Brammah T, P. H, A. R, Roxby M et al. Musuloskeletal pain is more generalised among people from ethnic minorities than among people in Greater Manchester. Ann Rheum Dis 2002;61:151-6.
29. IASP Task Force on Taxonomy. Classification of chronic pain. Second edition. In: Merskey H, Bogduk N, eds. Seattle: IASP Press, 2004:209-14.
30. Nickel R, Raspe HH. Chronic pain: epidemiology and health care utilization. Nervenarzt 2001;72:897-906.
31. Moisander PA, Edston E. Torture and its sequel – a comparison between victims from six countries. Forensic Sci Int 2003;137:133-40.
32. Asmundson GJ, Wright KD, Stein MB. Pain and PTSD symptoms in female veterans. Eur J Pain 2004;8:345-50.
33. Asmundson GJ, Coons MJ, Taylor S, Katz J. PTSD and the experience of pain: research and clinical implications of shared vulnerability and mutual maintenance models. Can J Psychiatry 2002;47:930-7.
34. Otis JD, Keane TM, Kerns RD. An examination of the relationship between chronic pain and post-traumatic stress disorder. J Rehabil Res Dev 2003;40:397-405.
35. Van Ommeren M, Sharma B, Sharma GK, Komproe I, Cardena E, de Jong JT. The relationship between somatic and PTSD symptoms among Bhutanese refugee torture survivors: examination of comorbidity with anxiety and depression. J Trauma Stress 2002;15:415-21.
36. Edston E. [Bodily evidence can reveal torture. 5-year experience of torture documentation]. Läkartidningen 1999;96:628-31.
37. Koren D, Norman D, Cohen A, Berman J, Klein EM. Increased PTSD risk with combat-related injury: a matched comparison study of injured and uninjured soldiers experiencing the same combat events. Am J Psychiatry 2005;162:276-82.
38. Schnyder U, Mörgeli H, Klaghofer R, Buddeberg C. Incidence and prediction of posttraumatic stress disorder symptoms in severely injured accident victims. Am J Psychiatry 2001;158:594-9.
39. Bryant RA, Marosszeky JE, Crooks J, Baguley IJ, Gurka JA. Interaction of posttraumatic stress disorder and chronic pain following traumatic brain injury. J Head Trauma Rehabil 1999;14:588-94.
40. Sharp TJ, Harvey AG. Chronic pain and posttraumatic stress disorder: mutual maintenance? Clin Psychol Rev 2001;21:857-77.
41. Shalev A, Peri T, Canetti L, Schreiber S. Predictors of PTSD in injured trauma survivors: a prospective study. Am J Psychiatry 1996;153:219-25.
42. Salomons TV, Osterman JE, Gagliese L, Katz J. Pain flashbacks in posttraumatic stress disorder. Clin J Pain 2004;20:83-7.
43. Beckham JC, Crawford AL, Feldman ME, Kirby

AC, Hertzberg MA, Davidson JR, et al. Chronic posttraumatic stress disorder and chronic pain in Vietnam combat veterans. J Psychosom Res 1997;43:379-89.
44. McFarlane AC, Atchison M, Rafalowicz E, Papay P. Physical symptoms in post-traumatic stress disorder. J Psychosom Res 1994;38:715-26.
45. Blanchard EB, Hickling EJ, Vollmer AK, Loos WL, Buckley TC, Jaccard J. Short-term follow up of posttraumatic stress symptoms in motor vehicle accident victims. Behav Res Ther 1995;33:369-77.
46. Morley S, Eccleston C, Williams A. Systematic review and meta-analysis of randomized controlled trials of cognitive behaviour therapy and behaviour therapy for chronic pain in adults, excluding headache. Pain 1999;80(1-2):1-13.
47. Foa EB, Keane TM, Friedman MJ. Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies. New York: Guilford Publications, 2000.
48. Richardson RD, Engel CC, Jr., McFall M, McKnight K, Boehnlein JK, Hunt SC. Clinician attributions for symptoms and treatment of Gulf War-related health concerns. Arch Intern Med 2001;161:1289-94.
49. Tatrow K, Blanchard EB, Silverman DJ. Posttraumatic headache: an exploratory treatment study. Appl Psychophysiol Biofeedback 2003;28:267-78.
50. Hickling EJ, Blanchard EB, Silverman DJ, Schwarz SP. Motor vehicle accidents, headaches and post-traumatic stress disorder: assessment findings in a consecutive series. Headache 1992;32:147-51.
51. Arena JG, Blanchard EB. Biofeedback and relaxation therapy for chronic pain disorders. In: Gatchel RJ, Turk DC, eds. Psychological approaches to pain management: a practitioner's handbook. New York: Guilford Press, 1996:179-230.
52. Schwartz MS. Biofeedback: A practitioner's guide. 2nd ed. New York: Guilford Press, 1995.
53. Rief W, Hiller W, Margraf J. Cognitive aspects of hypochondriasis and the somatization syndrome. J Abnorm Psychol 1998;107:587-95.
54. Sherman RA, Arena JG. Biofeedback in the assessment and treatment of low back pain. In: Bazmajian J, Nyberg R, eds. Spinal manipulative therapies. Baltimore: Williams & Wilkins, 1992:177-97.
55. Flor H, Birbaumer N. Comparison of the efficacy of electromyographic biofeedback, cognitive-behavioral therapy, and conservative medical interventions in the treatment of chronic musculoskeletal pain. J Consult Clin Psychol 1993;61:653-8.
56. Tsushima WT, Stoddard VM. Ethnic group similarities in the biofeedback training of pain. Med Psychother 1990;3:69-75.
57. Clark ME, Hirschman R. Effects of paced respiration on anxiety reduction in a clinical population. Biofeedback Self Regul 1990;15:273-84.
58. Gerlach AL, Mourlane D, Rist F. Public and private heart rate feedback in social phobia: a manipulation of anxiety visibility. Cogn Behav Ther 2004;33(1):36-45.
59. Peniston EG, Kulkosky PJ. Alpha-theta brainwave neuro-feedback for Vietnam veterans with combat-related posttraumatic stress disorder. Medical Psychotherapy 1991;4:47-60.
60. Banner CN, Meadows WM. Examination of the effectiveness of various treatment techniques for reducing tension. Br J Clin Psychol 1983;22 (Pt 3):183-93.
61. Silver SM, Brooks A, Obenchain J. Treatment of Vietnam war veterans with PTSD: a comparison of eye movement desensitization and reprocessing, biofeedback, and relaxation training. J Trauma Stress 1995;8:337-42.
62. Watson CG, Tuorila JR, Vickers KS, Gearhart LP, Mendez CM. The efficacies of three relaxation regimens in the treatment of PTSD in Vietnam War veterans. J Clin Psychol 1997;53:917-23.
63. Carlson JG, Chemtob CM, Rusnak K, Hedlund NL, Muraoka MY. Eye movement desensitization and reprocessing (EDMR) treatment for combat-related posttraumatic stress disorder. J Trauma Stress 1998;11(1):3-24.
64. Medina JL. Efficacy of an individualized outpatient program in the treatment of chronic posttraumatic headache. Headache 1992;92:180-3.
65. Onorato VA, Tsushima WT. EMG, MMPI and treatment outcome in the biofeedback therapy of tension headache and postraumatic pain. American Journal of Clinical Biofeedback 1983;6:71-81.
66. Flor H, Birbaumer N, Schugens MM, Lutzenberger W. Symptom-specific psychophysiological responses in chronic pain patients. Psychophysiology 1992;29:452-60.
67. Jacobson E. Progressive relaxation. Chicago: University of Chicago Press, 1938.
68. Mueller J, Karl A, Denke C, Mathier F, Dittmann J, Rohleder N, et al. Somatoform pain disorder and PTSD in migrants – initial findings on the efficacy and feasibility of CBT-Biofeedback (submitted).

Psychological evaluation of asylum seekers as a therapeutic process*

David Gangsei, Ph.D., Ana C. Deutsch, M.A., M.F.T.*****

Abstract

Torture survivors are often reluctant to tell their stories. They typically make every effort to forget this painful, traumatic experience. Often they do not share with family, friends or healthcare professionals the fact that they have been beaten, raped or subjected to electrical shocks and other terrors. Talking means retrieving memories, triggering the feelings and emotions that accompanied the torture itself. Furthermore, refugee torture survivors feel that people won't understand or believe their experiences. However, survivors who escape their country may need to reveal their torture experience as they apply for asylum in the host country. When they prepare for the asylum process, it may well be the first time that they talk about the torture. Mental health professionals are often called upon to evaluate survivors and prepare affidavits for the asylum process, documenting the effects of torture. This creates a unique and privileged opportunity to help survivors to address the devastating consequences of torture. Winning asylum is essential to recovery for a torture survivor in a country of refuge. Psychological evaluations of the consequences of torture can present information and evidence to asylum adjudicators which significantly increases understanding of the survivors' background and experiences as well as their manner of self-presentation in the courtroom or interview. They can empower the torture survivor to present his/her experiences more fully and confidently. Even apart from winning asylum, the process of the evaluation has many potential benefits for the survivor's emotional well-being. This includes helping the survivor understand the necessity of telling the story, illuminating the often poorly perceived link between current emotional suffering and past torture, facilitating the development of cognitive and emotional control, and healing the wounds of mistrust, humiliation, marginalization and fear.

Key words: torture, asylum, psychological intervention, rehabilitation

Within the overall framework of rehabilitation services for torture survivors, this paper discusses mental health evaluation for survivors applying for asylum in a country of refuge. Specifically, this includes assessment of the ongoing psychological effects of torture and, when appropriate, preparation of written documentation for submission to immigration courts.

The authors work at torture treatment centers in the United States where the majority of clients come initially for services as asylum seekers. Although neither program has in-house legal services, both programs work together with immigration attorneys, taking the role of documenting the physical

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and psychological effects of torture and providing written affidavits to the immigration court. As licensed mental health professionals and clinical directors of their respective programs, both authors have extensive experience conducting psychological evaluations as well as training and consulting with other professionals doing similar work.

It is our experience that this specific task, which has both legal and therapeutic dimensions, provides a unique opportunity to contribute to healing the wounds of torture. If the professional conducting the evaluation approaches this task clearly aware of its potential benefits, s/he has the best chance to make full use of that potential. It is in this context that we therefore, transform and reconceptualize the evaluation as a therapeutic process.

Background

This unique opportunity grows out of a contradiction that is familiar to those who provide psychological treatment to torture survivors.

On the one hand, the literature on the consequences of torture shows that the most long lasting and damaging consequences of torture are often psychological.[1,2] It also shows that untreated trauma may have long-term consequences and the symptoms may intensify later in periods of increased vulnerability, for instance late in life or under stressful life circumstances. Furthermore, we know that dealing with past traumas facilitates the survivor reconnecting with strengths that have been part of his pre-trauma life.[3]

Clinical experience and consultation with colleagues around the world confirm that survivors most often don't want to talk about the torture, even when they are experiencing significant ongoing psychological distress as part of the torture's aftermath. They often decline offers of psychological care, at least partly for this reason.

There are many reasons to explain why torture survivors don't want to talk about what they have been through. One of the most compelling is that the task of torturers is precisely to make their victims talk. Survivors therefore may associate talking with the experience of forced talking under torture.[4] Dictatorships and repressive regimen impose a social silence to strengthen terror; silence is adopted by people as a condition for survival, a pattern of behavior that survivors carry for years after torture.[5]

In addition, survivors frequently bear the burden of guilt and shame, which makes it too painful and humiliating to tell the outside world about the torture. They may be overwhelmed and experience fear, confusion, sadness, loss, worry for the safety of colleagues or loved ones, or fear of being disbelieved or misunderstood. They have often been told that no one will believe them and many have experienced that directly in their lives. If they talk, they may have been told that they or others they love will be killed. They may fear losing control if they allow the flood of terrorizing memories and feelings into full awareness. They may not fully recognize the connection between the extreme traumas they have suffered and the intensely disabling symptoms they are experiencing in the present. It may be culturally unfamiliar or even unacceptable to reveal psychological and emotional distress. In addition, they may believe that they can and must deal with the sorrow and suffering by themselves. Truthfully, of course, many survivors do show an amazing capacity for resilience.

These realities present a complex challenge to those working to help survivors recover and resume a meaningful life. How do we maintain respect and sensitivity for

the survivor's approach to his/her recovery and at the same time create opportunities to come to terms with the unthinkable?

Treatment literature often emphasizes the importance of going at the survivor's pace, creating safety and trust, and not pressuring for direct confrontation with the torture experience.[6] Rehabilitation models typically include a holistic approach with attention to basic survival needs as central.[7,8] Effective care is often future oriented, emphasizing hope and recovery and providing support for rebuilding life and reconnecting with pre-torture strengths.[9]

Within this framework we can understand the therapeutic possibilities of the psychological evaluation for asylum. In pursuing a petition for asylum, an applicant must present the basis for the claim, i.e. the nature of the persecution that s/he has directly and personally experienced. This reality imposes the necessity of speaking directly and in detail about the torture, no matter how painful, frightening and shameful that might be. The asylum case is central not only to the legal status of the applicant, but also to her/his path to recovery from the damage wrought by the torture. Safety is the most fundamental requirement for recovery. Asylum is the foundation of safety [10].

Documentation of psychological evidence in support of the case is often a critical part of a successful application.[10] In our experience, once the survivor understands this, s/he is willing to participate in the evaluation interviews and to describe the torture and its lingering effects. This well-timed occasion gives asylum seekers the opportunity – the forced opportunity in a sense – to come to terms with their traumas.

The more completely the evaluator is aware of the therapeutic issues and opportunities involved in this process, the more likely it is that s/he will be able to shape the process so that the survivor experiences a therapeutic benefit with minimal or manageable retraumatization.

Benefits of the written evaluation

The most fundamental benefit the psychological evaluation can have for the survivor's mental health is to help win the case. This does not mean that the professional takes the role of an advocate, but rather that the objective presentation of professionally documented evidence can be a powerful and persuasive part of the overall picture that the court is assessing. We have seen many times how winning the case – being granted asylum and the freedom to remain in safety – can significantly improve the survivor's mental and emotional condition.[11]

The written evaluation can strengthen the case in specific ways

1. Most obviously, it provides corroboration of the survivor's story. This is not assumed or automatic. The professional evaluator must approach the task with an open mind and arrive at conclusions based on the process of the evaluation, not on prejudgment. The evaluator can provide testimony if s/he feels confident of the survivor's account and can document psychological distress and/or symptoms resulting from the reported torture. If s/he observes and documents evidence of psychological trauma consistent with torture, the expert opinion can lend significant weight to a case where often the only evidence the applicant brings is his/her own word. In the US immigration system, this corroboration can have additional specific importance. The Real ID Act, passed into Federal law in 2005, makes winning asylum cases more difficult. One of its provisions gives immigration judges the option to deny a case if there is no corroborating evidence, even if they find the applicant

credible. The psychological evaluation can serve as such corroborating evidence.

2. The written evaluation can describe the survivor's typical mental processes, cognitive style, emotional demeanor and individual personality, as well as trauma symptoms, thus providing a framework for the court to understand his/her behavior in the courtroom. This can be important in cases where, for example, the person significantly manifests PTSD symptoms of withdrawal, numbing and avoidance. This can appear suspicious to lay persons, including judges and attorneys, who expect all traumas to manifest in flashbacks and arousal. We have numerous such examples in our experience. In one case, a South Asian man had suffered several episodes of detention and torture because of his activism for an opposition political party. His deep political perspective led him to perceive and analyze events, even his own torture, in intellectual and political terms. He discussed his torture in this way even while admitting that he felt "broken". In another case, an indigenous Guatemalan woman exhibited PTSD-induced numbing combined with a personal and cultural style that avoided strong emotional display. She spoke quietly and without emotion even while describing the massacre that killed her family members and led to her own kidnapping and rape. In both of these cases, a mental health professional who had spent hours with the applicant was able to describe the applicant's emotional style, confirm the presence of psychological trauma and explain how his/her presentation was consistent within the range of what would be expected from the reported torture experiences. This expert testimony played a key role in overcoming hostile suspicion on the part of attorneys for the government.

3. The evaluation can address questions about inconsistencies in testimony provided in written and verbal statements. An example is the case of a Muslim woman who omitted telling about a rape in a written application for asylum but revealed this later during a face-to-face interview with an asylum officer. The officer did not grant asylum but referred her case to the immigration court, citing this contradiction. Her attorney referred her to a torture treatment center, where her services included a psychological assessment and preparation of an affidavit. The psychologist was able to assess and document the specific and understandable reasons for the woman's initial omission of the rape from her application – shame, anxiety, grief, desperate hope that it would not be necessary to publicly discuss it, and fear of repercussions from her husband and community. The psychologist was able to affirm that the woman's account of the rape was consistent with her psychological presentation. This testimony contributed to the immigration judge's decision to grant asylum, avoiding finding the woman not credible because of inconsistency. In a similar case, the immigration judge decided to spare the applicant the pain of recounting the details of her rape in front of the court, citing her written declaration and the psychological report as sufficient for the purpose.[12]

4. All these components relate to the issue of credibility. In the task of deciding applications for asylum, the assessment of credibility is a primary obligation of the adjudicator. Under US immigration law, credibility is a legal concept and its assessment is the task of immigration officers and judges. At the same time, all evidence presented, including the psychological affidavit, implicitly if not explicitly addresses this critical issue. The psychological report can address

this issue by commenting on issues such as consistency – consistency in the survivor's report of his/her experience recounted over two or more evaluation sessions, consistency between content and emotion, consistency between the survivor's expressed and described symptoms and the DSM-IV, and consistency between the survivor's demeanor and self-presentation and that of other torture survivors the evaluator has assessed.[12] The evaluator can also offer professional observations on the limits of expecting perfectly identical accounts at different tellings of the torture events.[13] Addressing these issues throughout the written report can significantly contribute to illuminating the central judgment of credibility.

Psychological and therapeutic benefits of the evaluation process

The authors' experience is that apart from the question of winning or losing the case, and even before the final judgment is rendered, the evaluation process itself can have a direct therapeutic effect for the survivor. The following six points are especially important.

1. It is not uncommon that the torture survivor preparing his/her asylum case is talking about the torture for the first time. The survivor may reveal first to an attorney and later to the mental health professional the atrocities s/he has suffered. In some cases, the lawyer finds it impossible to get an accurate account of the torture due to the difficulties the survivor has in remembering, in verbalizing or in providing a sequential and consistent narrative.[14] The mental health professional's specific training will often allow her/him to get more complete information than the lawyer does initially. As this task unfolds, the process of organizing the torture story into a coherent narrative, with attention to its psychological effects, has specific benefits – including recognizing and diminishing guilt, shame and fear. The pioneering work by Chilean psychologists, amplified by others more recently, about testimony as a therapeutic process has highlighted this dynamic.[15,16] Even if not taken to the level of public denunciation, the evaluation for asylum has an intrinsic "testimony" component. The testimony is provided first to the evaluator and then to the court. The responsibility and shame of the torture is located in the torturer, not in the tortured. This dynamic is strengthened when the survivor is given the opportunity to review the written document prior to its submission to the attorney.

2. The most damaging and long lasting effects of torture are psychological. Survivors are often still suffering from symptoms directly resulting from the traumas of torture and its aftermath, but may or may not be aware of the connection between past trauma and current symptoms. Even if they are aware, the natural tendencies to avoid and suppress often prevent them from seeking professional help. The evaluation can open the door to a new perspective. Talking, disclosing events, retrieving painful memories – in summary, verbalizing experiences – sets up a process in which the individual can access the suppressed memories and feelings, gain consciousness of the origin and development of his/her current distress, and put words to previously undefined emotions. Knowledge can lead to cognitive control, which reduces the feeling or fear of being crazy. The process can also help the survivor develop skills in management of emotional arousal associated with memories of the torture.[17] Knowledge can open the door to possible future therapy.

While the psychological processes described here will likely not be consolidated

in this relatively short intervention, it is our experience that, over the course of the evaluation, this understanding generates emotional relief. One Sudanese woman, a community leader tortured for her opposition to forced recruitment of children into the military, realized for the first time during her evaluation for asylum that the nightmares, anxiety and suicidal hopelessness she experienced were direct results of the torture suffered four years earlier. This led to both cognitive and emotional control that she had been lacking. She stopped worrying that she was crazy and decided to accept both psychiatric treatment and counseling.

3. The evaluation can offer the survivor understanding and validation. By listening and being non-judgmental, the evaluator offers openness and acceptance in a context that includes an implicit statement that torture is wrong. This can powerfully combat feelings of guilt and blame instilled by the torturers and even by family and community who imply that somehow the victim is responsible and is to blame for what happened to him/her.

4. The process can empower the survivor to testify in court and to cope with the anxiety and stress of the asylum process. Applicants for asylum typically dread testifying in court. As they contemplate this necessity, they suffer a resurgence of sleeplessness, intrusive recollections of the torture, fear and depression. They fear losing emotional control on the witness stand; yet they know that their future safety depends on their ability to testify. During the evaluation, as the survivor becomes more able to tell his/her story, and gains the confidence that s/he can be believed, s/he gains more confidence to talk and to present him/herself effectively in court.

5. The evaluation process can help the survivor regain functionality by linking him/her to the person who s/he was before the torture. Because the evaluation includes a pre-trauma history, it can become a vehicle for identifying the arc of the person's life story and the recognition that the torture is not the only part of that story. By recounting to the evaluator his/her personal history, the survivor reconnects to positive events and accomplishments that are often present from childhood and pre-torture adult life. One evaluator began working with a Central African man in his 30s whose torture, loss of family and damage to physical function had left him with severely impaired self-esteem. The first two-hour session was devoted entirely to review his pre-torture life, after which he reported feeling more hopeful than he had for a long time. A Middle Eastern woman, a health care professional, reported that prior to her participation in the psychological evaluation, the torture so completely dominated her consciousness that she had literally forgotten that she had a masters degree from a major university. Re-awakening that part of her life experience helped to set her on the path of recovery.

6. The evaluation may also, by chance, create an opening to identify prior traumas unrelated to the torture. One Central American professional woman reporting a rape as part of the torture she had suffered suddenly associated to an episode of childhood sexual abuse, provoking intense emotion. In taking time to help her calm herself, the evaluator was able to acknowledge this injury and, later, to make a referral for therapy that included attention to the childhood trauma.

Technique and attitude in the evaluation

The mental health professional who is aware of the therapeutic potential of the evaluation

process has an opportunity to maximize this potential without abandoning or damaging the neutrality required for an objectively documented report. Some consciously applied techniques can help significantly:

1. The evaluator can consult with the attorney who represents the applicant prior to conducting the evaluation. He/she should clearly understand the issues that the attorney identifies in order to address as completely as possible the specific circumstances of the case. The case of the Muslim woman with conflicting statements about the rape is an example. Without input from the attorney, the evaluator would not know to inquire and to offer a professional opinion about this issue.

2. The evaluator can help the survivor to reduce anxiety about the evaluation itself by providing information about the nature and process of the evaluation. The issue of confidentiality also has special importance. The evaluator should make clear that the information will be shared only with the survivor's attorney, who will submit it to the court.

3. Without turning it into therapy, the evaluator can attend to the emotional process of the evaluation in a supportive manner. Sometimes, the evaluator must intervene to help the survivor manage arousal or symptoms that are emerging during the session. A common example is when a survivor breaks into heavy crying at some point in the narrative and the evaluator allows time for that expression, for a break if needed, and for empathic support. This can help the survivor strengthen both cognitive and emotional control and can provide the evaluator with a reading on how severe the survivor's traumatic condition is and the coping resources that s/he has available. Some survivors, for example, have had to cut short an interview and return a different day when the emotions become very intense. That, in turn, can provide useful information for the Behavioral Observations and Prognosis sections of the written affidavit. The evaluator can also help the survivor cope with the emotional strain of the evaluation by predicting that talking about the torture may likely lead to an upsurge of symptoms, including nightmares, sleep disturbance or depression. This awareness will again increase cognitive control, thereby diminishing the anxiety he might feel about such increased distress.

4. The evaluator should be aware of the many emotions and expectations that the process naturally raises in both parties, from the moment of the first phone contact, and can address these where necessary. These can include, on the survivor's side, investing the evaluator with power over the asylum process that s/he does not have and creating corresponding unrealistic expectations. On the other side, evaluators are impacted by the survivor's story and the survivor's psychological condition. Attention to the dynamic of vicarious traumatization can prevent the evaluator from losing neutrality and becoming either overinvolved or overly detached.[18]

5. Finally, the traumas and emotional wounds of torture occur in an interpersonal context. An attitude of respect can help to heal the wound of humiliation. Taking the survivor's emotional and physical comfort seriously can help to heal the wound of degradation. Information about the process, reliability in appointment times and consistent follow-through can help to heal the wound of mistrust. Also careful attentive listening can demonstrate that fellow human beings do care about the survivor's suffering.[19]

Conclusion and discussion

The authors' experiences as reported here point to some conclusions regarding practice and policy in providing torture treatment services.

1. In this paper, we are addressing the psychological evaluation as a professional role apart from psychotherapy. Professionals taking this role sometimes know that the survivor may not pursue psychotherapy once the evaluation is over and may worry about what will happen. Additionally, psychological evaluators are often acutely aware of the strain that survivors experience when participating in the evaluation interviews and may feel bad about re-traumatizing them. Indeed, it is true that survivors commonly, if not universally, suffer a resurgence of psychological distress in the form of nightmares, sleeplessness, crying, anxiety, etc. during the days and weeks surrounding the evaluation. Nevertheless, most survivors who we have questioned at the end of the evaluation report that they feel emotionally better as a result of the process, even though they would not have chosen to go through it but for the necessity of their asylum case. Having a clear understanding of the benefits that the evaluation process can hold for the survivor's health and well being can help the professional proceed with confidence to encourage the survivor's full participation.

2. A most fundamental question for torture treatment programs in countries of refuge is whether to provide this service at all. Is assistance to asylum seekers a genuine rehabilitation service? The authors' experiences described here suggest that even if a survivor does not continue with treatment after winning asylum, a significant and self-contained intervention has been accomplished in supporting the survivor to function and succeed in the asylum process, in establishing safety, the most fundamental component in the hierarchy of recovery needs, and in directly addressing the torture trauma, albeit briefly, with a competent professional. Further, it seems clear that in the absence of the support provided by psychological evaluations and affidavits, some torture survivors with legitimate claims for asylum will lose cases they could have won, with severe negative consequences for their mental health, if not for their lives. Torture treatment programs in countries of refuge are clearly well positioned to provide these services, provided they have the funding and policy support to do so.

3. It is important to acknowledge that in providing psychological assessment to asylum seekers, the evaluator must consider that some applicants could fabricate or exagerate torture stories in order to gain asylum. This possibility does not imply that the enterprise should be avoided, only that credibility must be assessed carefully and written affidavits provided only when the evaluator is confident of his/her findings.

4. Finally, this important issue warrants more formal investigation. This paper presents a clinical approach which the authors have found successful in facilitating a healing process in conjunction with the psychological evaluation for asylum. This process is most effective if the evaluator is aware of it and consciously takes advantage of the opportunity for healing. Research in this area could compare those who have received an assessment with those receiving the usual rehabilitative services but not this assessment, as well as the effect of granting or rejection of asylum applications on the psychological health of both groups of clients. Furthermore, considering that one

therapeutic mechanism at work in the evaluation process could be that which is effective in exposure therapies, future investigation could include constructing evaluation protocols specifically modeled to test that possibility.

References

1. Randall GR, Lutz EL. Serving survivors of torture. American Association for the Advancement of Science, 1991:29-30.
2. Gerrity E et al. Future directions. In: Gerrity E, Keane TM, Tuma F. The mental health consequences of torture. New York: Kluwer Academic/ Plenum Publishers, 2001:336-7.
3. Herman J. Trauma and recovery. New York: Basic Books, 1992:175-95.
4. Sartre J-P. Introduction. In: Alleg H. The question. New York: George Braziller Inc., 1957:29.
5. Kaiser S. Postmemories of terror, a new generation copes with the legacy of the "dirty war". New York: Palgrave Macmillian, 2005:65-8.
6. Briere J, Scott C. Principles of trauma therapy, a guide to symptoms, evaluation and treatment. Sage Publications, Thousand Oaks, 2006:75-8.
7. Quiroga J, Jaranson J. Politically-motivated torture and its survivors, a desk study review of literature. Torture 2005;15(2-3):39-45.
8. Bojholm S, Vesti P. Multidisciplinary approach in the treatment of torture survivors. In: Basoglu M. Torture and its consequences, current treatment approaches. Cambridge University Press, 1992:299-309.
9. Herman J. Trauma and recovery. New York: Basic Books, 1992:196.
10. Jacobs U, Evans E. B, Patsalides B. Principles of documenting psychological evidence of torture. Part I & II. Torture 2001;11(3):85-9; Torture 2001;11(4):100-2.
11. Davis RM, Davis H. PTSD symptom changes in refugees. Torture 2006;16(1):10-9.
12. Deutsch A. Psychological evidence of torture and the issue of credibility in asylum seekers. Presentation at the XXVIIth International Congress on Law and Mental Health, Amsterdam, the Netherlands, 2002.
13. Herlihy J, Turner S. Should discrepancy accounts given by asylum seekers be taken as proof of deceit? Torture 2006;16(2):81-92.
14. McNally R. Remembering trauma. Cambridge, Massachusetts, and London: The Belknap Press of Harvard University Press, 2003:211-3.
15. Cienfuegos AJ, Monelli C. The testimony of political repression as a therapeutic instrument. Am J Orthopsychiatry 1983;53: 43-50.
16. Van Dijk JA, Schoutrop MJA, Spinhoven P. Testimony therapy: treatment method for traumatized victims of organized violence. Am J Psychotherapy 2003;57:361-73.
17. Viñar M. Social catastrophe and mental space. In: Cancelmo J, Tylim I, Hoffenberg J, Myers H, eds. Terrorism and the psychoanalytic space. New York: Pace University Press, 2003:28-32.
18. Wilson JP. Empathy, trauma transmission, and counter-transference in posttraumatic psychotherapy. In: Wilson JP, Drozdek B. Broken spirits, the treatment of traumatized asylum seekers, refugees, war and torture victims. New York – Hove: Brunner-Routledge, 2004:277-316.
19. Van Der Veer G, Van Waning A. Creating a safe therapeutic sanctuary. In: Wilson JP, Drozdek B. Broken spirits, the treatment of traumatized asylum seekers, refugees, war and torture victims. New York – Hove: Brunner-Routledge, 2004:187-219.

Treatment of torture survivors - influences of the exile situation on the course of the traumatic process and therapeutic possibilities*

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Abstract

Traumatized refugees often suffer from complex posttraumatic disorders with a high tendency of chronicity. This is due to severe and often repeated traumatization in the course of political persecution on one hand and uprooting and ongoing stress caused by leaving their home country and society and living under an adverse situation in exile on the other hand. This article shows how positive and negative factors going along with migration interfere with the course of the traumatic process and the therapeutic possibilities and how the therapeutic process can be adjusted to the situation.

Key words: torture survivors, traumatized refugees, treatment

1. The traumatic process under stress factors in exile

Refugees living in Germany have often suffered from severe and repeated man-made traumatic situations in the course of political persecution, detention and torture. Sometimes the trauma also included the circumstances of their flight. Depending on the country of origin, about 40% of refugees are suffering from PTSD by the time of their arrival in the country of exile.[1] An even higher percentage has gone through potentially traumatizing situations. These individuals are at risk of developing trauma sequelae later on, if preventive measures are not granted in the country of exile.

Having been uprooted and having lost their material and social basis of living, close and beloved persons, social support, their home country and their cultural and political context, refugees are weakened in their capacity to cope with the traumatic impact to which they have been submitted. In addition to severe trauma, refugees pass through a situation of loss and ongoing stress.

Getting to Germany or other European countries means to the survivors that they can finally feel safe from persecution. The anxiety due to external factors ("Realangst") is reduced and the hope for a better future may alleviate depressive moods and pain.

But on the other hand – especially if the

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refugees are not granted asylum right after their first interview with the German immigration authorities (BAMF) – they will soon suffer from an exile situation with a variety of adverse factors such as:

- ongoing uncertainty (insecure residence status: asylum seekers, temporary permission to stay)
- lack of prospects for the future
- inactivity, interdiction to work/study, dependency on social aid
- subjection to degrading and incomprehensible bureaucratic acts
- housing in mass accommodations often far away from cities and exile communities
- restriction to leave their residence areas
- isolation within the German society and difficulties with communication
- sometimes violence with xenophobic context
- lack of access to adequate medical/psychological care[2]

About 90% of the patients treated annually at the Berlin Centre for the Treatment of Torture Victims (bzfo) do not have a secure residence status at the time of intake and sometimes for many years to follow. This means that treatment will be under a situation of ongoing stress and uncertainty. Being forced into a passive role is one of the important factors that hinder refugees in developing coping strategies after a trauma; it weighs heavily on their self esteem and reinforces states of depression.

Migration always means a process of changes and adaption. Sludzki[3] described the process of relocation as one in which the emotional needs of individuals increase markedly, while their support social network is severely disrupted. As a result, relocations are strongly associated with increased psychosomatic and interpersonal distress.

As Hans Keilson[4] found out in his study of holocaust child survivors, the period after the traumatic incidents is crucial for the development of the traumatic process. His concept of sequential traumatization, which distinguishes three consecutive phases of stress, is still fundamental to understanding the traumatic process that is induced by traumatic experiences but influenced by many external and internal factors (Figure 1).

Refugees are very likely to experience an extremely stressful and depressing situation ("ongoing stress") in the important third

1st phase	2nd phase	3rd phase
Repression Discrimination War Anxiety Isolation	Persecution/flight Torture, prison Lifethreat/agony, loss Traumatic events Anxiety	Exile Uprooting (new culture asylum situation) Uncertainty Anxiety Dissociation Chronicity of posttraumatic syndromes

Other influences: personal and social meaning of the trauma, consequences/losses
age, sex, pre-traumatic resources of the personality, active modus, social support

Figure 1. *Sequential traumatization.*[4]

phase of their traumatic process. The ongoing exposure to situations that are adverse to a process of trauma compensation goes along with a high tendency of chronicity of posttraumatic stress disorders. The more severe the traumatization is and the longer the traumatic process under conditions of ongoing stress continues, the higher the tendency to develop complex posttraumatic disorders with persistent or periodic PTSD symptomatology accompanied by increasing comorbidity such as:

- alterations in the regulation of affect and impulses
- disorders of attention and consciousness
- depression
- somatization
- anxiety
- alterations in systems of meaning, enduring personality changes
- changes concerning the interpersonal area
- worsening of pre-existing mental and somatic disorders[5,6]

Laban, Gernaat, Komproe, Schreuders and De Jong[7] recently published a study of the impact of long asylum procedures on the prevalence of psychiatric disorders of asylum seekers. The overall prevalence of psychiatric disorders increased from 42% to 66.2% when the (Iraqi) refugees had lived more than two years as asylum seekers in the Netherlands.

A posttraumatic stress disorder, even if the symptoms are already in remission, can be reactualized (updated) by renewed stress and stimuli which are connected with the trauma. If the victim is confronted with a severe or long lasting stressful situation or a new loss of safety and coping possibilities or with reactualizing stimuli in a situation that is experienced as uncontrollable, there is a risk for a so called retraumatization with acute crisis and eventually persistent exacerbation of the trauma related psychopathology. Unfortunately the life of a refugee bears a relatively high level of risk for retraumatization. We especially see such heavy decompensations when traumatized refugees are threatened with deportation to their countries of origin.

2. Adapted forms of treatment

2.1 Basic measures and necessary elements of health care

If we want to support torture survivors to overcome the traumatic impact that has shattered their lives, we have to try to minimize the risk factors for the worsening of the traumatic process on one hand and to increase protective factors on the other hand.

The initial treatment of torture survivors in exile is focused on secondary prevention in order to increase health promoting factors. What helps to overcome the traumatic impact and find a way into a worthwhile life after trauma and uprooting are basic measures in areas such as:

- security
- housing
- access to legal advice
- access to health care (with interpreters!)
- access to social support
- supporting autonomy wherever possible
- adequate physical conditions
- language skills, access to education
- occupation, access to work if there is ability
- respect, acknowledgement
- social contact, integrative activities
- developing future prospects (the survivors and their families)

Health care and the access to psychological care are important, but they are not the

only concern in the process of rehabilitation of torture survivors. There are many other factors playing an important role in the outcome of treatment for the traumatized refugees – some of them we can influence, others not.

Following the EU Council Directive laying down minimum standards for the reception of asylum seekers,[8] adequate material conditions and the "necessary treatment of damages" should be granted to persons who have been subjected to torture, rape or other serious acts of violence. Taking into account the experience of the treatment centers for torture survivors and refugees, the access to, and the realization of, a "necessary treatment of damages" consists of various steps (figure 2).

Upon arrival in the exile country all refugees need basic medical care and access to psychological diagnostics if it is wanted and necessary. Traumatized refugees need appropriate living conditions and psychosocial support and the possibility to take part in so-called low threshold offers. Some of the refugees need psychotherapy over a long period of time or at various times of the process after the traumatizing experiences.

2.2 What is offered by the Berlin Center for the Treatment of Torture Survivors

At the Berlin Centre for the Treatment of Torture Victims (bzfo) and the connected Center for Migrants and Refugees we offer: Diagnostics and medical reports, psychological and social counseling, language and professional training courses to support the process of integration in the country of exile, medical and psychiatric treatment, physiotherapy and psychotherapy. At the bzfo approximately 400 to 500 patients are treated annually.

Like other trauma centers, the bzfo works in an interdisciplinary, multi-professional and integrative manner, using elements of different forms of trauma oriented therapy. We have colleagues working psychodynamically and others who have a cognitive behavioral background and offer

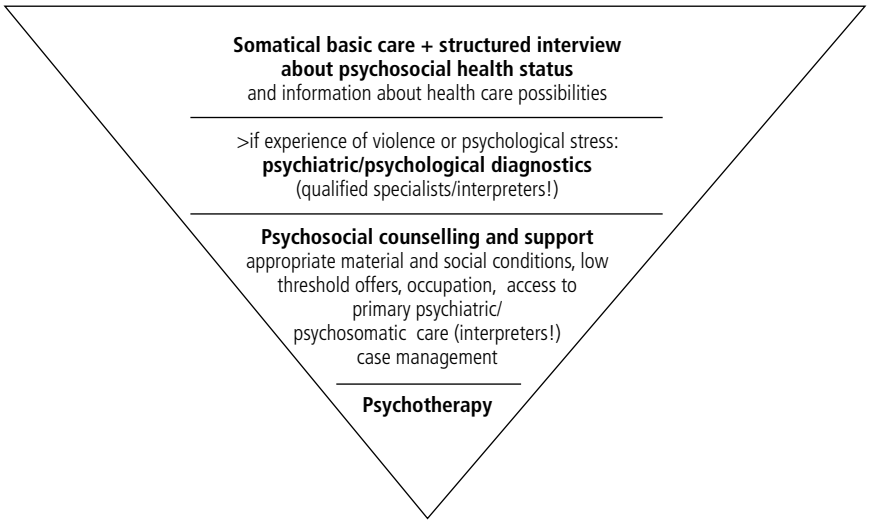

Figure 2. *Elements of necessary health care.*[2]

modules like psychoeducative groups with information and control focused elements or biofeedback programmes. There is a service for children and youth with specialized colleagues who work with a systemic approach with unaccompanied minors and families. Physiotherapy, body oriented psychotherapy, art therapy and music therapy and resource work in our "Intercultural Healing Garden" are offered as additional therapeutic approaches. We have an outpatient setting and also offer a day clinic program for survivors who are psychologically very unstable and who had frequently been admitted to psychiatric wards. Medical and psychiatric treatment is embedded in social therapeutic and psychotherapeutic processes. Interactions between psychic suffering and physical complaints and impairments require an integrative method, both in the diagnostic area and in the therapeutic area. The integration of the different views and approaches is possible through regular staff meetings and supervision where we evaluate cases, indications, the therapeutic relation, the long term course of treatment and necessary steps in the social area. A scientific service offers standardized diagnostics and evaluation. We work in close exchange with centers abroad (in Iraq, Ukraine, Uganda, Ethiopia and Kenya) especially on the topic of cross cultural diagnostics and treatment. Since in Germany there are not enough treatment opportunities specialized in diagnostics and treatment for traumatized refugees with a cross cultural approach, the bzfo also offers courses, counseling and supervision for colleagues that work in the public health sector.

2.3 Special aspects in the course of treatment

Due to the persistently stressful psychosocial situation of traumatized refugees, clinical social work often represents a main focus in the first phase of therapy. Giving social support should strengthen the autonomy of the clients, thus avoiding the trap of creating new dependencies. But, as always in trauma therapy, it has to be "safety first". Due to the restrictive asylum politics of Germany (and other European countries) about 90% of the patients do not have a secure residence status at the time of intake. That is why we have to provide medical/psychological reports for the asylum process of the torture survivors and traumatized war victims that we take in for treatment. We are also asked by courts to give expert opinions for refugees that are not in treatment at our center. For the medical report it is necessary to go through an initial narrative of the incidences of persecution and trauma. This means a difficult task for the refugees and a high responsibility for the therapists. It requires profound clinical experience with trauma in order to avoid destabilization or even retraumatization. On the other hand patients often feel relieved after overcoming their avoidance behaviour. They note that they start to control their PTSD symptoms and get encouraged to continue the treatment.

The form of treatment varies depending on the individual indication and the wishes of the patients. It can be merely supportive with medical psychosomatic or psychiatric treatment and stabilizing and social-therapeutic elements. In those cases, after an initial intensive phase of building trust and getting to know the patient and his/her former and current worlds, the frequency of sessions may be low, e.g. every two weeks or once a month, often accompanied by other measures such as physiotherapy or group activities. In most cases though, treatment consists of an intensive process of psychotherapy with individual sessions and sometimes group therapy. As we see a lot of traumatized families we offer family interventions, if necessary. The average time of the phase of in-

tensive therapy with at least weekly sessions is about two years.

Of central importance for the course of treatment are:

- a trusting and stable relationship between therapist and patient[9]
- sensitivity and openness for cross cultural encounters
- working with specially trained interpreters

The psychotherapeutic work may remain stabilizing and resource oriented or offer the opportunity to work more deeply in trauma focusing after a "good enough" stabilization of the patient. The course of psychotherapy has to be adjusted to the individual psychosocial and psychodynamic process. A schematic approach has turned out to be of limited practicability.[10] However, a "phase model", that shows the elements of treatment, is helpful (figure 3).

Following man made trauma and disruption of social connections patients prefer individual therapeutic settings because of the mistrust and shame induced by the traumatic experiences. However, additional psychoeducational[13] and resource work[14] can be done in a group setting, e.g. with art or music therapy or Concentrative Movement Therapy. Patients will meet others and learn that they are not the only ones who react this way after abnormal situations. Resource work can be fruitful because it facilitates vivid input of good memories and cultural richness. The resource orientated treatment, including the reconstruction of the biography and the strengthening of good inner objects,[15] often leads to a stabilization and reduces the posttraumatic symptomatology so that life can be confronted in a more positive and active way. Ongoing avoidance behaviour and dissociations often go together with persisting nightmares and pain.

Furthermore, to reduce the trauma related symptomatology it is important to look for symptom stabilizing psychodynamic aspects and cognitions like guilt or shame and to work on them. In order to reduce dissociations and the impact of the traumatic experience, trauma focusing and trauma related work is offered. Trauma focusing therapy, especially after such shameful events as sexual torture, normally has to take place in an individual setting. Due to the necessity for elaborate expert opinions for the asylum process (see above) in our institution, the first disclosure of the traumatic experiences usually takes place in an early stage of treatment. In most cases this will be during the first translation of the traumatic memories into a narrative. After this important and very *relieving* step of verbal, or at least symbolic communication, of traumatic experiences the further *processing of the trauma*, in most cases, ensues in a gradual process. For example, on the basis of the patient's stressful dreams or thoughts, a repeated focusing

1. Orientation	2. Stabilization	3. Focus on past	4. Focus on future	5. Farewell
Security Trust building Diagnostics Support Goal setting	Information Control Resources Medication Mourning (Individual therapy)	Reconstruction Trauma focused Transformation	Perspectives Relationships Social contact Crisis intervention (possibly group therapy)	Integration Employment Aftercare – social

Figure 3. *Elements of a trauma oriented treatment.*[11,12]

on traumatic experiences and the associated complexes from different perspectives takes place. If the patient feels up to the task at that particular point in time in her/his particular life situation to confront the traumatic experiences, then it can be possible to dissolve dissociations gradually and to assemble scattered fragments to integrate them into the patient's biographical context. Sometimes, though, it is not possible to work more intensively on trauma focusing because the patients are too unstable or decide that they want to stay in their avoidance behavior – which we have to respect. Trauma focusing work can only take place when there is sufficient outer and inner stability. The patient should have made a conscious decision after having being informed of the therapeutic steps.

In the later phase of therapy central points are questions of self-confidence, interpersonal relationships and prospects for the future and integration in the country of exile. A group setting can be very enriching in this later phase of therapy. The farewell has to be prepared as a gradual process.

Psychotherapy does not undo the trauma. Especially in those cases where people are already suffering from chronic trauma sequelae, one should not expect a full recovery. However, an important improvement in symptomatology, stabilization, development of coping strategies and the opening of new scopes of action (e.g. the ability to work and to have social contacts) usually is possible.

We offer aftercare for the patients. They can participate in self help groups that meet regularly or other activities offered by the bzfo. In crisis situations patients might come back for individual sessions.

3. Conclusion

Due to contextual factors and ongoing stress, a schematic approach has turned out to be of limited practicability in the treatment of traumatized refugees even though trauma oriented modules are useful parts in the therapeutic work. The therapeutic process has to be individually adjusted to the living conditions of the victims as well as to their personal way of dealing and coping with the trauma.

Of central importance is a trusting and stable relationship between the therapist and patient and flexibility, sensitivity and openness to the cross cultural encounter as well as working with specially trained interpreters.

References

1. Gäbel U, Ruf M, Schauer M, Odenwald M, Neuner F. Prävalenz der Posttraumatischen Belastungsstörung (PTSD) und Möglichkeiten der Ermittlung in der Asylverfahrenspraxis. Zeitschrift für klinische Psychologie und Psychotherapie 2006;35:12-20.
2. Wenk-Ansohn M, Gutteta T. Therapeutische Arbeit mit Folterüberlebenden: Möglichkeiten und Hindernisse: Soziale Psychiatrie 2005;110:35-40.
3. Sludzki CE. Migration and family conflict. Family Process 1979;18:379-90.
4. Keilson H. Sequentielle Traumatisierung bei Kindern. Stuttgart: Enke, 1979:58-60.
5. Hermann J. Complex PTSD: a syndrome in survivors of prolonged and repeated trauma. J Trauma Stress 1992;5:377-91.
6. Maercker A. Besonderheiten bei der Behandlung der posttraumatischen Belastungsstörungen. In: Maercker A, ed. Therapie der posttraumatischen Belastungsstörungen. Berlin: Springer, 2003:37-51.
7. Laban C, Gernaat H, Komproe I, Schreuders B, De Jong J. Impact of long asylum procedures of the prevalence of psychiatric disorders in Iraqi asylum seekers in the Netherlands. Journal of Mental Disease 2004;192:843-51.
8. Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers. Official Journal of the European Union, 6.2.2003.

9. Wenk-Ansohn M. Folgen sexualisierter Folter – therapeutische Arbeit mit Kurdischen Patientinnen. In: Birck A, Pross C, Lansen J, eds. Das Unsagbare. Berlin: Springer, 2002:57-70.
10. Gurris NF, Wenk-Ansohn M. Folteropfer und Opfer politischer Gewalt. In: Maercker A, ed. Therapie der posttraumatischen Belastungsstörungen. Berlin: Springer, 2003:221-46.
11. Meichenbaum D, A clinical handbook – practical therapist manual for assessing and treating adults with post-traumatic stress disorder (PTSD). Waterloo, Ont.: Institute Pr., 1994:331-6.
12. Biemans H. The process of employment rehabilitation of torture survivors. Curare 2001;16:245-51.
13. Knaevelsrud C, Liedl A. Psychoedukative Gruppen als psychosoziale Intervention für traumatisierte Flüchtlingen – ein Überblick. Verhaltenstherapie und psychosoziale Praxis 2007;39:75-85.
14. Reddemann L, Sachsse U. Stabilisierung. PTT – Persönlichkeitsstörungen 1997;3:113-47.
15. Haenel F. Zur Bedeutung der Psychiatrie in der Therapie von Folterüberlebenden oder: braucht eine Behandlungseinrichtung für Folteropfer einen Psychiater? In: Birck A, Pross C, Lansen J, eds. Das Unsagbare. Berlin: Springer, 2002:173-86.

The right to reparations for acts of torture: what right, what remedies?*

Dinah Shelton**

1. Introduction

In all legal systems, one who wrongfully injures another is held responsible for redressing the injury caused. Holding the wrongdoer accountable to the victim serves a moral need because, on a practical level, collective insurance might just as easily provide adequate compensation for losses and for future economic needs. Remedies are thus not only about making the victim whole; they express opprobrium to the wrongdoer from the perspective of society as a whole. This is incorporated in prosecution and punishment when the injury stems from a criminal offense, but moral outrage also may be expressed in the form of fines or exemplary or punitive damages awarded the injured party. Such sanctions express the social conviction that disrespect for the rights of others impairs the wrongdoer's status as a moral claimant. Remedies and sanctions thus affirm, reinforce, and reify the fundamental values of society.

International law has long insisted that a state act or omission in violation of an international obligation must cease and the wrong-doing state must repair the harm caused by the illegal act. In the 1927 *Chorzow Factory* case, the PCIJ declared during the jurisdictional phase of the case that "reparation … is the indispensable complement of a failure to apply a convention and there is no necessity for this to be stated in the convention itself."[1] Thus, when rights are created by international law and a correlative duty imposed on states to respect those rights, it is not necessary to specify the obligation to afford remedies for breach of the obligation, because the duty to repair emerges automatically by operation of law; indeed, the PCIJ has called the obligation of reparation part of the general conception of law itself.[2]

In a later phase of the same case, the Court specified the nature of reparations,

*) Unabridged keynote lecture

**) The George Washington University Law School, Washington D. C.

1) Chorzów Factory (Ger. v. Pol), Jurisdiction, 1927 PCIJ, ser. A, No. 9, para. 184 (Apr. 11).

2) Chorzów Factory (Ger. v. Pol.), Merits, 1928 PCIJ (ser. A) No. 17 (Sept. 13), at 29 ("[I]t is a principle of international law, and even a general conception of law, that any breach of an engagement involves an obligation to make reparation."). According to Fitzmaurice, "[T]he notion of international responsibility would be devoid of content if it did not involve a liability to 'make reparation in an adequate form'." Gerald Fitzmaurice, The Law and Procedure of the International Court of Justice[6] (1986).

holding that "it is a principle of international law that the breach of an engagement involves an obligation to make reparation in an adequate form."[3] According to the Court:

The essential principle contained in the actual notion of an illegal act ... is that reparation must, so far as possible, wipe-out all the consequences of the illegal act and reestablish the situation which would, in all probability, have existed if that act had not been committed. Restitution in kind, or, if this is not possible, payment of a sum corresponding to the value which a restitution in kind would bear; the award, if need be, of damages for loss sustained which would not be covered by restitution in kind or payment in place of it – such are the principles which should serve to determine the amount of compensation due for an act contrary to international law.[4]

These interrelated principles – that an international delict generates an obligation of reparation, and that reparation must insofar as possible eradicate the consequences of the illegal act – are the foundation of the international law on remedies. The 2001 International Law Commission's Draft Articles on State Responsibility[5] reaffirmed them, but they also innovated in significant ways to reinforce broader community interests in upholding the international rule of law. The ILC innovations reflect the fact that reparations not only help address the needs of the injured party, they avoid a climate of impunity and preserve principles of legality. In this respect, reparations for human rights violations not only may provide a remedy for past abuse, but may help persuade those in power to comply with human rights norms in the future and thus reduce the incidence of violations.

The ILC Draft Articles largely conceive of reparations as a set of duties imposed on a wrong-doing state in the framework of the traditional inter-state law of state responsibility. This presentation considers the extent to which the inter-state obligations set forth have been transformed into an international right of reparations for individuals who have been tortured or suffered other abuse at the hands of state agents. It also looks at the nature of the procedural and substantive remedies that form part of modern human rights law. It concludes that the right to

3) Chorzow Factory, Jurisdiction, supra n. 1 at 21, reaffirmed in the Reparation for Injuries Suffered in the Service of the United Nations (Advisory Opinion, 1949 ICJ Rep., para. 184. The ICJ has indicated that the basic principle of reparation articulated in the Chorzow Factory case applies to reparation for injury to individuals, even when a specific jurisdictional provision on reparation is contained in the statute of a tribunal. Application for Review of Judgment No. 158 of the UNAT, Advisory Opinion, 1973 ICJ Rep. 197-198 (July 12), citing Case Concerning the Factory at Chorzow (Merits)(Ger. v. Poland), 1928 PCIJ, ser. A, No. 17 (Sept. 13).

4) Factory at Chorzów, Merits, supra n. 2 at 47.

5) Draft Articles on Responsibility of States for Internationally Wrongful Acts, pt. 2, Arts. 28-41, in Report of the International Law Commission on the Work of Its Fifty-third Session, UN GAOR, 56th Sess., Supp. No. 10, at 43, UN Doc. A/56/10 (2001), available at <www.org.un/law/ilc>, reprinted in James Crawford, The International Law Commission's Articles on State Responsibility: Introduction, Text and Commentaries (2002).

6) Article 3 of the Hague Convention Regarding the Laws and Customs of Land Warfare obliges contracting parties to indemnify for a violation of the regulations. Similarly, Protocol I to the Geneva Conventions of 12 August 1949 and Relating to the Protection of Victims of International Armed Conflicts states that any party to a conflict who violates the provisions of the Geneva Conventions or the Protocol "shall ... be liable to pay compensation."

reparations is a part of international human rights law, contained in global and regional human rights treaties and other normative instruments, including those concerned with international humanitarian law[6] and international criminal law.[7] The growing consensus on reparations has had a clear impact in national and international venues. The demands of justice that underlay these developments will continue to be pressed in these venues as states grapple with the aftermath of serious abuses.

2. Treaty obligations

The protection of human rights is generally recognized to be a fundamental aim of modern international law. In recent decades, almost every international organization, regional and global, has adopted human rights norms and responded to human rights violations by opening avenues of redress for individuals against oppressive action by member states. The proscription of torture is among the non-derogable, most fundamental norms of international human rights law, recognized as a breach of customary international law by domestic courts[8] and as a jus cogens norm by international tribunals.[9] The right to be free from torture can never be suspended or overridden, whether by claims of national security or other purported justification.

The remedial task is to convert this law into results by providing redress and deterrence. The element of enforceability in fact is often included in the definition of legal rights,[10] because a right entails a correlative duty to act or refrain from acting for the benefit of another person.[11] Unless this duty is somehow enforced or enforceable, it may be seen as only a voluntary obligation that can be fulfilled or ignored at will. The aim of remedies, to vindicate interests that have been injured, thus requires that human rights law, representing fundamental interests, develop not only a primary theory of what duties are owed, but a secondary theory of what duties exist when a primary duty is violated.

In practice, the survivor of abuse typically seeks to have government conduct declared wrongful and to have a remedy imposed against the individual and the state responsible for the wrong. Remedies may range from relatively nonintrusive remedies, such as declaratory judgments and monetary damages, to injunctions, prohibitions and affirmative orders. A declaratory judgment merely pronounces a particular practice or condition to be illegal, leaving officials free to choose if and how to remedy the situation. A damage award attempts to assess the harm that the misconduct has caused,

7) Statute of the Permanent International Criminal Court, Art. 75.

8) See, e.g., *Filartiga v. Pena-Irala*, 630 F.2d 876 (2d Cir. 1980); *Hanoch v. Tel-Oren*, 726 F.2d at 781 (Edwards, J., concurring) (torture is violation of customary international law); *Tel-Oren*, 726 F.2d at 819–20 (Bork, J., concurring) ('the proscription of official torture [is] a principle that is embodied in numerous international conventions and declarations, that is "clear and unambiguous" . . . and about which there is universal agreement "in the modern usage and practice of nations" '); *Forti v. Suarez Mason*, 672 F. Supp. 1531 at 1541 (prohibition against official torture is 'universal, obligatory, and definable').

9) See, e.g., ICTY, *Furundzija Case*, Judgment of Dec. 10, 1998, IT-95-17/1; Eur.Ct.H.R., *Al-Adsani v. U.K.*, 21 November 2001, 34 Eur. Hum. Rts. Rep. 11 (2002).

10) See M. Ginsberg, *On Justice in Society* (1965), 74; I. Jenkins, *Social Order and the Limits of Law* (1980), 247.

11) W. Hohfeld, *Fundamental Legal Conceptions* (W. Cook (ed.), 1919), 38.

however difficult that may be, and impose the cost upon the wrongdoer. While there is always a danger of commodification, money is a substitute for restitution, because what has been taken cannot be restored in fact. In general, then, tribunals seek to create a hypothetical by aiming to produce the situation that would have existed if the wrongdoer had not violated the rights of the victim. This remedial role of tribunals is expressly mandated by international human rights law.

a. Global treaties

Global human rights instruments expressly guarantee the right to a remedy and oblige states parties to provide a remedy when human rights are violated. In addition, the UN General Assembly has adopted two declarations on the subject, giving greater detail and precision to the obligations of states. International human rights tribunals reviewing complaints of human rights violations have assessed state compliance with the obligation, in the process condemning state laws and policies that grant impunity to violators.

The texts of the treaties are clear on the duty of states parties to provide reparations for violations of rights guaranteed by national and international law. The International Covenant on Civil and Political Rights, which contains an absolute prohibition of torture, contains three separate articles on remedies, addressing the right of access to an authority competent to afford remedies and the right to an effective and enforceable remedy in Art. 2(3). Arts. 9(5) and 14(6) add that anyone unlawfully arrested, detained, or convicted shall have an enforceable right to compensation or be compensated according to law. The United Nations Convention against Torture, Article 14, is also forthright on the topic. Its mandate reads:

Each State Party shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible. In the event of the death of the victim as a result of an act of torture, his dependants shall be entitled to compensation.[12]

Applying these and similar provisions, nearly all UN treaty bodies have discussed reparations and identified the kinds of remedies required, depending on the type of violation and the victim's condition. There are many common aspects to the approach to reparations by UN treaty bodies. All of them strongly affirm the right of access to justice before an independent and impartial tribunal. They also adhere to the view that substantive reparations are a right of victims. The term "victims" has been given broad reading to include not only the person abused, but the family members of the person as well. A few of the more significant decisions are described in this section.

The Human Rights Committee adopted a General Comment entitled "The Nature of the General Legal Obligation Imposed on States Parties to the Covenant," concerning Article 2.[13] As the overarching framework of state obligations in the Covenant, Article 2 imposes both positive and negative obligations on the States Parties, including an obligation to provide redress for violations committed by private parties as well as state agents. On the procedural side, the

12) Convention against Torture and Other Cruel, Inhuman or Degrading Treatment, Article 14.

13) CCPR/C/74/CRP.4/Rev.3, *The Nature of the General Legal Obligation Imposed on States Parties to the Covenant*, May 5, 2003.

Comment notes the importance attached "to States Parties" establishing appropriate judicial and administrative mechanisms for addressing claims of rights violations under domestic law."[14] Administrative mechanisms are required to give effect to the general obligation to investigate allegations of violations promptly, thoroughly and effectively through independent and impartial bodies. "A failure by a State Party to investigate allegations of violations could in and of itself give rise to a separate breach of the Covenant."[15] In addition, cessation of an ongoing violation is an essential element of the right to an effective remedy.

Concerning substantive redress, the Comment affirmed that Article 2(3) requires states parties to make reparation to individuals whose rights have been violated. Otherwise, the obligation to provide an effective remedy is not discharged. Detailing this duty, the Comment suggests that the Covenant generally entails compensation, but, where appropriate, reparation can also involve restitution, rehabilitation and measures of satisfaction, such as public apologies, public memorials, guarantees of non-repetition, and changes in relevant laws and practices, as well as bringing to justice the perpetrators of human rights violations.

The duty to prosecute applies to violations of the Covenant that amount to criminal acts under either domestic or international law, which is the case with acts of torture. Commission of such acts can constitute a crime against humanity when committed as part of a widespread or systematic attack on a civilian population. In the Comment, the Committee also noted the possible need for provisional or interim measures to avoid continuing violations and repair harm at the earliest possible opportunity.

b. Regional instruments

Regional human rights treaties are equally concerned with ensuring that those whose rights are violated have access to justice and reparations. The European Convention for the Protection of Human Rights and Fundamental Freedoms[16] guarantees freedom from torture and in Articles 6 and 13 recognizes rights of access to justice and an effective remedy when rights are violated. The Council of Europe's Committee of Ministers reinforced Article 13 with a recommendation adopted in 1984 that calls on all Council of Europe member states to provide remedies for governmental wrongs.[17] European Convention Article 5(5) further requires that states compensate for arrests made in violation of Article 5.[18] Two texts of the European Union also address access to justice and compensation for victims of crimes.[19]

In the Inter-American system, Article XVII of the American Declaration of the Rights and Duties of Man,[20] guarantees every person the right to resort to the courts to ensure respect for legal rights and to obtain protection from acts of authority

14) Id, para 15. An earlier draft said that the Committee attaches "great" importance to the topic.

15) Id, para 14.

16) European Convention for the Protection of Human Rights and Fundamental Freedoms, 4 November 1950, 213 U.N.T.S. 221 (hereinafter European Convention on Human Rights).

17) Recommendation No. R(84) 15 on Public Liability, adopted by the Committee of Ministers on 18 September 1984.

18) *Brogan v. United Kingdom* (1988) 145B Eur. Ct.H.R. (ser.A) and *Fox, Campbell and Hartley v. United Kingdom* (1990) 182 Eur.Ct.H.R. (ser. A).

that violate any fundamental constitutional rights. The American Convention on Human Rights goes further, entitling everyone to effective recourse for protection against acts that violate the fundamental rights recognized by the constitution "or laws of the state or by the Convention", even where the act is committed by persons acting in the course of their official duties.[21] The states parties are to ensure that the competent authorities enforce the remedies granted and, indeed, are obliged to respect and ensure the free and full exercise of all rights guaranteed by the Convention (Article 1(1)). These obligations are linked to the fair trial provisions of Article 8, which requires the state to provide a fair hearing before a competent, independent and impartial tribunal. Article 10 of the Convention further provides that every person has the right to be compensated in accordance with the law in the event he has been sentenced by a final judgment through a miscarriage of justice.

The Inter-American Court has stated that under the Convention, States Parties have an obligation to provide effective judicial remedies to victims of human rights violations (Art. 25), remedies that must be substantiated in accordance with the rules of due process of law (Art. 8(1)), all in keeping with the general obligation of such States to guarantee the free and full exercise of the rights recognized by the Convention to all persons subject to their jurisdiction (Art. 1).[22] The Court has also concluded that the obligation of Convention parties to ensure rights generally requires that remedies include due diligence on the part of the state to prevent, investigate, and punish any violation of the rights recognized by the Convention.[23]

The African Charter on Human and Peoples' Rights[24] has several provisions on remedies. Article 7 guarantees every individual the right to have his cause heard, including "the right to an appeal to competent national organs against acts violating his fundamental rights as recognized and guaranteed by conventions, laws, regulations and customs in force." In addition, Article 21 refers to "the right to adequate compensation" in regard to "the spoliation of resources of a dispossessed people." Article 26 imposes a duty on States Parties to the Charter to guarantee the independence of the courts and allow the establishment and improvement of appropriate national institutions entrusted with the promotion and protection of rights and freedoms guaranteed by the Charter. The African Commission

19) See Council Framework Decision of 15 March 2001 on the standing of victims in criminal proceedings (2001/220/JHA, OJ L 82 of 2 March 2001 and Council Directive 2004/80/EC of 29 April 2004 relating to compensation to crime victims, OJ L 261/15 of 6 August 2004.

20) Adopted 2 May 1948, O.A.S. Res. XXX, adopted by the Ninth International Conference of American States (1948).

21) Article 25, American Convention on Human Rights, adopted 22 November 1969, in force 18 July 1978, OEA/ser.L/V/II.23, doc. 21 rev. 6 (1979), O.A.S.T.S. No. 36 at 1.

22) *Velasquez Rodriguez Case* (Preliminary Exceptions), (1987) 1 Inter-Am.Ct.H.R.(ser. C) para. 91; *Case of Las Palmeras*, (2001), 90 Inter-Am.Ct. H.R. (ser.C), para. 60; *Case of 19 Merchants*, (2004) 109 Inter-Am.Ct.H.R. (ser.C), para. 194; *Serrano-Cruz Sisters*, (2005) 120 Inter-Am.Ct. H.R. (ser.C), para. 194; *Moiwana Village v. Suriname*, (2005), 124 Inter-Am.Ct.H.R. (ser.C), para 142.

23) *Velasquez Rodriguez Case* (Merits), (1988) 4 Inter-Am. Ct.H.R. (ser .C), para. 166.

24) 27 June 1981, in force 21 October 1986, O.A.U. Doc. CAB/LEG/67/3 Rev. 5, (1982) 21 I.L.M. 58.

emphasizes the need for independence of the judiciary and the guarantees of a fair trial, calling attacks on the judiciary "especially invidious, because while it is a violation of human rights in itself, it permits other violations of rights to go unredressed."[25]

3. "Soft law" instruments

Declarations, resolutions and other non-treaty texts adopted by UN human rights Charter-based and treaty bodies also guarantee the right to a remedy. The UN efforts have been undertaken in the context of studies on impunity, disappearances, victims of crime, and historical injustices. Several of these are considered here.

The United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power[26] contains broad remedial guarantees for those who suffer pecuniary losses, physical or mental harm, and "substantial impairment of their fundamental rights" through acts or omissions, including abuse of power. Victims are entitled to redress and to be informed of their right to seek redress. Victims of public officials or other agents acting in an official or quasi-official capacity in violation of national criminal laws should receive restitution from the responsible state. Abuse of power that is not criminal under national law but that violates internationally recognized norms relating to human rights should be sanctioned and remedies provided, including restitution and/or compensation, and all necessary material, medical, psychological, and social assistance and support.

Special rapporteurs appointed by the Commission to study particular rights or duties have noted or emphasized the right to reparations. The mandate of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment has focused primarily on the prevention of torture, but has recently discussed remedies for victims.[27] The Rapporteur receives information, most often provided by non-governmental organizations, on specific cases of alleged torture and brings this information to the attention of the government concerned, which is asked for comments. The Rapporteur "requests the Government to look into the matter and to see to it that, if the outcome of the inquiry confirms the allegation is true, the perpetrators will be punished and the victims will be compen-

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25) Af. Comm'n Hum. Rts, Comm. 129/94, *Civil Liberties Org'n v. Nigeria*, AGH/207 (XXXII) Annex VIII 17, at 19.

26) U.N.G.A. Res. 40/34 of 29 November 1985. Paragraph 4 states that victims are entitled to access to the mechanisms of justice and prompt redress for the harm they have suffered. Procedures are to be expeditious, fair, inexpensive and accessible. Where appropriate, restitution should be made to victims, their families or dependants by offenders or third parties responsible for their behavior. (Para. 8) Victims of abuse of power are defined as those harmed by acts which do not yet constitute violations of national criminal laws. In 1990, the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders (Havana, Cuba, 27 August - 7 September 1990), recommended that states base national legislation upon the Declaration and requested the UN Secretary-General to study the feasibility of establishing an international fund for victims of transnational crimes. Report of the Congress, A/CONF.144/28. The Council of Europe produced the European Convention on the Compensation of Victims of Violent Crimes (1983), a 1985 recommendation R(85) 11 on the position of the victim in the framework of criminal law and procedure, and a 1987 recommendation R(87)21 on assistance to victims and prevention of victimization.

27) The current mandate is described in *Report of the Special Rapporteur on the question of torture submitted in accordance with Commission resolution 2002/38*, E/Cn.4/2003/68, 17 Dec. 2002, para. 3.

sated." In annual reports to the Commission, the Rapporteur routinely recommends an end to torture and sometimes calls for specific remedial measures.

In his 2003 report, the Special Rapporteur addressed a revised series of recommendations to UN member states which specify that all detained persons should have the ability to challenge the lawfulness of detention, e.g. through habeas corpus or amparo. In addition, the Rapporteur recommended that an inquiry always be undertaken when there is a complaint of torture. If the complaint is well-founded, it should result in compensation to the victim or relatives and the trial of anyone suspected of committing torture or severe maltreatment. If guilt is established, the person should be punished.[28] The recommendations are clear that any amnesty or similar laws that would prevent prosecution in the name of national reconciliation should be abrogated. Paragraph (l) of the recommendations details the various forms of redress:

Legislation should be enacted to ensure that the victim of an act of torture obtains redress and fair and adequate compensation, including the means for the fullest rehabilitation possible. Adequate, effective and prompt reparation proportionate to the gravity of the violation and the physical and mental harm suffered should include the following elements: restitution, compensation, rehabilitation (including medical and psychological care as well as legal and social services), and satisfaction and guarantees of non-repetition. Such legislation should also provide that a victim who has suffered violence or trauma should benefit from special consideration and care to avoid his or her retraumatization in the course of legal and administrative procedures designed to provide justice and reparation.[29]

In 1992, the Sub-Commission took up the question of the impunity of perpetrators of violations of human rights.[30] The final report submitted in 1997 speaks of three fundamental rights of victims: the right to know, the right to justice, and the right to reparation.[31] The report refers to "the right of victims or their families to receive fair and adequate compensation within a reasonable period of time"[32] and annexes set of principles on his topic, including issues

28) E/CN.4/2003/68, p. 12.

29) Ibid.

30) Sub-Commission Resolution 1992/23 of August 1992, approved by the Commission on Human Rights in resolution 1993/43 of 5 March 1993. The 1992 Vienna Conference on Human Rights supported the efforts of the Commission and Sub-Commission to intensify opposition to the impunity of perpetrators of serious violations of human rights. See the Vienna Declaration and Program of Action, A/CONF/157/3, para. II.91. The special rapporteurs, El Hadji Guisse and Louis Joinet, prepared an interim report for the 1993 session. E/CN.4/Sub.2/1993/6. In 1994, the Sub-Commission split the study into two parts, asking Mr. Guisse to complete the report in regard to economic, social and cultural rights, and Mr. Joinet to undertake to report on civil and political rights. Resolution 1994/34 of 26 August, 1994, E/CN.4/Sub.2/1994/56, p. 81. Each rapporteur presented reports in 1995 and 1996. See: E/CN.4/Sub.2/1995/19; E/CN.4/Sub.2/1996/15; E/CN.4/Sub.2/1995/18.

31) The right to know includes the right to the truth and the duty to remember. Two specific proposals call for the prompt establishment of extrajudicial commissions of inquiry as an initial phase in establishing the truth, and taking urgent measures to preserve access to archives of the period of violations. The right to justice implies the denial of impunity. The right to reparation refers to individual measures intended to implement the right to reparation (restitution, compensation and rehabilitation) as well as collective measures of satisfaction and guarantees of non-repetition.

directly relating to the right to restitution, compensation and rehabilitation of victims.[33] In resolution 2003/72, the Commission requested the Secretary-General to appoint an independent expert to study best practices and make recommendations to assist states in strengthening their domestic capacity to combat impunity, making use of the principles on the topic. The study, submitted in 2004, contains a chapter on the right to reparation,[34] which it refers to as a fundamental tenet of international human rights law.

Finally, after some fifteen years of study, negotiations and drafting, the United Nations in 2005 adopted *Basic principles and guidelines on the right to remedy and reparation for victims of gross violations of international human rights law and serious violations of international humanitarian law*.[35] The UN Sub-Commission on Promotion and Protection of Human Rights, began its work on reparations in 1988, recognizing in a resolution that all victims of gross violations of human rights and fundamental freedoms *should be* entitled to restitution, fair and just compensation, and the means for as full a rehabilitation as possible for any damage suffered.[36] A special rapporteur appointed by the Sub-Commission,[37] Theodoor van Boven, submitted a series of reports that ended in 1994 with a proposed a set of principles and guidelines.[38] After the Human Rights Commission asked for a revision in the light of comments from governments and others,[39] a new version expanded the text by adding humanitarian law violations and by articulating state duties before setting forth the basic principles on the right to a remedy. In 1998, the Commission appointed an independent expert, Mr. Cherif Bassiouni, who prepared another revision of the draft basic principles and guidelines.[40]

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32) E/CN.4/1998/68, Chapter II, section K.

33) E/CN.4/Sub.2/1997/20 of 26 June 1997 and E/CN.4/Sub.2/1997/20/Rev.1 of 2 October 1997.

34) *Independent Study on Best Practices, including Recommendations, to Assist States in Strengthening their Domestic Capacity to Combat all Aspects of Impunity, by Professor Diane Orentlicher,* E/CN.4/2004/88, 24 Feb. 2004.

35) U.N.G.A. Res. A/Res/60/147 of Dec. 16, 2005. The text was previously approved by the Commission on Human Rights, Res. 2005/35 of 19 April 2005 (adopted 40-0 with 13 abstentions).

36) Emphasis added in the text. Members of the Sub-Commission introduced the topic for study after attending a conference in Canada on the issue of World War II claims against Japan by persons used as forced laborers who had never received reparations. Communication from Th. Van Boven, May 4, 2004, on file with the author.

37) United Nations Sub-Commission on the Prevention of Discrimination and Protection of Minorities, Resolution 1989/13 of 31 August 1989. The Human Rights Commission authorized the study by resolution 1990/35 of 2 March 1990, and the Economic and Social Council approved by resolution 1990/36 of 25 May 1990.

38) *Study concerning the right to restitution, compensation and rehabilitation for victims of gross violations of human rights and fundamental freedoms, Preliminary report submitted by Theo van Boven, Special Rapporteur*, E/CN.4/Sub.2/1990/10, 26 July 1990; *Progress reports*, E/CN.4/Sub.2/1991/7 and E/CN.4/Sub.2/1992/8; *Final report*, E/CN.4/Sub.2/1993/8. The final van Boven report was sent to the U.N. Commission on Human Rights for consideration at its 1994 session. Sub-Commission on Prevention of Discrimination and Protection of Minorities, Resolution 1993/29 of 25 August 1993, E/CN.4/Sub.2/1993/45, 69-70. Governments and non-governmental organizations were asked to comment.

39) E/CN.4/Sub.2/1996/17 of 24 May 1996; E/CN.4/1997/104, Annex, of 16 January 1997 submitted in accordance with Sub-Commission resolution 1996/28.

40) E/CN.4/2000/62.

In 2002, pursuant to Commission resolution 2002/44, an international consultation in Geneva was held following which new revisions were made over the next year.[41] At its 2004 session, the Commission rather weakly affirmed that "victims of grave violations of human rights should receive, in appropriate cases, restitution, compensation and rehabilitation"[42] and asked for yet another revision. A final draft appeared October 1, 2004 which the Commission adopted without change; however thirteen states abstained from voting in favor of the Principles and Guidelines.[43] Only the German government explained its vote, but given the earlier U.S. opposition to including humanitarian law in the draft, it is probably fair to assume that its abstention was at least in part based on objections similar to those raised by Germany. According to the German government representative:

His delegation . . . deeply regretted having been unable to support the "Basic principles and guidelines" as included in the annex to resolution E/CN.4/2005/L.48. The text was an inaccurate reflection of customary international law. It erroneously sought to apply the principles of State responsibility to relationships between States and individuals and failed to differentiate adequately between human rights law and international humanitarian law. While certain instruments provided for the presentation of individual claims for the violation of human rights, such provisions did not exist for violations of international humanitarian law. The claim that such a right existed under the Hague Convention No. IV of 1907 or Protocol I Additional to the 1949 Geneva Conventions was entirely unsubstantiated. While the absence of a legal basis for individual reparation claims for violations of international humanitarian law might be regrettable, it must be taken into account. His delegation had repeatedly raised those concerns, which had compelled it to abstain from voting.[44]

The text of the *Basic Principles and Guidelines*, which was approved by the U.N. General Assembly, asserts that it does not create any new substantive international or domestic legal obligations, but instead concerns implementing existing legal obligations. Oddly, the report of the High Commissioner for Human Rights noted that "shall" was used in cases where a binding international norm is in effect; otherwise the term "should" was used.[45] In fact, liberal use of "should" in reference to existing obligations

41) Commission resolution 2003/34.

42) Commission resolution 2004/34.

43) Those abstaining were: Australia, Egypt, Eritrea, Ethiopia, Germany, India, Mauritania, Nepal, Qatar, Saudi Arabia, Sudan, Togo, and the United States of America.

44) E/CN.4/2005/SR.57.

45) E/CN.4/2003/63 of 27 December 2002.

46) Paragraph 18, for example, provide that victims of gross violations of international human rights and humanitarian law "should, as appropriate and proportional to the violation and the circumstances of each case, be provided with full and effective reparation . . . which include the following forms: restitution, compensation, rehabilitation and satisfaction and guarantees of non-repetition." The following paragraph contains a definition of restitution that is by no means innovative, but which uses "should": "Restitution should, whenever possible, restore the victim to the original situation before the violations . . . occurred." The next paragraph says that "compensation should be provided for any economically assessable damage . . . ." All of these statements appear to restate existing law and could have used "shall."

weakens the text and wrongly suggests that the right to a remedy is not current law.[46]

The preamble calls for the establishment, strengthening and expansion of national funds for compensation to victims and the expeditious development of appropriate rights and remedies for victims. It also asserts that the Principles are victim-oriented and directed at gross violations of international human rights law and serious violations of international humanitarian law "which, by their very grave nature, constitute an affront to human dignity." Consistent with the references to human dignity, the preamble recites its rationale for ensuring a right to a remedy, stating that by so doing, "the international community keeps faith and human solidarity with victims, survivors and future human generations, and reaffirms the international legal principles of accountability, justice and the rule of law." The following paragraph refers to "compassion" for victims and solidarity with humanity at large.

The decision to limit the major part of the Principles and Guidelines to "gross" and "serious" violations represents a compromise. In fact there are three separate categories of conduct referred to in the text: (1) obligations arising with reference to all internationally guaranteed human rights and international humanitarian law; (2) international crimes; and (3) "gross" violations of human rights law and "serious" violations of humanitarian law.

Parts I and II address the content and scope of obligations to respect, ensure respect for and enforce all international human rights and humanitarian law. These two sections distinguish and emphasize the dual nature of remedial rights: access to justice, on the one hand, and substantive remedies, on the other hand. Access to justice is required to be "fair, effective and prompt." Reparations should also be adequate, effective, prompt and appropriate. Action should be taken to prevent violations and to investigate promptly, thoroughly and impartially those which occur.

The remaining sections of the Principles and Guidelines apply to specific sub-sets of rights and obligations. Parts III and IV are concerned with human rights and humanitarian law violations that constitute crimes under international law. They iterate the duty of states to investigate and as appropriate, if evidence so warrants, to submit to prosecution those alleged to have committed crimes under international law. The text favors international judicial assistance and other forms of cooperation as well as the exercise of universal jurisdiction by states, where international law provides for it, and without application of statutes of limitations.

Most of the remainder of the Principles and Guidelines (Parts V-X) concern gross violations of human rights law and serious violations of international humanitarian law. They set forth the rights of access to justice and to substantive remedies. Part VII adds a third component to remedial rights, the "right to access to factual information and other relevant information concerning the violations." The meaning and scope of "other relevant information" that is not factual is unclear.

The notion of "victim" can include a dependant or member of the immediate family or household of the direct victim, or anyone who is injured in intervening to assist a victim or prevent further violations. Part VI on treatment of victims makes clear that victims should be treated with compassion and respect for their dignity and human rights, ensuring their safety and well-being and that of their families.

Access to justice forms the contents of Part VIII. Victims "shall" have equal access to an effective judicial remedy, although

administrative or other remedies may be provided in accordance with domestic or international law. Access to justice "should" include all available and appropriate international processes in which a person may have legal standing. Despite its use of "shall", the requirement of a judicial remedy goes further than the law contained in many human rights instruments, which call for an independent and impartial process that may be non-judicial in nature.[47] To make access to justice effective, states "should", inter alia, disseminate information about available remedies, take measures to protect victims and witnesses and "facilitate assistance" to victims. The latter term may suggest or refer to financial aid to indigent victims, but this is not made explicit in the text or commentary.

Part IX which details the forms of reparation and other appropriate remedies continues to shift between "shall" and "should." Part IX affirms that reparation "is intended to promote justice" by redressing injury and thus should be proportional to the gravity of the violations or the harm suffered. The inclusion of these two elements (scope of the injury and magnitude of the misconduct) as tests for the nature and range of reparations give more flexibility to the decision-maker in affording redress than if either factor alone were the basis for judgment.

The Principles and Guidelines diverge from the reparations provisions of the recent ILC Articles on State Responsibility in several respects. First, cessation of the breach is included among forms of satisfaction in the Principles and Guidelines, whereas the ILC convincingly places it as an obligation prior to and independent of reparation. Cessation is not part of reparation, but is part of the general obligation to conform to the norms of international law; it not a right of the victim capable of being waived.

The various forms of reparation follow the traditional categories found in the ILC Articles: restitution, compensation, satisfaction and guarantees of non-repetition. The Principles and Guidelines also add rehabilitation, something not in the ILC Articles. Restitution "should, whenever possible" restore the victim to a pre-violation status. Efforts to strengthen the language by using "shall" apparently ran into government objections during the consultations. The paragraph on compensation reiterates that the compensation provided should be "proportional to the violation" which allows the egregiousness of the act to be considered in evaluating moral damages, while not suggesting that punitive damage awards are appropriate. The Principles and Guidelines quite rightly include expenses for legal and medical assistance within the recoverable costs, as they are directly attributable to the wrong done.

Non-monetary remedies, apart from rehabilitation, are included as forms of satisfaction. While the ILC Articles disfavor satisfaction, they have been important in

47) Article 2(3)(b) of the ICCPR, for example, provides that each state party undertakes to ensure that any person claiming a remedy for guaranteed rights shall have the issue of reparations determined "by a competent judicial, administrative or legislative authorit[y], or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy." Article 6 of CERD similarly provides for remedies to be assured "through the competent national tribunals and other State institutions." It is not apparent that remedies for gross and systematic violations require greater judicial supervision that do remedies for individual violations; indeed, an argument can be made that the former require policy decisions and allocations of resources that may be better dealt with through other procedures.

48) The ICJ refused to indicate any guarantees of non-repetition in its judgments concerning US failure to comply with the Vienna Convention on Consular Relations, despite actions brought by several states asserting multiple violations of the Convention. See LaGrand (Ger. v. US); Avena and Others (Mex. v. U.S.).

49) Comm. No. 30/1978 *(Irene Bleier Lewenhoff and Rosa Valino de Bleier v. Uruguay)* U.N.UAOR, 37th Sess. Supp., No. 40, at 130, U.N. Doc. A/37/40 (1982) (deprivation of the right to life); Comm. No. 84/1981 (*Guillermo Ignacio Dermit Barbato and Hugo Harold Dermit Barbato v. Uruguay*) U.N. GAOR , 38th Sess., Supp. No. 40 at 124, U.N. Doc. A/38/40 (1983) (deprivation of the right to life); Comm. No. 107/1981 (*Elena Quinteros Almeida and Maria del Carmen Almeida de Quinteros v. Uruguay*) (disappearance) U.N. GAOR, Hum.Rts. Comm., 38th Sess., Supp. No. 40 at 216, U.N. Doc. A/38/40 (1983); Comm. No. 146/1983 and 148–154/1983 (*John Khemraadi Baboeram et al. v. Suriname)* U.N. GAOR, 40th Sess., Supp. No. 40 at 187 U.N. Doc. A/40/40 (1985) (deprivation of the right to life); Comm No. 161/1983 (*Joaquin David Herrera Rubio v. Columbia*) (disappearance and death) U.N. GAOR, Hum. Rts. Comm., 43rd Sess., Supp. No. 40, at 190, U.N. Doc. A/43/40 (1988); Comm. No. 194/1985 (*Jean Miango Muigo v. Zaire*) U.N. GAOR, Hum. Rts. Comm., 43rd Sess., Supp. No. 40, at 218, U.N. Doc. A/43/40 (1988) (right to life); Comm. No. 181/1984 (*A. and H. Sanjuan Arevalo v. Columbia*) (disappearances) U.N. GAOR, Hum. Rts. Comm., 45th Sess., Supp. No. 40, at 31 (Vol. 1), U.N. Doc A/45/40 (1990); Comm. No. 25/1978 (Carmen Amendola and Graciela Baritussio v. Uruguay) U.N. GAOR, Hum. Rts. Comm., 37th Sess., Supp. No. 40 at 187, U.N. Doc A/37/40 (1982) (torture); Comm. No. 124/1982 (*Tshitenge Muteba v. Zaire*) U.N. GAOR, Hum. Rts. Comm., 39th Sess., Supp. No. 40 at 182, U.N. Doc A/39/40 (1984) (torture); Comm No. 176/1984 (*Walter Lafuente Penarrieta et al. v. Bolivia*) U.N. GAOR, Hum. Rts. Comm., 43rd Sess., Supp. No. 40, at 199, U.N. Doc A/43/40 (1988).

50) Cases *Bleier, Barbato, Quintero, Baboeram, Miango, Muteba*, *supra* n. 33.

51) *Cases Bleier, Barbato, Muteba, Quinteros, Baboeram, Miango and Penarrieta, supra n. 33;* Case 45/1979 (*Suarez de Guerrero v. Colombia*) (killing by deliberate police action) U.N. GAOR, Hum. Rts. Comm., 37th Sess., Supp. No. 40, at 137, U.N. Doc A/37/40 (1982); Case No. 25/1978 (*Carmen Amendola and Graciela Baritoussio v. Uruguay*) (torture and detention); Case No. 110/1981 (*Antonio Viana Acosta v. Uruguay*) U.N. GAOR, Hum. Rts. Comm., 39th Sess., Supp. No. 40, at 169, U.N. Doc A/39/40 (1984) (torture).

52) Cases *Bleier, Barbato, Quintero, Baboeram*, Herrera *supra* n. 33; Case No. 80/1980 *(Elena Beatriz Vasilskis v. Uruguay*) U.N. GAOR, Hum. Rts. Comm., 38th Sess., Supp. No. 40 at 173, U.N. Doc A/38/40 (1983) (torture); Case No. 88/1981 (*Gustavo Raul Larrosa Bequio v. Uruguay*) U.N., GAOR, Hum. Rts. Comm., 38th Sess., Supp. No. 40 at 173, U.N. Doc A/38/40 (1983) (torture), *Muteba, Penarrieta, supra* n. 33.

53) Cases *Bleier, Barbato, Quintero, Baboeram, Herrera supra* n. 33; Case No. 80/1980 (*Elena Beatriz Vasilskis v. Uruguay*) U.N. GAOR, Hum. Rts. Comm., 38th Sess., Supp. No. 40 at 173, U.N. Doc A/38/40 (1983) (torture); Case No. 88/1981 *(Gustavo Raul Larrosa Bequio v. Uruguay*) U.N., GAOR, Hum. Rts. Comm., 38th Sess., Supp. No. 40 at 173, U.N. Doc A/38/40 (1983) (torture), *Muteba, Penarrieta, supra* n. 24; Comm. No. 965/2000 (*Karakurt v. Austria)* (modify the applicable law to eliminate discrimination).

54) Comm. No. 577/1994 (*Polay Campos v. Peru*), UN Doc A/53/40, Vol. II, 36, para. 10 (denial of a fair trial requires release of the applicant); Comm. No. 788/1997 (*Cagas et al. v the Philippines)*, UN Doc. A/57/40, Vol I, 116 (where authors had been detained for more than nine years without trial, either try them promptly or release them).

55) Comm. 641/1995 (*Gedumbe v. Congo*), UN Doc. A/57/40, Vol. 1I, 24, para. 6.2 (the author is entitled to reinstatement to public service and to his post, with all the consequences that this implies, or, if necessary to a similar post, with arrearages in salary); an identical remedy was awarded in Comm. No. 906/2000, (*Chira Vargas v. Peru*), Views of 22 July 2002, *id* at 228. The Committee also called for measures to ensure that similar violations do not recur in the future.

56) Comm. 747/1997 (*Des Fours Walderode v. the Czech Republic*), Views of 30 October 2001, UN Doc A/57/40, Vol II, 88, para. 95; Comm. No. 774/1997 (*Brok v. Czech Republic)*, Views of 31 October 2001, UN Doc. A/57/40, Vol. II, 110, para. 9 (restitution required for discrimination in property restitution).

the human rights field where the disparity of power between the state and individuals whose rights are violated make the state's role in disclosure of the violations and the reasons for them particularly important. Satisfaction thus includes truth-telling, recovery and reburial of victims' remains, actions to restore victims' reputation, apology and commemorations. It also may include judicial and administrative sanctions against those responsible, although the draft is clear that the duty to prosecute only applies to crimes and not to all human rights violations.

Guarantees of non-repetition, like satisfaction, are seen as largely inappropriate at the inter-state level,[48] but they are very important in human rights cases. The specific measures recommended in the draft mainly comprise strengthening of national institutions under the rule of law, including independence of the judiciary and civilian control of the military and security forces.

Final provisions recall the duty of non-discrimination and the due process rights of any accused person.

4. The content of remedial rights and duties

Comparing the texts that have emerged and international practice affords a glimpse into the key legal issues, underlying aims, priorities, and assumptions linked to norms on reparations. It is clearly accepted that the right to a remedy comprises two aspects, on the one hand, the procedural right of access to justice and, on the other hand, the substantive right to redress for injury suffered because of an act or acts committed in violation of rights contained in national or international law. Invoking the right of access to justice, victims have pressed claims in domestic and international tribunals, both of which increasingly face claims for reparations.

On the procedural side, the attributes of an effective remedy include the institutional independence of the remedial body from the authority responsible for the violation, the ability to invoke the guaranteed right, procedural fairness, the capability of the remedial body to afford redress, and effectiveness in fact. As seen above, some international agreements explicitly call for the development of judicial remedies for the rights they guarantee, although effective remedies also may be supplied by non-judicial bodies.

On the substantive side, the jurisprudence of the UN Human Rights Committee to date has specified one or more of the following remedies for violations of the Covenant:

(a) public investigation to establish the facts[49]
(b) bringing to justice the perpetrators[50]
(c) compensation[51]
(d) ensuring non-repetition of the violation[52]
(e) amending the law[53]
(f) providing restitution of liberty,[54] employment[55] or property[56]
(g) providing medical care and treatment[57]
(h) permitting the victim to leave the country[58]
(i) enjoining an imminent violation.[59]

Guarantees of non-repetition are an important aspect of the Committee's approach to remedies. It frequently calls upon states parties to take steps to ensure that similar violations do not occur in the future. It also has stressed repeatedly that states parties are under an obligation to take immediate steps to ensure strict observance of the provisions of the Covenant.[60] In the *J.D. Herrera Rubio* case, the Committee concluded that Colombia had not taken the measures needed to prevent the disappearance and death of the parents of the author of the communication,

had failed to adequately investigate, and that accordingly it had the duty to adopt effective measures of reparations, proceed with the investigations, and take measures to ensure that similar violations did not occur in the future.[61] Similarly, in *Frances et al v. Trinidad and Tobago,*[62] the Committee, calling the conditions of detention "deplorable," held that the state was under an obligation to improve the conditions of detention in its prisons without delay in order to bring them into line with Article 10 of the Covenant.

The focus of the Committee against Torture has largely been on rehabilitation of torture survivors. It recommended to the government Zambia that it establish rehabilitation centers and called on the government of Indonesia to "take immediate steps to address the urgent need for rehabilitation of the large number of victims of torture and ill treatment in the country."[63] On individual complaints, the Committee has recognized that a breach of the Convention requires the state to take remedial measures, including guarantees of non-repetition. In the case of *O.R., M.M. and M.S. v. Argentina*, the Committee found the cases inadmissible because they related to events prior to the entry into force of the Convention for the state. The Committee nonetheless expressed its view that the national "Full Stop Law" and "Law of Due Obedience" (the second adopted after ratification of the Convention) were "incompatible with the spirit and purpose" of the Convention against Torture, but the Committee observed that it could not fail to indicate that "even before the entry into force of the Convention against Torture, there was a general rule of international law that obliged all States to take effective measures to prevent torture and to punish acts of torture". The state was encouraged to adopt "appropriate measures" of reparation.[64]

The case law of regional human rights bodies is insistent on the obligation of states to provide broad and effective remedies on behalf of both direct and indirect victims. The European Court, for example, has made clear that failure to investigate and account for the disappearance of an individual con-

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57) Comm. No. 63/1979 (*Raul Sendic Antonaccio v. Uruguay*) (cruel, inhuman or degrading treatment or punishment); Comm. 684/1996, (*Sahadath v. Trinidad and Tobago*), Views of 2 April 2002, UN Doc A/57/40 Vol II, 66, para. 9 (the state party is under an obligation to provide appropriate medical and psychiatric care and improve the conditions of detention).

58) Comm. No. 52/1979 *(Sergio Ruben Lopez Burgos v. Uruguay*), I Selected Decisions 88, para 14 ("the State party is under an obligation, pursuant to article 2(3) of the Covenant, to provide effective remedies to Lopez Burgos, including immediate release, permission to leave Uruguay and compensation for the violations which he has suffered, and to take steps to ensure that similar violations do not occur in the future.")

59) Comm. No. 930/2000 *(Hendrick Winata et al. v. Australia*), UN doc. A/56/40, 199, para. 9 (wrongful threatened deportation of foreign parents of a naturalized child requires "refraining from removing the authors from Australia before they have had an opportunity to have their application for parent visas examined with due consideration given to the protection required by Barry Winata's status as a minor.")

60) Comm. No. 63/1979 (*Raul Sendic Antonaccio v. Uruguay*) (cruel, inhuman or degrading treatment or punishment).

61) CCPR, views of 2 November 1987, ICCPR, Selected Decisions of the Human Rights Committee under the Optional Protocol, vol. II, 1990, 194–95.

62) Case 899/1999, *Frances et al v. Trinidad and Tobago*, Views of 25 July 2002, UN Doc. A/57/40, Vol. II, 211, para. 7.

63) CAT/C/SSVII/Concl., 23 Nov. 2001 (Zambia); CAT/C/XXVII/Concl. 2, 22 Nov. 2001 (Indonesia).

stitutes a violation of the rights of remaining family members under Convention Article 3, which prohibits torture and cruel, inhuman and degrading treatment. In *Kurt v. Turkey*, judgment of 25 May 1998, the Court held that the failure to account for her son was a violation of the applicant mother's right to be free from torture and her right to a remedy under Article 13. The Court was clear that Article 13 imposes an obligation on the state to conduct for the benefit of relatives a thorough and effective investigation into the disappearance of a person in government custody, capable of leading to the identification and punishment of those responsible and with effective access for the relatives (para. 140).

In *Aksoy v. Turkey* the Court similarly established the link between the prohibition of torture in Article 3 and the Article 13 requirement of a remedy. According to the Court, the fundamental importance of the ban on torture means that Article 13 imposes, without prejudice to any other domestic remedy, "an obligation on states to carry out a thorough and effective investigation of incidents of torture." This duty arises whenever an individual has an "arguable claim" of torture committed by state agents. It entails "in addition to the payment of compensation where appropriate, a thorough and effective investigation capable of leading to the identification and punishment of those responsible and including effective access for the individual to the investigatory procedure." Thus, the substantive prohibitions of Article 3 are coupled with procedural duties that include investigation, prosecution, punishment and redress. Failure of the state to act on any of these points violates both Article 3 and Article 13.

The Inter-American Court has perhaps best summed up the requirements of international human rights law to afford full reparations. It has held that the obligation of reparation constitutes a rule of customary law that enshrines one of the fundamental principles of contemporary international law on state responsibility.[65] Thus, when an illicit act is imputed to the state, there immediately arises state responsibility for the breach of the international norm involved, together with the subsequent duty to make reparations and put an end to the consequences of the violation. The reparation of harm caused by the violation requires, whenever possible, full restitution (*restitutio in integrum*), which consists in restoring the situation that existed before the violation occurred. When this is not possible, the state should adopt a series of measures (which the Court can order in cases before it) that, in addition to guaranteeing respect for the rights violated, will ensure that the damage resulting from the infractions is repaired, by way, *inter alia*, of payment of an indemnity as compensation for the harm caused. All aspects of reparations (scope, nature, modalities, and designation of beneficiaries) are governed by international law.

The Inter-American Court has regularly ordered the state before it to take specific action to remedy a breach of the Convention, as well as to pay compensation. The Court has ensured the effectiveness of the remedies by setting up trust funds, appointing experts, designing non-monetary remedies, and maintaining cases open until the awarded remedies have been fully carried out.

64) Comms. 1/1988, 2/1988 and 3/1988, decision 23 Dec. 1989, U.N. Report of the Committee against Torture, G.A.O.R. XLV Sess. 1990 at 111-112.

65) *Moiwana Village v. Suriname*, (2005), 124 Inter-Am.Ct.H.R. (ser.C) para. 169.

As the Court's practice reflects and is clear from the nature of human rights violations, the payment of money is not the most appropriate form of redress in many cases and is usually inadequate unless coupled with other measures. Some human rights bodies have suggested that non-monetary remedies, i.e., those that require a state to take specified actions rather than pay compensation, are required to ensure adequate redress. The state should provide measures of rehabilitation, including medical and psychological care, rehabilitation for any form of physical or mental damage, legal and social rehabilitation, guarantees of non-repetition, restoration of personal liberty, family life, citizenship, employment or property, return to the place of residence, and similar forms of restitution, satisfaction and reparation to remove the consequences of the violation. Such actions can be useful not only in giving satisfaction to the victim, but in eliminating the cause of the violation and promoting respect for the human right that was violated. Common non-pecuniary reparations measures adopted include a public acknowledgment of the violation at official ceremonies;[66] publication of the violation and remedies afforded in local media,[67] an official apology by state officials,[68] or other public acts designed "to restore the victims' reputation and honor."[69]

Compensation, however inadequate, is the most common form of reparation. There are three kinds of compensatory damages: nominal (a small sum of money awarded to symbolize the vindication of rights and make the judgment a matter of record); pecuniary damages (intended to represent the closest possible financial equivalent of the monetary loss or harm suffered); and moral damages (compensation for dignitary violations, including fear, humiliation, mental distress). Compensatory damages generally provide for:

(1) past physical and mental suffering
(2) future physical and mental suffering
(3) medical expenses
(4) loss of earnings and earning capacity
(5) incidental out of pocket expenses, including e.g. travel, nursing care
(6) property injury or loss and
(7) permanent disability and disfigurement.[70]

The problem of calculating damages is complex. A decision-maker considering the case of a person who suffers a permanent disability as a result of official torture[71] can calculate the costs already incurred, such as past medical expenses, therapy charges, damage to property and lost earnings prior to judgment. Justice also demands, however, that the court consider lost future earnings and opportunities, and other losses which require prediction of future events, including loss in enjoyment of life. Reduced life expectancy may be claimed, although national

66) *Contreras San Martin Case*, at para. 17; *Carrillo Saldana Case*, at para. 13.

67) *Livia Robles Case*, at para. 13. *See also Merciadri de Morini Case*, at para. 14. In *Merciadri de Morini*, the state decreed amendments to national electoral legislation that reflected the state's decision in the petition before the Commission.

68) *Contreras San Martin Case*, at para. 14, 22-23.

69) *Carabantes Galleguillos Case*, at para. 12, 14; *Contreras San Martin Case*, at para. 14.

70) *Berry v. City of Muskogee*, 900 F.2d 1989 (10th Cir. 1990): "In an action involving death, appropriate compensatory damages would include medical and burial expenses, pain and suffering before death, loss of earnings based upon the probable duration of the victim's life had the injury not occurred, the victim's loss of consortium, and other damages recognized in common law tort actions".

jurisdictions are split on whether this is recoverable.[72]

There are few developed principles for calculating awards of non-monetary injuries like pain and suffering, fright, nervousness, grief, anxiety, and indignity.[73] While these injuries constitute recognized elements of damages, they are particularly personal and therefore difficult to measure. There is no objective test to measure the severity of a victim's pain, yet common human experience recognizes the reality of physical and emotional suffering.[74] The inherently subjective reaction to claims of pain and suffering can lead judges to award widely varying amounts for similar injuries. Some argue that intangible injury is so difficult to assess that there should be a conventional, set figure, perhaps calculated by unit of time.[75] Others claim that intangible harms like the loss of enjoyment of life are economic losses that can be consistently calculated from an *ex ante* perspective that asks how much a reasonable person would have paid to eliminate the risk that caused the injury.[76]

In practice, it seems clear that the award of moral damages is influenced by the government's conduct, but excessive amounts will not be awarded in the nature of aggravated or punitive damages. The Inter-American Court has said that the amount of moral damages should be "based upon the principles of equity" considering the "special circumstances of the case".[77] During one period the Court awarded an identical amount to each victim rather than individualizing the award,[78] setting the amount at US$20,000 per victim. Given that the average monthly income in one case was estimated at US$125, the sum was significant, although it was considerably less than the moral damages awarded in the *Velasquez Rodriguez* and *Godinez Cruz* cases. The state accepted responsibility in the former case, however, and this was explicitly relied upon by the Court as a factor in assessing moral damages.

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71) See M. Brody, 'Inflation, Productivity, and the Total Offset Method of Calculating Damages for Lost Future Earnings,' (1982) 49 *U. Chi. L.Rev.* 1003.

72) See J. Fleming, 'The Lost Years: A Problem in the Computation and Distribution of Damages,' (1962) 50 *Cql. L. Rev.* 598. Mexico's law implementing the United Nations Convention against Torture establishes the liability of persons who commit any of the designated offences for the legal, medical, funeral, rehabilitation and other expenses incurred by the victim or relatives of the victim. Federal Act for the Prevention and Punishment of Torture, Article 10. The law also calls for the offender to make good the damage for loss of life, impairment of health, loss of freedom, loss of income, incapacity for work, loss of or damage to property, and defamation of character. See *Report to the United Nations on Human Rights in Mexico*, HRI/CORE/1/Add.12/Rev.1.

73) See M. Plant, 'Damages for Pain and Suffering,' (1958) 19 *Ohio State L.J.* 200.

74) M. Geistfeld, 'Placing a Price on Pain and Suffering: A Method for Helping Juries Determining Tort Damages for Nonmonetary Injuries,' (1995) 83 *Cal.L.Rev.* 773.

75) B.S. Markensinis, *Tort Law* (1994), 708.

76) The dollar value of non-pecuniary loss is said to equal the difference between what people are willing to pay to avoid a particular risk or injury or death and the solely financial component – medical expenses, lost earnings – associated with that risk. Even someone fully insured against economic losses will pay for some safety measures and require a wage premium to run risks at work. Such behaviour is said to show the economic value of non-economic losses. See T. Miller, 'The Plausible Range for the Value of Life: Red Herrings Among the Mackerel,' (1990) 3 *J. Forensic Econ.* 17.

77) *Velasquez Rodrigues Case (Reparations), supra* n. 29, at para. 27; *El Amparo Case, supra* n. 29, at para. 37.

In the 2003 decision in *Myrna Mack Chang v. Guatamala*,[79] however, the Inter-American Court began shifting toward recognition that full reparation in some cases involves not only compensation but punishment. The judgment found that the victim was deliberately murdered as a consequence of a military intelligence operation planned and carefully prepared by the high command of the Presidential General Staff. The victim was selected because of her work documenting the abuse of indigenous communities in Guatemala. The government covered up the violation, obstructed the judicial investigation and attacked the investigating police. Judges, prosecutors, attorneys, the next of kin and witnesses were subject to harassment and threats. The Court deemed that the material before it established "aggravated violations" and that rendering a judgment would constitute a form of reparation and be "a way to avoid recidivism of facts such as those suffered by Myrna Mack Chang and her next of kin." The Court found a pattern of extra-legal executions fostered and tolerated by the state and awarded a lengthy list of non-monetary reparations as a consequence, in addition to compensation. The measures ordered were:

- that the State must effectively investigate the facts of the case, with the aim of identifying, trying, and punishing all the direct perpetrators and accessories, and all others responsible for the execution of Myrna Mack Chang, and for the cover-up of the execution and other facts of the case, aside from the person who had already been punished for those facts; and that the results of the investigations must be made known to the public,
- that the State must remove all de facto and legal obstacles and mechanisms that maintain impunity in the instant case, provide sufficient security measures to the judicial authorities, prosecutors, witnesses, legal operators, and to the next of kin of Myrna Mack Chang, and resort to all other means available to it so as to expedite the proceeding,
- that the State must publish within three months of notification of the judgment, at least once, in the official gazette "Diario Oficial" and in another national-circulation daily, the proven facts and operative paragraphs of the judgment,
- that the State must carry out a public act of acknowledgment of its responsibility in connection with the facts of this case and of amends to the memory of Myrna Mack Chang and to her next of kin, in the presence of the highest authorities of the State,
- that the State must publicly honor the memory of José Mérida Escobar, the murdered police investigator,
- that the State must include, in the training courses for members of the armed forces and the police, as well as the security agencies, education regarding human rights and international humanitarian law,
- that the State must establish a scholarship in the name of Myrna Mack Chang,
- that the State must name a well-known street or square in Guatemala City after Myrna Mack Chang, and place a plaque in her memory where she died, or nearby, with reference to the activities she carried out.

78) *El Amparo and Neira Alegria Cases, supra* n. 29.

79) Judgment of Nov. 25, 2003, 101 Inter-Am.Ct. H.R. (Ser. C).

In a concurring opinion, Judge Cancado-Trindade adopted the notion of aggravated responsibility, noting that the nature of the offense makes a link between reparations and combating impunity, with the former then taking on elements of compensation and punishment. He saw exemplary or dissuasive reparations as consistent with the idea of aggravated responsibility to ensure non-repetition of the offenses. He found that this aspect of punitive damages is consistent with the reparatory function of the Court, but not in the sense of monetary compensation (which he viewed as entailing a risk of "commercialization of justice"). Instead, the various forms of non-monetary reparations could be seen as being both compensatory and punitive, because they sought to ensure non-repetition as well as repair the harm caused. Thus, in his view, punitive damages have long been awarded in the Inter-American system. This approach probably claims too much, since some of the measures are clearly intended as satisfaction, but to the extent that all guarantees of non-repetition are intended to deter based on past conduct, they could be seen as containing an element of condemnation or punishment as well as reparation. Judge Sergio Ramirez also rejected the idea of punitive damages in monetary terms because "it corresponds more to the idea of a fine than to that of the reparation of damage and, in any case, it would be payable by the Treasury, which implies an additional burden for the taxpayer and also a reduction in the resources that should go towards social programs." The views of these judges explain more fully what is implicit in the Court's judgment. The idea of "aggravated" violations is now accepted in the Inter-American Court and can be the avenue for various new forms of non-pecuniary remedies.

As the Myrna Mack Chang case exemplifies, international tribunals have been particularly concerned with the issue of impunity. The Inter-American Court's decision in the *Velásquez-Rodríguez* case was the first to go beyond the discussion of redress and articulate the state's additional duty to prevent, investigate and punish serious human rights violations. The judgment thus established a mandatory interaction between criminal and civil remedies for certain serious violations.[80] Domestic norms and judicial practices that impede the investigation, prosecution and punishment of the perpetrators, should be annulled or repealed.[81]

International tribunals have reiterated that the obligation to investigate, prosecute and punish is not a mere formality and "must be complied with seriously."[82] States may not "resort to measures such as amnesty, extinguishment and [others] designed to eliminate responsibility."[83] In the landmark *Barrios Altos* case, the Court held firmly that amnesty laws passed in relation to gross human rights violations do not comply with the dictates of the American Convention or international human rights

80) *Loayza Tamayo Case*, Reparations, 11 Inter-Am. C.H.R. (Ser. C), para. 129(d) (1998); *El Caracazo Case*, 95 Inter-Am. C.H.R. (Ser. C), para. 77 (2002); *Castillo Páez Case*, Reparations, 43 Inter-Am. C.H.R. (Ser. C), para. 49 (1998); *Garrido and Baigorria Case*, Reparations, 39 Inter-Am. C.H.R. (Ser. C), para. 42 (1998).

81) Case 11.771 (*Catalan Lincoleo v. Chile*), Inter-Am. C.H.R. 96, OEA/ser.L/V/II.111, doc. 20 rev. (2001); Case 10.247, et al. (*Extrajudicial Executions and Forced Disappearances*), Inter-Am. C.H.R. 253, OEA/ser.L/V/II.114, doc. 5 rev. (2001); Case 10.488 (*Ellacuria, S.J., et al. v. El Salvador*), Inter-Am. C.H.R.241, OEA/ser.L/V/II.106, doc. 6 rev. (1999).

law generally.[84] Such actions are incompatible with the American Convention because "they are intended to prevent the investigation and punishment of those responsible for serious human rights violations such as torture, extrajudicial, summary or arbitrary execution and forced disappearance, all of them prohibited because they violate non-derogable rights recognized by international human rights law."[85]

Conclusions

The right of victims of torture to receive reparations is now widely acknowledged. Given the general recognition of the right to a remedy in law and practice, many consider it to be a norm of customary international law. Where states fail to provide the necessary remedies for human rights violations, international institutions are the forum of last resort. The authority of human rights tribunals to afford remedies is uncontested. Judicial bodies have inherent power to remedy breaches of law in cases within their jurisdiction. In addition, human rights treaties sometimes confer explicit competence to afford redress on the organs they create to hear cases.

The ancient adage *ubi jus, ibi remedium* (where there is a right there is a remedy) is reflected in the importance given in international human rights law to the existence of effective remedies, which are seen as necessary in order to ensure the full enjoyment of other rights. The international attention to remedies reflects concern with upholding and ensuring the effective enjoyment of guaranteed rights.

International human rights law and practice on remedies is evolving with the need to ensure the rule of law and promote compliance by states with their human rights obligations. International tribunals are also increasingly concerned with reducing their growing caseloads by emphasizing remedies at the national level. There is thus a new emphasis on eliminating systemic violations through changes in domestic laws, in additional to compensating the individual applicant who brings a case to an international tribunal. International tribunals are promoting and using innovative and specific non-monetary remedies, including requirements that the government acknowledge its responsibility and issue an apology, create a memorial to the victims, establish development or scholarship funds, build and operate medical clinics and schools, and provide medical treatment or other forms of rehabilitation. The notion of "aggravated violations" recognized in the Inter-American and European Courts is also having an impact on the nature of remedies and the quantum of compensation. Each decision contributes to the growing jurisprudence to guide states and assist in providing individualized justice to victims of human rights violations.

82) *Villagrán Morales et al. Case*, at para. 100. *See also Suárez Rosero Case*, at para. 79 and 80.

83) *El Caracazo Case*, at para. 119.

84) *See Barrios Altos Case*, Judgment, 75 Inter-Am. C.H.R. (Ser. C), at para. 41- 44.

85) *Barrios Altos Case*, Judgment,), para. 41 (2001).

Forensic medical examination of victims of trafficking in human beings*

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Abstract

Trafficking in human beings (THB) is recognized as a global public health issue as well as a violation of human rights. Trafficking has been identified to be associated with several health risks including psychological trauma, injuries from violence, and substance misuse. Public and media reports suggest that the morbidity and mortality associated with trafficking are substantial.

The need of medico-legal healthcare for THB victims is being neglected. Forensic medical examination, as specific intervention, is a highly desirable element of emergency health care provided for victims of tracking. Acting in such a way, the investigation should establish the facts related to the allegation of trafficking, thereby assisting in identifying those responsible, but also contributing to the procedures designed to obtain redress for the victims. Local anti-trafficking policies and interventions, however, have not acknowledged these needs. Therefore, the agenda of anti-trafficking policies needs to be redrawn to include forensic medical assessment of victims for legal purposes.

Key words: human trafficking; victim; clinical forensic examination; injury; age estimation

Despite the definition given to trafficking in international law, the term and issues surrounding it remain confused both conceptually and in government policy and practice.[1] Definitions of trafficking in migrants vary widely (Text box 1). Terms such as "human trafficking", "people smuggling" or "alien smuggling" often intend to describe the same thing, but in many cases definitions remain unclear and imprecise, overlap with other terms, or describe different phenomena.[2] Trafficking involves the organized movement of persons by means of force, coercion, and/or deception for the purpose of exploitation.[4]

In the past few years, there has been an upsurge in concern about trafficking and reports that the crime is growing. Such anxieties have flourished in the post-September 11 climate, which is marked by deepening apprehensions about transnational crime, terrorism, and border security, and a hardening of attitudes to illegal immigrants.[1] The crime of human trafficking has become a truly global phenomenon.[5] Various statistics indicates that between 600,000 and 800,000 people are trafficked across international borders each year,[6] while UNICEF estimates that more than 1.2 million children are trafficked annually.[7]

Trafficking organizations usually remove the identity documents of the migrant customers prior to their arrival in the destina-

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tion country. The main reasons for such action are to make return to their home countries impossible and to protect the trafficking organization.[8,9] As indicated above, many children are victims of trafficking. Therefore, if no identification documents are available, in any case in which there is a doubt as to whether the individual is a child or not, that individual will be presumed to be a child pending verification of age.

A recent study identified trafficking to be associated with health risks such as psychological trauma, injuries from violence, sexually transmitted infections, HIV and AIDS, other adverse reproductive health outcomes, and substance misuse.[10] These health risks are present throughout the transportation and exploitation phases of trafficking that include movement internally or externally and coercion into the range of exploitative practices.[5] Traffickers make full use of violence and the threat of violence as an effective means of control. Victims of trafficking may be beaten, tortured, exposed to a range of sexual violence, confined, and deprived of food, water and sanitary needs. Traffickers are known to supply narcotic substances to their victims to create addiction and dependence.

> "Trafficking in persons" means the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs.[3]

Palermo protocol. *Definition of trafficking.*

Victims of an alleged crime or suspected perpetrators often have to be examined with regard to the presence of injuries.[11] It is essential to apply forensic principles and skills, those regularly used in forensic pathology, in the examination of living individuals, since the observations and the medical report on the wounds is likely to play an important part in any subsequent legal proceedings. Therefore, the physical examination and the documentation of the relevant results must be performed in an adequate and accurate manner. The purpose of assessment and documentation is to assist in establishing how a wound or injury is caused, which may often be at issue in courts or tribunals of law. Witnesses may give different accounts of the incident; it is the forensic physician's role to assist the court in determining the true account.[12]

Moreover, exposure of trafficking victims to various health risks may lead to permanent loss or abnormality of psychological, physiological, or anatomical structure or function, which, according to WHO definition, constitutes basis of impairment.[13] In the cases where permanent impairment is supposed, a proper medical evaluation should be performed for accurate documenting of the individual's clinical status. In general, it is a physician's responsibility to evaluate a patient's health status and determine the presence or absence of an impairment.[14] Assessment of permanent impairment may be necessary if victims pursue civil claims against their traffickers, as well as if their requests for compensation and restitution for damage suffered are placed.

Medical care of trafficking victims should be arranged in a manner to provide medical treatment and intervention if needed, but also to include forensic medical examination. Medico-legal examination must be carefully planned and structured to furnish medical

corroborative evidence of any injury, infection or illness that may have occurred as a result of the trafficking abuse. Such practices may lead to scientific evidence of serious physical and/or psychological consequences. This, in turn may provide grounds for conviction for an aggravated form of trafficking in which usually serious penalties are applicable. Even if the national legislation has no provision of so-called aggravated forms of trafficking, substantial trauma, if appropriately documented, will be taken into account in the sentencing process. Forensic medical examination is regarded as a matter of emergency once the victim of trafficking is in the custody of the appropriate authority or international or non-governmental organization. Therefore, it is necessary to carry out the examination as soon as possible to avoid deterioration of evidence. In addition, it should be carefully considered on a case-to-case basis whether a medical follow up would be needed, including subsequent examination.

Certain international standards for forensic medical examination of victims, including the victims of torture and sexual violence, are available in forms of protocols or guidelines.[12,15] To our knowledge, such standards are not yet available for the examination of trafficking victims. It is impossible to prescribe a standardized format to suit every case, as the circumstances differ so much. Apart from the actual examination procedures, it has to be decided if samples need to be taken (for instance blood for alcohol or drugs, genital swabs, urine, hair samples and so on). In most cases photography is helpful and desirable, especially in complex and patterned injuries.[11]

However, clinical forensic examination must not be undertaken without obtaining a valid and informed consent. It is also important to consider the patient's freedom of choice regarding the gender of the forensic medical practitioner and also the freedom of choice for a particular examiner. Under unfavorable conditions, such as an emergency, or when other constrains are present, freedom of choice may be restricted to a certain extent. Evidence gathering must be sensitive to children and victims, and must not re-traumatize the trafficked person. Forensic examination of the victim is supposed to incorporate medical, psychiatric as well as psychological assessment, the later two being out of the scope of this article.

What forensic medical examination should cover

1."Head-to-toe" examination, necessarily methodical and detailed, that aims to disclose all injuries and marks. If deemed necessary, the examination should extend to the use of imaging techniques, laboratory tests, and other auxiliary diagnostics. The findings of such examination must be accurately recorded and documented .[11,16]

Although injuries are mainly non-specific, the so-called pattern of injury is one which has a tell-tale marker for the tool that inflicted it. The list of 'tools' is infinite. Commonly used ones are: hands, belts, baseball bats, kitchen utensils and curling irons. Each of these tools leaves a skin imprint that reflects its shape and is, therefore, unique to it. Pattern injuries are consistently reproducible. They can be classified into three major categories, according to their source: blunt force, sharp force and thermal.[17]

A knowledge of pattern injuries and the precise documentation as to the anatomic location of each injury will assist the physician and law enforcement officer in determining what implement, tool or weapon was responsible for producing a particular wound. Knowing which tool or weapon was used will help the investigator to determine

if the injury is consistent or inconsistent with the history given .[11,16,17]

The offending weapon, sometimes of unique shape or configuration, when sufficient pressure is applied, will stamp a mirror image of itself onto the skin. The examples include slap marks from the hand digits delineated, looped or flat contusions from belts or cords, contusions from fingertip pressure, scratches from fingernails, parallel contusions from contact with a linear object, and contusions from the heels and soles of shoes.

The dating or aging of a contusion or bruise has been the focus of much debate within forensic community. The development of a contusion is under the influence of numerous variables so that no reproducible standard exists for the dating of a contusion based on its color.

Examples of pattern abrasions include fingernail scratches, bite marks, imprints of carpet fabric, and ligature marks around the wrist or neck.

A thermal pattern injury is an injury whose offending force is heated and whose physical appearance belies the heat source, such as flat iron burns, curling iron burns, splash burns, and immersion burns.[17]

Forensic examination in sexually abused and/or exploited victims of trafficking may give further evidence such as with a recent termination of pregnancy (abortion), as well as genital and/or anal injuries.

2. Besides documenting injuries, medical examination may reveal conditions such as malnutrition, vitamin deficiency or other alterations due to, for example, inhuman treatment. Such evidence may be used to corroborate a victim or witness statement. Sometimes it will be necessary to gather more evidence, such as circumstantial, by on-site investigation that may provide further details on the detention in slave like conditions.

3. Appropriate and timely collection of forensic samples (orifice swabs, hair, blood, urine, etc) is an indispensable component of victim examination. Samples should be systematically collected, labeled and stored for future analyses if required.[18]

4. Forensic age diagnosis for the purpose of criminal investigations should consist of a clinical examination, including the recording of body measurements and an evaluation of signs of sexual maturity, an X-ray examination of the left hand, and a dental examination which records dentition status and evaluates the dental radiography (orthopantomogram).[19,20] A lot of research has already been done in the field and the results provided by the leading Study Group for Forensic Age Estimation that has 50 members from Germany, Austria, Norway, and Switzerland are available.[21]

5. Finally, clinical examination of a victim of trafficking in human beings is a good screening opportunity for sexually transmitted diseases (syphilis, gonorrhea, chlamydia), as well as for other infections that may be sexually transmitted (HIV/AIDS, hepatitis B and hepatitis C). The value of such testing is multiple – for the victims themselves, but also for public health and epidemiological purposes.

Conclusion

In conclusion, it should be pointed out that the application of specific clinical forensic medical knowledge in the management of victims, including victims of trafficking in human beings, is crucial for the improvement of the quality of gathered evidence. Existence of a widely accepted standard, and its application in casework, such as the use of the Istanbul Protocol, gives standardized output. Besides enhancing the quality of every single

forensic medical report, following the protocol will ensure data comparison and study on local, national, and international levels. Such analysis is helpful for a better understanding of the health hazards related to trafficking in human beings and the possible development of specific preventive measures and strategies. Finally, it can be seen from the above outline of forensic medical procedures present in the protocol that this approach to the examination of the victims may be more efficient and less re-traumatizing for them.

References

1. Loff B, Sanghera J. Distortions and difficulties in data for trafficking. Lancet 2004;363:566.
2. Schloenhardt A. Trafficking in migrants: illegal migration and organized crime in Australia and the Asia Pacific region. Int J Sociology of Law 2001;29:331-78.
3. UN Protocol to prevent, suppress and punish trafficking in persons, especially women and children, supplementing the United Nations Convention against Transnational Organized Crime. New York: United Nations, 2000. www.uncjin.org/Documents/Conventions/dcatoc/final_documents_2/convention_%20traff_eng.pdf (accessed on 1/3/2007).
4. Recommended principles and guidelines on human rights and human trafficking. Report of the UNHCHR to the United Nations Economic and Social Council. New York: United Nations, 2002.
5. Training for specialist investigators to combat trafficking in persons for the Western Balkans region, trainee version. Strasbourg: Council of Europe, 2006.
6. Victims of trafficking and violence protection act of 2000: trafficking in persons report 2005. Washington: U.S. Department of State, Office to Monitor and Combat Trafficking in Persons, 2005. www.state.gov/documents/organization/47255.pdf (accessed on 1/3/2007).
7. United Nations Children's Fund, Child Protection Information Sheet: trafficking. New York: UNICEF, 2005. www.unicef.org/protection/files/trafficking.pdf (accessed on 1/3/2007).
8. Beare ME. Illegal migration: personal tragedies, social problems, or national security threats? Transnat Organize Crime 1997;3:11-41.
9. Beare ME. Illegal migration. In: Hernandez CG, Pattugalan GR, eds. Transnational crime and regional security in the Asia Pacific. Quezon City: CSCAP & Institute for Strategic Development Studies, 1999:231-84.
10. Zimmerman C, Yun K, Shvab I, Watts C, Trappolin L, Treppete M et al. The health risks and consequences of trafficking in woman and adolescents. Findings from a European study. London: London School of Hygene and Tropical Medicine, 2003.
11. Pollak S, Saukko P. Clinical forensic medicine – overview. In: Siegel J, Knupfer G, Saukko P, eds. Encyclopedia of forensic sciences. New York: Academic Press, 2000:362-8.
12. The Istanbul Protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment punishment. Geneva: United Nations High Commissioner for Human Rights, 2004.
13. International classification of impairments, disabilities, and handicaps. Geneva: World Health Organization, 1980.
14. Guides to the evaluation of permanent impairment. Chicago: American Medical Association, 1993.
15. Guidelines for medico-legal care for victims of sexual violence. Geneva: World Health Organization, 2003.
16. Payne-James J, Crane J, Hinchliffe AJ. Injury assessment, documentation, and interpretation. In: Stark MM, ed. Clinical forensic medicine – a physician's guide. Tototwa: Humana Press, 2005:127-58.
17. Smock W. Recognition of pattern injuries in domestic violence victims. In: Siegel J, Knupfer G, Saukko P, eds. Encyclopedia of forensic sciences. New York: Academic Press, 2000:384-91.
18. Recktenwald K, Hunsaker DM, Corey TS et al. Clinical forensic medicine introduction for healthcare providers. J Ky Med Assoc 2005;103:433-5.
19. Schmeling A, Kaatsch H-J, Marré B et al. Empfehlungen für die Altersdiagnostik bei Lebenden im Strafverfahren. Rechtsmedizin 2001;11:1-3.
20. Brkic H, Milicevic M, Petrovecki M. Age estimation methods using anthropological parameters on human teeth (A0736). For Sci Int 2006;162(1-3):13-6.
21. Schmeling A, Olze A, Reisinger W, Geserick G. Age estimation of living people undergoing criminal proceedings. Lancet 2001;358: 89-90.

The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) - – Articles 22 and 20*

Bent Sørensen, MD, DMSc**

Article 22: Persons' right to complain

Article 22 gives a person the right to complain to the Committee Against Torture[1] (hereinafter the Committee) if he presumes that a country which has ratified the CAT is in breach of one or more of the CAT provisions.

The main conditions to be fulfilled in order to launch a complaint are found in the following paragraphs of Article 22:

Par. 1:
- Independent ratification
- (56 out of 142 states have ratified as of January 2006)[2]

Par. 2:
- Minus anonymous
- Minus abuse

Par. 5 (a):
- Minus other international procedures

Par. 5 (b):
- + exhausted domestic remedies
- Dialogue with state party and complainant

Par. 8:
- Possibility to withdraw from Article 22

The CAT secretariat registers the complaint. If it fulfills the mentioned conditions, the Committee will start an investigation. The duties of the Committee regarding Article 22 are the following:

- All proceedings in private meetings (confidential)
- Receiving communications from individuals and considering:
  i. Admissibility
  ii. Substance

Until now all proceedings are in private.

The outcome:
- Decisions (on i and ii) are published in the Annual Report
  - Name of author anonymous (if he so wishes)
  - Name of country public

Only 56 State Parties of the 142 states that have ratified CAT, thus declared themselves in favour of Article 22.[2] The geographical distribution of the ratifications is remarkable (Table 1).

It might have been expected that most of the cases would consider breaches of Articles 2 and 1, where claimants accuse the state

*) Adapted version from panel discussions

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Table 1.

	Western states, incl. the former Eastern European states	Africa	Latin America & the Caribbean	Asia	Total
No. of state parties	36	10	10	0	56

parties of having carried out torture. However, less than five cases deal with this. A possible explanation can be that the claimants prefer to turn to the regional courts (the European Court in Strasbourg or the Inter-American in Costa Rica). If they win the cases in the regional courts, the state will be sentenced to pay quite substantial amounts of money to the claimants, while the Committee can "only" blame the state and make suggestions.

In the area regarding the problem of sending persons back to countries where they risk being subjected to torture, the articles of CAT prevail over the provisions of all other conventions. That is Article 3, par. 1 of the CAT reads:

"No state party shall expel, return ('refouler') or extradite a person to another state where there are substantial grounds for believing that he would be in danger of being subjected to torture."

As of 20 May 2005[3], the experience is that:

269 complaints have been registered, derived from 24 countries:

- 69 discontinued
- 47 declared inadmissible
- 111 final decision on merits, of these:
  - 32 were found as violations of the Convention
  - 42 still pending

Out of these 269 complaints, not less than 126 case decisions are regarding Article 3.1: (Table 2).

The CAT overrules other conventions, e.g. *Paez versus Sweden (Case 39/1996):*[4]

Table 2.

Country	+ Violation	- Violation	Inadmissible	Total
Sweden	11	22	8	41
Switzerland	3	22	4	29
Canada	2	7	11	20
Netherlands	1	8	4	13
France	2	0	4	6
Australia	2	2	1	5
Denmark	0	5	1	6
Norway	0	0	2	2
Hungary	0	1	0	1
Greece	0	0	1	1
Finland	0	1	0	1
Germany	0	1	0	1
Total	**21**	**69**	**36**	**126**

All, i.e. Mr. Paez, the Committee, and the authorities of Sweden agreed that Mr. Paez was a terrorist. Sweden claimed that according to international law it was not allowed to give asylum to a terrorist. The Committee answered that under no circumstances should Mr. Paez be sent back to Peru where he would risk being tortured. How Sweden would solve this problem was up to Sweden. It was neither for the Committee nor for Mr. Paez to solve this problem. Finally, Sweden did not extradite Mr. Paez, but accepted his presence in the country.

Frequently, the involved state parties asked the members of the Committee: 'How can the Committee, based only on the case papers, come to another decision than the state, who has interviewed the person several times, often for years?" Our answer was that the Committee knows a great deal about the behaviour of a torture victim and we refer to the conclusions in case 41/1996 – *Ksoki versus Sweden - Communication No. 41/1996:*[4] "Par. 9.3." The state party has pointed to contradictions and inconsistencies in the author's story, but the Committee considers that complete accuracy is seldom to be expected by victims of torture and that such inconsistencies as may exist in the author's presentation of the facts are not material and do not raise doubts about the general veracity of the author's claims."

Finally, I wish to make a comment about the problem of the thresholds for what is "substantial". When the United States ratified the Convention it defined "substantial" as being at least 50 percent probability. However, the more one knows about torture and the horror of it, the lower one sets the threshold.

I have been deeply involved in many of the decisions about Article 3 of the Convention, during my work in the Committee from its start in 1988 to 2000. I will confess that the decisions regarding sending back or not have been the most difficult to take in my whole life.

The Committee has to be accepted by the state parties for its impartiality, accountability, sense of justice and fairness. At the same time, it has a very big responsibility for the well-being and possibly of the life of the complainant. I still have nightmares now and then … not due to the 21 cases where the Committee prevented an expulsion, but because of some of the 69 cases where the Committee found no violation of Article 3, resulting in an expulsion. Have any of these been tortured when they were returned? One is one too many.

Article 20: The Committee against the state"

Article 20, paragraph 1, reads as follows:

"If the Committee receives *reliable information* which appears to it to contain *well-founded indications* that torture is being *systematically practiced* in the territory of a state party, the Committee *shall* invite that state party to cooperate in the examination of the information and to this end to submit observations with regard to the information concerned." (Author's emphasis)

Article 20 is a potentially forceful article – which no doubt explains the existence of Article 28 of the Convention[1], which, quite unusually for a human rights convention, specifically raises the possibility that states may make a reservation in respect of Article 20 "at the time of ratification". While reservations to Article 20 (or to any other provision of the Convention) may be subsequently withdrawn, the phrase "at the time of ratification" appears to exclude the possibility of state parties making a reserva-

tion to Article 20 post-ratification. Thus, it is possible to change a "no" to Article 20 to a "yes", but it is impossible to change a "yes" to a "no".

By January 2006, Article 20 was in force with respect to all states except the following: Afghanistan, China, Equatorial Guinea, Israel, Kuwait, Mauritania, Morocco, Saudi Arabia and Syria[2].

Para. 5 of article 20 says that "all the proceedings of the Committee referred to in paras. 1 to 4 of this article shall be confidential, and at all stages of the proceedings the cooperation of the state party shall be sought".

However, when all investigations have finished, the Committee can decide "after consultation with the state party concerned, to include a summary account of the results of the proceedings in its annual report made in accordance with article 24 of the Convention".

The Committee's rule of procedure no. 73[5,6] is in accordance herewith, but para. 2 reads "meetings during which the Committee considers general issues, such as procedures for the application of article 20 of the Convention, shall be public, unless the Committee decides otherwise". It is obvious that the Committee has discussed the contents and definition of "reliable information", "well-founded indications" and "systematically practiced" thoroughly because the Convention's text is quite clear: If the three questions are answered in the affirmative, the Committee *shall* invite the state party.

Naturally, only incidents that have taken place after the Convention came into force in the country concerned are of interest.

Furthermore, the torture described must comply with the definition of torture as stated in the Convention's Article 1:

- "*severe* pain or suffering, whether *physical or mental*"
- "inflicted *intentionally*"
- "for such *purposes as* …"
- "by a *public official*"

In should be noted that article 20 only concerns torture. It does not concern "other cruel, inhuman or degrading treatment or punishment", or any other form of organised violence which is not defined as torture (e.g. forced disappearances and extrajudicial executions), nor does it concern capital punishment.

The number of actions that have been taken under Article 20 is also very limited as only six reports have been published:

- Turkey (1993)[7]
- Egypt (1995)[8]
- Peru (2001)[9,10]
- Sri Lanka (2002)[11]
- Mexico (2003)[12]
- Serbia and Montenegro (2004)[13]

During its Article 20 investigations the Committee found systematic torture in Turkey, Egypt, Mexico and Peru. In Sri Lanka and in Serbia and Montenegro systematic torture belonged to the past, while sporadic torture still occurred. Of those countries only Egypt and Sri Lanka have *not* declared themselves in favour of Article 22.

Making a reservation to Article 20 prevents the Committee against Torture from exercising one of its potentially most effective powers in relation to the concerned State Party. Nevertheless, it should be noted that less than five per cent of state parties (7 out of 142) have chosen to do so.

References

Please turn to page 128.

The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)/ Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)*

Bent Sørensen, MD, DMSc, Ole Vedel Rasmussen, MD, DMSc*****

The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) was adopted in consensus by the UN General Assembly on December 10, 1984 and went into force on June 26, 1997. The first meeting of the UN Committee Against Torture (hereinafter called the Committee) was in April 1988. The Convention for Prevention of Torture under the Council of Europe was adopted in February 1989, and the first meeting of the Committee (CPT) took place in November 1989.

Article 11 in the CAT states that:

"Each state party shall keep under systematic review interrogation rules, instructions, methods and practices as well as arrangements for the custody and treatment of persons subjected to any form of arrest, detention or imprisonment in any territory under its jurisdiction, with a view to preventing any cases of torture".

Very early in their functioning the two committees realised that this Article was nearly never respected by the countries examined. If it had been, there would have been no need for OPCAT. Furthermore, the two committees understood that the inspection procedures done by CPT were very successful.

Consequently, a group consisting of members of the CAT Committee, the CPT, Amnesty International, and the International Committee of the Red Cross suggested that the old idea of an inspection procedure in connection with the CAT should be revived.

*) Adapted version from panel discussions

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Authors' note: Upon writing the above for TORTURE (April 2007), the election as well as the first meeting of the Subcommittee have taken place. Some of the new elected members are present or former members of the CPT, in particular Sylvia Cassale (UK), who has been the president of the CPT and is now elected as president of the OPCAT. Consequently a smooth start of the Subcommittee can be anticipated.

Further, Costa Rica suggested that an open-ended working group under the Human Rights Commission should be established. So it was, and for ten years the working group held an annual two-week meeting in Geneva with participation of interested states, Association de Prevention de Torture (APT) and CAT.

When the open-ended working group gave up reaching consensus, it was possible to create a draft protocol. Furthermore, at the very end of the work it was suggested and accepted that a national inspection mechanism should be established.

The OPCAT history is as follows:

- Workshop established in 1991
- 7 November 2002: UN General Assembly
  •140 votes in favour
  •8 votes against (China, Cuba, Israel, Japan, Nigeria, Vietnam, Syria and USA)
  •37 abstentions
- 18 December 2002: UN General Assembly
  •Formal adoption
  •127 votes in favour
  •4 votes against (USA, Nigeria, Marshall Islands, Palau)
  •42 abstentions

By June 22, 2006 the situation was as seen in Table 1.

Only states that have ratified UN CAT (at the moment 142) can ratify OPCAT.

OPCAT went into force on June 22, 2006 and the first election to the membership of the international committee was scheduled for December 18, 2006.

The subcommittee shall be:
- elected for four years
- consisting of 10 members
- [50 states – 25 members]
- able to serve in individual capacity
- independent
- impartial
- available

Table 1.

Western States incl. the former Eastern European States	Africa	Latin America & the Caribbean	Asia
Albania Armenia Croatia Czech Republic Denmark Georgia Liechtenstein Malta Poland Republic of Moldavia Serbia Spain Sweden Ukraine United Kingdom	Benin Liberia Mali Mauritius Senegal	Argentina Bolivia Costa Rica Honduras Mexico Paraguay Uruguay	Maldives
15	**5**	**7**	**1**

Signatories: 56, Parties: 28

The function of the Subcommittee is similar to the function of the CPT: Periodic or ad hoc visits to all places where persons are detained against their will by the individual state, and to write a confidential report which is sent to the state in question. Based on the facts found during the visit, the report asks questions and gives comments and recommendations to the state.

The composition of the national prevention mechanism is as follows:

State party shall establish
- Independent
- Preventive
- One or several national mechanisms
- Within one year (three years) after ratification

State party shall ensure
- Independence of the committee
- Professionalism of members
- Necessary resources

Tasks
- Regular visits to places of detentions
- Recommendations
- Annual report

Finally, the mandate for both the international subcommittee and the national is the following:

- Visits to all target places
- Talk in private with detainees and others
- See all premises
- See all papers
- Unannounced visits
- Repeated visits

(References from page 125)

1. The Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT). Fact sheet no. 17.
2. Links to the official reports of the Committee Against Torture can be found at www.unhchr.vh
3. Report of the Committee Against Torture. General assembly. Official records: 60th session. Suppl. no. 44 (A/60/44). New York: United Nations, 2005.
4. Report of the Committee Against Torture. General assembly. Official records: 51st session. Suppl. no. 46 (A/51/46). New York: United Nations, 1996.
5. Report of the Committee Against Torture. General assembly. Official records: 43rd session. Suppl. no. 46 (A/43/46). New York: United Nations, 1988.
6. Report of the Committee Against Torture. General assembly. Official records: 44th session. Suppl. no. 46 (A/44/46). New York: United Nations, 1989.
7. Report of the Committee Against Torture. General assembly. Official records: 48th session. Suppl. no. 44 (A/48/44). New York: United Nations, 1993.
8. Report of the Committee Against Torture. General assembly. Official records: 51st session. Suppl. no. 44 (A/51/44). New York: United Nations, 1996.
9. Report of the Committee Against Torture. General assembly. Official records: 55th session. Suppl. no. 44 (A/55/44). New York: United Nations, 2000.
10. Report of the Committee Against Torture. General assembly. Official records: 56th session. Suppl. no. 44 (A/56/44). New York: United Nations, 2001.
11. Report of the Committee Against Torture. General assembly. Official records: 57th session. Suppl. no. 44 (A/57/44). New York: United Nations, 2002.
12. Report of the Committee Against Torture. General assembly. Official records: 58th session. Suppl. no. 44 (A/58/44). New York: United Nations, 2003.
13. Report of the Committee Against Torture. General assembly. Official records: 59th session. Suppl. no. 44 (A/59/44). New York: United Nations, 2004.

Headlines from the presentations, sessions and workshops

Dealing with impunity

In his paper "The psycho-social effects of repression and impunity in Argentina", Dr. Lagos introduced the social struggle for justice and the fight against impunity after the dictatorship in Argentina. The statistics of the military dictatorship in Argentina in from 1976 to 1983 showed 30,000 missing detainees, 10,000 detained in jails, hundreds of thousands exiled or internally displaced, thousands executed, and 500 children born into captivity and deprived of their identity. Despite trials against the Junta in the mid 1980's many crimes have not been addressed, pardons have been given to members of the military Junta, and the law of due obedience and the law of full stop were passed, granting impunity to perpetrators.

Twenty years after the military coup the struggle against impunity was reactivated in 1996. Demonstrations again led to arrests and even killings by the police (2002). This incident and the strong social response caused the resignation of the president and a new election and led eventually to legislative change annulling the laws of impunity, new judicial trials and a conviction for genocide in 2006. The effects of re-traumatisation include, above all in young people, personal experiences of defencelessness and abandonment; anguish and anxiety, fear, panic, feelings of persecution; paranoid anxieties; nightmares/flashbacks; and fantasies of insecurity, based on the principle of reality. Dr. Lagos stresses the importance of upholding a social response and the use of organised social response to force governments and the international community to react, to not forget and to end impunity.

In her paper "Fighting impunity: working with the inter-American human rights court" Ms. Deutsch introduced the "Miguel Castro Castro Prison case". It refers to the massacre of political prisoners in 1992 in the Castro Castro prison in Lima. The case was heard by the Court in June 2006. In recent years international attention has focused on finding ways to fight impunity surrounding gross violations of human rights.

Monica Feria was one of the few survivors and was involved in the case at court. She shared her personal experience and the prosecution procedures.

In his lecture, "Preventing impunity for torture in India" Mr. Kumar presented a definition of impunity and elaborated on human rights violations in India and the provisions in the Indian constitution, legislation and case law, calling upon legislative changes to comply with and endorse international law and prevent impunity for human rights violations and torture. India has still not rat-

ified the Convention against Torture and is not a member of the International Criminal Court.

The theoretical doctrine of Sovereign Immunity still exists, but it is being applied in a liberal manner. The courts interpret "sovereign" narrowly as shown in recent case law. The courts believe that the doctrine of Sovereign Immunity is inapplicable in the case of violation of fundamental rights (life and personal liberty) and establish victim entitlement to compensation. He followed up with case examples:

The Rampur Tihara Incident in 1994: here the government of Uttar Pradesh claimed sovereign immunity to disown its liability for the excesses committed by the police personnel against the peaceful demonstrators of the Uttrakhand Movement.

The Punjab Mass Cremation Case from 1996: Serious allegations were made in the writ petitions about large scale cremations resorted to by the Punjab police of persons allegedly killed in what were alleged as "encounters".

In many other cases Indian security forces have shot civilians under the authority of laws. For example, on February 23,2006, soldiers in Handwara shot at a group playing cricket, suspecting that a militant was hiding among them.

The impacts of impunity on victims are multiple. They include depression, anxiety, sleep disorders, suicidal tendencies, alcohol and drug addictions, depression, distrust of authority, alienation, divisions in society that takes long time to heal, feelings of helplessness, retaliation and insecurity by victims and witnesses.

Mr. Kumar presented a long list, comprising 29 recommendations.

There was a high level of interest in the presentations, the session was lively and the discussion animated.

In general it was agreed that there is a lot to be done to prevent torture as it happens, beyond follow-up on impunity: US renditions, the situation in Afghani and Iraqi prisons, and disappearances. These need to be prevented and urgent intervention is needed. The comment was made regarding the important impact that court cases can have on prevention and other current cases, as well as future cases through non-repetition by creating precedent.

After 30 years of research, doctors are ready to document and to prove torture in cooperation with lawyers.

Reparations, including rehabilitation for torture survivors – with a special focus on gender

This symposium presented the theme of the sexual torture of both men and women with cases highlighted from the Iraq and Afghanistan wars, Peru, and Bosnia. It also focused on papers about the psycho-legal approach in cases of human rights violations, male rape and sexual torture as a wartime crime against humanity and examined victims of trafficking from a forensic point of view, including the importance of accurate forensic documentation in cases of trafficked persons.

In the first presentation Juana de Fernandez expressed that lawyers and psychologists could work together with the patient to explain the legal process. She outlined how a workshop helped victims to gain more confidence and understand the legal process and the problems entailed. As a result, people began to act together for justice. It was also noted that lawyers needed to be educated about the psychological effects of rape, especially when victims can be retraumatised during the trial. Cases were pre-

sented with traumas due to pregnancies, for example the mass rape of a 14 year old girl and how childbirth affected the lives of two raped married women. Sexually violent acts destroy individual and family development. At the conclusion of the symposium it was evident that a multi-disciplinary approach is necessary. There is also a need to help with secondary trauma and the need to protect the individual and communities.

Hilmi Zawati covered the topic of rape victims and presented that they are broken down and that this affects both family and society. In total, 4000 men were sexually abused during the Bosnian war. There is evidence of rape of Bosnian and Croatian Muslims and cases of castration. In Iraq rape was carried out on men and women in Abu Ghraib prison. The American policy of coercive interrogation continued even after the abuses at Abu Ghraib were exposed. The US signed a military bill rendering Geneva conventions not applicable for US personnel. According to US Statutes, US personnel cannot be prosecuted for war crimes. The policy of coercive interrogation was authorised at the highest levels in Abu Ghraib prison.

Zawati concluded with three kinds of remedies for victims:1) Legal remedies 2) psycho-social community remedies and 3) overcoming the culture of impunity by making rape a crime against humanity. Wartime rape should be considered as a war crime. Male rape victims should be encouraged to come forward. His presentation was the basis for an article in Torture, Volume 1, 2007.

Djordje Alempijevic spoke about human trafficking and presented a definition that is generally acknowledged by the UN. The crime of trafficking is a growing transnational crime, and a global phenomenon where 600,000 to 800,000 adults and up to 1.2 million children are trafficked. Forensic medical evidence helps documentation and prosecution and contributes to awareness. Better procedures mean fewer traumas for victims. An article on this topic appears elsewhere in this issue of Torture.

During the discussion it was said that no international conventions mention rape as a war crime. This is because statutes do not give a clear definition of rape. Further, the example was given as to how it is very difficult to bring cases to trial in Peru so there are few cases that come to court. Victims don't have access to justice because of the lack of lawyers and rape victims prefer to be silent as they may be stigmatised in the family or society. There was lively discussion about the Abu Ghraib scandal. The question was asked as to why Iraq doesn't make a complaint to the International Criminal Court. The response was that sometimes political actions keep things from being brought forward.

Rape and sexual violence are common practices. Acts take place in the context of war, but social ideas still exist. For example, there are ideas about how it could be a solution for victims to marry their perpetrator. In addition, male rape is even less recognised or commented on. There was a general feeling that it is good that this is being brought to our attention. There were questions as to why it is difficult to bring it up as a human rights violation.

The session was lively and provoked a lot of questions. The speakers were informative and highlighted a number of key issues about rape as a war crime and the importance of documentation of evidence and psycho-social support for victims, especially when it comes to prosecution.

Transcultural and culturally sensitive strategies in diagnosis and treatment

The presentations focused on disrupted cultures and torture, models for multi-disciplinary and transcultural approaches based on eight years of work in a clinic for Latin American refugees, and the question of possible cultural limits to psychiatric diagnoses and treatment guidelines.

During the discussion, the impact of the new cultural environment on the torture survivor refugees and their children was touched upon. It was mentioned how second generations often see some dysfunctionalities related to identity and the two cultures they are faced with, and how indigenous populations faced with PTSD often show specific symptoms. It was also mentioned how it is often a challenge to get both men and women to participate equally in rehabilitation efforts and activities.

The discussion then turned to the question of the possibility of developing clinical guidelines, which are adaptable to the different countries and cultures, taking the cultural dimensions of diagnosis into consideration.

It was also mentioned that personality structure differs from culture to culture, and it was suggested that there are different symptoms of PTSD depending on the culture and personality structures.

The cultural expression of suffering was estimated to be important and to be missing in the evaluation and monitoring of questioning methods; this is increasingly evident in a gradually more globalized world.

Istanbul Protocol and forensic physicians

This workshop presented on the Istanbul Protocol in the every day practise of physicians. People where encouraged to participate openly and actively.

During the discussion, the concern that doctors working in a rehabilitation centre for torture victims would never be considered independent by the state was expressed. To this the reply was that it does not have to be a doctor from a rehabilitation centre as long as the doctor is qualified to carry out an examination and as long as no law enforcement officials are present.

Concentrative movement therapy

This workshop presented on the use of concentrative movement therapy (CMT) with traumatized refugees and torture survivors.

The discussion following the workshop presentation touched upon the characteristics of patients receiving CMT, as well as of those who will not benefit from such treatment. Typically, patients with bad feelings about their bodies will receive CMT – these are mainly pain patients.

There was also some discussion about the use of regular objects that resemble torture instruments, and how patients can gradually be taught to accept these in their treatment and their daily lives.

Secondary trauma, burnout and care for caregivers

Subsequent to the symposium presentation a lively and animated discussion took place. Many agreed with the speakers and had experienced personally, or seen in their organizations, elements of secondary trauma or burnout. One of the main concerns was the need to break the taboo about speaking about these issues within the organizations themselves.

Among the questions raised was the need for external supervision which would benefit neutrality and efficiency. To avoid burn out it was recommended to take breaks, make sure to separate work and personal life, and

possibly change job tasks to a less stressful area of work, such as taking on administrative duties. It was commented that therapists are often "anti-authoritarian" and have little interest in doing administrative work – this was considered to be particularly true for NGO workers.

One participant commented that some staff would be hesitant or resistant to receive supervision, in which case a long process of persuasion would be necessary, convincing involved parties to see it as protection, not stigmatization.

There seemed to be some consensus that there should be protection against secondary trauma built into organizations. While the work against torture is seen as rewarding, it can seem futile as well. It is important to break the taboo and denial about burn out.

Dance/movement therapy approaches to fostering resilience and recovery among African adolescent torture survivors*

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Abstract

Dance/movement therapy (DMT) interventions, if designed to promote cultural relevance and community ownership, may enhance healing among African adolescent survivors of war and organised violence. The author posits a theoretical rationale for body movement-based approaches to psychosocial rehabilitation, and offers DMT's holism as evidence of transcultural applicability. Two distinct DMT initiatives with this population are discussed in terms of theoretical assumptions, implementation, and outcomes. Both efforts afforded creative means for discharging aggression and restoring interpersonal connection. The first of these programes engaged a community of South Sudanese refugee youths, resettled to the U.S., in a series of gatherings for traditional dancing and drumming that reconstituted a central culture-of-origin ritual. Anecdotal evidence supports this psychosocial intervention's emphasis on group cohesion as a vehicle with both preventive and reparative capacities. Also a series of DMT groups with youths in Sierra Leone. All organized several years post-conflict, these interventions involved applying the DMT modality within a framework of Western psychotherapeutic conventions described in a series of groups with youths, all organized several years post-conflict, is presented. Programe evaluation revealed a drop in average symptom expression among a group comprised of former boy combatants who reported continual reduction in symptoms of anxiety, depression, intrusive recollection, elevated arousal, and aggression. The group´s teenage males joined actively in improvisatory dancing and in other structured creative exercises. Theese former child soldiers later elected to demonstrate their wartime experiences through public presentation of a role-play. A report on this event illustrates the success of the process in overcoming stigma and enabling meaningful community reintegration. Thus, whether introduced in refuge or post-conflict, DMT approaches are shown to embody revitalizing psychosocial support in the aftermath of massive violence.

Key words: Torture, trauma, child soldier, refugee, war, Africa, reconciliation, creative arts therapy, sociodrama, dance/movement therapy

Introduction

In the year 2000, UNICEF estimated that armed conflicts worldwide had traumatized ten million children during the decade-long span that began in 1986.[1] Given the impact of war and organized violence on children's well-being, initiatives targeting the psychosocial needs of war-affected young people would logically amount to a global priority. Whether in developed or developing countries, however, programmes that deliberately

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1) Children and armed conflict: report of the Secretary-General. New York: United Nations, 2000 19 July. Report No.: A/55/163-S/2000/712.

and meaningfully address psychosocial problems among children of war remain relatively uncommon, despite the potential for strengthening identifiable protective factors that may shield children and adolescents from severe emotional and psychological harm.

Engaging cultural resources, including those associated with creative artistic expression, has been shown to enhance communities' resilience in the face of terror and deprivation, and to cultivate children's capacities in particular.[2,3,4] Dancing is one such expressive activity, the collective performance of which delivers strong potential for sublimating inter-group tensions, while increasing interpersonal connection and strengthening solidarity. Although rarely utilized as modes of psychosocial intervention, dance/movement programmes, if appropriately designed to maximize cultural relevance, may prove an effective means of fostering resilience after massive violence. This essay documents the author's use of dance as a medium of healing with war-affected African youth, both those in refuge in the West and those living in a post-conflict situation in their war-ravaged homeland. In detailing the pertinent benefits of particular dance-based initiatives—including but not limited to relaxation that flows from the pleasurably contained release of aggression through body movement—the discussion below focuses on methods applied for ensuring the programmes' community ownership and cultural appropriateness.

Structured in three interconnected parts, this paper begins with a brief rationale for body movement-based interventions in torture rehabilitation. There follows an introduction to dance/movement therapy ("DMT"), particularly as defined in terms of this psychotherapeutic modality's suitability for fostering recovery among young African survivors. Concluding the argument are descriptions of two distinct DMT approaches to working with young torture survivors, as inherent in a pair of interventions – preventive, on the one hand, and largely reparative on the other – with African youths in quite differing environments. It cannot be overemphasized that each of these two unique DMT programmes was developed with a specific sociocultural context in mind: A situation of resettlement in the developed North, and a situation of a post-conflict society in the global South. Any programmatic generalizability, therefore, would have to be elicited from the broader therapeutic vision of the interventions, rather than from their specificities, which involved considerable adaptation to social, cultural, and political realities in the two environments.

Chronologically first among these programmes was an initiative that served 70 unaccompanied South Sudanese refugee minors resettled to the United States. Traditional dance was this programme's defining communal activity. The second programme to be discussed, and the more recently completed, concerns a series of four gender-specific counseling groups conducted

2) Richman N. Annotation: Children in situations of political violence. J Child Psychol Psyc 1993;34:1286-302.

3) Miller KE, Billings DL. Playing to grow: a primary mental health intervention with Guatemalan refugee children. Am J Orthopsychiat 1994;64:346-56.

4) Boothby N. Mobilizing communities to meet the psychosocial needs of children in war and refugee crisis. In: Apfel RJ, Simon B, eds. Minefields in their hearts: the mental health of children in war and communal violence. New Haven: Yale University Press, 1996:149-64.

with adolescents in a remote rural district in Sierra Leone. All of the young participants in these four DMT counseling groups – including the one discussed below with former child soldiers – originated from or had returned to border communities at the epicenter of atrocity during the recent 11-year war.

These DMT projects were sponsored by two different humanitarian agencies, and involved quite contrasting sets of objectives and therapeutic paradigms. By here identifying and analyzing the strengths of the two interventions—which succeeded in remarkably different ways—it may be possible to elucidate the underpinnings of DMT's un-usual flexibility and relevance in fostering resilience and recovery among African youth. Indeed, comparing observations from this pair of programmes sheds light on what appears to be a broad capacity in the DMT modality for promoting healing among distinct populations of African youth to have survived egregious violations of their human rights and intrinsic dignity as persons.

Focusing on the body and body movement in torture treatment

Even cursory analysis of the psychophysiology of trauma and posttraumatic distress reveals that human beings both live and relive traumatic exposures. The original incident and the reliving alike tend to be experienced "at the body level" through such functions as heart rate, respiration, and perspiration, often in tandem with images that may seem to overrun the mind. It is commonly agreed that initially our bodies respond to life-threatening events through fight or flight, or by undergoing a sort of temporary paralysis likened to freezing.[5] Long after the disappearance of genuinely acute danger, the involuntary functions controlled by the autonomic nervous system may continue to operate as if the threat were present. This posttraumatic phenomenon of re-experiencing agitation and elevated arousal associated with memories of grave threats to well-being, moreover, is observed across cultures, regardless of vast differences in local understandings of the idea of trauma, and of suffering itself.

In underscoring advances in neuroanatomy research that have buttressed contemporary practice in the field the psychophysiology of trauma, Bessel van der Kolk and his colleagues[6] have taken a lead in turning the attention of psychotraumatology to the importance of addressing the body in trauma treatment. In a November 1988 presentation, entitled "Neurobiology, Attachment and Trauma," at the annual meeting of the International Society for Traumatic Stress Studies, Van der Kolk postulated:

If it is true that at the core of our traumatized and neglected patients' disorganization is the problem that they cannot analyze what is going on when they re-experience the physical sensations of past trauma, but that these sensations just produce intense emotions without being able to modulate them, then our therapy needs to consist of helping people stay in their bodies and to understand these bodily sensations.[7]

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5) Rothschild B. The body remembers: the psychophysiology of trauma and trauma treatment. London: WW Norton & Co, 2000.

6) Van der Kolk BA, McFarlane AC, Weisaeth L. Traumatic stress: the effects of overwhelming experience on mind, body, and society. New York: The Guilford Press, 1996.

7) See note 5. p 3.

Van der Kolk's advice to clinicians to monitor trauma sufferers' capacity for making sense of the connection between sensation and experience serves as a guiding principle for many mental health service providers, and not only those with a decidedly somatic orientation. Yet techniques for regaining such corporeal understanding differ widely from one culture to another.

Dance/movement therapy and its transcultural applicability

Dance/movement therapy is particularly well-equipped for overcoming cultural differences, while helping traumatized persons gain the skills they need both for grounding themselves "in their bodies," and for comprehending the relationship between bodily sensation and traumatic memory. The American Dance Therapy Association, a four-decade-old professional organization active in the United States, has defined DMT as "the psycho-therapeutic use of movement as a process that furthers the emotional, cognitive, social, and physical integration of the individual."[8] Thus, dance/movement therapists engage at the locus of the human body an extraordinary fount of meanings – physical, affective, cognitive, developmental, and even spiritual. According to one leading exponent of the modality in the United States, DMT's central premise is that "the visible movement behavior of individuals is analogous to their intrapsychic dynamics."[9] Perhaps anticipating the field's lack of consensus over such psychodynamic terminology, this same practitioner managed to coalesce divergent perspectives on the profession by identifying along with her basic premise three core assumptions concerning DMT practices that elaborate on it:

1. Movement reflects personality.
2. The relationship established between the therapist and patient through movement supports and enables behavioral change.
3. Significant changes occur on the movement level that can affect total functioning.[10]

The dance/movement therapist, accordingly, utilizes movement interaction as the primary – but not the only – means for accomplishing therapeutic goals in both assessment and treatment.

For the most part, DMT has been articulated within the United States and Europe, nonetheless, the modality's application may extend far beyond the developed North, since its origins and development are informed by a fusion of Western psychological precepts and dance – itself a worldwide form of cultural expression with its beginnings in celebratory ritual. Fundamental to this body-oriented mode of psychotherapy, moreover, is the notion that health and well-being are predicated on an integral connectedness of psyche and soma. Such an abiding ethos of intrinsic holism would appear at one with that of many cultures of the developing world. Given the unusual concurrence in one treatment modality of these three elements – foundations in Western psychotherapeutic theory and practice, association with the global phenomenon of ritual, and holistic belief in the unity of mind and body – DMT should prove ideally suited to respond to the effects of torture

8) American Dance Therapy Association, 2006. www.adta.org [cited 2006 Dec 15].

9) Schmais C. Dance therapy in perspective. In: Focus on dance. Washington, DC: American Alliance for Health, Physical Education and Recreation, 1974:10.

10) Ibid.

and war among persons from holistic, collectivist cultures.

Indeed, with body movement accepted across many such cultures as a "basic mode of communication,"[11] dance/movement therapists may be especially well prepared to engage survivors transculturally. Furthermore, the modality in its early years – as practiced by founder Marian Chace at St. Elizabeth's Hospital in the U.S. capital – was virtually indivisible from the treatment regimen of numerous psychiatric casualties of the Second World War.[12] Despite these diverse, transcultural origins and a history as postwar treatment, this form of therapeutic intervention has, to date, been little utilized in prevention and recovery programmes addressing the needs of either children or adolescents affected by war and organized violence, whether in the developing or the developed world. As of this writing, apparently nothing has been printed on DMT that specifically considers an application with children of war.

There is, however, an emerging literature that addresses DMT as torture treatment.[13,14,15,16,17] Karen Callaghan, a therapist at London's Medical Foundation for the Care of Victims of Torture, has underscored in accounts of her movement psychotherapy with survivors an essential oneness of being that is the specific target of the torturer's cruelty. "Memories live in the body," she posits, "and are stimulated by one's own or another's movements." Pointing to the fundamental unity of mind and body she locates resources at the body level – including "[m]uscular and visceral responses to emotions and memories"[18] – for repair of the body/mind split that many survivors experience as an overwhelmingly dehumanizing consequence of the terror they have endured. The dance therapist's holistic conviction thus harmonizes well with Van der Kolk's blunt deduction: "Brain, body, and mind are inextricably linked, and it is only for heuristic reasons that we can still speak of them as if they constitute separate entities."[19]

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11) Pallaro P. Culture, self and body-self: dance/movement therapy with Asian Americans. Art Psychother 1997; 24(3):227.

12) Johnson DR. Marian Chace's influence on drama therapy. In: Sandel SL, Chaiklin S, Lohn A, eds. Foundations of dance/movement therapy: the life and work of Marian Chace. Columbia, MD: The Marian Chace Memorial Fund of the American Dance Therapy Association, 1993:176-89.

13) Callaghan K. Movement psychotherapy with adult survivors of political torture and organized violence. Art Psychother 1993;20:411-21.

14) Callaghan K. In limbo: movement psychotherapy with refugees and asylum seekers. In: Dokter D, ed. Arts therapists, refugees and migrants: Reaching across borders. London: Jessica Kingsley Publishers, 1998:25-40.

15) Callaghan K. Torture-the body in conflict: the role of movement psychotherapy. London: Medical Foundation for the Care of Victims of Torture. Paper No. C36.

16) Gray AEL. The body remembers: dance movement therapy with an adult survivor of torture. Am J Dance Ther 2001; 23(1):29-43.

17) Harris DA. Remaking the world: dance/movement therapy with survivors of torture and war. In: Proceedings of the thirty-eighth annual conference of the American Dance Therapy Association [CD-ROM]. Denver, CO: ADTA, 2003.

18) Callaghan K. Movement psychotherapy with torture survivors [master's thesis]. Philadelphia, PA: Hahnemann University, 1991:59-60.

19) Van der Kolk BA. The body keeps the score: approaches to the psychobiology of posttraumatic stress disorder. In: Van der Kolk BA, McFarlane AC, Weisaeth L, eds. Traumatic stress: the effects of overwhelming experience on mind, body, and society. New York: The Guilford Press, 1996:216.

Such holism is indeed core within the field of dance/movement therapy, and on occasion is linked with what are deemed timeless cosmologies and practices. While some dance/movement therapists focus on the Western psychotherapeutic side of the DMT healing continuum, there are others guided by the modality's primary antecedents in dances of communal affirmation and defence – in "roots . . .[that] extend back to ancient times in dances of celebrations and crises, in dances that define individual and group identity, and in dances of death and exorcism."[20] Dance therapists, accordingly, have referenced the scholarship of ethnologist Judith Lynne Hanna, who discerns among traditional cultures a number of specific functions for dance, all possibly pertinent to healing from organized violence:

(a) the mediation of unknown and uncontrollable forces within participants and their environment,
(b) a safe way of acting out negative or deviant emotions and behaviors,
(c) a means for self-transformation or for enacting changes in adopted role or status,
(d) a way of releasing emotions arising from personal conflicts or pent-up frustrations and (e) the reaffirmation of an individual's inclusiveness within the communal group.[21]

A search for ways of galvanizing the restorative strengths of the communal, as for sources of regeneration, release, and renewal – functions Hanna identifies in dance itself – leads certain DMT practitioners and theorists beyond examination of dance ethnography to that of the rituals and traditional healing practices of non-Western cultures. It would follow that applying relevant DMT methodologies, not only with individuals from societies where an *egocentric* identity structure prevails, as among the cultures of the developed North, but with groups of people from *sociocentric*[22] cultures that exist in much of Africa[23] and elsewhere in the global South, has potential to yield revitalizing transformation in the wake of massive violence.

Desomatizing memory through mindfulness and creative symbolization

"Trauma" may be understood as a process that encompasses an interaction of risks associated with exposure to stressors and factors that may mitigate the potential impact of such an encounter. Overcoming the consequences of such traumatic exposures as those to extreme terror and violence involves what Van der Kolk refers to as a practice of "desomatizing" recollection.[24] So long as the mind deems the traumatic event unutterable, he theorizes, the body automatically re-

20) See note 9, p. 7.

21) Dosamantes I. Body-image: repository for cultural idealizations and denigrations of the self. Art Psychother 1992;19:265.

22) Shweder RA, Bourne EJ. Does the concept of the person vary cross-culturally? In: Shweder RA, LeVine R, eds. Culture theory: Essays on mind, self and emotion. Cambridge: Cambridge University Press, 1984:158-99.

23) Okeke BI, Draguns JG, Sheku B, Allen W. Culture, self, and personality in Africa. In: Lee Y-T, McCauley CR, Draguns JG, eds. Personality and person perception across cultures. Mahway, New Jersey: Lawrence Erlbaum Associates, 1999:139-62.

24) Van der Kolk BA. The complexity of adaptation to trauma: self-regulation, stimulus discrimination, and characterological development. In: Van der Kolk BA, McFarlane AC, Weisaeth L, eds. Traumatic stress: the effects of overwhelming experience on mind, body, and society. New York: The Guilford Press, 1996:205.

sponds to the intrusive remembrances of the experience as if it were happening all over again. Healing means altering that feedback loop, identifying the "triggers" to such bodily responses and attaching words to these painful "somatic experiences" affords a potential to loosen terror's grip. "[T]he task of therapy," observes Van der Kolk, "is both to create the capacity to be mindful of current experience, and to create symbolic representations of past traumatic experiences, with the goals of taming the associated terror and of desomatizing the memories."[25] Enhancing mindfulness, or reunifying mind with body in a way that cultivates awareness of being in the present moment, the here-and-now, is thus posited as an act that both precedes and informs symbolization, and in turn opens the way to recovery. These as well are core DMT processes in trauma treatment – promoting awareness of a reintegrated body/mind oneness, and facilitating creative expression to represent the traumatic suffering, its origins, and the personal or collective strengths available for recovering from its pain.

In further situating DMT in the assessment, prevention, and treatment of emotional or psychological disturbances associated with children's exposure to the stressors of war, it may be useful to consider the application of other expressive arts therapy modalities in such contexts. Creative activities are broadly seen to afford children a valuable way of coping meaningfully with their suffering through "symbolic expression of shared feelings" that may enable "reaffirming [their] identity or competence."[26] The creative process, improvisatory thought and action, and symbolization more generally, are innately therapeutic.[27,28] All are basic as well to the creative arts therapy modalities, just as they are valued for their role in furthering children's healthful development.

There is a role for such pivotal creative processes in coping with and integrating experiences of traumatic disturbance. Van der Kolk indicates that individuals enacting posttraumatic repetition compulsions are frequently more capable of expressing "internal states more articulately in physical movements or in pictures than in words."[29] Writing within the framework of Western psychotherapy, he prescribes expressive arts interventions in response: "Utilizing drawings or psychodrama may help [these individuals] develop a language that is essential for effective communication and for the symbolic transformation that can occur in psychotherapy."[30] As Van der Kolk suggests, the *language* of creative arts expression may indeed compensate for or even overcome difficulties in using words to convey feelings. This difficulty, alexithymia, is a common occurrence after exposure to extreme stressors, and one that this prominent trauma researcher and others have found "mirrored in actual changes in brain activity."[31]

Children of war – and adolescent torture survivors too – may experience just such impediments to verbal expression, or may

25) Ibid.

26) See note 2, p. 1296.

27) Maslow AH. The farther reaches of human nature. New York: Penguin Books, 1976.

28) Goodill SW, Morningstar DM. The role of dance/movement therapy with medically involved children. Int J Arts Med 1993; 2(2):24-7.

29) See note 24, p. 195.

30) Ibid.

31) See note 19, p. 233.

come from cultures that restrain altogether discursive processing of both posttraumatic and more commonplace disturbances. Evidence suggests that these youths may be usefully encouraged to engage in representing their feelings and thoughts through artistic means – at least those considered culturally syntonic. For young refugees, creative production may be associated with the "construction of meaning and identity,"[32] a process that enables safer psychic passage between the country of origin and the site of exile or asylum. Rädda Barnen's approach to helping Southern Sudanese children in the Pignudo refugee camp in Ethiopia – members of the same group of so-called Lost Boys who comprise the resettled refugee community served years later by the DIER programme discussed in this paper – thus incorporated a range of creative activities.[33] The landmark United Nations study, "The Impact of Armed Conflict on Children," (termed the Machel Study, after lead author Graça Machel) endorsed such approaches explicitly, noting that children's ongoing need for emotional and intellectual stimulation may be fulfilled in part through "structured group activities such as play, sports, drawing and storytelling" (Par. 179).[34] Surely, dancing and DMT approaches merit inclusion in any update of the Machel Study's otherwise partial list.

Comparing two distinct DMT approaches for enhancing coping capacity among African adolescent survivors

Two humanitarian organizations in recent years, first a U.S. refugee resettlement agency, and later an international NGO in Sierra Leone, launched quite different dance-based psychosocial interventions, both coordinated by the author, in the service of resilience and torture rehabilitation among African youths. These two programmes articulated differing methods for achieving similar goals considered fundamental in the promotion of resilience and recovery after exposure to extreme traumatic incidents, namely: (1) desomatizing memory, (2) nurturing experiences of mindfulness, (3) enabling meaningful experiences for the contained discharge of anxiety and aggression, and (4) unleashing the pleasure of creativity, and thereby freeing participants to symbolize their traumatic losses and future hopes.

The Dinka Initiative to Empower and Restore, started in 2001, served a community of just over one hundred unaccompanied refugee minors from the Southern Sudan, all resettled in southeastern Pennsylvania. An activity programme open to an entire community, DIER utilized traditional Dinka dance as its vehicle for fostering resilience. By contrast, the series of DMT groups sponsored in three towns within the devastated Kailahun District of Sierra Leone were short-term psychotherapeutic interventions for smaller numbers of identified clients suffering severe sequelae of torture. Combining experiential psycho-educational exercises that focused on the somatic implications of trauma with improvisatory group movement designed to enable symbolic representation of traumatic experiences, these counseling groups incorporated local music

32) Rousseau C, Heusch N. The trip: a creative expression project for refugee and immigrant children. Am J Art Ther 2000;17(1):31.

33) Petrén A. The unaccompanied minors of southern Sudan. Stockholm: Rädda Barnen, 1994.

34) Impact of armed conflict on children: report of the expert of the Secretary-General, Ms. Graça Machel. Document A/51/306 & Addenda. New York: United Nations, 1996.

and dance, while adhering to the ethical standards and formal conventions of Western psychotherapy.

DIER: a community-based traditional dance program

In the years 2000 and 2001, the United States government resettled a population of some 3800 young Southern Sudanese – the nation's largest ever resettlement of unaccompanied refugee minors – in cities and towns across the country, many of which had no pre-existing Sudanese community.[35] Slightly more than 100 of these young people, mostly minors but including a few "majors" as well, arrived in the Philadelphia, Pennsylvania (PA) metropolitan area under the sponsorship of Lutheran Children and Family Services (LCFS) of PA. Ranging in age from 13 to 25 – with most in their late teens and less than 10 percent female (as was the case with the entire population resettled in the U.S. at that time) – all had spent a minimum of five years in the Kakuma refugee camp in Kenya prior to their departure for a new life in a post-industrial society of the global North. In escaping an ongoing war in the Southern Sudan, most of these young refugees had endured a thousand mile ordeal on foot over the course of a decade. They had witnessed numerous killings and other acts of violence and terror, some directed at family. At some point in their lives, extreme deprivation had brought many to the brink of starvation.

Acculturating teenagers are highly susceptible to marginalization and need ongoing opportunities to engage with both the host culture and culture of origin.[36] Given the multiple traumatic exposures in the group's collective history, resettlement agency staff members were alerted that these young people might well prove vulnerable to both clinical and sub-clinical complaints. Empowering this young community to meet the challenges of adapting to a previously unforeseen way of life in the host culture necessitated programmatic innovations aimed at reinforcing the resilience these remarkably resourceful young people brought with them to their new environment. Offering an authentic experience of temporary culture-of-origin immersion was deemed a productive, and cost-effective way of helping these young people face acculturation without succumbing to emotional or psychological distress. By giving priority to strengthening inherent protective factors borne in the culture of origin, those developing the programme hoped to reduce susceptibility to the many new risk factors for posttraumatic stress in the culture of refuge.

Appreciating that dance and healing are essentially one in Dinka culture, the author contacted the resettled youths in September 2001, introduced himself as a counselor and dancer, and asked that they meet with him on an ongoing basis over the subsequent academic year to teach him their traditional dances. With the refugees' consent – in fact, their enthusiastic endorsement – LCFS launched the Dinka Initiative to Empower and Restore (or DIER, which is the Dinka word for *dance*) the following month, and in so doing served a Sudanese refugee community that was about 98 percent of Dinka

35) Corbett S. The lost boys of Sudan. The long, long, long road to Fargo. New York Times Magazine 2001 Apr 1.

36) Berry JW. Refugee adaptation in settlement countries: an overview with an emphasis on primary prevention. In: Ahearn FLJ, Athey JL, eds. Refugee children: theory, research, and services. Baltimore, MD: The Johns Hopkins University Press, 1991:20-38.

tribal origins. Beyond agency support, DIER benefited as well from that of the Zion Mennonite Church of Souderton, the Lutheran Immigration and Refugee Service, and the DMT clinical internship programme of MCP Hahnemann (*now* Drexel) University, which provided the author professional supervision as DIER's coordinator.

A substantial body of research indicates that, while the psychosocial sequelae of exposure to the stressors of war and organized violence can be severe, most children survive war and flight without seriously debilitating psychological disturbance.[37] As a health promotion project, DIER aimed to reach the entire community of young South Sudanese, without regard to level of function or disability. The goal was to provide culturally relevant group activities for young refugees, who as individuals may have presented with diagnosable disorders, sub-clinical mental health concerns, or no discernible psychosocial problems whatsoever. Instead of separating children with perceived disorders from the group, the continuity of which sustains identity structure in the African sociocentric environment, the cohesion of the group itself was engaged for its combined preventive and reparative capacity. As such, the project's main objectives involved fostering resilience and healthy, adaptive development, rather than diagnosing or treating mental disorder in Western terms – an action that was judged likely to effect a schism, increasing chances of marginalization.[38]

For Southern Sudanese youths – singled out in the Machel study for their extraordinary resilience in the face of horrific adversity – a prevention strategy with emphasis on fortifying group capacity to cope with ongoing and newly encountered stressors[39] was an especially suitable one. Such a plan may have been all the more important, given findings of significant potential for delayed onset of posttraumatic stress disorder (PTSD).[40] War refugee children not suffering disturbance may potentially begin to do so later. Indeed, in promoting "adjustment mechanisms" through a programme of creative arts activities, sports, and scouting, Rädda Barnen[41] had utilized a parallel prevention approach with these youth in camps in both Ethiopia and Kenya. The Swedish NGO had initially implemented a Western-styled treatment programme, but abandoned it later as inappropriate. Making a deliberate effort to examine the role of traditional cultural expression in this group's remarkable level of resilience, Rädda Barnen encouraged the young people in the camp to engage in writing compositions about what happened to them on their long journeys, performing traditional songs and dances, recording favorite Sudanese folk tales, drawing places encountered on the way, and telling and discussing their dreams – a traditional cultural activity. While no empirical data is available to demonstrate effectiveness of these prevention efforts, anecdotal evidence confirms their value.[42]

37) Cairns E, Dawes A. Children – ethnic and political violence – a commentary. Child Dev 1996;67(1):129-39.

38) Hicks R, Lalonde RN, Pepler D. Psychosocial considerations in the mental health of immigrant and refugee children. Can J Community Ment Hlt 1993;12(2):71-87.

39) Ajdukovi M, Ajdukovi D. Psychological well-being of refugee children. Child Abuse Neglect 1993;17:847.

40) Sack WH, Him C, Dickason D. Twelve-year follow-up study of Khmer youths who suffered massive war trauma as children. J Am Acad Child and Psy 1999;38:1173-9.

The DIER project, in addition, was designed to fulfill all three of the structural factors Cowen identified as requirements for an effective primary prevention programme. It was: (1) "group oriented", (2) targeted to a group without significant maladjustment, while risks of such problems (not an exclusionary criterion, according to Cowen) were certainly present, and (3) built on the foundation of a "solid knowledge-base."[43] The programme also modeled transcultural sensitivity, as reflected in assertions that programmes targeting the needs of war-affected children from developing countries may be successful to the extent that they forego "conventions of Western diagnosis" and concentrate on matters of "social adaptation and functioning."[44]

The preponderance of evidence in the existing literature shows that children of war may be usefully encouraged to represent their feelings and thoughts to symbolise their experiences of rupture and potential restoration through means that are syntonic to their culture. The DIER programme provided just such culturally specific opportunities for personal expression within a collective context that helped sustain communal equilibrium. DIER consisted of an ongoing series of two-hour gatherings that enabled participants to perform the dances and songs they had brought as an ancestral legacy from Africa. Some 18 sessions were slated over the course of an academic year in each of two locations – the LCFS offices in the urban West Philadelphia neighborhood that was home to about half of the youths, and the fellowship hall at a suburban church – a central meeting point accessible to about 40 youths who resided in small towns north of the city. Attendance was strong and grew throughout the year. Of the 10 female Sudanese – equally divided between the urban and suburban communities – spring attendance averaged over 80 percent, male attendance in percentage terms was about half that number for the same time period.

For the most part, sessions were unprogrammed opportunities for the youths themselves to organise dancing and drumming. From the outset, the author in coordinating DIER determined not to assert a form, nor attempt to control the use of time and space. Instead, the youths were presented the challenge of teaching him about their dances and their culture. Rather than offering the role of passive consumer of an intervention, this improvisatory arrangement supported the overriding goal of fostering resilience through empowerment and collective action. This innovation indeed placed the youths in the role of experts and the facilitator in the role of recipient of the group's collective wisdom.

On the whole, the young refugees approached their role with enthusiasm. A dynamic sense of collective agency was especially manifest in the way the group's

41) See note 33.

42) Tefferi H. Building on traditional strengths: the unaccompanied refugee children from South Sudan. In: Tolfree D, ed. Restoring playfulness: different approaches to assisting children who are psychologically affected by war or displacement. Stockholm: Rädda Barnen; 1996:158-73.

43) Williams CL. Toward the development of preventive interventions for youth traumatized by war and refugee flight. In: Ahearn FLJ, Athey JL, eds. Refugee children: theory, research, and services. Baltimore, MD: The Johns Hopkins University Press, 1991:207.

44) Boothby N. Mobilizing communities to meet the psychosocial needs of children in war and refugee crisis. In: Apfel RJ, Simon B, eds. Minefields in their hearts: the mental health of children in war and communal violence. New Haven: Yale University Press, 1996:161.

members organized music to accompany their dancing. A drum of Ugandan origin and set of drumsticks, both brought in by the author, were the only objects utilized in DIER's core activity. These were placed actually and symbolically at the center of the process. Drumming is a constant during Dinka dance, and is itself for the most part extremely forceful and vigorous—to a degree that occasionally meant replacing broken drumsticks. The physical requirements of drumming were such that no one in the group had the stamina needed to drum on his or her own throughout the duration of a session. As a result, there was a constant shuttling in and out of drummers. Usually this was managed by the group in such a seamless flow that the drumbeat was seldom lost, and the dancing continued without break. Within this unequivocally sociocentric order, almost everyone had an opportunity to drum at some point in the course of a gathering.

The programme proved successful at both augmenting participants' awareness of the cultural strengths that had enhanced their collective resilience and increasing their capacity to negotiate with the host culture. While traditionally only males drum, in the central city group females began to assert their interest in the role of drummer. Coming well beyond the halfway point in the programme, this evolution potentially suggested an increasing degree of acculturation on the part of the young women – and perhaps of the young men, as well, in acceding to change. Traditionally, gender roles in the dancing are apparently strictly defined. While there are important tribal distinctions as well as variations from one region of the Southern Sudan to another, women generally assume a more deferential stance. In the suburban group, whose membership largely emanated from one particular Sudanese region, women sat at the sidelines and would deliberately ignore their male counterparts. The women would cast their gaze aside as crews of three to seven men engaged in group courting behavior that involved vigorous gesticulating, standing very close to the woman in question, and chanting poetry to her loudly – all in competition with other teams of male cohorts also vying for her attention and approval. While feigning disinterest, the women in fact were following tradition and actively assessing the competing crews, choosing a winning entry among them. Once a young woman's selection was made, a silent nod from this ostensibly reluctant judge sent the victorious team of young men leaping high into the air in a celebration of collective prowess. Soon afterwards, the little throng would form a semi-circle around the woman – after she had walked quietly to her place an appropriate distance from the drum. With the drumbeat thickening the air, everyone of both genders would jump up and down in a sustained rhythmic pattern, traveling a counterclockwise orbit around the drummer. Indeed, this basic constellation formed and dissolved over and over again in the course of each gathering. Big, powerfully ecstatic bursts on the part of the young men, and expressions of diffidence from the women, were followed by fairly measured – though still vigorously aerobic – circling by everyone to a constant pulse. What appeared at first to the author's unpracticed Western eye as rather constrained unison movement, in fact allowed for a subtle range of individual expression within a collective whole. Moreover, virtuosity proved treasured, and the height of a leap suggested to all present the measure of a man.

At about the same time in the course of the programme year that the young women at the Philadelphia site began drumming,

at the other location there was a parallel incursion of gender role reversal. During one of the formations, a small cluster of women formed a semi-circle around one of the especially virtuosic young male dancers. While the women vocalized behind him in decidedly "male" chants, he danced alone, fully and respectfully performing a woman's role, prancing forward in the conventionally proscribed orbit, and with the slenderest of smiles on his face.

As among other sub-Saharan dance traditions, DIER thus apparently afforded a degree of playful improvisation that overturned temporarily the social group's usual hierarchies of power. Drawing from anthropologist Victor Turner's revealing analysis of the "ritual order," it could be argued that the liminal potential for *communitas* as social change was thus embedded in DIER's performative moment.[45] Extrapolating further from Hanna's contribution to the ethnology of African dance, the gender role reversals may be considered indicative of the dance form's psychotherapeutic function in the culture as a mechanism of collective psychic management.[46] The dance circle itself afforded an avenue for resolving potential conflicts between the demands of the new culture and those of tradition.

Hence, in DIER, dancing and drumming functioned as something of a surrogate for the culture as a whole, a synecdoche, a part that represented the entirety, and one which was grounded in a ritual order that repairs "psychic distress" – for the individual and the social group – through the medium of the body. The ritualized form itself provided the therapeutic *container* for the participants' anxieties and emotions, and in much the same way that in Western psychotherapy groups, the group as an entirety *contains* the tensions of its individual members. Typically in DMT, as practiced in egocentric cultures, particularly among trauma survivors, it is the function of the therapist to define "boundaries." Dance/movement therapists working with abused children in such Western contexts appropriately introduce notions of "personal space" and "territory" that enable these children to begin to gain an enhanced sense of control over their bodies within the safety of a therapeutic contract.[47,48] With DIER, however, the group created its own container and the therapist's role was one of *facilitator*. While manifesting to the extent of his abilities the presence of a consistently caring adult, the author worked fluidly to ensure that conditions were in place for what one cultural anthropologist working among African refugees has referred to as the "regaining of sociality."[49] This facilitating role, informed as much by the writings of anthropologists as those of Western psychology, was born of a conviction that healing itself is a function of the community's capacity for social cohesion. The desired "corrective emotional experience" was that of the cohesiveness innate in the timelessly holistic culture itself.[50] Revisiting the culture of ori-

45) Turner V. The ritual process: structure and anti-structure. Ithaca, New York: Cornell University Press, 1977.

46) Hanna JL. African dance: some implications for dance therapy. Am J Dance Ther 1978;2(1):3-15.

47) Weltman M. Movement therapy with children who have been sexually abused. Am J Dance Ther 1986;9:47-66.

48) Goodill SW. Dance/movement therapy with abused children. Art Psychother 1987;14:59-68.

49) Englund H. Death, trauma and ritual: Mozambican refugees in Malawi. Soc Sci Med 1998;46:1176.

gin through even occasional forays into traditional dancing and drumming thus opened the possibility for the liminal experience that is at the core of healing and regeneration – for individuals and community alike engaged in a daunting post-war acculturative process.

When addressing participants, the author thus referred to himself not as a "dance/movement therapist," but as a "dancer and student counselor." This name choice helped avert linking DIER with the shame that the community associated with Western mental health interventions. Assuming the title of "therapist" might have risked invoking a stigma that would undermine participation in an activity otherwise far from stigmatized. Rather than avoiding participation, the vast majority of young Sudanese embraced the opportunity, and came together to engage in a revitalizing activity that helped them transcend in the oneness of their bodies, minds, and spirits the vast geographic and cultural expanse between Philadelphia and the Dinka homelands of Southern Sudan.

DMT groups in Sierra Leone's Kailahun District

In recent decades the world has seen a virtual rewriting of the codes of international and civil warfare, such that noncombatant populations have experienced unprecedented devastation. This development, combined with that of the simultaneous, widespread proliferation of automatic weapons light enough for a pre-adolescent child to operate handily, has made the phenomenon of child soldiering commonplace around the globe. Since the late 1990s, international NGOs involved in children's rights advocacy have estimated that worldwide nearly 300,000 children, persons under age 18, are involved in military or paramilitary operations at any given time.[51] Indeed, according to the Child Soldiers Research Project (CSRP), the period since World War II may accurately be termed, "the era of the child soldier."[52]

The CSRP collected data from 24 countries around the globe where children in the mid-1990s, or just prior, were actively involved in conflict. Subsequent analysis contributed significantly to the 1996 United Nations Machel Study, which in turn focused global attention on the struggle in post-conflict societies to reintegrate demobilized child soldiers into functioning communities. The report generally supported the notion that interventions to address the psychological and emotional sequelae of such traumatic experiences as those endured by children with past involvement in armed groups ought to be integrated into broader efforts to rebuild communities, and to attend to the systemic problems confronting children.

Among the many protracted conflicts that have plagued sub-Saharan Africa in recent decades, few have exacted a more terrible price on children than the 11-years' war that erupted in Sierra Leone in March 1991. Launching attacks initially in the outlying Kailahun District, the Revolutionary United Front (RUF) targeted undefended communities from the start. Systematic deprivation,

50) Eisenbruch M. From post-traumatic stress disorder to cultural bereavement: Diagnosis of Southeast Asian refugees. Soc Sci Med 1991;33:673-80.

51) Coalition to stop the use of child soldiers. London: Coalition to Stop the Use of Child Soldiers, 2006. www.child-soldiers.org [cited 2006 June 15].

52) Brett R, McCallin M. Children: the invisible soldiers. Stockholm: Rädda Barnen, 1996.

rape, slaughter, amputation, and the burning of entire villages were common tactics in the rebels' broader strategy of spreading terror as a way of silencing opposition and securing territory. In the process, the RUF recruited – often forcibly – thousands of people, male and female, into its guerilla army. Moreover, as estimated near the midpoint of the prolonged war, perhaps half of the roughly 50,000 irregular combatants, mostly with the RUF, were thought to be between eight and fourteen years of age.[53] Sierra Leone government forces, following the rebels' lead, also conscripted large numbers of minors. As a result, children were directly engaged in fighting on behalf of all the various armed factions throughout a decade-long war marked by unthinkable atrocities.

The war was declared officially over in January 2002, yet children's enforced participation in the fighting seems not to have afforded them a proportionate share in the benefits of peace. In the waning months of conflict, the United Nations helped establish a Disarmament, Demobilisation, and Reintegration Programme (DDR) in collaboration with international humanitarian aid and development groups. The DDR demobilized 6,845 child combatants,[54] and its related initiatives offered services to thousands of former combatants of all ages, who turned over their weapons in exchange. Unfortunately, anecdotal evidence from Kailahun – the last district in which demobilization took effect[55] yet probably the biggest in terms of the vast need for child soldiers' care – suggests that most such programmes largely ignored the emotional and psychological needs of participants, and also failed to ensure educational opportunity for many demobilized children.

In 2006, programmes designed to address the non-material needs of children affected by the war were few, even in those parts of the country where the war left its deepest wounds. In this context, the Minneapolis-based Center for Victims of Torture (CVT) – operating in devastated regions of Sierra Leone, where apparently a large percentage of present day adolescents were recruited as children into service with rebel groups – has provided psychosocial support to child and adult survivors of war trauma and torture since 2003, and trained Sierra Leoneans to serve their communities as paraprofessional trauma counselors. Among other initiatives, in 2005 CVT began to sponsor therapeutic activities specifically targeting former child combatants in Koindu, one of the Kailahun District towns worst scarred by the war's violence. Earlier that same year, also in Koindu, CVT had sponsored its initial DMT group in Sierra Leone – apparently the first DMT intervention anywhere in West Africa – for eleven adolescent males.

In March 2006, the CVT Kailahun District programme (which terminated in September 2006 for lack of funding) opened three more time-limited DMT groups, one each in the towns of Kailahun, Buedu, and Koindu. The group in Kailahun town was comprised of six female clients, aged 16 and 17. A second, in Buedu, involved eight

53) Peters K, Richards P. Fighting with open eyes: youth combatants talking about war in Sierra Leone. In: Bracken PJ, Perry C, eds. Rethinking the trauma of war. New York: Free Association Books, 1998:76-111.

54) Landry G. Child soldiers and disarmament, demobilisation, rehabilitation and reintegration in West Africa. Dakar, Senegal: Coalition to Stop the Use of Child Soldiers. www.child-soldiers.org.

55) Ibid.

young Muslim male torture survivors, all aged 23 or 24. Functioning within their community as late adolescents, and not yet considered fully adults even by themselves, the young men in the latter group were all in the midst of completing their final year of primary school, given that their educational careers had been truncated by the violence and lingering threat in their border town. These two therapy groups, facilitated by the author in tandem with teams of local CVT trauma counselors, met for nine sessions each on a weekly basis. Both interventions emphasized the rebuilding of safety and trust, and the empowerment of clients to cope with ongoing problems as well as past traumatic histories. Both in turn yielded strong results in terms of symptom amelioration, as well as in participants' self-reported improvements in functionality and overall outlook.

Comparison of programme evaluation data from intake and three-month assessments among the female DMT clients, for example, reveals a marked decline between the average level of both elevated arousal and avoidance symptoms, as well as those of anxiety, and depression, as indicated by such client self-reports. The average level of symptoms for intrusive recollection, however, increased from the intake assessment to that at the one-month point, as would be expected given clients' entry into a process of re-examining traumatic losses. By the three-month point, which for most clients loosely coincided with the termination of the DMT group, the trend had reversed itself, such that reported levels of nightmares, flashbacks, or other intrusive memories had diminished below the threshold established at intake.

Likewise, in March 2006 CVT-Koindu inaugurated what appears to have been the world's first DMT group specifically for former child soldiers. Originally also planned for nine sessions, this counseling intervention was ultimately extended to include a total of 16, in order to better address client needs. Twelve male teenagers, eight of them aged 18, and the rest somewhat younger, joined three psychosocial counselors (or PSCs: Training Supervisor Omenga A. Kormoh, Site Administrator Laurence H. James, and Mustapha Abdulai) and the author for the intervention, which honored such fundamental standards of psychotherapy as a commitment to avoiding physical confrontation in the group, and the maintenance of client confidentiality. The group's dozen members all had been orphaned during the war, and all had a history of active involvement in warfare by the age of 13. Their recruitment as clients and subsequent psychological assessment took place in the couple of months preceding the start date for the initial phase of the intervention. Prior to joining the group, each of the participants had thus engaged with a paraprofessional counselor in a number of individual debriefing sessions in his own language.

A semi-structured interview had yielded, in addition, quantification of a range of symptoms of anxiety, aggressive behaviors, depression, posttraumatic stress, and other behavioral indicators of functional capacity – all on a Likert-type scale. As with all CVT clients, follow-up reassessments, surveying the same symptoms, were slated for one, three, six, and twelve months after intake, with the aim of monitoring therapeutic progress. After completing client identification and symptom assessment, the three counselors whom the author had trained in DMT fundamentals, joined him in developing a highly detailed group treatment schedule. This plan included methods for addressing 17 specific clinical objectives associated with helping reduce the former

child combatants' posttraumatic symptom expression, while also encouraging the clients to regain a sense of personal and collective wholeness.

Adapting the framework developed for the 2005 DMT group in Koindu with adolescent males (which had included a few former boy soldiers), the facilitators introduced in the sessions a series of decidedly structured exercises and deliberately improvisatory movement experiences – the latter based on the model that DMT pioneer Marian Chace had developed with "shell-shocked" American veterans fifty years before.[56] Some activities provided a container for the physical discharge of aggression as a way of reducing anxiety, while others promoted relaxation or offered skills for overcoming sleep disturbances or minimizing the impact of flashbacks. Participants devoted many hours over the course of several sessions to a number of creative exercises, some involving verbalization as well as physical expression through gesture and action and all designed to elicit symbolization as a vehicle for the clients to integrate their trauma. Overall, the facilitators aimed to foster a safe environment for rebuilding dignity and trust, and thereby empowering the former child combatants to address two simultaneous, paradoxical needs for acceptance and accountability.

From the outset, members demonstrated willingness to engage with facilitators and one another in vibrant movement, usually performed to recordings of the latest Sierra Leonean popular music. A long history of surviving through taking unusual risks perhaps reinforced this communal capacity for creativity. The openness demonstrated in movement exploration, however, rarely extended to overt emotional expression. Although direct in their glorification of certain war-related actions – most notably rape – members displayed little affect when describing even the most horrific of acts, regardless of whether they were targets or perpetrators of the atrocities in question.

Early in the process Training Supervisor Kormoh, in a debriefing with his colleagues, framed this blunting of affect as a likely consequence of participants' violent histories. Throughout the 11-year conflict, it had been common for rebels to force their conscripts to laugh – and indeed, to dance and sing – after committing such acts as killing, raping, or mutilating civilians. Certainly, years of celebrating involvement in such war crimes would have contributed to severe desensitization among perpetrators, especially preteen soldiers, just as it has among other survivors driven to numbness through relentless exposure to senseless violence. Thus, from the beginning of the intervention the group's members exhibited great difficulty even recognizing their own feelings about their experiences, and seemed distinctly unable to express empathy for one another.

With the blunting of affect a group norm, a pivotal struggle played out between suppressing feelings associated with traumatic experiences and revealing them – often embodied in the group in a symbolic and quintessentially adolescent contest between mockery and sincerity. By the end of the second session, facilitators thus identified the need to revise treatment plans in order to address members' detachment from emotion and their broader sense of fundamental dehumanization. Moreover, recognizing participants' difficulty reconnecting to their place within the community and the human family more generally, the facilitators added a new treatment objective and began creating movement activities for achieving it:

56) See note 12.

To stimulate reflection on personal involvement in the events of armed conflict in a way that promotes clients' awareness of themselves as part of humanity.

Notwithstanding such efforts, the avoidance of emotional vulnerability persisted through several of the weekly sessions. Facilitators understood that for members of the group – many of them living on the street in an impoverished community without access to any viable means of social support – the conditions of peacetime had produced little improvement in meeting life's necessities. It would be awfully difficult to let themselves be vulnerable to feelings and open to expressing them when struggling day by day simply to stay alive. Nonetheless, encouraged by some specifically designed expressive movement activities – and perhaps by the facilitators' offer to reconvene the group for five additional sessions following a dozen-week hiatus – even the more emotionally defended members would ultimately begin speaking about their own need for connection with one another, including through dance. As the sessions proceeded participants began interacting more in their movement together, speaking more confidently to one another, sharing both leadership and empathy with peers, and verbalizing an appreciation of the therapeutic process as important to their lives. With the establishment of a sense of safety afforded by a ritualized familiarity came increasing emotional openness. Members chose for themselves a group name, *Poimboi Veeyah Koindu*, meaning Orphan Boys of Koindu in Kissi, their mother tongue, and invested more and more in sharing a group identity. In time, even sadness and the desire for forgiveness emerged as themes to be shared aloud. Indeed, by the ninth session, all of the dozen participants had expressed feelings of remorse in both action and word.

Ultimately participants demonstrated enhanced self-awareness, including through willingness to examine and symbolize through gesture their involvement in the suffering of others. Authentic feelings of sorrow, along with worry, arose in connection with such acknowledgements, and members linked these concerns verbally and nonverbally to certain religious and spiritual beliefs. By the "closing" session in May – that is, the one before the 12-week break – a high level of trust and dynamic interaction in the group had thus freed expression and enabled these "victim-perpetrators" to identify their ambivalence and confusion over the dynamics of power and powerlessness in their lives. While the central question of reintegration into their communities remained major unfinished business, in gearing toward this preliminary termination there was significant evidence of members' readiness to experience feeling grounded and connected to the present, to gain strength through expression of authentic emotion, and to continue investment in a collective process of recovery.

Before reconvening it had remained uncertain how well *Poimboi Veeyah Koindu* (more often by this time called "PVK" by its participants) might function following its three-month break. To the surprise of the local facilitators who were stunned to find adolescent clients walking long distances in order to attend sessions after the long hiatus, particularly at the height of the rainy season in August, attendance proved quite consistent, precisely 90.0 percent in the course of the entire two-phase therapy cycle. During the tenth session in mid-May, the last of the initial phase, each of the former combatants had taken an opportunity to position himself in front of his peers and review aloud his personal progress, along with that of the group as a whole. Beyond speaking of the pleasure they had enjoyed together, several

members openly expressed satisfaction in the management of their own angry outbursts and appreciation for the encouragement and support that they had shared with one another and secured for themselves. Most identified new-found capacities for coping with their horrific memories and handling their accumulated losses: Gaining "a cool heart" was a common refrain. Some participants named as well behaviors that they had come to view as important to avoid in future: stealing, selfishness, withdrawal from friends, killing.

In reconvening 12 weeks later participants were encouraged to assume ever greater authority for the structure of session agendas and for ensuring their capacity for meeting self-defined aims for behavioural change. Collectively, they voiced a desire to continue in the direction established in the group's first phase, and proposed repeating all of the activities enjoyed then. When questioned if there was something that PVK as a whole might need to achieve before its termination the following month, members initially were uncharacteristically still. A client who at the outset had seemed the one among them most often enraged, especially because of the ongoing stigma he had claimed to face as a former fighter, then spoke up. This young man, alluding to the group's shared experience in symbolizing members' traumatic pasts through the enactment of sociodramas that illustrated each client director's own worst moments, urged his peers to perform a role-play before the broader community, depicting "what we did in the war." After discussing together the advantages and disadvantages of revealing to the people of Koindu histories that had until that moment been guarded as secrets, confidences only to be shared in the context of the PVK sessions, the members unanimously agreed to stage such a dramatization. They chose to devote an hour of each remaining session – and, later, an added four-hour rehearsal – to devising a script and practicing its performance. Following extensive deliberations they endorsed the suggestion of a second member who proposed including in the role-play scenes that would illustrate three experiences shared by all in the group: (1) The slaughter of group members' families, and their own forced recruitment, (2) Their subsequent direct involvement in killing and other abuses, and (3) Their desire to be reintegrated back into the community. Other participants articulated this hope for reconciliation in terms reflective of a nascent awareness of the need for healthy attachment: "We want the community to accept us as their children, and we will accept them as our mothers and fathers."

On the September evening prior to the final PVK session, CVT sponsored what local staff publicized as a Community Cultural Healing Event. This included choral singing and a young women's traditional dance troupe, as well as the PVK youths' 25-minute dramatization of their wartime experiences. With hundreds of people of all ages filling the local hall to capacity, the youngest among them seated just before the stage area, it was evident throughout that this special gathering might potentially both represent and animate Koindu's renewal and revitalization. Indeed, there was an undeniable sense of the depth of the event's meaning to participants and audience members alike. Tears were seen in the eyes of one woman, for example, while watching the early scenes of the dramatization. The former combatants here portrayed the agony of one boy's coerced recruitment when driven to fire bullets into the corpses of his own father and sister, killed by the very rebel fighters who had forcibly inducted him into their ranks. After this painful scene, another

depicted further violence committed by the boy against his will upon recruitment into the rebel army. Finally, in a post-war scene, the child returned to his village, and on his knees asked forgiveness of the local chief and others.

As challenging as the story may have been to perform and to view, watching it prepared many in the audience for a genuine change of heart. Several local authorities – the Section Chief, Youth Chairlady and Chairman, the Officer-in-Charge of the local Sierra Leone Police, and a female board member of a local community-based organization – all spoke immediately after presentation of the role-play. Each addressed the young men, welcoming them back into the community. One leader asked PVK's members to renounce violence in the future, which they willingly did on the spot. Another speaker, pointing to Koindu's future, emphasized the role the youths might play in local development. For their part, the war orphans themselves had deliberately included in their script a collective wish to be accepted again as "your children," and these words reverberated in the hall, echoed back by the newly welcoming adults.

In debriefing the event at the final group session the next day, the member who had first proposed the scene representing members' welcome by village elders stated that in preparing the role-play he had had "no idea how sweet" the evening would come to be for them. The teens all concurred that the event had truly become a watershed moment in opening a brighter future for them as members of the Koindu community. Moreover, in the days following the performance, a number of community members reported appreciation for coming to understand better what these child soldiers themselves had endured. Perhaps representing the feelings of many, one townswoman told facilitators that witnessing such former combatants renouncing their violent past had helped her feel safer. It became clear to CVT staff that PVK members' public admission of participation in human rights crimes, an acknowledgement that arose directly from the will of the youths themselves, ultimately had profound consequences. Not only those seeking mercy, but the community as a whole had been helped meaningfully. Healing was a collective choice they had made together for reintegration.

Clearly DMT group participants prospered from their active engagement with one another and their community. Benefiting measurably from the course of their intervention, these youths experienced an appreciable drop in symptom expression, as quantified through CVT's systematic application of a follow-up assessment tool for programme evaluation. Average levels of the symptoms of anxiety, depression, intrusive recollection, elevated arousal, and aggression – which CVT surveyed through client self-reports at intake, 1-month, 3-month, 6-month, and 12-month intervals – all underwent continual reduction. Having begun what they termed a therapeutic "journey" from a baseline of extreme traumatization and incongruent affect, the PVK membership had undergone a sequence of incremental changes – experienced in stages, as anticipated in all effective psychotherapy interventions. The opportunity to release aggressive drives through vigorous improvisatory dancing and more contained exercises had led in time to disinhibition and the expression of otherwise suppressed rage. Along with a growing sense of safety and trust, encouraged within the container of the group process, and furthered especially by the kinesthetic empathy established in movement activities had emerged greater ownership and interaction, and in turn,

authentic expression of a broadening range of emotions and cognitions. Regaining a capacity to feel kinship with one another had afforded a familial atmosphere to the PVK group, and expressing concern for peers led clients to similar expressions for their victims, and for themselves. Members came in time to voice the word *forgiveness* – and through it, their collective desire to make amends, and to accept the gift and responsibility of being forgiven by the community. Indeed, through the role-play about their war experiences that they elected to perform before the people of Koindu, they created a culturally relevant vehicle for ritualizing both the truth of their experience and their need for community reintegration. Appropriately, they *embodied* their own journey through creative movement performed as communal rite. Ultimately it may be inferred from this emergent therapeutic process that, by fostering conditions for a much needed synthesis of acceptance and accountability, the mindfulness and symbolic capacities inherent in DMT created a pathway for a unique passage toward recovery and reconciliation in the aftermath of torture and war.

Conclusion

Dance/movement therapy interventions designed to foster resilience or recovery among African adolescent survivors of torture and like wartime exposures may maximize the healing capacity of widely available cultural resources. Drawing on dance's rich potential for heightening communal solidarity, along with the sense of wholeness and well-being animated through purposeful engagement in bodily expression, DMT is flexible enough to be adapted for application in various contexts. The DIER programme in the Philadelphia area used dance to reinforce traditional coping mechanisms among a particularly resilient population of recently resettled Dinka refugee minors. The programme's reconstitution of a ceremonial Sudanese dancing circle afforded its participants an opportunity to revisit their culture of origin and deliberately hold onto its ancestral strengths while adapting to new challenges in a very foreign host culture. Similarly the CVT-Sierra Leone DMT programme in the war-ravaged Kailahun District enabled its clients – notably a group known as PVK comprised of former child combatants – to master skills for reducing hyperarousal and managing difficult emotions indivisible from their background as "victim perpetrators." Opportunities in PVK for creative expression through dance and non-dance movement facilitated clients' integration of extreme traumatic histories. The embodiment of personal experiences and attitudes through active participation in contained thematic exercises helped these teenage ex-fighters come to terms with the past in a way that enhanced longer term prospects for survival, and provided a model for reconciling to a community still torn apart by years of brutal war.

Both of these quite dissimilar groups ultimately found ways through DMT to overcome the serious ruptures associated with their trauma. Eventually DIER's participants openly voiced the need to embrace the traditional strengths of their culture as a means to thrive during exile. PVK's members, not physically segregated from their home culture yet suffering nonetheless a stigma that excluded them from its heart, developed an innovative way to reconcile themselves with the community to which they had returned after years of violence. Having found in dancing a culturally acceptable release of long held muscular and psychic tensions, the former soldiers reclaimed a capacity, recovered as well by the resettled Dinka, for mindfulness, connecting to the

reality of the present moment. By then representing war experiences through a communal rite that PVK members themselves devised to be performed in the presence of the community and its elders, the group found a formal way to symbolize at once traumatic powerlessness and power, the losses of their past and their hopes for the future. Indeed, symbolization through bodily performance created a container for wartime terrors, members' own and those of their audience, and literally set the stage for reconciliation, opening a new pathway for the youths to assume meaningful roles in their impoverished community's renewal.

Whether introduced in a post-conflict situation in the global South, or in one of refuge in the North, the DMT modality, embodying an integrated, holistic approach to psychosocial support and transformation in the aftermath of horrific violence, effectively mobilizes the empowering and restorative functions of dance, with collective revitalization a foreseeable result.

Integrating rehabilitation of torture victims into the public health of Iraq*

"Many who live with violence day in and day out assume that it is an intrinsic part of the human condition. But this is not so. Violence can be prevented. Violent cultures can be turned around ...Governments, communities and individuals can make a difference."

Nelson Mandela

Suad Al-Saffar, M.D.**

Abstract

For the last three decades torture has been highly prevalent in Iraq. Surveys indicate that close to 50% of households have family members who have been tortured. The traumas of two subsequent wars further add to the traumatisation of the population as does the persistent violence. Re-traumatisation makes healing difficult. As a result trauma-related disorders are likely to be the number one public health problem in Iraq.

In December 2004, the author was tasked with the responsibility of planning and implementing rehabilitation activities for victims of torture in Iraq. Basra, in southern Iraq, was chosen as the place for the first clinical treatment and rehabilitation Centre, the Al-Fuad Centre for Rehabilitation of Torture Victims (FRCT). The Centre was to function as a training institution for the entire country. In an effort to bridge the gap between vast needs and limited resources, the Centre has begun applying a public health perspective, which means to develop its work in relation to the concepts of illness prevention and health promotion. Treatment and rehabilitation, i.e. the secondary and tertiary levels of prevention, can be multiplied through the training of professionals who will be able to establish treatment facilities in new areas of Iraq. By training GPs, psychiatrists and physicians and by expanding FRCT services to victims' families, signs and symptoms of trauma can be addressed at early stages of disorder and long-term illness averted. Human Rights advocacy and legal work at the Centre will address the primary level of prevention through diminishing human rights abuses. Finally, engaging in the reconstruction of the civil society alongside other NGOs and government authorities is to build democracy, which is a cornerstone of health promotion, especially so when the illness panorama is related to violence.

Key words: Torture, rehabilitation, prevention, public health, Iraq

Background

During Saddam Hussein's rule in Iraq torture was used systematically and extensively to prevent and oppress any opposition to the Bathist regime. After the fall of Saddam Hussein's regime in 2003 the use of torture has persisted. Today, the need for rehabilitation of torture victims in Iraq is extensive. However, until recently Iraq had no services

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specifically aimed at rehabilitating torture victims, and the country's health care facilities are in need of assistance and cooperation to meet the special needs of the victims. There is no training of clinical psychologists and the number of psychiatrists is alarmingly low. The Ministry of Health (MoH) and the Ministry of Human Rights (MHR) were both troubled by the plight of those who had suffered punitive ear amputation (due to the decree 115 that was passed by Saddam in 1994 against army defectors) and the gross stigmatization they face in society. The punishment was ostentatiously aiming at instilling fear to prevent others to follow the example of the defectors.

During an assessment mission in Basra, the author was alerted to the situation of these victims both by the MoH and MHR as well as by the non-governmental organization (NGO) that had been formed by the ear amputees themselves.

Regarding torture sequelae, the picture given by NGOs and governmental officials alike was that the proportion of individuals who had been subjected to torture is high and that the torture had often been physically violent resulting in fractures, burns and sometimes life long disability, in addition to the psychological sequelae that were sometimes less obvious to the professionals interviewed. In Basra, like in other parts of Iraq, torture and executions were part of everyday oppression during the regime of Saddam Hussein.

The impressions have been substantiated by a survey by Physicians for Human Rights undertaken in Southern Iraq. During the survey 16,520 household members were interviewed. The results revealed that since 1991 nearly one out of every two families has directly experienced torture or other serious human rights violations.[1]

In addition to the sequelae of torture, during the last three decades the population of Iraq has experienced two wars: The war against Iran and the Invasion of Kuwait. During both of these wars the governorate of Basra was heavily affected due to its geographical position. Both the occupation and the recent sectarian violence have added further to the traumatisation of the population, even if not to the extreme extent in Basra as in many other areas of the country. As the violence continues, it is also the source of persistent re-traumatization of those already afflicted. This adds to the complications of treatment.

In response to the situation the International Rehabilitation Council for Torture Victims (IRCT), commenced implementation of the project "Reaching Torture Victims in Post-War Iraq: Coordinating and Facilitating Interventions to Deliver Rehabilitations Services to Iraqi Torture Victims".

Basra was chosen as the place for establishing the first center that apart from rendering clinical services would also function as a training institution for the entire country. The choice was motivated both from the needs of the population and from the practicality of Basra being relatively secure. Professionals from other provinces of Iraq could come to Basra for training. In case security would become unsatisfactory, training could be held abroad.

The aim of the Centre is to develop holistic rehabilitation methods that are culturally relevant in order to support the large numbers of torture victims. Treatment and training at the Centre would not suffice to meet the needs of the Iraqi population, no matter how well it would function. The frequency of torture and the fact that the trauma does not only affect the individual but also the family and the community at large, indicates that consequences of trauma ought to be part of the public health pro-

gramme, thus reaching larger segments of the population.

With this background, a process was initiated, beginning with the establishment of the Al-Fuad Centre for Rehabilitation of Torture Victims (FRCT). The Centre has been operating since November 2005 but was officially opened at a ceremony on the 13th of March, 2006. The opening was delayed due to security reasons. The ceremony was attended by the deputy Governor of Basra, the Head of the police, medical personnel, academics from Basra University and a large number of human rights activists for a total of 120 people.

Theoretical background of a public health perspective

Means and methods by which a governmental administration tries to improve the health status of the population in a country carry the label of public health. When financial resources are meagre and the health status poor, the public health perspective favours that prevention is given priority over treatment as it can be more cost effective, i.e. rendering more health for money. At the same time, this kind of rationality may be difficult to uphold in the face of suffering individuals, whose treatment is ignored. The right to the best attainable health for the individual has been acknowledged as a Human Right by the UN. Treatment normally has a greater acceptance in the population than prevention, the outcome of which is less visible. It thus seems likely that public health can only work well if treatment is also cared for at a reasonable level. Whereas a public health approach does not exclude treatment, outcome is measured in the entire population rather than in individuals. This is why public health will often rely on epidemiology.

Traditionally, areas of concern for public health have been nutrition and communicable diseases, occupational health and environmental health. Lately there has been a shift of focus to lifestyle related disorders, mental health and violence. In 1995, mental disorders and behaviour-related diseases were described as causing close to 50% of the loss of Disability Adjusted Life Years in a global perspective by a group of researchers from Harvard Medical School.[2] An increased awareness during the last decade of how mental disorders affect mortality[3] would probably place this group of disorders as the number one cause of loss of Disability Adjusted Life Years. Violence is one of the prominent factors that contribute to the increase of mental disorders.[4]

In Iraq there has been a growing concern of Mental Health, and the MoH has created a National Mental Health Council. Both at the national level and at the local level of the Public Health Office in Basra, there is a slowly increasing awareness of the role the widespread traumatisation of Iraq's population plays for mental health. It seems obvious that trauma and its consequences ought to be addressed in the public health planning and hopefully it will be given increasingly more attention.

From a public health perspective, the means by which the health status may be improved are prevention and health promotion. Prevention addresses the effects of identified agents of disease, trying to eradicate them or counteract their consequences, whereas health promotion is less concerned with the specific causes, but tries to enhance salutogenic factors and resilience through healthy lifestyles and good living conditions. For operational reasons prevention is often divided into primary, secondary and tertiary prevention.

The aim of primary prevention is to prevent exposure to harmful agents. It often focuses on the entire population or indi-

viduals at risk in its approach, e.g. through vaccinations against communicable diseases. Secondary prevention focuses on those who have been exposed to a harmful agent, those who are especially vulnerable among exposed individuals or those who are in early stages of developing a disease. Tertiary prevention is equal to treatment, and rehabilitation of individuals with an identified disease back into society.

The main mandate of FRCT is treatment and rehabilitation. Still, the role of FRCT ought to be seen in a public health perspective as its treatment and rehabilitative capacity obviously would not suffice in relation to the numbers of tortured and traumatized people in Iraq. Increasingly, such a perspective has been tried during the development of the project, in order to bridge the gap between the immense needs and the limited resources.

Method of developing the centre

While we were starting the project in Basra several of the international NGOs were about to leave the country. In order to get sufficient knowledge and to involve local stakeholders such as professionals and NGOs in the planning, a series of meetings were held in Basra. It was important to reach broad segments of the society to build acceptance, future support and security. At these meetings we became increasingly aware that any treatment developed would have to be adapted to local circumstances and be culture sensitive in order to gain acceptance. After initial consultations the decision was taken to have a first seminar abroad for professionals in different disciplines, especially from the medical and legal fields. The seminar included presentations covering the UN convention against torture, traumatisation and sequelae of torture, and community effects and responses to torture. The methodology of identification and documentation of sequelae of torture was described with a gender perspective. With this common basis, participants spent the following days discussing perceived needs, structure of a centre-to-be and how to build collaboration between different disciplines and institutions.

Participants pointed out that the centre would need to be independent from government in order to maintain its neutrality. At the same time it should establish close collaboration with government. The recommendation was to create the Centre as an international NGO in the first phase, in order to obtain sufficient support. Subsequently, when feasible and sustainable, it would turn into a local NGO with full autonomy.

An advisory group was proposed to support the centre. The advisory board appointed had representation both from government bodies and NGOs (Figure 1). From its ranks were supplied the official board of the centre. According to several members, meeting each other in the advisory board has proved fruitful also for building confident relationships between the NGOs and government representatives. Previously there had been no tradition for consultations between government and NGOs.

One difficulty that had to be addressed was the lack of staff with sufficient training. There was a complete lack of clinical psychologists and physiotherapists and a shortage of psychiatrists. Among medical employees, there was no previous experience of multidisciplinary teamwork and cooperation normally followed a hierarchical structure. Administration likewise had a reminiscent hierarchy and administrators also had limited training with modern equipment. Traditionally, treatment of torture victims had been ignored or performed secretly.

In planning the centre's activities the am-

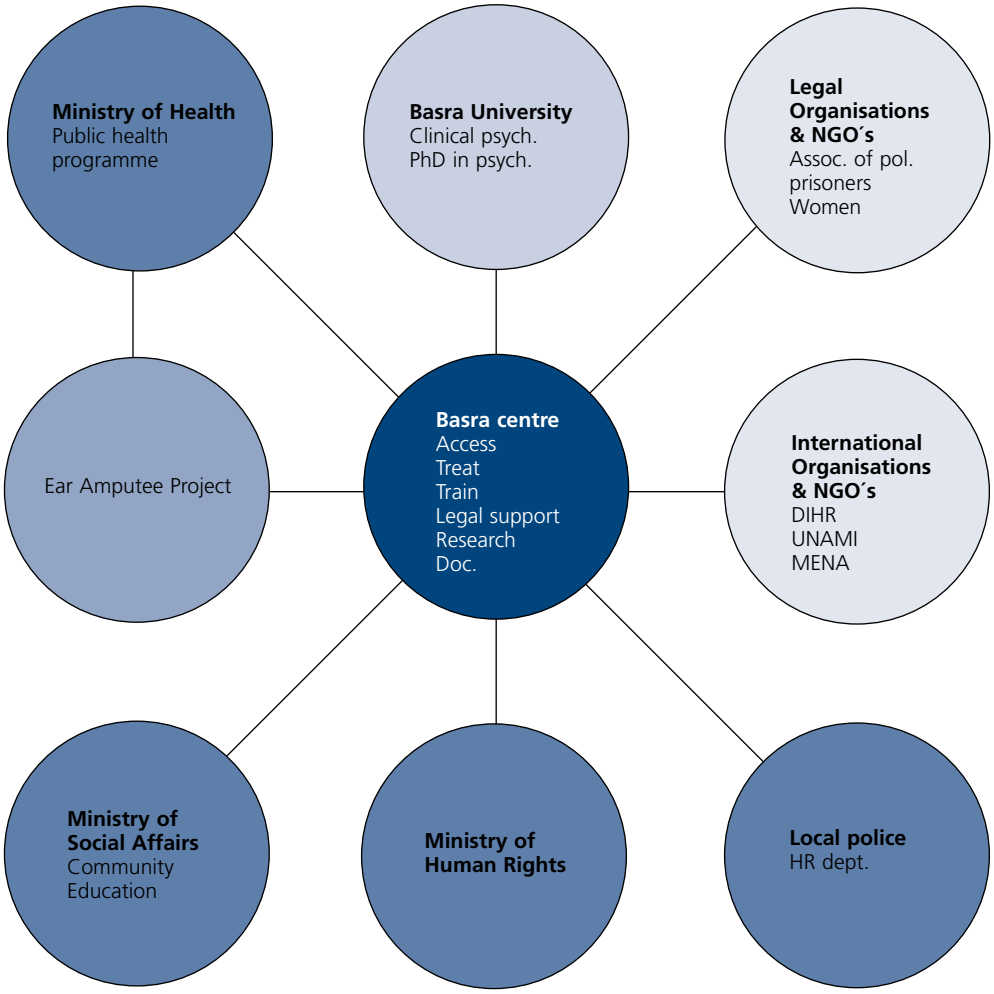

Figure 1. *The original advisory board of FRCT.*

bition was to let the perceived needs of the patients guide the development. A multidisciplinary treatment team was created to cater to the multitude of needs of the victims. Apart from medical and psychological treatment, legal advice would also be provided.

Documentation and data collection were seen as prerequisites for guarding the legal rights of the victims but also to supply a basis for evaluation and quality assurance. Until then data regarding torture and rehabilitation of torture victims had not been collected systematically in Iraq and it was therefore seen as essential for the country to develop methods to assist in creating a medico-legal data base regarding victims. As insight grew that treatment and rehabilitation resources will always be insufficient compared to the vast needs, it became increasingly essential to view the centre's activities in relation to a public health perspec-

tive. How could the Centre contribute to the health in Iraq? It was therefore planned that knowledge gathered through the data base would be utilized for future collaboration with the public health sector, and specifically the mental health programme (Figure 2).

Integrated in the original plan was the assumption that the assistance from IRCT would gradually phase out. Simultaneously FRCT would turn into an independent national NGO. Since January 2007 it has been registered as such. Provided that further funding will be obtained it thus seems likely that the goal of sustainability will be reached. FRCT is now a focal point of a variety of activities, aimed at assisting victims of torture.

Clinical activities

As of February 2007, 242 clients have been registered at FRCT. The largest age group is between 26 and 35 years of age and the

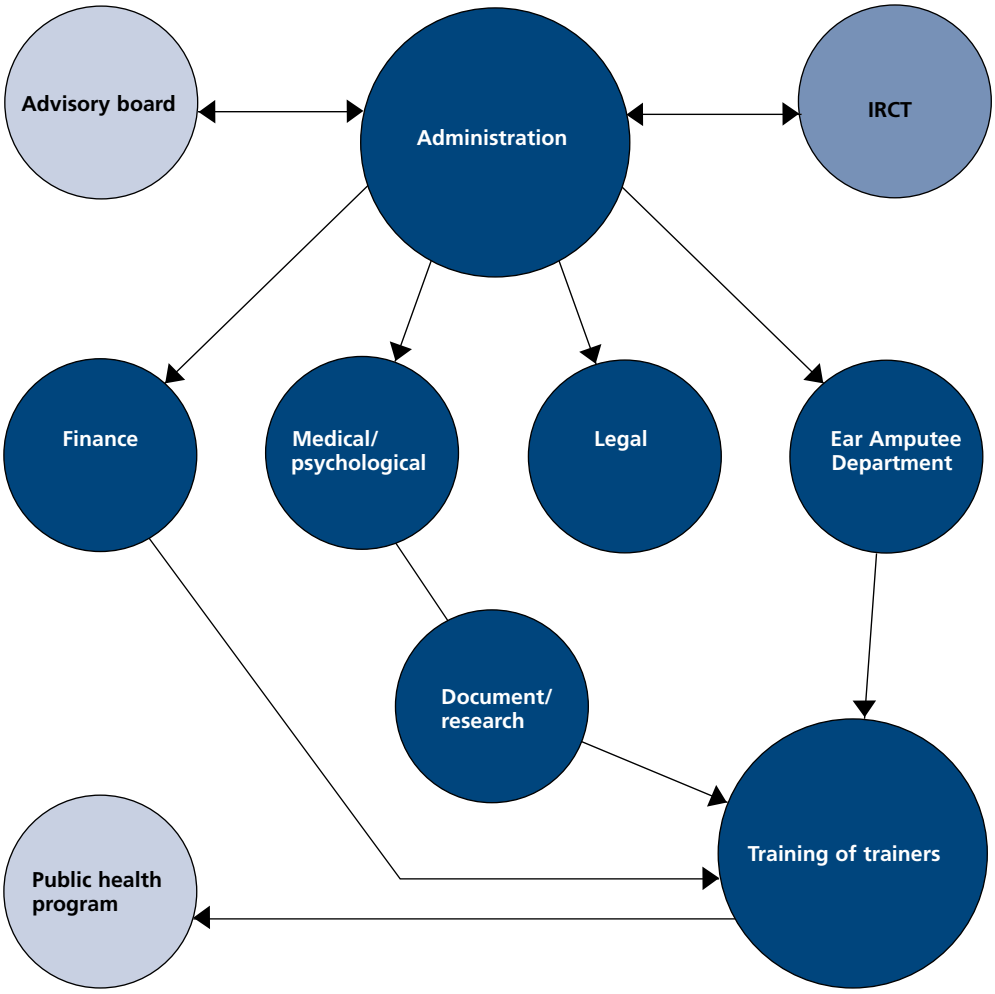

Figure 2. *Organizational structure of the FRCTT (before turning into national NGO).*

mean age of 37.5 years. Educational levels vary from illiterate (10%) to college (9%). About half (51%) of the clients have primary education or lower as highest attained education level, whereas the other half have intermediate, secondary, institution or college education.

84% of the victims have experienced their torture in prison or in connection to being arrested and detained. Regarding the forms of torture that victims have experienced statistics are yet to be prepared, but the Centre has revealed in its daily work with victims the following as common patterns of torture: The victims have been arrested, threatened, blindfolded, stripped of their clothes and suspended from their wrists for long hours either to a rotating fan in the ceiling or from a horizontal pole. Electric shocks have been used on various parts of their bodies, including the genitals, ears, the tongue and fingers. They have been beaten with canes, whips, hosepipes or metal rods. Some victims have been forced to watch others, including their own relatives, or family members, being tortured in front of them. Other forms of physical torture described by survivors include falanga, extinguishing of cigarettes on various parts of the body, extraction of finger nails and toe nails and piercing of the hands with an electric drill. Some have been sexually abused and others have had objects, including broken bottles, forced into their anus. Threats have often been extended to include family members.

In addition to physical torture, detainees have been threatened with rape and subjected to mock executions, placed in cells where they can hear the screams of others being tortured, been deprived of sleep, been denied food and water and subjected to solitary confinement in long periods. Often they have not been allowed to visit the toilet without permission.

The torture techniques also include burning with hot irons and blowtorches, dripping of acid on the skin, and breaking of limbs. Ear amputation was the punishment of army defectors according to decree 115, and thus not formally torture (as it was included in the penalty code). The victims of ear amputation have, however, been treated at the Centre. Often an "X" was branded in the forehead of the defecting soldier in order to assure that citizens would not think that he was a wounded veteran.

A case-finding survey conducted by FRCT in collaboration with victims' organizations revealed that about 400 individuals had suffered from punitive ear amputation in the area of Basra.

Physical sequelae are common among FRCT clients, indicating the brutality of the torture, and include fractures (wrongly healed), joint problems especially from shoulders, scars and unhealed skin lesions and pain from different parts of the body. A slight majority of victims present with physical symptoms as their chief complaint (56.5%). Among those who present with psychological complaints, depressed mood is the most frequent (56.4%). Anxiety and personality changes with both extreme withdrawal and difficulties in handling aggressiveness are other common complaints.

The most prominent diagnosis is posttraumatic stress disorder (PTSD) of varying severity. Psychological and psychiatric assessment reveal that more than 60% of victims fulfill criteria for posttraumatic stress disorder (PTSD) both according to a self-rating questionnaire (61.8%) and according to clinical diagnosis (62.8%). Intrusion symptoms (in the form of nightmares, flashbacks etc.), avoidance and hyper-reactivity symptoms are all present. Patients display a high number of avoidance symptoms, which

when present will often lead to a very circumscribed psychosocial life and inability to keep a job. Mental symptoms are also common among close relatives of victims, often fulfilling criteria of a complete PTSD diagnosis.

Most of the victims have impaired working capacity and have often lost their jobs. Many of them are unable to support themselves and their families economically.

The majority of patients have been men (87%), women being more reluctant to come forward due to societal constraints. However, a newly developed, more community directed programme, is aimed to attract women who need rehabilitation. This kind of programme provides the opportunity to reach the whole family including the children. The employment of a female gynecologist with an interest in psychotherapy has started to pay off in a higher proportion of female attendants. She has also attended training in narrative as well as in cognitive psychotherapy.

The Centre has been urged to address the plight of the victims of punitive ear amputation. In an effort to respond to these needs – although not covered for in the original budget – the Centre has, in collaboration with London Clinic (UK) and Mount Vernon Hospital, initiated a programme whereby a couple of patients were operated on in London by highly skilled plastic surgeons specialized in ear reconstruction. In the first phase of the project three surgeons and one surgical nurse from Iraq were trained in London simultaneously. Training was given free of charge, courtesy of the collaborating partners. The successfully completed first phase of this activity received a great deal of press coverage including a documentary by BBC which was extremely well received. As a result of the initial first phase training, three simple cases of ear amputations were successfully operated on in Basra.

In a second phase, an additional two surgeons were sent for training to perform the required surgical procedure. Upon returning to Iraq they have already started operating.

Patients referred to the centre for reconstructive ear surgery go through a medical checkup as well as psychological supportive therapy prior to their surgery. The majority of the ear amputee victims are smokers. Due to the very thin and sensitive blood supply around the ear area, smoking risks failure of the procedure. Smokers therefore attend group supportive therapy to quit smoking prior to operation. As an outcome of the ear reconstructive surgery project, Iraqi surgeons are now able to perform the operations at some hospitals in Iraq. An especially equipped operation theatre has been allocated to FRCT for one week each month in collaboration with the MoH. Psychosocial needs of the ear amputees are cared for at the FRCT like for all other patients.

The basis of the clinical work is teamwork with a wide variety of professional staff involved to address the sometimes complicated medical and psychological sequelae of torture; nurses, physiotherapists, social workers and physicians like general practitioners (GPs), orthopedic surgeons, gynecologists, and plastic surgeons. Psychiatric and psychological treatment as well as social support is regularly integrated into all treatment plans. Due to lack of clinical psychologists and psychotherapists in Iraq, we have developed methods that build on the patients' narratives in combination with pedagogical interventions. Another method that is based on the victims' beliefs is now being developed. The method relates psychological interventions to the content of religious texts.

Family therapy is increasingly practiced at the Centre. The high level of teamwork is a novelty to Iraqi medical tradition and has thus called for planning and supervision. It has been well received.

Each victim referred to the Centre is interviewed and introduced into the working mode and facilities of the centre as part of an initial pedagogical programme. The victim is then assessed with standardized psychometric self-rating instruments in addition to the clinical evaluation. All victims are then seen by a GP and a psychiatrist. When called for, other specialists will get involved and see the patient at the Centre. A social worker will map the social situation of the patient and, when needed, perform home visits to talk to family members. A treatment conference will propose a treatment plan and a contact person will be selected for the patient. This person will discuss the

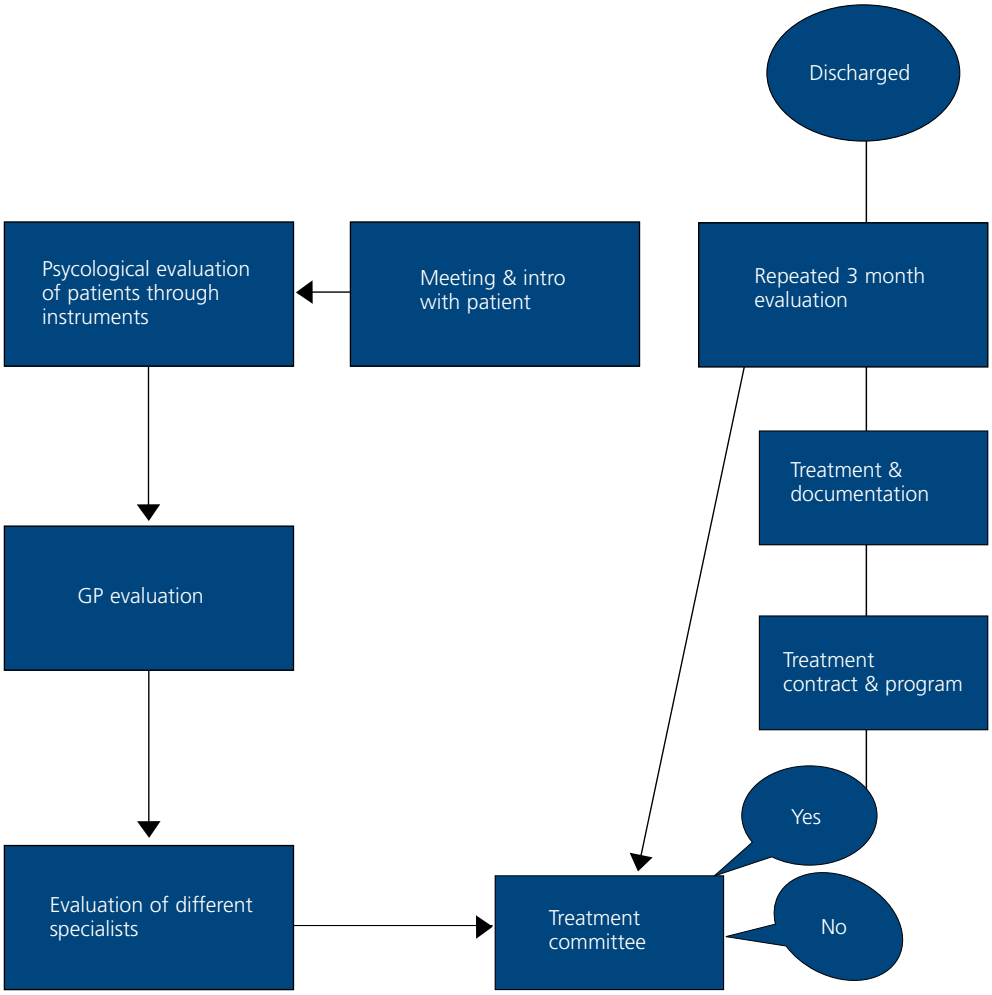

Figure 3. *Mode of reception, treatment and evaluation of treatment at the FRCT.*

proposed plan with the patient, who may accept it, reject it or suggest alterations. After treatment is commenced, progress will be measured by regular reassessments through applying the same instruments that were used at intake.

The condition of each patient will be re-evaluated every three months; continuation or discontinuation of treatment is decided based on these evaluations. For a schematic view of the treatment mode see Figure 3. The social worker mentioned above is also responsible for a micro grant programme that has so far only been tried on a dozen of occasions when victims have been unable to economically support themselves and their families. If they have presented an economically sound idea of an income generating activity they have been given support of a few hundred USD, e.g. to buy an oven in order to start a bakery. The majority of these projects have been successful. One has lead to a business that has expanded and employed others, but a couple of the projects have failed.

Data collection and quality assurance

At intake, all patients are interviewed by a specially trained educational psychologist, who, in addition to the interview, will use standardized self-rating instruments like the Self-rating Inventory for PTSD (SIP-22),[5] Self-rated Health,[6] Hopkins Symptom Check List, HSCL-25,[7] and Depression Subscale of SCL-90 (13 items).[8] Through an interview with a psychiatrist, a clinical diagnosis is established. The double diagnostic system built into the system allows us to get a better understanding of the patient and at the same time enables us to validate the self-rating instruments. All patients are seen by a GP for a general medical evaluation and documentation of physical sequelae of torture. Doctors at FRCT have been trained in medico-legal documentation of torture in accordance with the Istanbul Protocol.[9]

Specialist evaluations, when called for and the patient's subjective evaluation add to the perspectives. A social worker maps the patient's personal history and social life prior to and after torture.

All data collected – with the exception of data that may be sensitive from a security perspective – are directly fed into an SPSS programme as part of daily routines.

The data collection serves multiple aims. Apart from legal aspects it serves the purpose of quality assurance needed by the Centre. At the same time data collected gives the basis for research purposes, e.g. to measure PTSD prevalence among patients, their needs, co-morbidity etc. But data will also serve to gather knowledge for the mental health programme in order to better address the needs of traumatized people. FRCT has established collaboration with the Public Health Office in Basra with the dual purpose of introducing health office staff to the needs of traumatized people and at the same time learn the strategies of prevention and health promotion on a societal level. As a result, a joint mental health programme is gradually developing. Not only health hazards and symptoms but also salutogenic factors – such as social network – are recorded in the register. The fact that internationally recognized and culturally validated instruments are applied gives the possibility of international comparisons.

Training

Training seminars have been conducted with different professional groups, including police officers, teachers, journalists, judges and lawyers. GPs have been a central group receiving training regarding trauma and PTSD. About 700 professionals have so far taken part in these seminars. In ad-

dition, a common training programme with the Public Health Office in Basra has been developed.

Seven seminars arranged outside Iraq have dealt with legal and clinical aspects of torture, including forensic aspects, how to combat torture and how to organize and administer rehabilitation services for torture victims. Although a pronounced aim of the seminars has been to facilitate the organization of the work in Basra, participants have not been limited to FRCT staff but also included professionals from other parts of Iraq. One seminar, however, was exclusively for FRCT staff. Subjects covered have included computer skills, office administration, the SPSS statistical package, teamwork etc. Lately, much time has been devoted to developing psychotherapeutic skills, both in narrative therapy and cognitive therapy. The latest seminar selected participants who will in future function as trainers for their peers. One seminar, arranged in collaboration with The Olof Palme International Centre addressed conflict management. In collaboration with the Danish Institute of Human Rights, a seminar focusing on combating torture and policing based on human rights values has been provided to high ranked police officers and lawyers.

Thirty-nine seminars covering similar subjects have been organized inside Iraq by FRCT, although human rights and legal aspects have had a slightly more prominent position. They have also included training in data collection and documentation.

Eight symposiums have also been organized, sometimes in collaboration with victim organizations. In addition, seven peer supervision programmes have been implemented.

FRCT collaborates with Basra University in developing curricula for clinical psychologists. Karolinska Institutet in Stockholm has been approached to take an active part in this task and has responded positively. A programme in basic psychotherapy for Iraqi physicians has also been approved by Karolinska Institutet.

Training may multiply the outcome of clinical work. Clinical professionals from different parts of the country have repeatedly attended seminars arranged by the FRCT and thus established links with the Centre.

Several of the FRCT trainings have been more directed to primary prevention as they have targeted human rights and legal issues, thus helping in preventing exposure to human right abuses.

Prevention

From a public health perspective treatment and rehabilitation could be seen mainly as tertiary prevention, which is considered to have a limited impact on public health. But the multiplying effect that lies in training of new health professionals, especially if they acquire enough knowledge to function as trainers themselves, has then not been taken into account. With this perspective, training, and training of trainers (ToT) should be viewed as one of the central commitments of FRCT.

By applying a family perspective in the centre's activities, the FRCT will also work on a level of secondary prevention; i.e. through treating traumatized individuals prior to the development of PTSD or other serious disorders severe sequelae may be averted and chronic stages prevented. Relatives of our patients are often seriously affected, but may not have reached the stages of disorder that are difficult to reverse. In this way, the counseling of couples has frequently contributed to an increased understanding on the part of the spouse, and given means to deal with aggressiveness or avoidant behavior. In many cases divorce has been prevented.

Similarly, through training of professionals, especially GPs, who reach traumatized people in their daily work, early stages of disorder may be detected and addressed. Doctors who, as part of their service, attend to the prisons (both male and female prisons) do notice traumatisation among the inmates and have been able to engage in treatment.

The activities of FRCT have on many occasions been covered by TV and radio and opportunities have then been given to explain in a simple language the psychological consequences of torture. Describing common symptoms in a generalizing way is very reassuring for numerous victims of torture who feel that they are alone in their suffering and sometimes fear that they are becoming mentally ill. Without doubt this is secondary prevention and at the same time a way of raising the knowledge level of the general public and of professionals.

Family work is planned to be further developed and expanded at FRCT, both as a means of reaching more females who are reluctant to come forward for treatment and also for having an opportunity to assess and attend to the situation of children. Such activities should be seen as examples of primary prevention.

The training of judges, police and investigating officers, and prison staff as well as doctors, regarding the United Nations Convention against Torture, the Istanbul Protocol, clinical signs of torture and traumatisation as well as stressing their professional obligations are other examples of primary prevention.

The FRCT training programme, with a focus on trauma and the consequences of trauma on the family and community, has now been included as part of the developing programme on mental health in Basra. FRCT is also engaged in the National Network for Mental Health in collaboration with the National Mental Health Council. The Centre intends to share its gathered experience regarding torture, sequelae of torture, effects on relatives and possible preventive measures. The Mental Health Council is regularly invited to take part in the center's training activities. Another task delegated to the FRCT from the Mental Health Council is to create a national bank of psychometric instruments that are linguistically and culturally validated. This work has not yet been finalized.

Towards health promotion?

To address a health promotion strategy in Iraq in its present situation of continuous violence may be seen as utterly unrealistic. Factors that are detrimental to mental health are abundant and violence seems never ending.

Naturally the main responsibility of health promotion falls outside the boundaries of any health institution, as most decisions affecting health are taken at higher political levels. Still, the civil society may play a role regarding many factors that contribute to health promotion: The dissemination of knowledge and respect for human rights, respect for professional obligations and accountability and the creation of an atmosphere where human rights violations can be openly discussed are such factors. The fact that victims are suddenly seen and their plight addressed may instill hope and contribute to a more humanitarian interpersonal understanding. In this respect there is still a gender difference, male victims being the ones who have come forward first. Female victims still often feel that there is shame attached to their victimization and families have difficulties in handling the situation in more constructive ways than through denial. Here is obviously an area where the pres-

ence of a treatment institution increasingly attending to woman and opening dialogues with NGOs like women associations, victims' organizations, and influential professionals may play a role. Our pronounced aim is to increase the proportion of new female attendances from the present 14% to 30% in one year's time. The large number of seminars that the centre is capable of arranging is a powerful way of discussing and influencing attitudes.

Engaging in the reconstruction of the civil society alongside other NGOs and government authorities is to build democracy, which is a cornerstone of health promotion, especially so when the illness panorama is violence related.

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References

1. Amowitz LL, Kim G, Reis C, Asher JL, Iacopino V. Human rights abuses and concerns about women's health and human rights in southern Iraq. JAMA 2004;291:1471-9.
2. Desjarlais R, Eisenberg L, Good B, Kleinman A. World mental health. Problems and priorities in low-income countries. Oxford University Press, 1995.
3. Hannerz H, Borgå P, Borritz M. Life expectancies for individuals with psychiatric diagnoses. Public Health 2001;115:328-37.
4. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World report on violence and health. Geneva: World Health Organisation, 2002.
5. Hovens JE, van der Ploeg HM, Bramsen I, Klaarenbeek MTA, Shreuder JN, Riviero VV. The development of the self-rating instrument for posttraumatic stress disorder. Acta Psychiatr Scand 1994;90:172-83.
6. Bjørner JB, Kristensen TSS, Orth-Gomer K, Tibblin G, Sullivan M, Westerholm P. Self-rated health. A useful concept in research, prevention and clinical medicine. FRN report 1996;96:9.
7. Nettelbladt P, Hansson L, Stefansson C-G, Borgquist L, Nordstrom L. Test characteristics of the Hopkins Symptom Check List-25 (HSCL-25) in Sweden, using the Present State Examination (PSE-9) as a caseness criterion. Soc Psychiatry Psychiatr Epidemiol 1993;28:130-3.
8. Derogatis LR. SCL-90-R. Symptom check list-90-R. Administration, scoring, and procedure. National Computer Systems Inc., 1994.
9. Office for the United Nations High Commissioner for Human Rights, Professional training series No.8 – Istanbul Protocol. Geneva: United Nations, 2002.

Sexual violence against women: psycho-juridical approach*

J.Luisa Ll. de Fernández & Carmen Wurst*****

Abstract

In December 1982, the Peruvian government declared emergency zones in the country, giving control to the armed forces who applied operational plans aimed at eliminating guerrilla violence. The report of the Truth and Reconciliation Commission[1] concludes there is evidence that sexual violence was a generalized practice quietly tolerated by the security forces, and in some cases, openly permitted by immediate superiors. The violence took place during military operations, but also inside certain army and police facilities. This practice may have taken place in a systematic way, linked with the repression of guerrilla violence, in certain provinces of the regions of Ayacucho, Huancavelica and Apurímac. The same report argues that "one of the most affected groups in a context of armed conflict is women, who suffer not only the general effects of this type of situation, but also numerous violations of their rights by the mere fact that they are women."

Key words: Sexual violence, social consequences, psycho-juridical view, impunity

Evaluation

As a result of the trials of cases of women who were sexually abused, an organization of the National Human Rights Coordinating Body (CNDDHH) requested that we carry out psychological evaluations. Five victims had been evaluated previously by psychologists of the Institute of Legal Medicine and only one case of Post Traumatic Stress Disorder had been diagnosed. In other cases, it was concluded that they did not have psychological disorders. This was determined after an assessment made during a 15-minute interview in which the women felt mistreated by the psychologist and that their stories were being questioned.

Taking this background into account, we considered it necessary to conduct a new psychological evaluation that would not signify a secondary trauma to the affected women. Therefore, before the interview, a coordinated intervention was planned along with lawyers and an educator. This resulted in what we may call a psychological, legal and educational intervention, with different tasks being assigned to each professional.

The first meeting of the team in the locality, prior to the encounter with the women, made it possible for us as psychotherapists to obtain information about the trial and about the circumstances of the summons made by the lawyers.

*) Revised version from paper presentation

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Later, a workshop was held with the five women, giving them the time necessary to express their doubts and questions about what it meant to face the trial. In this way, they could later explain the legal process to their families and better understand the scope of the process and the difficulties they might face. At the same time, the psychotherapists explained our role and the reason for the evaluation. This involved explaining the psychological damage caused by the violence they had experienced. In this way, the team was able to focus on the common goal: obtaining justice, relieving the psychological consequences caused by the traumatic situation and fighting impunity.

This approach made it possible for everyone to meet and get to know each other and share their experiences throughout the two days of the workshop. By the end, most of the women succeeded in feeling a part of the group.

The need to coordinate the effort

Lawyers had to be taken into consideration as well: although they had an awareness of the subject matter, there were some gaps due to the lack of information on the psychological consequences of a rape. That is why it was necessary to inform them that one of the difficulties victims have in making the accusations is that on remembering the facts, they relive the traumatic scenes, which can produce a new trauma if the memories are not channeled towards the search for a meaning, in this case, justice. Understanding the complexity of this subject gave the professionals more elements with which to conduct the interviews.

At the same time, as psychotherapists we tried to keep in mind the customs of the communities to which the victims belonged. It was important for us as a team to reflect on how the harm suffered on an individual level represented harm to the social group, how that community was also damaged psychologically and at the same time rejected the women who had been raped.

The women's difficulties in talking about the torture and horror of these events are due to the fact that the psyche is unable to create a representation of what occurred. They related that after the rape they could not talk about the experience. When we have tools to help us understand this human behaviour then we can understand that certain responses are not necessarily a rejection of the judicial process, but the fear of reliving past experiences that have left a mark of constant pain.

As psychotherapists we seek to generate a recounting of the events that makes it possible to make sense of the events. We do not limit ourselves to giving an account of the symptoms in the here and now. By relating what occurred, we seek to place the trauma in the life history of the person and her community, so that the trauma does not remain locked inside and without representation.

As part of this effort, a social acknowledgement of the events is necessary, so that they do not remain in the private domain. For this reason, in these cases the acknow-ledgement of the other, that is, the society and the community, is necessary.

The experience we learned through this investigation is that lawyers and psychotherapists who are committed to human rights and fighting impunity relate to the affected people in different ways: we suffer the impact of the terrifying stories we hear. However, we can share the psychotherapist's skills of listening, the management of emotions and an understanding of the defense mechanisms developed by torture. Lawyers can share their knowledge of the legal processes related with the external reality, which is necessary for the emotional support of those affected.

Two cases which focus on consequences and challenges posed for the psycho-juridical and educational approach are presented below:

Traumatic episodes

First case

In 1987 Jacinta was 14 years old. During a family reunion approximately 30 soldiers showed up and took her and other people to a place where she heard screams and moans of pain. They asked her if she was a terrorist and made her take off her clothes. Since she refused to undress they hit her with a gun. The captain entered and started raping her, then the other soldiers followed; she does not remember exactly how many they were, she thinks there were around 6 soldiers. As she left the room they made fun of her; she had been a virgin and she was bleeding and in pain. They threatened her saying that she had to get married in a month.

She comments: "After they abused me, I don't remember what I did, I went to my house crying and I couldn't tell my mother. Other people later told her, so then my mother and father asked me … and then I told my mother."

She feared that she was pregnant and agreed to accept the young man who had proposed to be her boyfriend, and she went to live with him shortly afterwards.

Second case

Inés was 50 years old. She was married and had six children. In 1988 her father had been arrested. She went to the military base to ask about him. A military officer told her she was a terrorist, which she denied.

She comments: "I told them I needed to see my father, 'Oh, the old man. Are you going to give something in return?' I responded 'yes' and he said: 'Get up against the wall … how tall are you?', and he turned me against the wall and got close to me ... he told me 'take off your pants.' I spat at him and he hit me, he took out a knife, I said 'I prefer to be dead' and I told him they would look for me and he insulted me with swear words. He grabbed me and kissed me in a horrible way. It made me want to throw up and he knocked me against the wall ... and I had to receive (being raped) in silence"...then others came and since then I am sick ... and I never told anyone anything."

She was pregnant as a consequence of the rape, and had a baby that was different from her other children. She comments: "A husband knows when he can get you pregnant and when he can't. My period didn't come and I said nothing until I told him and he was surprised because he had calculated the days. Weeping and in pain, I told him what happened and since then I have lived a terrible hell. Having been abused, my husband, who was drinking all the time, insulted me saying I was a whore."

Consequences

The sexual violence against women in the Andean regions of Peru signified a traumatic intrusion in their personal life, family life and community relations. Women in Andean society are responsible for the care and education of their children and participate in earning a livelihood for the family by working in the countryside. In community life, it is men who make the decisions and actively participate in public meetings, have access to education and learn Spanish while women have a subordinate role and lack access to further development.

The traumatic events experienced by the women in the Andes aggravated this prior situation of being marginalized and excluded at the community level; nevertheless within the family, in their role as daughters, mothers or spouses, they maintained bal-

ance and stability sustained by the customs and the culture of their communities. In the cases analyzed, the horrific acts perpetrated against them interrupted this balance, leaving psychological consequences that have destroyed the development of their lives.

At the individual level, we have noted a state of depression, apathy and (in one of the cases) personal and professional abandonment, fear of unknown people, feelings of guilt for having been raped, fear in the presence of strangers. As a result they become mute in their native language (Quechua) as well as in Spanish.

We have noted a depressed attitude. Some are confused in relating the events while others remember the scene very clearly. They all are burdened with a lot of sadness and weep when relating what happened. The comments were that after the rape episode they felt different. For example, one said that she didn't "feel like cooking and I have remained pensive, sometimes I would tremble and run out of the house, I was afraid of being raped again in front of my husband."

We found that due to the memories of the rape, some of them started to drink in order to forget, which affects even their maternal and cognitive functions.

Regarding the family situation, these consequences led to neglect in exercising their role as a mother. One of the women, on being forced by threats to take a spouse, and due to her ignorance of contraceptive methods, had a lot of children who also suffer because of her fragility and state of emotional imbalance. She often feels violent and loses control, making her feel that she doesn't recognize herself when she reacts violently against her children.

Another of the women who became pregnant by force was rejected by her husband when he learned of the rape. When the baby was born, since the child was physically different from the others, he was rejected, made fun of and scorned by the whole family. The boy grew up in a hostile environment, stopped studying and went to work as a domestic servant at the age of 10, until he disappeared without leaving a trace of his whereabouts. She has looked for him constantly but has been unable to find him, which increases her anguish and pain. Due to their situation of poverty, the older children have not finished school and their development as a family has been disrupted as a consequence of the rape.

We observed how the trauma is transmitted to the children since they see their mother unsatisfied, irritable, depressed, fearful, and liable to lose control of her anger because of the atmosphere of frustration in which she lives.

The women have complained that since the rape they want to forget everything that has happened in their towns, they constantly feel nervous, are very distrustful and no longer feel joy in living. They suffer from pain in the lower part of the stomach, or have urinary or gynecological problems, feel repulsed by sex and associate everything as a direct consequence of the rape.

Torture and rape left the affected women psychologically paralyzed, as if they were experiencing the pain in the present, their memories focused on the past, preventing them from living in the present without these memories. The memories have the power of attracting all their associations as if they were a magnet, making their lives revolve around those thoughts. As Cardenas and others (2005)[2] note: Those affected "have put to sleep the collective registry of everything before the entry of the Shining Path and the armed forces. It is difficult to remember beyond these events their personal and collective history. It is in this way

that the affected women said that after the rape they could not express the traumatic experience of torture and horror."

Discussion

These same stories can be heard in other parts of the world. They persist because people who commit them know that these crimes will go unpunished because the women do not easily file complaints about sexual abuse, as they are not always believed. They can even be made to feel guilty. The perpetrators have told their relatives what happened, and the relatives have come to their defense, while the victims have put off taking action.

If we look at the stories presented, the women have felt humiliated, scorned, with fears that paralyze them, and their families are still suffering the consequences of the rapes. Their lives have been destroyed, they feel their identities have been taken away, and even feel guilty for what has happened to them.

According to Puget:[3] "It is likely that in these conditions the population starts incorporating, unconsciously, a way of making possible the impossible," so they will develop defense mechanisms to face the official statements being made, especially when they are full of messages that are contradictory and distort reality. "These defense mechanisms cover a wide spectrum and manifest themselves especially in what I understand to be the order of social subjectivity and thus the behaviour of the social groups. Sometimes it manifests itself as an attitude of anything goes or as a wall of indifference."

Apart from this, the survivors of rape live with the fear that their families and communities will condemn them if they are publicly identified as victims of abuse. This issue comes from the fact that women are so vulnerable, especially in zones of conflict, where they are used as if they were cannon fodder.

The perpetrators want to dominate, leaving the trace of horror in the victim without the possibility that she would be able to represent it somehow, or process the anger, the vulnerability and everything it brings up in the victim. This situation remains fixed in a psychic space that will last an entire life.

Despite the existence of an important number of cases of sexual violence, there is little information about legal processes concerning sexual violence committed by members of the armed forces or police. Neither has there been many effective investigations regarding complaints filed by women who were victims of sexual abuse perpetrated by members of the military men or police.

Conclusion

Twenty years have passed since these events took place and we can observe that the psychological consequences still persist and they will do so as long as a multidisciplinary approach is lacking. This approach would involve legal, psychological, anthropological and sociological teams working together. One has the impression that the magnitude of the damage, which has gone beyond the private realm, has not been taken into account. Although she may want to hide it, the victim will express her experience through her symptoms which will not be fully addressed by the public health and government officials.

In human rights violations there is an ethical commitment, which corresponds not only to psychotherapists and lawyers but also to society as a whole. We therefore propose the need for better treatment in the management of this problem which affects family and community relationships, so that the trials of the cases of sexual violence against women will be dignifying and healing for them and will not produce a secondary

trauma. It will also make it possible to fight impunity and to prevent the repetition of these patterns of human rights violations against the country's citizens.

References

1. Comisión de la Verdad y Reconciliación. Informe Final, Lima, 2003.
2. Cardenas N, Crisostomo M, Niera E, et al. Noticias remesas y recados de Manta Huancavelica. Lima: Demus, 2005.
3. Puget J. Lo común entre dictaduras, terror de estado y exclusión social. IPA 44th Congreso Rio de Janeiro, 2005.

Care for caregivers – self care strategies and other methods for work, care and casehandling

*The Hungarian rehabilitation centre "The Cordelia Foundation" exhibited their centre's objectives, training and strategies in brief sentences at the poster session**

The first steps

In 1998, the Cordelia Foundation recognized the need to address the issue of care and empathy on the part of staff and administrators working in the refugee camps. As an NGO providing psychological support for these refugees, we realised that the staff had not received even the minimum training teaching them how to cope with the psychosocial problems facing the asylum seekers, how to handle the so-called "difficult cases" and conflicts. Our positive psychological attitude toward the asylum seekers met a hostile response from some of the shelters' staff.

The great fluctuation of the staff members at the reception centres also drew the attention of the Immigration Office, and it "ordered" its employees to participate in our sessions. Two of us – one is the medical director and a psychiatrist, the other is a non verbal therapist – began to support the social workers and the nurses.

With the help of the Hungarian UNHCR Office, we began providing regular psychologically oriented training sessions to the staff.

Step-by-step we moved forward, and some years later, the staff realised that the work with refugees could be seriously traumatic. At the same time, they recognized the need for regular psychological support and self care strategies to protect them from vicarious traumatization and from burn-out.

Hungarian experiences – focus points

- Psychological mindedness
- Training
- Vicarious traumatization

*) Cordelia Foundation www.cordelia.hu

Psychological mindedness

- Vulnerability
- Traumatization
  – primary – secondary
- Empathy
- Compassion fatigue

Training

Participants

- decision makers/ immigration officers
- border guards
- social workers
- nurses
- members of other NGOs involved in refugee issues

Topics

- trauma and torture issues
- basic health care issues
- psychological definitions
- care and cure
- vicarious traumatization
- burnout

Vicarious traumatization

- is originating from the "intrusive nature of trauma" that invades the listener as well

Symptoms

- Anxiety
- Depression
- Helplessness
- Flashbacks
- Alienation from "normal" life
- Dissociative episodes
- Paranoid thoughts
- Cynicism, pessimism
- Extended helper's role
- Overidentification with the aggressor
- Feelings of guilt
- Hypervigilance
- Social dysfunction
- Mistrust
- Existential panic

The burn-out syndrome

- is a psychological phenomenon of caregivers/ helpers changing their relationships towards clients, colleagues and family. A person can burn out if s/he used to or had the capacity to "burn" before!

Solution strategies

Active

- Changing stress situation
- Influencing certain stressors
- Positive attitude

Passive

- Denial of certain elements of stress
- Playing down the elements of the stress
- Leaving the stressful situation

Direct

- Speak about the stress!
- Insight, understanding
- Other activities

Indirect

- Drinking (alcohol abuse)
- Escaping into disease
- Breakdown

Supervision

It is not "super" and not a "vision"

The "rule of the 3 N-s" (never, nowhere, nobody)

Its aim is

- to elaborate a self image through introspection
- to analyse the work in a self-reflective manner
- to discuss work and self-image in a group situation

Each session is divided into a verbal and a non-verbal part

Verbal part

Focusing on psychological processes concurrent (individual) psychotherapeutic

Non-verbal part

Relaxation and contact exercises

Conclusions – where we stand now

The use of regular care for caregivers

- changing attitude towards applicants
- sensitisation towards human and psychological problems
- psychoeducation
- better understanding of clients
- more constant working teams
- prevention of vicarious traumatization and burn-out

Employee turnover at reception centres has decreased.

The rate of recognised refugees used to be very low in Hungary in the past. It was one percent per year. Lately it has increased to nine percent as the result of trainings, supervision and the impact of medico-legal reports about the victims/ survivors of torture.

Recently, in the summer of 2006, thirty Somalian refugees arrived in Hungary. After the first hearing the eligibility officers were intimidated by the "torture stories" of each of these applicants and they requested extra supervision sessions to discuss the trauma they had suffered during the hearings. The entire Immigration and Naturalization Office was deeply moved. They arranged for special care for this group of torture survivors requesting the help of Cordelia Foundation in providing services to the Somalian refugees. Each of them has received refugee status.

A final note – some advice for the prevention of vicarious trauma and burn-out

- Make your reactions conscious in the stress situation!
- Examine your ability to adapt and your coping mechanisms!
- Prioritize your aims!
- Divide your energies!
- Separate your private life and work!
- Evaluate the situation and your ego-forces!
- Positive attitude: humour and delight.