Producing medico-legal evidence: Documentation of torture versus the Saudi Arabian State of Denial

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Abstract

Five British men were detained and allegedly tortured in Saudi Arabia in 2000 and 2001. Two were sentenced to death and three were sentenced to 12 to 18 years of imprisonment. They received clemency in 2003 and were deported to England.

After their homecoming, the men have unsuccessfully attempted to sue Saudi Arabian officials who had been responsible for their false accusations and human rights abuses. Saudi Arabia denies any form of torture and ill treatment of the five men, who maintain their allegations against the authorities responsible in Saudi Arabia. This article provides medical documentation of torture of the five British men by comparing: 1. Alleged torture methods, 2. Histories of immediate effects of torture, 3. Objective medical observations using clinical examinations as well as ultrasound scans of the victims' feet. The article concludes that there is a high degree of consistency between the claims of torture and observations, despite Saudi Arabian denial.

Key words: torture, medico-legal documentation, falanga, ultrasound

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Introduction

In the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment from 1984, torture is defined as the *intentional* infliction of *severe* mental or physical pain or suffering by or with *the consent of the state authorities* for a specific purpose[1]. In the convention, article 10, point 1 states: "Each State Party shall ensure that education and information regarding the prohibition against torture are fully included in the training of law enforcement personnel, civil or military, medical personnel, public officials and other persons who may be involved in the custody, interrogation or treatment of any individual subjected to any form of arrest, detention or imprisonment".

This paper describes the case of five British men who were imprisoned in Saudi Arabia. They were arrested by the Saudi Arabian police in connection with a series of bomb explosions in 2000 and 2001 in Riyadh where they lived and worked. The men were accused of planting bombs as part of a feud between rival gangs dealing in illicit alcohol. After a long period of interrogation, including daily torture, all five men

confessed to the accusations. Two men were sentenced to death and three to periods of imprisonment ranging from 12 to 18 years.

After more than two years' imprisonment the men received clemency on August 8, 2003 from the state of Saudi Arabia and were deported to England. The men, who claimed their innocence, then began an attempt to sue Saudi Arabian officials who had been responsible for their false imprisonment and human rights abuses – for details of the legal case, see Ferstman 2006.[2] Such attempts at legal redress on a national level are complicated by political and state interests and are most often denied. This was also the case for the five men. In order to produce valid documentation of torture inflicted on the men while imprisoned, their five solicitors contacted the Parker Institute, Frederiksberg Hospital in Copenhagen. The Parker Institute is experienced in documentation of torture. In November and December 2003 and in February 2004 medical doctors examined the five men.

The documentation is based on systematic comparison of the alleged methods of torture, psychological and physical complaints reported by the victims at the time of torture and at the time of examination, and the medical doctors' objective observations. The medical examinations were performed between three and six months after the men's release and between two and three years after torture commenced upon their arrest and interrogation. The examinations were performed by medical doctors with specific experience and expertise in documenting torture and in the institutional setting of a public hospital and research institute independent of any political or institutional interests of Saudi Arabia or the United Kingdom where the five men were attempting legal redress.

The following account of the torture and ill treatment is extracted from the medical reports made by medical doctors at the Parker Institute and Clinic of Rehabilitation, Frederiksberg Hospital, Denmark. The examinations were conducted in accordance with the principles for examination of evidence of torture as declared in the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment – The Istanbul Protocol.[3] All five men described in this paper have given their written consent and permission to publish their torture history and medical reports.

Background information

All five men were psychologically and physically well functioning and had been living in Saudi Arabia for five to 25 years. At the time of their arrest they were working for Saudi state or private companies: as a chef in the Royal Military Hospital in Riyadh, as chief anaesthetic technician at the Security Force Hospital in Riyadh, as a marketing consultant in the pharmaceutical industry, as a project manager for a British aerospace housing compound in Riyadh, and as an employee in the construction industry. Four men were married (one of whom was divorced) and all four men had children.

Past medical history

The five men were in relatively good health prior to their arrest. Three had been diagnosed with mild hypertension, of these three, two were taking antihypertensive medication and one had been diagnosed with type II diabetes mellitus. Additionally, three men had known minor musculoskeletal problems: one had been diagnosed with bilateral knee osteoarthritis, one had had arthroscopic meniscus surgery in the right knee, one had a past history with a fibular and a humeral shaft fracture on the left side leaving no im-

pairment, and one had a fracture of the fifth finger on the left hand with reduced range of movement in the distal interphalangeal joint. These chronic injuries do not relate to torture.

Allegations of torture and ill treatment

The five men were arrested individually by officers dressed in plain clothes. On their arrest the men were at home, walking along the street or at work. The first arrests were on 17 December 2000 and the last one in June 2001. All men were accused of taking part in a series of bombings in Riyadh and illicit trading of alcohol; two were additionally accused of being British spies. The men were handcuffed, blindfolded, and taken to an interrogation centre where they were detained without trial or sentence for up to 10 weeks. During daily interrogation sessions lasting several hours they were all subjected to torture and ill treatment with the aim of extracting information about other named British citizens who were said to have been involved in the bombings, and to extract confessions of having taken part in the bombings, including signed written statements.

All men confessed to the accusations and after various periods of time all were transferred to the al-Hair prison in Riyadh. There the torture and ill treatment continued on a regular basis during further interrogation sessions; the aim still being to extract information and signed confessions. After four to five months the interrogation sessions became less frequent and the physical abuse ceased. In July 2001 three men were forced to appear in a publicly televised confession.

In the al-Hair prison the five men were kept in solitary confinement for between nine and 31 months. Two shared a cell after solitary confinement for nine and 12 months, respectively; two others shared a cell after solitary confinement for 15 and 24 months, respectively. The last prisoner remained in solitary confinement for 31 months.

The men appeared in court up to three times during their imprisonment, without legal representation. Two were sentenced to crucifixion and partial beheading for state terrorism; three were sentenced to 12 to 18 years of imprisonment, but were not informed of the sentence and until shortly before their release, and feared they would be sentenced to death and executed.

The five men were kept imprisoned until August 2003 when they were pardoned and deported from Saudi Arabia.

Alleged physical torture methods

The five men give similar accounts of the torture methods they were exposed to during detention and imprisonment. All men were subjected to systematic and unsystematic beatings, including falanga, and to various forms of positional torture (Table 1 on the next page).

During most torture sessions the men were blindfolded and handcuffed. They all allege to have been subjected to *unsystematic* beatings of the body and extremities with stiff, rounded instruments such as an axe handle or a cane. The beatings left extensive bruising, haematomas and purple/black discolouration, but no open wounds or fractures.

All men were beaten about the head causing bleeding from the mouth, swelling and bruising, leaving four men with dental lesions. The beatings left no open wounds or fractures and no men recall loss of consciousness.

Two men had *telephono,* simultaneous beatings on the ears causing bleeding from the ears, tinnitus and hearing impairment in the acute phase and subsequent persist-

Table 1. *Distribution of alleged physical abuse.*

No. of men	Subject no.	Torture method
5	1,2,3,4,5	*Unsystematic beatings with blunt instruments*
5	1,2,3,4,5	*Systematic beatings:*
5	1,2,3,4,5	Beatings on head/face
2	1,3	Beatings on ears (telephono)
3	1,3,5	Beatings on lower back and kidney regions
3	1,3,5	Beatings on palms
5	1,2,3,4,5	Beatings on soles of the feet (falanga)
5	1,2,3,4,5	*Forced positions:*
5	1,2,3,4,5	Chained standing
3	1,3,4	Prolonged standing, arms elevated
1	2	Prolonged head and hand stand
3	1,2,3	*Strapping and suspension:*
3	1,2,3	Chicken pole suspension
1	3	Suspension upside down
1	1	Suspension by one arm
1	3	Strapping of wrists and ankles in supine - position
1	2	*Asphyxiation*
1	3	*Sexual assault (including rape)*

ent tinnitus. On one occasion one man was forced to place his head on a desk with the left side of his face facing up; in this position he was beaten on the left ear.

On two occasions the same man was exposed to low back trauma. On the first occasion a prison guard stamped on his lower back and pelvic region while he was lying on the floor on his stomach, leaving him with severe pain and stiffness in the lumbar-sacral region. On the second occasion he was attacked in his cell by several prison guards and thrown against the edge of the bed plinth. This resulted in a direct trauma to the lower back causing severe, immobilising low back pain but no radiating pain or other neurological symptoms. Two other men were also beaten systematically on the lower back and kidney regions. They observed blood in the urine, stiffness in the lumbar-sacral region and severe, immobilising low back pain.

Three men were exposed to *systematic beating of the palms* with a thick cane causing severe pain, discolouration and swelling of the palms and fingers and impaired function of the hands in the acute phase. The beatings left no open wounds or fractures.

All men were subjected to falanga performed with rounded, stiff instruments such as an axe handle or wooden canes. One man describes being subjected to *falanga* while lying on his stomach on the floor with his ankles and wrists strapped together, his arms tied behind his back and his knees flexed with his soles facing up. The immediate effect of the falanga torture is described by the men as severe pain in the feet and lower legs, symmetric swelling of the feet spreading up to the ankle region, blistering and discolouration of the soles due to haematoma formation and sensory disturbances (pins and needles) with numbness in the soles in addition to impaired walking, making it impossible to wear shoes for several weeks after the event. The beating left no open wounds or fractures.

All men were subjected to *forced positions.* At the interrogation centre they were all handcuffed and chained to a grill in the door resulting in them being unable to lie down or sit when in their cells. The handcuffing left superficial abrasions in the wrist regions, but no radiating pain or other neurological manifestations. Additionally, some men were forced to maintain positions of prolonged standing with their arms elevated causing pain and pronounced swelling of the lower legs. One man was forced to lie on the floor on his back holding his extremities and head off the ground for prolonged periods. When his head or extremities dropped the torturers beat him with an axe handle or cane.

Various forms of *strapping and suspen-*

sion were applied to three men. One form was *chicken pole suspension,* suspension on an iron bar inserted behind the knee joints with the arms handcuffed in front of the knees. In this position the men were beaten on the back and buttocks as well as being subjected to falanga. This torture method caused severe pain in the knees and left superficial abrasions in the ankle and wrist regions, but no joint dislocation or joint swelling and no radiating pain or other neurological manifestations. One man was *suspended upside down* hanging from a rope from the ceiling, with his ankles and wrists strapped together, his arms tied behind his back, knees flexed, head facing down and his body weight loading his shoulder joints. In this position he was beaten on the soles, the abdomen and the testicles. The man reports that this type of suspension caused severe pain in both shoulder regions and a sensation of dislocation of the shoulder joints, but no radiating pain or sensory disturbances in the arms. One man was suspended by his left upper arm for nine days; his arm was strapped at the wrist and fixed to the wall. He was supported only when standing on his toes.

Another man was subjected to *asphyxiation.* When subjected to falanga torture the pain was so severe that he began screaming. He did not stop screaming when ordered to and his torturers removed his blindfold and pushed it down his throat while also blocking the airways in the nose. This was maintained long enough for the man to believe he would die from suffocation.

One man was exposed to sexual torture, which included homosexual rape. This was most likely due to his single status and because he was above the standard age for marriage. Physically, the sexual assaults caused pain and soft tissue lesions in the anal region.

Notably, despite the force of violence of the assault, no open wounds or fractures occurred. The apparent aim was to leave few visible permanent marks.

Alleged psychological torture methods

All men allege to being exposed to solitary confinement, deprivation of basic needs, sleep deprivation, and threats during their imprisonment (Table 2).

The five men were detained in small, solitary cells with constant lighting and closed circuit cameras. The *solitary confinement* lasted for up to 31 months.

They were *deprived of basic* needs i.e. kept under unhygienic conditions without access to washing/bathing facilities and clean clothes and with only limited access to toilet facilities. Due to lack of food and loss of appetite all men had a considerable weight loss during the confinement (between 14 and 40 kg). At times, some men were denied their prescribed medication.

The men were exposed to *sleep deprivation* for prolonged periods (days) during which they became disoriented and some hallucinated.

They were *exposed to threats* of continued torture e.g. electrical torture, suspension from the window and off the roof, and executions. Those who had a wife and children experienced threats being made concerning

Table 2. *Distribution of alleged psychological abuse.*

No. of men	Subject no.	Torture method
5	1,2,3,4,5	Solitary confinement
5	1,2,3,4,5	Sleep deprivation
5	1,2,3,4,5	Deprivation of basic needs
5	1,2,3,4,5	Exposure to threats
4	1,2,3,4	Overhearing torture
3	2,3,5	Waiting
1	3	Mock-execution
1	3	Sexual harassment and sexual intimidation

their lives and well-being. The torturers told one man that his wife was imprisoned in a cell in the basement and that they would torture and assault her.

Four men reported *overhearing torture* in the form of screams and crying from neighbouring cells and at times they recognised the voices of their colleagues who had been arrested at the same time. Three men report *waiting* sitting blindfolded for several hours outside the interrogation room before being brought in for questioning and torture. One man reports of *mock-execution:* he was told he was to be executed and was blindfolded, handcuffed, shackled and led from his cell to a police van waiting in the prison yard. He was driven around in the van, but after a time returned to the prison and led back to his cell where he was told the execution had been postponed. The same man reports *sexual harassment and sexual intimidation.* Due to his single status he was accused of being a homosexual and threatened with sexual assault as well as the death penalty according to Shariah Law.

Medical attention

A medical doctor attended the men in the al-Hair prison. They saw this prison doctor at regular intervals and after interrogation sessions. In addition, the doctor was sometimes summoned during the interrogation sessions to sign the prisoner fit for further interrogation. At times the men received medical care; at other times the prison doctor withheld treatment and medication.

Three men were hospitalised during their imprisonment. One was admitted to hospital three times: once after feeling dizzy and blacking out during interrogation, he was then diagnosed with atrial flutter, but was not informed of the diagnosis; another time with chest pains and dizziness after interrogation; and a third time when he underwent cardiac catheterisation, but was not informed of the reason for or the outcome of the examination. Another man was hospitalised on several occasions (the man does not recall the exact number) because of high blood pressure, chest pains, or severe headache and sensory disturbances with cold sensations in the right arm. When he received visits from the British Embassy he was ordered not to discuss any health matters with the embassy official; two interrogators were present throughout the meetings. A third man was hospitalised on three occasions. Prior to the first occasion, the prisoner, who had no known predisposition to ischaemic heart disease, collapsed during interrogation with a heart attack. An acute angiogram and percutaneous coronary angioplasty was performed. Throughout the hospital stay the prisoner was chained to the bed and guards were present in the room 24 hours a day. One month later he was readmitted with a long-lasting angina attack after interrogation and had a second coronary angioplasty. On the third occasion he was hospitalised with severe, immobilising back pain caused by a direct trauma to the back after fierce beatings.

In addition, one man had a visit by a psychiatrist provided by the Canadian Embassy.* Throughout the visit from the embassy the interrogators were present in the room and claimed that the man's injuries were sustained when they prevented him from committing suicide. This was not the case.

Physical complaints at the time of examination

Since their imprisonment and exposure to torture the five men have had a series of

*) The man has dual citizenship: Britisk and Canadian

physical problems. These problems have been assessed and treated by various specialists after the men's homecoming. Four men report reduced overall physical fitness with general fatigue and lack of energy. Four men report deteriorated eyesight and hearing impairment and/or tinnitus. Four men have *dental lesions* resulting from beatings. Other complaints vary from person to person and include heartburn after eating, recurrent angina, and reduced libido.

The persistent and major physical complaints are mostly related to the *musculoskeletal system.* Four men experience pain, stiffness and/or reduced range of movement in the back or lumbar-sacral junction. Other reported symptoms related to the musculoskeletal system are sensation of weakness in the wrists and fingers with reduced muscle strength on gripping, pain in the neck and shoulder girdle, intermittent pins and needles in the buttocks and thighs on prolonged sitting, and pain in the knee, shoulder and elbow joints.

Four men report persistent pain in the feet and ankle regions. They have slight pain or discomfort in the feet at rest, which intensifies with weight loading and walking – for two men to a degree causing impaired gait. They can walk only a limited distance during which the pain in the feet and lower legs intensifies and inhibits continued muscle activity. After resting the pain subsides and walking can be resumed (Table 3).

Table 3. *The most frequent physical complaints.*

No. of men	Subject no.	Physical complaints
5	1,2,3,4,5	Reduced physical fitness
4	1,2,3,5	Deteriorated eyesight
4	1,2,3,5	Hearing impairment and/or tinnitus
4	1,2,3,5	Pain, stiffness and/or reduced range of movement in the back or lumbar-sacral junction
4	1,3,4,5	Persistent pain in the feet and ankle regions

Psychological complaints at the time of examination

Since their release and homecoming the men have had persistent psychological symptoms, in particular *sleeping difficulties* often due to *nightmares* during which they re-live the torture sessions, waking up sweating. In general the men experience *intrusive thoughts* with distressing images and unwanted memories related to their torture and imprisonment combined with *flashbacks* triggered by situations or sounds reminding them of the torture situation. One man describes this as a feeling of not being in control of his life and life circumstances. In response to unwanted memories another man reports *avoidance* of potential reminders, emotional numbness and general unresponsiveness to the environment.

In addition all men report *impaired concentration and difficulties with attention and memory,* e.g. difficulties watching television or reading due to concentration lapses and bouts of absentmindedness resulting in losing track of conversations or forgetting the topic of conversations or the identities of the persons present. Some men report note taking in order to remember daily activities.

Four men have children; three men are married, and one is divorced. The men report *shame and guilt* especially towards their family for what they have been subjected to and for not being able to provide for them after homecoming. The shame and guilt towards the family have incurred marital problems. The men are also ashamed of having given information and naming people during torture and for confessing to the accusations publicly.

The men report *change in mood and personality.* They experience depressed mood,

fatigue, loss of energy, generalised anxiety and constant arousal. They also experience heightened sensitivity to situations of potential confrontation and mood shifts pertaining to physical intimacy. Accordingly, some men avoid crowds and social participation as these situations may precipitate anxiety reactions with heightened pulse, sweating, tremor and nervousness, especially in crowded or frenetic environments. The men describe themselves as formerly being patient and relaxed and now finding themselves irritable and emotionally labile, afraid of losing their temper. Before their imprisonment they perceived themselves as strong and outspoken; now they report perceiving themselves as weak and have low self-esteem.

Four men are unable to return to work due to physical and psychological symptoms. One man has returned to working as a chef despite being diagnosed with post-traumatic stress disorder and associated symptomatology related to the torture and imprisonment. He moved to the US with his family and has been offered psychological evaluation and assistance there but at the time of examination at the Parker Institute this treatment had not been established. The other four men have been offered limited assistance. One was offered psychological assistance and has received trauma counselling on a regular basis. Another was offered psychiatric evaluation and a brief counselling course of six therapy sessions. A third was offered a few psychiatric treatment sessions. A forensic psychiatrist assessed the last man, who was having weekly treatment sessions with a cognitive therapist at the time of the examination. He has also been offered social counselling. None of the men has been offered extensive, specialised treatment and care or financial compensation (Table 4).

Table 4. *The most frequent psychological complaints*

No. of men	Subject no.	Psychological complaints
5	1,2,3,4,5	Sleeping difficulties
4	2,3,4,5	Intrusive thoughts and flashbacks
5	1,2,3,4,5	Impaired concentration and memory
4	1,2,4,5	Shame and guilt
5	1,2,3,4,5	Change in mood and personality

Objective examination

A systematic medical examination according to the guidelines offered by the Istanbul Protocol was performed on all men. The formal and informal contact during the medical interview and clinical examination was good. All men were well oriented in their own data and presented the torture history, the immediate symptoms caused by the torture and present symptoms and consequences of the torture in a consistent and unexaggerated manner. Mentally, the men appeared coherent with a slightly depressed mood. The registered mental reactions and psychological distress caused by the interview were foreseen and appropriate in the context.

The overall physical condition of the five men was good with normal vital signs at the time of examination. Findings suggestive of torture were found mainly in relation to the oral cavity and in the musculoskeletal system, including the feet and gait.

Concerning the oral cavity, four of the five men were missing teeth. Two had signs of tooth avulsions and sequelae after tooth extraction and in one there was evidence of dental lesions with avulsions from molars. Otherwise, there were few positive findings of evidence of torture at the general objective examination (Tables 5 and 6).

Table 5. *Distribution of findings at general objective examination.*

Body part	Objective findings
Skin	No cicatricial changes related to torture on the body surface or extremities including the soles. No cicatricial alopecia in wrist or ankle regions
Face	No evidence of fractures. No muscular soreness. No signs of motor or sensory nerve lesion
Nose	No evidence of fractures
Oral cavity	Signs of tooth avulsions and sequelae after tooth extraction. No signs of soft tissue lesion
Heart auscultation	No abnormal findings
Lung auscultation	No abnormal findings. No thoracic soreness or evidence of rib fractures
Abdomen	No soreness in the abdomen or renal region. No organ enlargement or fillings
Genitourinary system	Systematic examination not performed

The musculoskeletal system (Tables 7 and 8)

Findings in the musculoskeletal system were in general unspecific and primarily confined to the soft tissues. The examination of the musculoskeletal system was organised under the following headings: cervical spine, upper extremities, thoracic and lumbar spine, pelvic girdle, lower extremities.

Cervical spine: One man had reduced rotation and lateral flexion bilaterally with increased muscle tone and tender points in neck muscles and soreness at occipital muscle attachments.

Upper extremities: Increased muscle tone and/or tender points in the shoulder girdle were found in all five men. One had reduced active abduction and inward rotation with pain response at end-range of movement in the right shoulder and soreness at the rotator-cuff attachment on that side. Another had decreased extension in both elbow joints with a 20° extension defect on the left side and a 10° extension defect on the right side. Joint mobility was otherwise normal in all men. One had symmetrically reduced muscle strength at handgrip, finger spreading, extension and flexion over the elbow joints. Apart from that, examination showed muscle strength, tendon reflexes and sensibility to be normal.

Thoracic and lumbar spine: At inspection three men had a discrete lumbar-thoracic scoliosis. None had vertebral soreness and only one had reduced range of movement in the lumbar spine. At palpation, all five men had increased muscle tone and/or tender points in the lumbar muscles and two had tightness and soreness in ilio-lumbar ligaments. In one man dysaesthesia in the Th12 dermatome was present on the left side.

Pelvic girdle: Increased muscle tone and/or tender points in gluteal regions were found in three men and two had soreness and positive stress test of sacroiliac joints.

Table 6. *Reporting of pain per body region at the time of examination.*

Pain distribution	Subject 1	Subject 2	Subject 3	Subject 4	Subject 5
Headache	-	+	-	-	-
Neck and shoulder girdle	-	-	-	+	-
Upper extremities	+	-	+	+	-
Thoracic spine	-	-	-	-	-
Lumbar spine and pelvic region	+	+	+	-	+
Lower extremities	+	-	+	-	-
Feet including ankles	+	-	+	+	+
More than three regions	+	-	+	-	-

Table 7. *Alleged torture method, reported immediate effects, complaints and objective physical changes.*

	Effects	Subject 1	Subject 2	Subject 3	Subject 4	Subject 5
Beatings around head/face		+	+	+	+	+
Immediate effects	Swelling and bruising	+	+	+	+	+
	Open wounds and fractures	-	-	-	-	-
	Loss of consciousness	?	-	-	-	-
	Tooth extractions	+	-	+	+	+
	Tooth avulsions	+	-	+	+	+
Complaints at examination	Dental caries	-	-	+	-	-
	Gum disease	-	-	+	-	-
	Tooth extractions	-	-	+	-	+
	Headache	-	+	-	-	-
	Cognitive impairment	+	+	+	+	+
Objective physical changes	Tooth avulsions and sequelae after tooth extraction	+	-	+	+	+
	Soft tissue lesion	-	-	-	-	-

Table 8. *Alleged torture method, reported immediate effects, complaints and objective physical changes.*

	Effects	Subject 1	Subject 2	Subject 3	Subject 4	Subject 5
Beatings at low back and kidneys		Systematic	Unsyste-matic.	Systematic	Unsyste-matic.	Systematic
Immediate effects	Low back pain	+	+	+	-	+
	Reduced range of movement	+	+	+	-	+
	Irradiating pain	-	-	-	-	-
	Sensory disturbances in UE	-	-	-	-	-
	Blood in urine	+	-	+	-	+
Complaints at examination	Low back pain at rest	-	+	+	-	-
	Low back pain at activity	+	+	+	-	+
	Reduced range of movement	+	+	+	-	+
	Irradiating pain	-	-	-	-	-
	Sensory disturbances in UE	+	-	-	-	-
Objective physical changes	Vertebral soreness/ soreness in SI-joints	-	+	+	-	-
	Abnormal posture	-	+	+	+	-
	Soreness and increased muscle tone in lumbar/pelvic muscles	+	+	+	+	+
	Reduced movement in lumbar spine	+	-	-	-	-
	Sensory disturbances in LE	-	-	-	-	-
	Abnormal reflexes	-	-	-	-	-
	Reduced muscle strength in LE	-	-	-	-	-
	Positive Laségues	-	-	-	-	-

Table 9. *Alleged torture method, reported immediate effects, complaints and objective physical changes.*

	Effects	Subject 1	Subject 2	Subject 3	Subject 4	Subject 5
Falanga		+	+	+	+	+
Immediate effects	Swelling and bruising	+	+	+	+	+
	Pain	+	+	+	+	+
	Sensory disturbances	-	-	+	-	+
	Impaired walking	+	+	+	+	+
Complaints at examination	Pain in feet at rest	+	-	+	+	+
	Pain in feet at activity	+	-	+	-	-
	Pain in ankles at rest	+	-	+	-	-
	Pain in ankles at activity	+	-	+	-	+
	Sensory disturbances	+	-	+	-	-
	Impaired walking	+	-	+	-	+
Objective physical changes	Reduced elasticity in heel pads	-	+	+	+	-
	Soreness in the plantar fascia	+	-	+	+	+
	Loosening of skin	-	+	-	-	-
	Sensory disturbances in soles	+	+	+	+	+
	Tender points in anterior tibial muscle	+	-	+	-	-
	Tenderness in Achilles tendons	+	-	+	-	-
	Ankle joint dysfunction	-	-	+	+	-
	Abnormal gait	+	-	-	-	+

Lower extremities: In two men, soreness was present in the medial knee region at pes anserinus and in one man in the iliotibial tract and the biceps femoris muscle. Two men presented with soreness and increased muscle tone in the anterior tibial muscle and at palpation along the medial aspect of the tibia. Soreness in Achilles tendons and restricted passive dorsal flexion and pronation in the right ankle joint was found in two men. Joint mobility was otherwise normal. Two men had discrete pitting oedema in the ankle regions. None had reduced muscle strength or reflex abnormalities. In one man diffuse hyperaesthesia was present in both knee regions, but apart from that none had sensory disturbances involving the lower extremities (excluding feet).

Feet and gait: The findings at clinical examination of the feet are summarised in Table 9. They are predominantly confined to the soft tissues and characterised by soreness in the plantar fascia, reduced elasticity in the heel pads and sensory disturbances in the soles.

Soreness of the plantar fascia was present in four men and reduced elasticity in one or both heel pads in three. Sensory disturbances involving light touch and/or pinprick sensation in one or both soles were present in all men, whereas vibration sensation was normal.

None of the men showed evidence of fractures of metatarsal or tarsal bones and mobility of toe joints was normal.

Loosening of the skin from the underlying tissues in the soles was found in one man and one presented with symmetric pustular eruptions in the arches of both feet representing possible pustolosis palmo-

plantaris or pustular psoriasis. The skin rash that had appeared after exposure to falanga and pustular psoriasis is described to occur as a Koebner reaction to trauma.

In two men an abnormal gait was demonstrated at examination. In one there was a slightly abnormal gait pattern with avoidance of unwinding over the first toe. In the other the toes were kept in a flexed position during the entire gait cycle in order to avoid weight loading of the forefoot and weight loading was shifted with a compensatory relief over the heel region and lateral border of the foot.

Ultrasound examination

Ultrasound scans of the feet were performed independently by a medical doctor blinded to the results of the clinical examination.

The scans were performed according to standard protocol in all five men: the subject was examined in the supine position with both legs on a transverse cushion – the feet hanging freely. Scanning was performed with a Siemens Acuson Sequoia equipped with a 14 MHz linear array transducer. The plantar fascia was investigated in transverse and longitudinal planes from its origin on the calcaneus to the metatarsal heads. Digital images were stored from standardized transducer positions:

1. Proximal longitudinal image in a plane through the second toe.
2. Distal longitudinal image in a plane through the second toe.
3. Transverse image five cm distal to the origin.
4. Transverse image 10 cm distal to the origin.
5. Live sequence during passive extension of the toes from the mid portion of the fascia in a longitudinal plane through the second toe.

The scans demonstrated almost identical pathologies: the fascia had irregularly thickened superficial and deep interfaces. The internal layer (the layer between these interfaces) showed a loss of fibre structure compared to normals. These changes gave the fascia a distinct three-layered appearance. In transverse the median portion of the fascia was thickened and was indistinctly and irregularly separated from the surrounding connective tissue. The fascias behaved normally during extension – dorsiflexion of the toes resulting in tension of the fascias.

Comparison of clinical findings and ultrasound imaging

As illustrated in Table 10 there was an overall accordance between findings at clinical examination and ultrasound imaging supportive of the allegations of exposure to falanga torture. As can be seen from Table 10 the localisation and severity of objective findings at clinical examination are in agreement with findings at ultrasound examination in all of the performed scans.

Discussion

The medico-legal examinations of the five men have demonstrated that all five cases can be labelled only as torture as defined in the UN Convention against torture article 1 where torture is defined as the intentional infliction of severe mental or physical pain or suffering by or with *the consent of the state authorities for a specific purpose.*[1]

Despite the prohibition of torture contained in the Universal Declaration of Human Rights, the world is far from seeing an end to this practice – a practice that can be stopped only by breaching impunity. Challenging torture therefore entails not only reparations for the individual but also challenging the perpetrators and bringing them

Table 10. *Clinical findings compared to ultrasound imaging.*

	Findings	Subject 1	Subject 2	Subject 3	Subject 4	Subject 5
Clinical examination	Elasticity in heel pads	Normal	Reduced bilaterally	Reduced bilaterally	Reduced in right foot, normal in left foot	Normal
	Soreness of plantar fascia	Yes, bilaterally	No	Yes, especially in the right foot	Yes, bilaterally	Yes, bilaterally
	Sensory Yes, disturbances	Yes, in the bilaterally	Yes, especially right sole	Yes, in the right foot	Yes, heel bilaterally	region of the left sole
	Skin loosely attached	No	Yes, mostly in the right foot	No	No	No
Ultrasound scanning	Thickened fascias	Yes	Yes, most pronounced on the right side	Yes, most pronounced on the right side	Yes, most pronounced on the right side	Yes, most pronounced on the left side

to justice. Health professionals have a role in both these tasks, an obligation spelt out in international declarations for doctors, nurses, and physiotherapists, largely endorsed by their national and/or international professional bodies.[4-6]

Medical documentation of alleged exposure to torture is based on the reporting of the degree of consistency between: 1) the torture history, 2) symptoms as described by the victim and 3) possible findings at medical examination. Standardised medical examination according to international guidelines has therefore become routine procedure in assessing torture victims for medico-legal purposes.[3]

In the present case of five British citizens alleging exposure to torture and ill treatment during detention and imprisonment in Saudi Arabia, there was a high degree of consistency between the allegations of psychological and physical abuse and the history of acute and chronic symptoms and disabilities described by these five men. The alleged torture methods were all well known and their after-effects are well described consequences.[7-11] Likewise there was a high degree of consistency between allegations of abuse and the findings at medical examination.

Before imprisonment all the men were psychosocially well functioning. A psychological evaluation based on clinical testing was not included in the examination but the reported psychological symptoms were all typical reactions to extreme stress. The diagnosis most commonly associated with consequences of torture is post-traumatic stress disorder (PTSD), which includes several of the symptoms described by the men. Symptoms of PTSD may fluctuate over extended periods of time and may take a chronic course. Depressed mood and a perception of changed personality, shame, guilt and low self-esteem are likewise frequent and well described psychological consequences of torture.[12-14]

In most cases physical torture is directed towards the musculoskeletal system with the aim of inducing severe pain and, in the hands of the skilled torturer, few permanent marks. Characteristically the resulting soft

tissue lesions heal within weeks, leaving relatively few and unspecific findings despite possible subsequent physical disabilities. The absence of specific physical findings in the later stages therefore does not exclude the possibility that torture was inflicted.[15,16] Absence of evidence is not evidence of absence.

Pain in the musculoskeletal system is the dominant physical symptom in the chronic phase. The clinical picture is one of regional or widespread muscle pain, joint pain, pain related to the spine and pelvic girdle, and neurological complaints, mainly radiating pain in the extremities and sensory disturbances.[9, 16-18] Visceral symptoms (cardiovascular, respiratory, intestinal and urogenital complaints) and headache also prevail.[19-22]

Falanga is an ancient physical torture method widely practised especially in Middle Eastern countries.[7, 10] The effect of falanga torture is typically as described by the men. In the acute phase bleeding and oedema in the soft tissues of the feet and severe pain are characteristic with symmetric swelling and discoloration of the soles due to haematoma formation. Extensive ulcerations and gangrene of toes due to ischaemia have been described but are uncommon. Fractures of tarsal, metatarsals and phalanges are reported to occur occasionally.[7, 15] The acute changes disappear spontaneously after a few weeks as the oedema and extravasation of blood resolve but the induced soft tissue lesions may be permanent.

The cardinal symptom in the chronic phase is pain in the feet and calves and impaired walking.[9, 15] At clinical examination reduced elasticity in the foot pads, loosening of the skin, soreness and coating of the plantar fascia (aponeurositis), sensory disturbances in the soles, joint dysfunction, and myofascial changes in the lower extremities are reported as being characteristic although not pathognomonic.[15, 23] The prevalence of clinical findings after falanga, however, is unknown. A normal examination of the foot does not rule out exposure to falanga.

The use of imaging in substantiating the clinical diagnosis and documentation of falanga is based on MRI and ultrasound studies showing morphological changes with a layered plantar fascia in torture victims exposed to falanga.[24, 25] These global changes involving the full length of the fascia are not seen in normals. The changes have not been described as part of any disease such as plantar fasciitis where there is a focal thickening at the origin of the fascia or plantar fibromatosis where there are focal areas with thickening more distally.

Conclusion

This examination has demonstrated that all five cases can only be labelled as torture, as defined in UN Convention Against Torture article 1.

Despite this evidence the Saudi Arabian State denies torture of the five British citizens. The methods of torture applied and the medical examination of effects of torture indicate that torture methods were chosen deliberately so as to leave as few visible marks as possible.

It is further worth noting that a medical doctor attended the victims during and after torture sessions in order to assess and allow the type and force of violence deployed. Further, during the various hospitalisations the medical staff must have observed and recognised signs of physical abuse. This participation of medical staff was applied systematically as part of common prison practice despite the World Medical Association's Declaration of Tokyo from 1975[4] stipulating the obligations of the medical profession towards human rights, and in particular torture. The case of medical assistance in the

torture of five British citizens demonstrates that medical doctors violate ethical standards and are involved in the execution of torture in Saudi Arabia.

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Documentation of torture victims, assessment of the Start Procedure for Medico-Legal Documentation

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Abstract

A Pilot Study was performed at the Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen in order to explore the possibilities for adding a medico-legal documentation component to the rehabilitation of torture victims already taking place. It describes the process and results on implementing medico-legal documentation in a rehabilitative setting.

A modified version of the Guidelines in the Istanbul Protocol was developed on the basis of the review of literature and current practices described in "Documentation of torture victims. implementation of medico-legal protocols".[1] The modified guidelines were tested on five clients. The aim was twofold: 1) To assess the client's attitude towards the idea of adding a documentation component to the rehabilitation process and: 2) To assess the practical circumstances of implementing the Istanbul Protocol in the everyday life of a rehabilitation centre. Results show that all five clients were positive towards the project and found comfort in being able to contribute to the fight against impunity. Also, the Pilot Study demonstrated that a large part of the medico-legal documentation was already obtained in the rehabilitation process. It was however not accessible due to lack of systematization and a data registering system. There are thus important *synergies* in collecting data for rehabilitation and documentation but a joint database system is necessary to realize these synergies.

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Key words: torture, torture prevention, medico-legal documentation, impunity, legal, Istanbul Protocol

Introduction

The first step of the Pilot Study was to develop a tailored version of the Istanbul Protocol, which was adapted to the needs and possibilities at the RCT. The first draft contained all the information listed in the Istanbul Protocol as well as an expansion of the legal aspects. The later versions, which were eventually tested on the five clients, were somewhat condensed and the categories without relevance for the specific context was taken out. The format can be found in Annex I.

Medically

The medical and psychological part of the examination corresponds largely to the data collected in the ordinary rehabilitation process and only differences were explored in detail since the RCT staff already performs a thorough examination of each client. Detailed descriptions of the examination of torture victims can, for example, be found in the Istanbul Protocol.[2]

One of the main differences between the medical documentation and the rehabilitative examination is the need to record injuries and traces of injuries even if they cannot be treated. Scars can, for instance,

be highly indicative of torture and should always be recorded, preferably photographed, when performing medical documentation. Scars are however largely irrelevant for the rehabilitation process, since they are already healed and rarely affect the present health status of the victim. Documenting thus requires the doctor to "read" the signs of torture and record them accordingly even if they are without significance to the current treatment.

Also specific to medical documentation is the necessity of rendering an interpretation about how the physical and psychological findings correspond with the account of torture and abuse. This requirement places the doctor in a new role, where the patient-doctor relationship is no longer purely treatment-oriented. This role change was, however, not considered difficult by the RCT physician performing the documentation, since there is hardly any doubt whether the accounts given by RCT's clients are true. The clients at RCT have already obtained asylum or a permanent residence permit and have no inclination to exaggerate claims of torture. Moreover, the rehabilitative process is so thorough and the RCT personnel so experienced in dealing with torture victims that false statements would most likely be discovered along the way.

Legally

The RCT staff is not used to collecting information for legal purposes and it was particularly this aspect of documentation which required a review of the literature and existing practices.[3] There was a need for finding out what type of information was required and how detailed it should be. Was it, for example, enough that the name of the prison and the prison cell number was recorded or did the physician have to record the client's description of the cell, the size and the daily regimen? The literature generally recommends that as much detail as possible is recorded, but this is difficult due to time constraints.

Since the implementation of medico-legal documentation was directed at finding ways of assisting the relevant authority in investigating crimes of torture, a list of pertinent information was prepared by the Special International Crimes Office (SAIS), the relevant Danish authority:

The information sought by SAIS corresponds largely to the information listed in the Istanbul Protocol, with the exception of the three bullets specific to the Danish context.

- An indication of whether or not any witnesses or the alleged perpetrator resides in Denmark. If the victim has met either, then their names, and time/place for the meeting
- SAIS would also ask RCT to inform the victim about SAIS and the possibility of persecuting perpetrators residing in Denmark
- An indication of whether or not the client would permit SAIS to read his/her journal/file.

The results of the Pilot Study

Four out of five clients were positive towards participating in the Pilot Study and expressed comfort in being able to cooperate in the fight against impunity. One client was concerned about his anonymity, but positive once this was guaranteed.

The documentation component was added late in the rehabilitation process, approximately after seven to nine months of rehabilitation. This approach was chosen because much of the information would already be recorded in the rehabilitation process and because after a trusting rela-

tionship between the doctor and the client would need to be established. From a legal point of view, it could be worth considering if some of the basic, but important, information such as name and address of the prison could be obtained earlier and thus be accessible for SAIS at an earlier stage.[4] This would also prevent the victim from forgetting information.

The modified RCT version of the Istanbul Protocol (Annex I) generally follows the format listed in the Istanbul Protocol. Throughout the testing of the guidelines, it became clear that a large part of the information has been obtained in the rehabilitative process and could be found by reading through the files. The information was, however, not registered systematically. For instance only some journals contained information about where the torture took place. Moreover, every journal had to be meticulously analyzed in order to extract the information.

The information in the RCT format can generally be categorized according to:

- Information already recorded in the text of the patient's journal
- Information already recorded systematically in the patient's journal, i.e. in predefined categories
- Information recorded through the existing monitoring and evaluation system
- New information

Despite variation in the type and detail of information gathered, most of the information in the RCT version of the Istanbul Protocol falls into the first three categories. It is, however, not gathered and stored in a way where it is accessible for medico-legal purposes. The information that tends to be missing from the files is:

- The physician's qualifications
- The date of the arrest
- The arresting authority
- Identification of the perpetrator(s)
- The place(s) where the torture took place
- Identification of physician(s) present during the torture incident or consulted in connection with it
- Identification of witnesses
- Photographs
- Contact with authorities (i.e. complaints) before/during/after abuse
- Conclusions: Consistency between findings and torture story

The first bullet, the physician's qualifications, would not be included in the physician's everyday work, but it should be noted who performed the documentation. The remaining questions are all central, but the level of detail can be varied. The question about identification of perpetrators can, for example, be limited to the unit of the police and their rank, but can also include a detailed description of their appearance, dialect, behaviour etc. Interviewing the victim about the remaining information and filling out the format took about a half hour to one hour extra per client.

All in all, the Pilot Study pointed to three important conclusions for the implementation of the Istanbul Protocol in an RCT-context:

- A large part of the information in the Istanbul Protocol is already recorded in the rehabilitation process
- The information is not easily accessible in the current system
- Obtaining the additional information will take a half hour to one hour extra per client depending on the level of detail

There are thus important *synergies* between collecting data for the rehabilitation process

and for medico-legal documentation. A large part of the implementation of the Istanbul Protocol thus consists of finding a way of systematizing the data already collected in connection with the rehabilitation process.

Data collection and storing

The Pilot Study demonstrated the need for a database system for registering medico-legal documentation. For the synergies in data collection between documentation and rehabilitation to be realized it is necessary to create database where *all* data – monitoring and evaluation, client journals and documentation – can be registered simultaneously, and where information for one purpose can be used for other purposes and where cross-referencing of data is possible. The ultimate vision is one central system with the ability to feed the various purposes of treatment and rehabilitation, national and international legal proceedings, research, lobbying, and advocacy activities.

The question thus arises: How can information gathering for the Istanbul Protocol be combined with information gathering for other purposes such as monitoring, evaluation efforts and the client journal? One possibility is a central data registering system, where data is recorded by the rehabilitation team throughout the rehabilitative process, thus obtaining most of the information required for the Istanbul Protocol in connection with other purposes, leaving only a half hour to one hour's interview with the doctor in the end in order to fill out the blanks. However, this does present certain problems for the validity of the data, since it significantly diminishes if many people are involved in the data-entry-process. In order to deal with this problem, the information and documentation could be noted separately by the rehabilitation team and then entered into the system by a specialized employee. The exact set-up of the data-registering system will have to be determined under consideration of the amount of medico-legal documentation collected at RCT (or whoever does data collecting), the existing or anticipated systems of monitoring and evaluation, and the resources available for both constructing and maintaining the database. It is, however, important that the implementation is incorporated into the rehabilitation process and monitoring and evaluation system in order to realize the synergies.

Issues of anonymity

A dilemma in implementing medico-legal documentation is safeguarding the anonymity of the patient. One of the most basic principles in the doctor-patient relationship is confidentiality, and the patients have the final say in how information about his/her case is used, or even if it should be used. The client concerned with maintaining his anonymity in the Pilot Study is fully entitled to refuse documentation. The results of medico-legal documentation at RCT can thus not be shared with the SAIS or other institutions unless it is with the explicit permission of the client. This presents certain problems, since safeguarding anonymity requires more than just concealing the name of the client.[5]

When constructing a central database, it will be necessary to consider how the identity and privacy of the individual torture victim can be safeguarded while still allowing for the identification of clients. Moreover, it seems obvious that RCT will have to administer the database, conduct searches on behalf of external actors interested, then contact the victim or witness, and obtain explicit permission to pass the information on to the relevant institution. Only then can the prosecutor begin to communicate with the client. Another possibility is to include a section at the end of the documentation format,

where the client can authorize other departments of RCT and/or external actors to access the information. Proceedings on behalf of the client or other use of the information would, however, still require explicit permission of the client.

Is it worthwhile?

The quality and thus the use of the medico-legal data depend heavily on the effort put into gathering it: Important data may be overlooked and the quality of the data invariably diminishes if the process is rushed and not prioritized by staff. For legal purposes a screening system may be enough to identify possible victims/witnesses but, even then, valuable information risks being overlooked or oversimplified by being rushed into predefined categories. For research purposes, the quality of the data and the data gathering process is even more defining for the result, since both validity and reliability are at stake and since the amount of data collected and the level of detail more or less defines the research scope.

On the other hand, collecting detailed data of a high quality is a time-consuming and therefore costly task. In the field of torture rehabilitation and prevention where resources tend to be scarce, choosing to perform high quality medico-legal documentation thus implies spending less time and resources on other activities. Before commencing on gathering medico-legal documentation on a large scale, an important question must be answered:

Do the anticipated results and the probability of reaching them justify the resources spent?

The lack of research on the effect of medico-legal documentation in preventing torture makes it difficult to answer this question. Measuring the results from medico-legal documentation is, however, not an easy task. Performing medico-legal documentation is a relatively new task with ample space for continued research in both documentation methods and their reliability. The effect of using medico-legal documentation in the prevention of torture is, however, even more under researched.

A connection between preventing torture and applying high-quality medico-legal documentation in legal proceedings, advocacy and lobbying activities and asylum cases is widely presumed by both practitioners and scholars in the field, but hardly evidence-based in any scientific way with the exception of the notable research by Malcolm Evans and Rod Morgan.[6-8] More research on the effect of applying medico-legal documentation to the various purposes listed in this report is thus urgently called for. Especially since medico-legal documentation is becoming more and more accepted as a means by which the anti-torture movement can help prevent and alleviate torture worldwide.

Conclusion

Before implementing medico-legal documentation, it is necessary to consider the role change of the health care personnel – adding an investigative perspective to the treatment oriented focus. It is also important to consider how the anonymity of the client can be safeguarded and whether or not documentation is worthwhile. To answer the last question, more research is needed regarding the effect of medico-legal documentation on the prevention of torture. If solutions to these dilemmas can be found, the synergies between rehabilitation and documentation can be realized, allowing the rehabilitation activities of the RCT to be used for various preventive purposes as well.

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ANNEX I: The RCT Version of the Istanbul Protocol

1. General information

a. Date and place of examination
b. File number
c. The name of the client
d. Social security number
e. Age
f. Sex
g. Country of birth
h. Current address
i. Name of the interviewer
j. Name of the interpreter and the language of interpretation

2. The physician's qualifications

a. Resumé, including specialties, clinical experience, scientific publications and special education.

3. Background information

a. Marital status
   i. Married
   ii. Unmarried
   iii. Divorced
   iv. Widower
b. Number of children
   i. In Denmark
   ii. In the country of origin
   iii. Deceased
c. Education
d. Occupation before the torture incident
e. Present occupation
f. Pre-torture medical history, including physical and psychological health status prior to the torture incident and any hospitalization
g. Previous medical examinations/reports in relation to the torture incident
h. Social status before the torture incident
i. Political activity and/or affiliation

4. Description of torture and ill-treatment

a. Arrest(s)
   i. Date and time
   ii. Arresting authority, including a description of the number of persons, names, titles, description of clothing/uniform, weapons, vehicles, license plates, and witnesses.
      a. Police
      b. Military
      c. Others
   iii. Reason for arrest(s)
      a. Political activities
      b. Family relations
      c. Accusations of crime
      d. No particular reason
      e. Other
b. Detention centre(s)
   a. Name(s)
   b. Address(es)
   c. Time spent in the detention centre(s)

   d. Circumstances
   e. Names of witnesses (fellow prisoners, staff or others)

c. Prison(s)
   a. Name(s)
   b. Address(es)
   c. Time spent in the prison(s)
   d. Circumstances
   e. Names of witnesses (fellow prisoners, staff or others)

d. The place where the torture took place
   i. At the home of the client
   ii. In connection with the arrest
   iii. On the way to detention/prison
   iv. In the detention centre/police station
   v. In prison
   vi. Other

e. Description of the place, where torture occurred
   i. Cell/room number, address, description of vehicle, etc.
   ii. Number of people present, active and passive
   iii. Names, means of identification
   iv. Name and identification of any doctors present and a description of his/her role

f. Methods of torture
   i. Physical (check-list)
   ii. Psychological (check-list)
   iii. Sexual (check-list)

g. Any medical treatment before, during and after the torture incident

h. Total time in detention

5. Patient's description of symptoms immediately after the torture incident

a. Physical (check-list)
b. Psychological (check-list)
   i. Diagnostic tests used

6. Patient's description of current symptoms

a. Physical (check-list)
b. Psychological (check-list)

7. Physical examination

a. Physical (check-list)
b. Psychological (check-list)

8. Psychological examination

a. Physical (check-list)
b. Psychological (check-list)

9. Medication, including any substance abuse

10. Photographs

11. Supplementary examination (x-ray, scanning, blood samples etc.)

12. Contact to authorities/complaints

a. Attempts of family/friends/neighbors to contact the authorities
b. Presentation before a judge/legal assistance
c. Legal proceedings
d. Official investigations of the incident

13. Conclusions

a. Consistency between the patient's description of torture, the patient's symptoms and the findings of the examination
   i. High degree of consistency
   ii. Consistency
   iii. Partial consistency
   iv. No consistency
b. Remarks

14. Recommendations

15. The physician's signature

16. If the information has been passed on to other institutions/people

17. Annexes

a. Anatomical drawings
b. Photographs
c. Diagnostic test results
d. Etc.

How therapists cope with clients' traumatic experiences

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Abstract

An initial finding of high emotional stress in trauma therapists working in a specialized trauma institute led to three empirical studies on trauma-related therapist reactions. The purpose of these studies was to investigate the relation between high emotional burden and burnout, and the trauma-specific processes described by the concepts "secondary traumatic stress", "vicarious traumatization" and "traumatic countertransference".

The initial qualitative/quantitative study examined how a group of specialized trauma therapists (N=63) coped with clients' traumatic experiences. The results on trauma-related reactions were inconclusive.

This motivated a qualitative study of expert psychotherapists (N=11). Interviews with expert trauma therapists and other expert therapists were focused on reactions to the confrontation with traumatic experiences and differences between both groups of experts. Results indicated a specific reaction pattern to traumatic situations, but revealed no other differences between trauma specialists and other experts.

To further examine trauma-specificity of this reaction pattern, a third study was conducted with psychology students (N=100) using an experimental design. The results suggest the existence of a trauma-specific reaction pattern, characterized by shock, anxiety and the experience of being carried away by strong emotions. The relation of trauma reactions with traumatic situations is endorsed by results on differential reactions to traumatic and interactionally difficult situations, although results suggest that other kinds of situations with high emotional impact may also evoke trauma-reactions.

In the discussion the results are considered in relation to the limitations of the studies are followed recommendations for further research. Our results thus far support the high emotional impact of confrontation with traumatic material, but nuances psychopathological or other long-term negative changes that are suggested by the terms secondary or vicarious traumatization.

Key words: traumatic countertransference, secondary traumatic stress, vicarious traumatization, trauma therapy, psychotherapist

Introduction

Traumatic experiences are the ultimate confrontation with human vulnerability, ugliness and perversion. This is especially so in situations of interpersonal violence, war and persecution. They evoke great stress, anxiety, threat and helplessness, and disturb the foundation of someone's personal and interpersonal existence.[1, 2]

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The Netherlands

In therapy with traumatized clients, the therapist becomes witness and in transference-countertransference enactments sometimes even part of the past dramas of the client. This cannot leave a therapist untouched, and since the nineties of the past century trauma therapists have sought to conceptualize the impact of trauma therapy on the therapist in his/her empathic connection with the client.

The sudden confrontation with clients' traumatic experiences may cause symptomatic reactions in the therapist that resemble the symptoms of the post-traumatic stress disorder – "secondary traumatic stress". In the long run these reactions may cause emotional exhaustion (as in burnout) of the therapist, described as "compassion fatigue".[3] The accumulated violation of existing (benign) basic assumptions by the trauma narratives of clients could cause "vicarious traumatization" – distortions of trauma-relevant cognitive schemas regarding safety, trust, esteem, intimacy and control.[4, 5] The high emotional and "forbidden" traumatic themes that emerge in the therapeutic relationship evoke strong emotional reactions and countertransference reactions, which gain a specific colour when they reflect the roles of the traumatic situation or dissociative reactions of the client.[5, 6] Whereas secondary traumatic stress reactions are described as relatively independent of therapist factors, cognitive distortions and countertransference reactions are viewed as the result of an interaction between clients' material and the personal make-up of the therapist. However, the distinctions between the different aspects of the therapist's process in reaction to clients' traumatic experiences is less clear than it seems in this description, and authors use the concepts often as (almost) synonymous.[7]

At the time we started our research, studies were scarce and valid instruments non-existent. Although this situation has changed during the last decade, trauma-specificity of these therapist reactions is still unclear, especially for cognitive distortions and countertransference.[8] The interest in the sources and dynamics of the high emotional burden reported by trauma therapists continues and this was the motivation of our first and subsequent studies. In short, the purpose of these studies was to investigate whether the high emotional burden reported by Centrum '45 therapists[9] was related to the confrontation with clients' traumatic experiences and how it related to burnout and to the trauma-specific processes described by the concepts "secondary traumatic stress", "vicarious traumatization" and "traumatic countertransference". Further, we aimed to clarify the short-term and long-term changes and coping strategies described by these concepts.

Study 1 – Emotional burden and burnout

The common factor in the concepts "traumatic countertransference", "secondary traumatic stress", and "vicarious traumatization" is that they are seen as effects of the stressful encounters with traumatized clients. Contextual and temporal elements in the descriptions of these concepts point to the possibility that they may be part and parcel of the therapist's coping process, of which emotional burden and burnout could be negative outcomes. Therefore, the framework we adopted for this study was an interactional coping model, as it relates to the normality of the stress-coping process as well as to the sequence and mediating factors of coping with traumatic stress.[2, 10] This model enabled us to temporarily step back from the known concepts, which still could be related to this coping process. It offered a structure for studying the actual coping process of

therapists and its influencing factors. Our research questions for the first study were:

1. What kind of difficulties do trauma center therapists experience in their clinical work?
2. Is emotional burden related to burnout?
3. Are there indications of traumatic countertransference, secondary traumatic stress or vicarious traumatization in trauma center therapists?

Method

Design

The study had an explorative, descriptive design, using qualitative and quantitative methods. It was conducted in Centrum'45, the Dutch national institute for treatment of victims of violence, war and persecution. Participants worked either in the department for survivors and veterans of the Second World War and their children (WW II department) or the department for traumatized refugees and asylum seekers (Refugee department).

Participants & procedure

Fifteen therapists participated in a semi-structured interview. They had different backgrounds (psychiatrist, psychotherapist, art or psychomotor therapist and milieu therapist) and different lengths of work experience in Centrum '45. The interviews started with the description by the therapists of two self-experienced difficult situations with clients, the therapist's own emotional reactions and coping behaviour, and reflections on helping and hindering factors in dealing with the situations. In addition, they filled in a questionnaire (see instruments). To ensure privacy of the participants, the interviews were conducted by an interviewer who was contracted for the study. Interviews were only available to the researchers after removal of all possible identifying elements in the transcribed text, which was analyzed according to the principles of grounded theory analysis.[11]

After this pilot phase the questionnaire was distributed amongst all employees of Centrum '45, including administrative and housekeeping staff. Ninety-two questionnaires were returned, a response rate of 72%. Forty percent of the respondents were male, 62% were over 40 years of age, 35% worked less than 3 years in Centrum '45 and 45% longer than 5 years. The therapist group consisted of 20 milieu therapists and 43 other therapists, including psychiatrists, psychotherapists, art or psychomotor therapists and social workers. Thirty-seven therapists worked in the WW II department and 25 worked in the Refugee department.

Instruments

The questionnaire contained instruments for burnout, work experience, situational strain, coping, resources, countertransference, sleep disturbances and nightmares, and cognitive schemas. Emotional burden was measured by a single item. Impact of a self-experienced difficult situation and the intensity of emotional reactions was measured by the STRess Appraisal INventory (STRAIN).[12] Work experience was measured by 4 item scales, including scales for role-clarity, loyalty to the organization, and the intention to change jobs.[12] For burnout we used the Dutch version of the Maslach Burnout Inventory.[13] Countertransference was measured with the Emotions Questionnaire (EMO), which was constructed for this study on the basis of existing literature on traumatic countertransference. It contained 5 items on awareness of countertransference reactions and 13 items in 3 subscales relating to role reactions, negative emotions and distancing.[14] We assumed that sleeping difficulties would first signal

secondary traumatic stress. Items relating to nightmares and restless sleep were taken from the Nightly Intrusions after Traumatic Experiences questionnaire (NITE)[15] as measures for secondary traumatic stress. Three subscales of the World Assumptions Scale (WAS),[16] Good World, Good People and Just World, were translated into Dutch and used in this study to evaluate cognitive schemas that are relevant to coping with traumatic experiences.[a]

Statistical Analysis

Analyses was mostly correlational, with t-tests or cross-tabulation used for comparisons between groups, Pearson correlations for relations between variables, and hierarchical regression analyses for the exploration of contributing factors in emotional burden and burnout.

Results

Difficult situations

The 15 therapists described a total of 44 difficult clinical situations. In 55% the difficulty was attributed to the psychopathology of the client: aggression, post-traumatic symptoms or other psychopathology. Therapeutic relationship difficulties accounted for 34% of the difficult situations and had to do with failing to establish a working alliance, anxiety of the client to start talking about past experiences and insufficient progress in the therapy. The last category of difficulties (11%) consisted of dilemmas for the therapist because of ongoing violence, double agenda of the client (for instance related to getting a refugee status in The Netherlands), or severe and unsolvable psychosocial problems.

In the quantitative study, therapists in the WW II department mentioned more often difficulties with colleagues or the organization, whereas therapists of the Refugee department more often reported client-related difficulties (Chi-square (3, 63)=8.44, $p<.05$).

Emotional burden and burnout

Emotional burden was higher in therapists than in administrative and housekeeping staff (45% and 11% respectively reporting high emotional burden) and higher in therapists working with refugees (M= 2.64, SD=.70) than in therapists of WW II survivors (M=2.22, SD=.67), t(60)=2.40, $p<.05$). The level of emotional exhaustion of therapists of Centrum '45 was somewhat higher than in a general mental health (GMH) reference group:[17] Centrum '45 therapists M=20.0 (SD=7.7), GMH M=17.5, t(58)=2.47, $p<.05$. In contrast to the findings on emotional burden, burnout level was similar for both Centrum '45 therapist groups.

Two hierarchical regression analyses were conducted with emotional burden and burnout as dependent variables. Situation related factors (impact and total emotional strain) and work related factors (teamwork, role-clarity and loyalty) were entered as independent variables (see Table 1). Burnout was related to organizational stress (the wish to change jobs), whereas experienced emotional burden was primarily linked to work with clients (impact and role-clarity).

Traumatic countertransference, secondary traumatic stress and vicarious traumatization

Comparison of means did not reveal significant differences between the two Centrum '45 therapist groups with regard to total countertransference, countertransference subscales, on sleep disturbances or on basic

a) A more comprehensive description of the study and the instruments can be found in Smith et al.[12, 14]

Table 1. *Client related and work related contributing factors in experienced emotional burden and emotional exhaustion (burnout). Hierarchical regression (N=63).*

	Emotional burden			Emotional exhaustion		
variable	**B**	**SE B**	**ß**	**B**	**SE B**	**ß**
Step 1						
Impact	0.28	0.07	0.59***	0.60	1.03	0.11
Total Strain	0.00	0.01	0.08	0.23	0.10	0.41*
Step2						
Impact	0.24	0.07	0.50***	0.17	0.92	0.03
Total Strain	0.00	0.01	0.04	0.19	0.09	0.35*
Role-clarity	–0.07	0.03	–0.33**	–0.11	0.34	–0.04
Loyalty	0.03	0.03	0.14	–0.41	0.38	–0.14
Job change	0.01	0.03	0.03	1.06	0.34	0.42**

Emotional burden R2=0.42; Δ R2=0.10* for Step 2; Emotional exhaustion R2=0.24; Δ R2=0.25*** for Step 2; * p<0.05, ** p<0.01, *** p<=0.001

assumptions. However, Centrum '45 therapists' reported fewer negative feelings than client-centered therapists: trauma therapists M=14.2 (SD=3.5), client-centered therapists M=17.8 (SD=4.0), t(82)=4.4, p<.001. Client-centered therapists scored higher on disgust (p<.01), anxiety (p<.001), sorrow (p<.001), anger (p<.01) and feeling estranged (p<.05). A comparison of basic assumptions between trauma therapists and client-centered therapists showed a significant difference on the scale "goodness of people" (trauma therapists M=14.2 (SD=4.0), client-centered therapists M=16.1 (SD=2.6), t(82)=2.50, p<.05). Trauma therapists were more cynical about the goodness of people than client-centered therapists.

Discussion study 1

Although burnout levels were hardly higher than in other mental health professionals, the results on experienced emotional burden support the relevance of research on trauma-specific effects on therapists.

Since all of our participants worked primarily with traumatized clients, the situation categories represent different aspects of trauma-related difficulties. About 50% was related to post-traumatic psychopathology, and the differences between therapists working in the two departments suggest that severity of symptoms and a high level of psychosocial problems of the clients may contribute to emotional stress in therapists. However, the difference in emotional burden could also have been related to the pioneering situation in the new Refugee department. The higher level of problems with colleagues in the WW II department could signal parallel processes of the deeply engraved (dysfunctional) post-traumatic coping strategies of the clients. The difficulties in the therapeutic relationship and the dilemmas of the therapist suggest that the dynamics of the traumatic situation extend into the therapy. Most clients had the experience that talking was dangerous and even life-threatening and existential threat was not over for most of the asylum seekers who were waiting for the decision about their permit to stay.

Our results on specificity of the effects of trauma-related therapeutic difficulties were ambiguous. Although we found some differences in countertransference profile and basic assumptions, these results should be considered with caution because of differences in study designs between the Centrum

'45 and the client-centered studies (the latter were convenience samples for validation of the EMO and WAS).

These results, the lack of reliable instruments for measurement of therapist reactions to clients' material,[18] and serious doubts about trauma-specificity in the literature[8] motivated another explorative study. In this study, we set out to interview trauma therapists and other therapists (not specialized in trauma treatment) on their reactions to traumatic and other difficult clinical situations.

Study 2 – Trauma confrontations and other therapeutic difficulties

The previous study only explored reactions to their clinical work of a group of specialized trauma therapists working in the same institution. Despite precautions to ensure privacy, participants' narratives may have been influenced by the in-company character of the study. Symptomatic reactions and long-term negative changes were not prevalent in our qualitative material. However, these kind of semi-acute and long-term changes are the core of trauma-specific effects as described in the literature, with potentially strong negative impact on in-session therapist coping behaviour. So, we decided to pay more attention to semi-acute and long-term changes in relation to psychotherapeutic practice in the second study. Our investigation into trauma-specificity was two-fold: therapist reactions to traumatic situations and differences between specialized trauma therapists and other (non-specialized) psychotherapists.

Our research questions for this study were:

1. How do therapists react to traumatic material compared to other difficult situations?
2. Do trauma therapists and other psychotherapists differ with regard to their coping with difficulties in clinical practice?

Method

Design

The study had an explorative qualitative design, using in-depth interviews about therapists' own experiences of difficult clinical situations.

Participants & procedure

A convenience sample of five expert trauma therapists and six expert therapists working in regular psychotherapeutic practice participated in a 90 minute interview (conducted by the first author). The open structure of the interview (similar to that of study 1) allowed for personal accounts about the participants' reactions in emotionally taxing situations with clients and on long-term personal changes and coping with the stress of the profession. The experts had backgrounds as psychiatrists or psychologists and most of them were either psychoanalytic or client-centered psychotherapists.

Analysis

The audiotapes of the interviews were transcribed and subsequently analyzed according to principles of grounded theory analysis. The emerging categories of therapist reactions were used in a checklist to quantify the original interview material. This enabled frequency analyses and Multiple Correspondence Analysis (SPSS) of the data to explore patterns and clusters of therapist reactions.[19]

Results

Difficult situations

The grounded theory analysis resulted in three kinds of difficult situations: traumatic situations,[20] existentially difficult situations[7] and interactional difficulties.[9] In traumatic

situations the material of the client reflected traumatic experiences according to the DSM-IV A criterion for post-traumatic stress disorder.[1] Existentially difficult situations were those situations in which the therapist deeply felt the hopelessness of the situation of the client, whereas in interactional difficulties the main difficulty was in the strong emotional demands of the client on the therapist.

Therapist reactions

Therapist reactions were initially analyzed separately from the situational content, which resulted in 20 categories of reaction types. Almost all therapists mentioned that they experienced shock, anxiety, helplessness and intrusions, and that they ruminated about sessions, felt provoked, or were carried away by strong feelings of the client. They used talking with colleagues or others about their in-session experiences to unburden. In the Multiple Correspondence Analysis, most of these reactions clustered around traumatic situations. This result points to a trauma-specific therapist reaction pattern: shock, anxiety, feeling overwhelmed and carried away by strong feelings of the client, somatic reactions and talking. In existential situations therapists reported a strong sense of responsibility for the client or the therapeutic process. Intrusive experiences were not discriminating among therapists or different types of difficult situations. The other therapist reaction categories clustered as a function of the therapist's personal style in therapy.

Differences between expert trauma therapists and other expert therapists

Although we did find differences between therapists in relation to their work setting (therapists in private practice felt more responsible), no differences emerged between trauma therapists and other therapists within the expert group. A Multiple Correspondence Analysis of the combined quantified data of the interview material of the first and second studies revealed, however, differences between the group Centrum'45 trauma therapists and the experts. Therapists working in Centrum '45 reported more active interventions, whereas the expert therapists tended to more reflection and an experiencing position in therapy.[19]

Discussion of study 2

The results of the analyses of the quantified interview material showed a reaction pattern that was specifically related to the described traumatic situations. This pattern included anxiety, shock, somatic reactions and the feeling of being carried away, and being overwhelmed by the strong feelings of the client. This pattern was replicated in the combined analysis of the qualitative data of study 1 and study 2. Intrusive experiences were reported by all experts, but only in relatively few situations. They seemed not exclusively related to traumatic situations, as they were also reported in other situations with high emotional impact. Traumatic situations can be overwhelming, even for very experienced therapists, and work setting and other therapist characteristics seem to exert little influence on this reaction pattern.

Although this trauma pattern is highly arousing, our data do not suggest that therapists are traumatized by the confrontation with difficult traumatic situations. On the contrary, the expert therapists were all well-functioning and enjoying their profession. This reaction pattern may have contributed to the high emotional burden of Centrum '45 therapists, who are more frequently confronted with clients' traumatic experiences than the experts who had a lot of other tasks besides their psychotherapeutic work. How-

ever, the high emotional burden of Centrum '45 therapists did not lead to symptomatic reactions, indicative of secondary traumatization of the therapists.

Furthermore, the results of this study do not give clear support of long-term changes that colour in-session reactions of therapists to clients as conceptualized in the countertransference-vicarious traumatization cycle.[5] We found no differences in reaction patterns related to trauma specialization of the expert therapists. The difference between Centrum '45 therapists and expert therapists in therapeutic attitude (active versus reflexive/experiencing) may reflect a coping strategy with high emotional burden or with feelings of helplessness in face of the severe post-traumatic and existential problems of the clients. Other explanations are possible but cannot be decided on these analyses: reflections of an organizational culture, an interview artifact, or an effect of the different levels of experience of Centrum '45 and expert therapists.

Trauma-specificity thus seems probable for reactions to traumatic situations. Experience with particularly severely traumatized clients, combined with frequent confrontations may influence therapists' in-session reactions. However, our results oppose the view that long-term trauma therapy experience as such negatively influences therapist's well-being or in-therapy behaviour. Given the exploratory nature of our studies thus far, these results need to be tested in a controlled quantitative design.

Study 3 – Specificity of trauma-reactions

Specificity of reactions to different kinds of high impact clinical situations was the topic of the third study, the more active in-session behaviour by Centrum'45 therapists could reflect a coping strategy to alleviate the impact of trauma confrontations. Our research question for this study was:

1. Are trauma-reactions specifically related to the confrontation with traumatic experiences of clients?

Method

Design

The study had an experimental design, using four clinical vignettes as stimulus material. It was approved by the Ethics Committee of the Department of Psychology in the Faculty of Social and Behavioural Sciences at the University of Amsterdam.

Participants & procedure

Participants were psychology students (N=100, mean age 21.4 (SD 1.7), range 18-34 years), who received credits or a small financial compensation for their participation. After giving informed consent and completing a short demographic questionnaire, they viewed videotaped vignettes of enacted clients telling their therapist about a recent event. Two vignettes were Dutch translations of vignettes used in the Psychological Mindedness Assessment Procedure (PMAP),[20] showing clients with relational problems. Two vignettes were constructed for this study[a]. In one vignette, a refugee, doing fairly well, suddenly confronted her therapist with the traumatic story of the loss of her child during her flight. The second vignette showed a borderline client who first idealizes the therapist and then suddenly turns into a fierce rage, threatening suicide. The procedure followed the PMAP manual,[20] to which was added that participants reported their emotional reactions on a checklist after each

a) Both vignettes were constructed by Ton Haans, with cooperation of the first author.

viewing. Only the results of the emotional reactions on the two newly constructed vignettes are reported here.

Instruments

The Therapist Reactions and Emotions questionnaire (TREq) is a 20 item questionnaire developed to measure therapist emotions and behavioural tendencies in clinical situations. Intensity is scored on a 5 point Likert scale ranging from "hardly or not at all" to "very strongly". Items reflect the 20 reaction categories found in study 2; the five subscales reflect the clusters of therapist reactions. The subscale Responsible includes items about feeling more responsible than usual, engaged, fascinated or carried away by strong feelings of the client. The subscale Active Coping comprises ruminating as an attempt to find a solution, talking, asking advice, and attempts to change the situation of the client. The Trauma subscale includes shock, anxiety, intrusive images, and somatic reactions. Anger, sorrow, helplessness, and feeling provoked or manipulated are combined in a subscale Negative Feelings, and the subscale Distancing includes disconnecting from the client, limit setting, feeling a great distance, and emotional withdrawal of the therapist. The subscales are comparable with categories of countertransference found in other studies,[21] except for the trauma subscale which is specific for the TREq. Internal consistency of the total scale ranged from Cronbach's alpha .84-.87 over different vignettes, subscales alpha's from .53-.72. The TREq-total score differentiated neurotic vignettes and both vignettes with high emotional impact ($p>.001$). The Refugee and Borderline vignettes evoked significantly different scores on the TREq-subscales "trauma-reactions" ($p=.001$) and "distancing" ($p<.001$), which supports construct validity of the TREq.[22]

Analysis

We used multivariate analysis of variance (MANOVA) to study the effects of vignette-type on therapist reactions, with subsequent univariate analysis of variance (ANOVA) to study interaction effects.

Results

To investigate specificity of therapist reactions to different clinical situations, we conducted a MANOVA with the five subscales of the TREq as dependent variables and "vignette" (Refugee or Borderline) and gender as independent variables; age was entered as co-variate. We found a main effect for vignette on trauma-reactions ($F(1,192)= 8.15$, $p<.01$) and on distancing ($F(1,192)= 23.62$, $p<.001$). Trauma-reaction scores were significantly higher for the refugee vignette, whereas more distancing was related to the borderline vignette.

To study the relation between trauma-reactions and distancing, we created two groups of participants with respectively low and high scores on distancing reactions by using a median split on TREq-distancing. Gender, vignette and low versus high distancing were entered as independent variables; age was entered as co-variate. Again, a main effect for vignette emerged. The refugee evoked significantly more trauma-reactions than the Borderline ($F(1,192)=7.30$, $p<.01$). An interaction effect was found for gender and low/high distancing on trauma-reactions ($F(1,192)=4.46$, $p<.05$): male participants with high distancing also scored high on trauma-reactions, which was not the case for female participants whose scores were not related to high vs. low distancing. In addition, we found an interaction between vignette and low/high distancing on trauma-reactions ($F(1,192)=5.78$, $p<.05$).

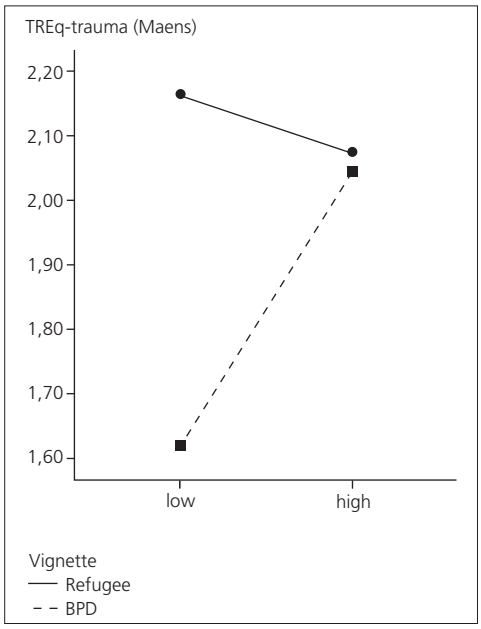

Figure 1 *Effects of vignette and low/high distancing reactions on trauma-reactions.*

Figure 1 shows the plot of this analysis. For the refugee, scores on trauma-reactions are high whether distancing is low or high. Although high distancing seems to alleviate trauma-reactions somewhat, the difference is not significant (no main effect for low/high distancing). In reaction to the borderline client, low distancing goes with low scores on trauma-reactions. However, participants with high distancing report significantly more trauma-reactions. Low scores on both trauma-reactions and distancing suggest low impact, whereas the combination of high distancing with trauma-reactions probably reflects a high impact of the borderline vignette on these respondents.

Discussion of study 3

In this study, of all possible therapist reactions, trauma-reactions and distancing emerged as specifically related to the refugee and the borderline vignette, respectively. The refugee client, whose narrative suited the criteria of a "traumatic situation", evoked mainly trauma-reactions, whereas participants reacted to the borderline client with distancing. Because we supposed that distancing could also be a coping strategy against high impact, we compared groups of participants with low or high distancing on trauma-reactions. Distancing was hardly functioning as a coping strategy with the traumatic situation. Instead, it seemed to be a sign of strong countertransference reactions to the borderline client. It is not to be decided on these data whether these strong countertransference reactions or the situation itself acted as "traumatic stimuli". These results suggest that trauma-reactions are related to a high impact of clinical situations on the therapist. However, although trauma-reactions are not exclusive for traumatic situations, it was not only the dominant reaction pattern in the traumatic situation of the experimental condition, but it was also not influenced by the level of distancing or by other reaction patterns. The summary conclusion of this study could then be that trauma-reactions are specific for, but not exclusively related to, traumatic situations.

Apart from the inherent limitations of an experimental analogue for generalizability of the results to therapeutic situations, our participants were psychology students and not therapists. This could influence the psychometric properties of the TREq, as well as the countertransference patterns evoked by the experimental vignettes. The study should be replicated with a therapist group, to account for this. Further, the TREq measures behaviour tendencies and emotional reactions to a clinical situation, but not cognitive countertransference reactions. These should

be included in a more comprehensive study on therapist reactions and coping with difficult clinical situations.

General discussion

The purpose of our studies was to investigate whether a high emotional burden of trauma therapists was specifically related to the confrontation with clients' traumatic experiences. Further, we aimed to clarify the trauma-specific effects on therapists: "secondary traumatic stress", "vicarious traumatization" and "traumatic countertransference".

The sequence of these three studies points to the relevance of further research on therapists' own experiences during psychotherapeutic practice, especially with traumatized clients. The first study differentiated burnout and emotional stress; the former was mainly related to organizational factors, the latter to clinical situations. Our findings lend empirical support for trauma therapists' reports of the high emotional impact of their work, and role clarity was identified as an important supportive work related factor.

The second and third studies identified a trauma-reaction pattern that was clearly related to the encounter with traumatized clients, although it was also evoked in other high impact situations. Trauma-reactions were related to traumatic situations rather than to therapist factors, which supports trauma-specificity of these reactions, and distinguishes them from countertransference (in the classical sense), in which the therapist's own conflicts play a decisive role. However, this does not mean that such a trauma-specific reaction pattern necessarily points to secondary traumatization of the therapist. The link with traumatic situations and post-traumatic reactions is emphasized in the term "secondary traumatic stress". An alternative naming as "confrontation anxiety"[23] symbolizes the sudden emotional impact and intensity of reactions to traumatic and other high impact situations, without pointing to a pathological process in the therapist.

The second study revealed no differences between expert trauma therapists or other expert psychotherapists, which suggests that at least these experienced trauma therapists had no signs of trauma-specific long-term negative effects of their work, described as "vicarious traumatization", showing in their reactions towards clients. This result could have been influenced by the experts' long-time and outstanding experience. They seemed to have found a balance in coping with the impact of clients' traumatic experiences. This may however be different for younger therapists. The difference between the expert group and the therapists of Centrum '45 suggests that therapeutic style may change with growing experience. Alternatively, the active therapeutic style could represent a coping strategy with the high exposure to traumatic material of Centrum '45 therapists. However, it is also possible that these results reflect the influence of underlying trauma-specific cognitive distortions signifying vicarious traumatization, or of organizational factors.

Further research should thus include trauma specialists as well as psychotherapists in regular psychotherapeutic practice of different levels of experience, and should investigate their reactions to emotionally neutral, traumatic and other high impact situations. This research focused on therapist reactions to difficult clinical situations, and specifically on behavioural tendencies and emotional reactions. Further research should also investigate the interaction between cognitive functioning and behavioural and emotional reactions, and the influence of the underlying emotional state of the therapist.

More research is also needed on the reaction patterns as operationalized in the TREq. A factor-analysis of the TREq-items could possibly refine the differential reactions to high impact situations in general and traumatic situations.

Departing from the concepts "traumatic countertransference", "secondary traumatization" and "vicarious traumatization", our research has covered a broader field. Our studies underscore how an empathic connection with severely traumatized clients naturally gets to the therapist. Although stressful, this inescapable part of the psychotherapeutic profession can possibly turn into a personally enriching experience for the therapist, as most of the therapists told us. But a therapist cannot do it on his/her own. A supportive professional environment may make the difference between growth and burnout, which is a message for both therapists themselves as well as for the organizations in which they work.

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Human rights abuses, transparency, impunity and the web

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Abstract

This paper reviews how human rights advocates during the "war-on-terror" have found new ways to use the World Wide Web (Web) to combat human rights abuses. These include posting of human rights reports; creating large, open-access and updated archives of government documents and other data, tracking CIA rendition flights and maintaining blogs, e-zines, list-serves and news services that rapidly distribute information between journalists, scholars and human rights advocates. The Web is a powerful communication tool for human rights advocates. It is international, instantaneous, and accessible for uploading, archiving, locating and downloading information. For its human rights potential to be fully realized, international law must be strengthened to promote the declassification of government documents, as is done by various freedom of information acts. It is too early to assess the final impact of the Web on human rights abuses in the "war on-terror." Wide dissemination of government documents and human rights advocates' reports has put the United States government on the defensive and some of its policies have changed in response to public pressure. Even so, the essential elements of secret prisons, detention without charges or trials, and illegal rendition remain intact.

Key words: human rights, war, war crimes, internet, torture

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War crimes, impunity and the Web

The World Wide Web's (Web) profound effect on all forms of communication extends to human rights advocacy. The web is transparent in ways that are well suited to human rights work. It is transparent with regard to the information itself: it can transmit text, pictures, video clips, sound or facsimiles of government documents showing marginal notes and signatures of government officials. The photographs of smiling guards abusing men at Abu Ghraib or of President Bush's signature on a directive suspending the Geneva Conventions for Taliban and al-Qaeda prisoners are powerful images. This transparency is magnified by the Web's ability to carry limitless amounts of such documents in large archives that can be indexed, linked and sorted for specialized use. Second, the Web is transparent in the way that it crosses international borders and equally reaches diverse political constituencies. Access to information is available through internet cafes, libraries and personal computers. Third, the Web is transparent in its speed; it instantaneously distributes information to human rights advocates and media outlets. This changes the time scale of human rights work. The speed of the virtual information networks means that information about human rights violations can be compiled, researched, analysed and disseminated in

"news-cycle" or "political" time rather than in the slower cycles of professional historians. Transparency is the first antidote to impunity for war crimes. The Web is a powerful advance in the fight against impunity for crimes against humanity.

The Web and the "War on Terror"

The "war-on-terror" offers many examples of how the Web changes human rights advocacy. This article focuses on activities with regard to the United States operations in Iraq and Afghanistan, Guantanamo Bay and in countries to which persons have been taken by the illegal process of extraordinary rendition.

The most common and conventional Web activity is the posting of human rights reports and analyses and commentaries. Such postings are done by many non-governmental human rights groups including Amnesty International[1], Center for Constitutional Rights[2], Human Rights First[3], Human Rights Watch[4], Physicians for Human Rights[5] and The World Organization for Human Rights.[6] It is also done by international organizations such as the Office of the United Nations' High Commissioner for Human Rights,[7] its Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment,[8] the European Parliament or the Council of Europe (both of which have addressed renditions).[9,10] In this use, the Web offers an inexpensive fast way to distribute to an audience of human rights advocates and media outlets that extends far beyond membership lists and media distributions.

A more innovative human rights use of the Web is the creation of open-access and updated data archives. The Center for Public Integrity posted all of the appendices to General Taguba's investigation of the abuses at Abu Ghraib prison in Iraq.[11] The American Civil Liberties Union's (ACLU) website posts more than 100,000 pages of government documents that it obtained by a law suit using the United States' Freedom of Information Act.[12] Unfortunately, the utility of this immense archive is limited by poor indexing and organization which the ACLU is gradually improving. In addition, many of the documents are in a facsimile form which does not permit text searching – reading is a formidable challenge.

Nevertheless, there are a number of specialized websites. Minnesota's Human Rights Library section, entitled United States Military Medicine in War on Terror Prisons, contains 60,000 pages of government policies, investigations and death records pertaining to medical operations in the US war on terror prisons. Its indexes are cross linked to the government and index items can be found by general web search engines even though the documents can not be internally searched because they are in a facsimile form.[13] This site is used by 500 visitors per month. Iraq Body Count culls media and Defense Department sources to maintain an updated list of civilian casualties in Iraq.[14] Cage Prisoners posts information and advocacy appeals for prisoners at Guantanamo.[15] Each of these archives is maintained by a few, mostly unpaid, volunteers.

The Web has also been used to identify the flight plans and aircraft used for the Central Intelligence Agency's illegal program of rendition. Stephen Grey used databases compiled by hobbyist plane spotters and computer archives of flight plans to identify and track individual renditions, the fleet of CIA planes, countries that supplied transit airports and the final destinations for these flights.[16]

Blogs, e-zines, list-serves and RSS feeds rapidly distribute information amongst journalists, academic sources and human rights

advocates. Daily Kos is one general news service which has extensive human rights information.[17] Psyche, Science and Society is a moderated blog that focuses on organizing to change the policies and leadership of the American Psychological Association which supports psychologists' involvement with coercive interrogations at Guantanamo Bay and elsewhere.[18]

Discussion

The Web can play a key role in fighting impunity for human rights abuses. To understand its emerging role, it is useful to distinguish between several senses of what ending impunity can entail:

- *Moral delegitimization:* This is exemplified by the arrest warrant for General Augusto Pinochet for murders committed by his Chilean regime. Although General Pinochet was never tried, the warrant precipitated a historical reevaluation of his regime that lead to prolonged legal proceedings, constitutional changes, prosecution of his collaborators and confiscation of family assets. Similarly, legal summons and accusations relating to crimes committed by Operation Condor in South America have made it difficult for former United States Secretary of State Henry Kissinger to freely travel. Delegitimizing is the most common way to attack impunity and it begins with disseminating authoritative reports from human rights organizations. The experience in the war on terror shows the Web's ability to promoting transparency in a way that leads to moral delegitimization. Unfortunately, moral opprobrium is a weak punishment and deterrent.
- *Redress for victims:* This is exemplified by Filartiga v Peña Iralaa.[19,20] In this 1979 United States civil case, a federal court found a Paraguayan police official liable for civil damages for the torture and murder of Joelito Filartigo which violated various international laws to which the United States is a party. Redress for victims is available only to a few persons who can overcome poverty and stigmatization to obtain expensive legal assistance and a sympathetic court. Nevertheless, attorneys are using Web archives of government documents to prepare cases for persons who are detained without charges or evidence.
- *Civil sanctions:* It is possible to deny work permits or visas to persons who have committed crimes against humanity. Human rights abusers increasingly risk deportation from countries to which they have immigrated. It is likely that the Web archives can play a role in promoting civil sanctions if human rights advocates can use such information to mobilize governments to apply the sanctions.
- *Criminal punishment:* The trials of Saddam Hussein of Iraq, Serbia's Slobodon Milosevic, and Charles Taylor of Liberia all exemplify varying kinds of formal prosecutions for crimes against humanity. In 2006, Thomas Lubanga, former leader of a Congolese militia, became the first person to be arrested under a warrant issued by the new International Criminal Court.[21] Criminal punishment is the rarest form of ending impunity. It is costly and generally reserved for leaders. It is politically charged and highly selective: Cambodia's Pol Pot was never tried, Radovan Karadžić and Josef Mengele were sheltered from protection. The International Criminal Court should post evidence on the Web as soon as it has been vetted. Courtroom proceedings must be fair, but a crime against humanity is a crime against every member of

the human community; we all deserve to see the evidence.

The Web is an incomplete remedy to the lack of transparency that shields human rights abusers from accountability. It only works to the degree that information can be obtained and that people are willing to accept the risk of posting information. The "war on terror" experience shows that some information is available about abuses in Iraq and at Guantanamo but much less is available from Afghanistan and almost nothing is available from the secret prisons where the CIA has taken persons via the process of illegal extraordinary rendition. The human rights community is insufficiently organized or funded to fully exploit this resource. There is no central listing of the human rights web archives and very limited cross linking from one archive to the other.

It is too early to assess the final impact of the Web on the human rights abuses in the "war on terror." Even so, scholarship of the prisons and the policies is at an advanced stage and defensive United States officials have tempered some policies in response to public pressure. Unfortunately, however, the essential elements of secret prisons, detention with charges or trials, and illegal rendition remains intact.

International law is insufficient to allow the Web to fully develop its capacity to advance human rights. Article 19 of The Universal Declaration of Human Rights correctly notes the relationship between access to information and freedom of speech: "Everyone has the right to freedom of opinion and expression; this right includes freedom ... to seek, receive and impart information and ideas through any media and regardless of frontiers." Article 19 of the United Nations International Covenant on Civil and Political Rights does not go further.[22] The goal of open access to information is restated in the United Nation's 1996 Johannesburg Principles on National Security, Freedom of Expression and Access to Information, Freedom of Expression and Access to Information:[23]

Principle 11: Everyone has the right to obtain information from public authorities, including information relating to national security. No restriction on this right may be imposed on the ground of national security unless the government can demonstrate that the restriction is prescribed by law and is necessary in a democratic society to protect a legitimate national security interest.
Principle 12: A state may not categorically deny access to all information related to national security, but must designate in law only those specific and narrow categories of information that it is necessary to withhold in order to protect a legitimate national security interest.
Principle 13: In all laws and decisions concerning the right to obtain information, the public interest in knowing the information shall be a primary consideration.
Principle 14: The state is obliged to adopt appropriate measures to give effect to the right to obtain information. These measures shall require the authorities, if they deny a request for information, to specify their reasons for doing so in writing and as soon as reasonably possible; and shall provide for a right of review of the merits and the validity of the denial by an independent authority, including some form of judicial review of the legality of the denial. The reviewing authority must have the right to examine the information withheld.
Principle 15: No person may be punished on national security grounds for disclosure of information if: 1) the disclosure does not actually harm and is not likely to harm a

legitimate national security interest, or 2) the public interest in knowing the information outweighs the harm from disclosure.

The private sector has not been supportive of the human rights need for access to information. The Electronic Frontier Foundation (EFF) and the OpenNet Initiative (ONI) promote freedom of speech on the internet, but neither promotes access to government information as articulated in the Johannesburg principles.[24,25] Large corporations that make Web servers and search engines, including Google, Yahoo, Cisco and Microsoft, have actively diminished the human rights' utility of the internet by developing filters to enable governments China, Cuba or Turkey to block access to politically charged information. In addition, they have disclosed the names of persons or computer identifying numbers of persons who post human rights information to governments that brutally suppress dissent.[26,27] Human rights activists have been imprisoned because of such acts.

More work should be done to make the concept of freedom of access to government information an integral part of the right to free speech and a free press. Without such information, free speech can be little more than opinions. Amnesty International aggressively promotes the right of access to government information and protection for persons who use the internet for human rights work.[27,28] Human rights advocates might seek allies in the business community; an honest and efficient global economy requires transparent government institutions.

The Web has the elements of a powerful communication tool for human rights advocacy. It is international, instantaneous, and accessible for uploading, archiving, locating and downloading information. It enables human rights advocates to communicate in "political time" rather than in the delayed time of traditional academic or historical research, a delay that allows abuses to go unchallenged as researchers commute to central libraries or use easily interdicted mail or telephone connections. The Web democratizes information and takes down barriers of time and space. Such transparency is a key step to ending impunity.

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Beyond where it started:

A look at the "Healing Images" experience

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Abstract

In March 2004, the Baltimore-based nonprofit organization Advocates for Survivors of Torture and Trauma (ASTT)** initiated a photography-based therapeutic programme for clients. Developed by a professional photographer/teacher in collaboration with a psychologist, the programme has the goal of enabling clients to engage in creative self-exploration within a supportive, group setting. Since its inception, thirty survivors of conflict-related trauma and torture from five different countries have taken part in the programme, known as "Healing Images," using digital cameras to gather individually-chosen images that are subsequently shared and discussed within the group. These images include depictions of the natural and manmade environments in which clients find themselves; people, places and objects that offer comfort; and self-portraits that reflect the reality of the life of a refugee in the United States.

This description of the "Healing Images" programme is based on comments gathered through discussion with participants and through interviews. Additional information was gathered from observation of early workshop sessions, review of numerous client photographs and captions, and pertinent organizational materials.

A fundamental benefit of the programme was that it offered a mutually supportive group environment that diminished clients' feelings of psychological and physical isolation. Participants gained deep satisfaction from learning the technical skills related to use of the cameras, from the empowering experience of framing and creating specific images, and from exploring the personal significance of these images. Programme activities sparked a process of self-expression that participants valued on the level of personal discovery and growth. Some clients also welcomed opportunities to share their work publicly, as a means of raising awareness of the experience of survivors.

Key words: Torture survivors, therapeutic photography, group therapy, creative arts therapy, physical & psychological trauma

Background

Advocates for Survivors of Torture and Trauma

Founded in 1994, Advocates for Survivors of Torture and Trauma (ASTT), a non-profit organization in Baltimore, Maryland, has as its mission "to alleviate the suffering of those who have experienced the trauma of torture, to educate the local, national, and world community about the needs of torture survivors, and to advocate on their behalf."

The need for ASTT's services is great. The Washington, D.C. metropolitan area has become one of the top "magnet" areas for immigrants in the United States;[1] as a result, the District and the surrounding region are characterized by a broad and growing diver-

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sity of immigrant communities and related social networks. United States Government estimates place the number of torture survivors in the United States at over 400,000,[2] and it is estimated that approximately 40,000 survivors live in the greater Washington/Baltimore region. As one of only three specialized care centers for torture survivors in the mid-Atlantic region, ASTT has seen a significant increase in the demand for its services. At present, the organization serves approximately 200 survivors a year.

ASTT clients have experienced many types of torture. These include beatings, rape, stabbing, suspension, forced positions, burns and electric shock. Psychological forms of torture to which clients have been subjected include death threats, mock executions, sleep deprivation, forced observation of the torture of other individuals, humiliation, and sound and light over-stimulation and under-stimulation. PTSD and Major Depression are the two most common psychological diagnoses shared by ASTT clients.

ASTT provides comprehensive services for clients. Mental health services include psychological assessment, individual and family psychotherapy, and group treatment. Social support services address client needs pertaining to living situation, health and nutritional status, and educational or employment goals. All services are provided free of charge.

ASTT's work with torture survivors centers on the Strengths-Based Model, an approach rooted in the belief that every individual has deep internal resources and the inherent capacity to transform his or her life.[3] A central role of ASTT psychotherapists and case managers is helping survivors identify these strengths and build upon them. Each client helps to develop his or her own plan for personal wellness, based on individual, prioritized needs that may be psychosocial, medical, or legal in nature. Through the inherently enabling nature of the Strengths-Based approach, clients become active partners in the process of healing.

In addition, ASTT has developed a variety of special programmes and activities for the benefit of clients.

"Healing Images": an overview

In March 2004, ASTT initiated a new programme for clients: a workshop combining digital photography training and group therapy within a creative arts context. The project was developed by Steven Rubin, a photojournalist/instructor, in collaboration with Karen Hanscom a psychologist who is also ASTT's director. The goal of the workshop was to enable clients to explore paths of creative self-expression within a supportive, therapeutic setting.

Entitled "Healing Images," the programme was inspired in part by the principles and techniques developed by Judy Weiser of the PhotoTherapy Centre in Vancouver, British Columbia. Approach and implementation, however, were strongly informed by Rubin's own professional experience, which has included documenting the situation of refugees held in detention in the United States as well as photo essays depicting individuals affected by conflict in Kosovo, Rwanda and elsewhere.

During initial planning, ASTT therapists and case managers helped identify potential workshop participants. The primary consideration was that participating clients would be at a stage of sufficient emotional stability that possible exposure to sensitive material within the group – the spontaneous sharing of stories of past abuse, for example – would not have detrimental consequences. ASTT staff also sought to prioritize clients who had

limited occupational or social opportunities, and who seemed to be particularly isolated.

ASTT's director perceived the photography workshop as an opportunity to explore an alternative, group-oriented approach to working with torture survivors. At the same time, the programme aptly reflects the organizational perspective that the healing process takes place on many levels and does not always require psychotherapy.

Thirty ASTT clients from five different countries have taken part in what has come to be known simply as "photo group." The number of participating female clients has been slightly greater than that of male clients, a reflection of gender statistics among ASTT's overall client base.[4] Group size has been kept small, with four to six clients participating at a given time in successive workshop cycles. Either ASTT's director or another staff therapist is present at each class meeting, along with the photo specialist.

The original grant-funded period lasted approximately 14 months. An interval between workshop sessions in mid-2006 afforded the opportunity to assess programmatic and technical needs. During this time, reflections on the "Healing Images" experience to date, along with suggestions that could help inform future activities, were gathered from a small group of former participants/clients as well as from the founding instructor and principal ASTT staff. Inquiry was carried out through one-on-one interviews, email exchanges, and discussion with clients. This paper is based primarily on information and observations gathered through that qualitative inquiry process.

The "Healing Images" experience

Early stages

During the first workshop meetings, clients were invited to bring with them and share images that were important to them, such as photographs of family members or friends, provided they felt safe and comfortable doing so. They were also encouraged to share images gathered from newspapers, magazines, or other sources that held meaning for them. The resulting exchanges helped initiate discussion around the power of the photographic image as well as such factors as composition and perspective. Just as importantly, these early sessions helped participants get to know one another and become increasingly comfortable as a group.

During these initial meetings, the use of already-existing images as triggers for discussion – the "passive" application of photography in counseling – served as a springboard for the project's central focus on "active" engagement of individuals in gathering and sharing their thoughts about images of their own making.[5] From the workshop's start, ample "hands-on" practice helped demystify the technology of digital photography. Clients gathered images inside and around the ASTT office during class meetings, and subsequently began to take photographs between sessions as well.

Meetings of the photo class took place weekly, and ranged from two to three hours in length. Occasional field-trips enabled participants to explore various sites around Baltimore, including the Inner Harbor and the Visionary Arts Museum, as well as the neighborhood surrounding the ASTT office. These group expeditions – and, to an even greater extent, the work carried out by clients on an individual basis between class sessions – yielded a multitude of images for sharing and discussion. The nature of these images, and the reflections that they evoke, are the focus of the following section of this paper.

Inner and outer worlds

Clients participating in the Healing Images workshops photographed myriad aspects of

the world around them: their living spaces and personal effects, neighborhoods, friends and family members, and social events and celebrations. Nature images abound, especially photos of flowers and of trees, both fully-leaved and bare, and with roots. Many clients gathered nighttime shots: the swirl of neon signs and city lights against darkness, or the gleam of moonlight on snow.

Some photographs relate to occasional assignments suggested by the instructor, including those designed to help participants better understand certain functions or technical features of the camera. From early on, however, it was clear that the images that clients created were not bound by the parameters of proposed themes. The psychologist suggests that explicit assignments represented "too much of a construct" for individuals functioning in "survival mode." Ultimately, clients photographed what they wished to photograph: "It was going to go where they needed it to go."

For some clients, the camera directly opened the way to exploration of their new surroundings and physical environment:

"I was given the camera and I went and took the photos that I wanted to, everywhere I wanted ... that also really helped me to see the city – I hadn't even paid attention to many things. Now that I have the camera I look around a lot, I look around to photograph this building, which is taller than this one or that one. I searched for statues, I went around downtown to take photos of lots and lots of little statues ... In between I stopped and read and said, 'Ah, I never paid attention to all that!' So, with the camera I have now, I've started to pay attention to many things."

Another client describes the satisfaction he gained from pursuing a self-chosen subject – in this case, a series of nighttime winter images:

"... I saw how the landscape was different that day, and I set myself to try to capture certain things when I went out. And there was a lot of wind and snow and it was cold, but I went out and took some photos that pleased me in the end ... I felt that I devoted myself ... it allowed me to create certain challenges or do certain things that maybe I could not have done".

For this client, photography became a way of exploring the dynamic relationship between subject matter and state of mind:

"Day after day, without personally having anticipated it, [using the camera] helped me to learn how to discover another side of shooting certain things. Because when you see things in a different manner, from one day to another ... your mental state is different on each day. This let me notice certain changes, to discover that, oh, maybe in this state I discovered this or that, there was a change in me internally, and for me this was positive."

He adds, "Seeing something under another aspect than that in which I was used to seeing it every day – I tried to capture that and it made me happy."

Self-portrait as statement

ASTT staff and instructors were struck by the number of self-portraits created by participants, and by the candid nature of many of these images. Clients photographed themselves or were photographed, at their request, by others – class members, family members, friends – in situations reflective of their day-to-day experiences. One picture shows a client standing at a public telephone, listening intently. The closely-framed

image bears the simple caption "A refugee's life in America."

Other self-portraits include objects or elements that give clients comfort or strength. One image shows a client miming the feisty gesture of the emblematic World War II figure "Rosie the Riveter," featured in a poster on the wall behind her. The caption reads, in part:

"After my housemate told me the real story of that lady, Rosie the Riveter, I decided to have a copy of the poster in my own bedroom, just in front of my bed, and every day before I go out in the morning I will look at her and just say to myself ... you too can do it. I was so weak at that time and wanted to give up. The poster was just a good expression for my life ... when I feel weak, or under a lot of stress, I will just take a look at it and feel strong."

In another self-portrait, a client wears traditional clothes from her homeland. "When I wear my African clothes," the accompanying caption reads, "I feel like I'm in my house."

Some self-portraits were made expressly for mailing to distant family members or friends. It was noted that many of these tend to show the client well-dressed and standing near a car or in a nicely-furnished room – portrayals that feature reassuring signs of well-being and stability.

Commenting on the number and diversity of the self-portraits, the psychologist observes: "In psychology, one of the ways we know ourselves is by what others tell us about ourselves ... how others reflect back to us." She suggests that:

"When people move here, they've changed all the culture and scenery and everything around them, and they don't have a picture in their mind of themselves in space and time and environment."

These photographic self-portraits, she feels, actually help clients in constructing "the sense of self in place, and seeing themselves here in the United States – making it real." She further observed that, over time, clients tended gradually to create fewer and fewer self-portraits.

You never know what you can do unless you try. I stood in the cold for the first time without a coat to shelter me, to provide warmth. I just wanted to try it, to see how it felt. In my country I wanted to try politics, as one of the few women who do. I then too stood alone in the cold, unprotected and unsheltered.

This reminds me of one of the tallest buildings in downtown Dakar, which is the administrative building. People think we have no roads, no cars, no houses, no buildings and this shows we have buildings like this in Dakar. Everywhere in the world there are poor and rich. People here in America only show the bad parts of Africa.

Look at these girls! Their lives are beautiful and without worry. They reflect the joy of life. Will my life one day resemble that of these little ones?

Since humans are not snails that move with their homes (shells) on their back, I was not going to be that exceptional human to do it ... Words will never be sufficient enough to thank who offered that little space. That's my world. I lived in a small space but with a free mind and with other conditions like the photography class my mind grew lighter. I liken myself to a corn grain: if it drops someplace no matter how shallow it was buried, if conditions are favorable it will grow.

This photograph reminds me of my transition from my life in Africa to my new life here in America. In Africa I was a light to my family, my friends, my children. I provided for my family, we were a happy family. Then I got involved in politics and this light went out. Then I came to America … a second light went on for me, ASTT. ASTT is the light for me, a guide for me now.

A thumbnail view

The photographs included here, a minute sample of the work produced through the "Healing Images" project, offer some examples of the kind of pictures under discussion. (For purposes of confidentiality, no identifiable images of clients are included, and no attributions are attached to the photographs or accompanying captions.)

Talking about the photographs

As suggested by the images included here, clients' photographs sparked reflection and discussion around such themes as "identity, dislocation, loss, renewal, and American culture."[6]

Within the class, clients shared their photographs with one another by displaying their work as a slide-show, during which any participant could hit the "pause" key to request the photographer's thoughts regarding a particular image. Clients always had the "first word" about their own photographs, with ASTT staff and other participants offering their comments only afterwards. The resulting insights were often unexpected as well as deeply revealing.

A photograph taken by one client, for example, shows the exterior of a Chinese restaurant, its façade topped by a canopy decorated with artificial rocks. A discussion revealed that:

"the rocks made the client think of the coast where she used to live and how they'd go down the coast if you were pregnant and get some of the calcium rocks and chew on them… so you'd get enough calcium for you and your baby."

As noted by ASTT's director:

"It's really the same thing as art therapy with interpretative painting…the picture means something to the person that took it. We can have a reaction to it, we can have our own reaction, but it really has this meaning only to the person that took it."

As Weiser has stated, "The surface visual contents of people's photos, along with the unconscious decisions they make while planning or taking them, are all indications of people, places, and things that have mattered most inside them."[7]

Benefits of the "Healing Images" experience

Beyond photography

For some clients, the opportunity of gathering with one another on a regular basis, for both social and learning purposes, was the first benefit they mentioned when asked about the workshop:

"For me, it was very good: it really helped me meet people who I didn't know before, to make their acquaintance ... Coming each week to the meetings – that really helped me a lot. To come and talk together, it was very good for me."

The fact that all of the participants shared the bond of having survived trauma or torture made the rapport a unique one. "The photo course in itself became a way to meet with people with whom you shared a few of the same experiences," said one client.

"On my part it's had an effect, because I suffered inside ... I was in the first place troubled by my problems. To come to the photo group, meet with brothers, share the same ideas, discuss things ... it helped me a lot."

Another client comments:

"To be with people who are a little in the same situation as you…one feels that one is not isolated, one is not alone ..."

Participants shared not only a past history of trauma, but a present situation marked by uncertainty, owing to their status as asylum-seekers or as individuals who had recently gained asylum and were in the process of creating new lives for themselves. The class gave clients the opportunity "to share their asylum experiences and to be supportive of each other."

Seeking to involve clients who had been socially and emotionally isolated proved a critically important aspect of the course. One participant describes how the photography class encouraged her to escape the "four walls and stress" of her everyday situation:

"The fun of handling the camera, it took away the stress that I had. Like going out – the camera even motivated me to go out of the house ... just taking some pictures of beautiful flowers, appreciating nature ... you know, just living with the world."

Further, the workshop fostered a process of exchange that helped clients regain a sense of trust in others. An early sign of the rekindling of trust emerged very early in the project. A number of ASTT's clients at the time were from Cameroon, a country where political conditions have ignited conflict along sociocultural, ethnic, and linguistic lines. Concerns arose on the part of ASTT staff when both Francophone and Anglophone clients from Cameroon – putatively, individuals from opposing sides of the conflict in their home country – expressed interest in the photo class. The decision was made to raise the matter within the group itself. According to the psychologist, Karen Hanscom, the clients' response was striking in its unanimity: "Each time the groups shifted and we had that [situation], people said basically the same thing: 'We were both hurt' ... Never at any time did they get into a discussion of 'my side and your side'." The recurrence of this response suggests that, from the outset, a sense of shared identity as survivors outweighed other, potentially divisive distinctions among these clients; a common interest in the photo project helped to consolidate this sense of shared experience, and, arguably, to deepen and strengthen it in unexpected ways.

Another factor that strengthened group identity was that of shared language skills. During the first few class meetings, a volunteer interpreter was present to assist those clients from Central and West Africa who spoke French; subsequently, though, it became clear that some clients were sufficiently multilingual (in English as well as French and/or local languages) to translate for their fellow students. This process nurtured a sense of solidarity among participants and created an atmosphere of sharing and mutual support.

Beyond skills acquisition

Compounding the satisfaction that came from gaining photographic skills was the special excitement associated with use of up-to-date digital equipment. In the words of one client:

"I will talk now about how it feels to have and handle a digital camera, to have a camera in your possession. Not only a camera, but a *digital* camera – something not yet common in my part of the world, which is Africa. My experience with a camera is this: you feel like you are moving with the world ... You feel like you are going along with technology, you are not left behind, you are going with the time ..."

The prevalence of this attitude among participants prompted the instructor's observation that "the use of current digital technology with clients who typically have access to antiquated or run-down materials in their homeland [if they have access to anything at all]" carried benefits in itself.

An important corollary benefit was the acquisition of basic computer skills. Clients who had not been computer literate at the workshop's outset became adept at using a mouse, creating files, and transferring pictures from one file to another; some clients also learned to upload and email photo files through the Internet. At the end of each workshop cycle, participating clients received CDs of their photographic work.

The nature of the digital medium, apart from its novelty, offered another particular advantage in working with this group of clients. As noted by the instructor:

"I think the digital camera's immediacy of result was very useful and even therapeutic

for those survivors waiting in lengthy limbo for the U.S. government's long-awaited decision on their asylum status."

In contrast to the lack of personal control that characterized many critical aspects of their lives, the photography programme enabled these individuals to set their own goals, to autonomously select, frame, capture, and describe various aspects of their world. The deep sense of satisfaction conveyed by clients' comments on the workshop experience suggests the inherently empowering effect of this opportunity.

Perhaps most importantly, participants' reflections on the Healing Images experience suggest that, far from being a unidirectional device, the camera can become a channel for multiple connections between the individual and his or her world. Taking place at many different levels and in ways that cannot necessarily be defined, these interactions appear to help foster a process of re-engagement. The client who described the camera's role in motivating her to leave the confinement of her house and re-discover the small beauties of nature describes as well the re-awakening she feels taking place inside her. "Some life is creeping back into me," she says. She adds:

"I think things are kind of improving, my spirits are coming out until where I am today – because I can tell you that I am looking like a human being now, I have a smile on my face and everything."

Her words suggest the powerful connection between new ways of seeing the world and new ways of being in it.

*Sharing "Healing Images" with the public**

ASTT's mission statement includes the goal of helping "educate the local, national, and world community about the needs of torture survivors." In consonance with this aim, the possibility of exhibiting photographs created by the photo group was considered from the project's outset. Once the group had generated a body of work, each client made an individual decision about taking part in public exhibitions, and selected what image(s) would be included if s/he indeed wished to participate.

One client described the decision to "opt out" as follows:

"Not taking part in certain events was sometimes, for me, a personal choice ... I take the photos for personal expression. That's to say, for me, photography is a personal experience. I can mount and show the photos, but I don't; it's not with that view in mind that I take photos. It was a personal experience, and helped me internally ..."

Other clients embraced the opportunity to show their work. "When I saw all my photos, it gave me a lot of pleasure," said one client who took part in an exhibition. Some photo group members have attended opening events and spoken of their workshop experiences before the public.

Challenges

Balancing flexibility and focus

It quickly became clear to those involved with coordinating the photo group that flexibility would be essential in working with these participants, chiefly because of the flux and uncertainty that characterized their personal situations. Despite strong interest in the course on the part of clients, attendance was often sporadic. Any number of issues might arise on a given day that prevented an individual from taking part in class: difficulties regarding living situation, follow-up on legal or health matters, or a need to retreat into solitude.

ASTT sought to alleviate obstacles posed by questions of transportation. As with clients benefiting from the organization's other services, funds were made available to help class participants cover public transport costs. In addition, the course instructor was able to pick up some participants and bring them to class. He observes that "sometimes it seemed that it would have been better to hold the class not at ASTT but in their communities – but that poses its own problematics, given that not all clients live in the same area."

During the photojournalist/instructor's involvement with the programme during the original grant period, three different groups of clients took part in photo activities; however, the parameters of class "sessions" were often flexible, with some clients continuing while new students joined. As a result, working on a consistent basis with the same group of individuals was rarely possible. Despite the challenges posed by this situation, it was recognized that this flux and flow reflected the reality of clients' lives:

"Some clients would curtail their involvement due to immigration matters. Some would drop out when they got asylum and then found jobs or started English classes. But these were all essential steps toward their resettlement and healing, a goal ultimately consistent with the program even if they meant disengagement with the program itself."

Integrating classwork into individual therapy

The photography class significantly complemented the therapeutic services and other support that clients were receiving at ASTT. Powerful and revealing discussions of images took place within the group; in addition, clients often talked about the photo workshop experience during their individual therapy sessions. However, the integration of the photo work itself into these individual sessions did not take place as originally intended. This was chiefly owing to technical obstacles; namely, the lack of a photographic printer and necessary accessories. Within the photo group itself, the sharing of clients' photos through computer-based slideshows worked very effectively; the use of computers or laptops in therapy sessions for this purpose, however, was less practicable. This issue has since been addressed through the acquisition of two printers as well as a new computer and photo programme, a projector, screen, and additional digital cameras.

Conclusion

Based on the feedback they offered, we can conclude that participating ASTT clients perceived several benefits deriving from the "Healing Images" programme. The photo class provided an occasion for them to come together in an empathetic and caring group; for many, doing so represented an escape from psychological and physical isolation. This was a very positive and powerful experience.

As clients gained skills in using the cameras and began to depict different aspects of their lives, the class became an empowering experience at practical and personal levels. Clients describe a process of self-discovery sparked by the act of taking, viewing, and/or discussing the photographs. Talking about their images and the feelings associated with them appears to have deepened group sharing and mutual understanding.

Some differences in response emerged around the sharing of photographs with people outside the workshop or organization. For at least one client, creating and reviewing images sparks a valuable process of personal reflection; making them available for viewing by individuals outside the class

group is extraneous to his sense of satisfaction. Other clients welcome the opportunity to share their images with a broader audience through exhibitions or similar events, both in order to celebrate the collective achievements of the photo group and to help raise awareness of survivors' issues. These contrasting views indicate that respecting the individual preference of each participant on this decision, as ASTT has done to date, will continue to be essential.

All of the former participants who provided their feedback on the "Healing Images" experience strongly recommended that the programme continue into the future – "because," as one of them explained, "it will help many people. We ourselves, we have seen it; why not others?"

"It will help, so I hope it will continue. These are activities that help even without one's perceiving that they help us ... the photo course, like the English course, goes beyond being a simple photo class in which you learn how to use the camera. It becomes a family gathering ... it goes beyond where it started. It's tremendous."

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The proposal for supervision training in Palestine/Middle East

Ton Haans, Clinical Psychologist*

Abstract

Clinical supervision has been known for decades. However, only in the past decade have training courses for supervision been developed and offered for health professionals working with a severely traumatized client population. Health professionals working as supervisors in this field are faced with specific problems. Together with Johan Lansen and Ton Haans, the Berlin Treatment Center for Torture Victims (bzfo) adapted the training method developed by Lansen/Haans in 1999, which offers participants a structural framework.

In cooperation with the German Society for Supervision (DGSv), the bzfo offers this training course in Germany where it takes one and a half years to complete. To meet the vast need for supervision in countries where health professionals work under difficult and adverse conditions, the bzfo is now in contact with colleagues in the Gaza region with a proposal for supervision tailored to their specific needs.

Key words: Supervision, training method, health professionals

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Project proposal for supervision Training in Palestine/Middle East

Basics of culture sensitive supervision training in areas of armed conflict

During recent years the German Berlin Treatment Centre for Torture Victims (bzfo) has developed a licensed training course for trauma supervisors and supervisors for complex mental health problems. Parts of this training course can be adapted to specific requests and tailored to local circumstances. This paper describes some basic principles of this training as a basis for further discussion and colloquium development. It also presents a selection of papers and books written in English about trauma and cross-cultural supervision.[1-5]

We distinguish management supervision from clinical supervision. Management supervision is a means of control, of judgement about the right applications of methods in relationship to work output.

Clinical supervision is a joint reflection of supervisor and supervisee about professional problems of the latter. In this context the supervisor is an experienced counsellor or therapist with an additional formation as supervisor. Her/his task is to stimulate the critical reflection of the counsellor/therapist and to promote a higher level of professional and personal self-awareness. The ultimate beneficiaries of the supervision

are of course the clients of the counsellor/therapist.[1]

The target institutions and professionals of this training method are local trauma counselling and social organisations that provide assistance to survivors of man-made disaster. These include survivors of political violence, refugees and internally displaced persons, as well as survivors of domestic and social violence, including children, adults, women and men.

In the training, intercultural aspects are very important. Not only because of cultural distinctions between the European trainers and the trainees, but also because of cultural differences within the trainee group. Especially in large countries, the cultural differences between regions and varying levels of education can have a substantial impact on the counselling and supervision process.[2]

In any supervision the supervisor has to address her/himself to basic concepts in a specific manner. Elisabeth Holloway (1995) described these as tasks and functions.

According to her, the supervisor performs several tasks during a supervision session. She/he observes the skills of the supervisee, her case concept, the professional role, emotional awareness and the capacities of self-evaluation. If the supervisee has a supervision question, this question can be categorized under one of these tasks. The supervisor monitors to which tasks the supervision question applies, and also searches for the more complicated interconnectedness of these tasks and a, sometimes hidden, theme that the supervisee is unaware of.[3]

According to Holloway,[4] the actions of the supervisor are the functions of supervision. The supervisor monitors and evaluates the professional activities of the supervisee; he provides instruction and advice if required. The supervisor is also a model, both explicitly and implicitly. He/she can give advice to the supervisee, support him and share own professional or, if necessary, personal experiences with him.

These are very formal criteria and topics derived from Western supervision practice. In non-western cultures these elements acquire a culture specific outlook. In the training these culture specific manifestations of the general supervision features (tasks and functions) are the basic part of the training.

Next to this cultural adaptation practice, supervision is a real life simulation. Here the trainees perform supervisions on the spot, which are observed and commented on according to the tasks and functions. In this way the daily practice of the trainees, their complicated war and post war events are an integrated part of the training.

The most effective form of supervision is group or team supervision.[5] Lansen & Haans[1] developed a trauma group supervision method which is applicable to the consequences of man-made disaster in politically insecure conditions. It is highly structured in several rounds, which allows the supervisees to identify with relevant aspects of the case presented. It also helps the supervisee who presents the case to acquire new perspectives on her/his difficult professional situation.

The supervisor works with the problem solving potential challenges of the group and team members using their knowledge, skills and experience for the benefit of the patient. Thus, this structure is a reliable instrument in different cultural settings. Here again, the actual professional situations of the trainees form the basic exercise material of this training to connect the acquiring of the supervision skills as closely as possible to the supervisee's questions.

Concept of a training course in Palestine/Middle East

Step 1

Investigation of the needs and the working conditions of the prospective supervisors via e-mail and telephone.

Investigation of the need for group, team or individual supervision.

Step 2

Training Block 1 (5 days).

Proposed topics: what is clinical supervision, local characteristics of joint reflection, tasks and functions of the supervisor, application in the most desired setting (group, team, individual).

Step 3

Practice in daily life, consulting via e-mail (3-6 months).

Step 4.

Training Block 2 (5 days).

Based on the consultations and experiences from step 3, a deepening of skills and knowledge will be developed according to the needs of the trainees.

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Clinical Psychologist, psychotherapist
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The role of the Istanbul-Protocol[a] in the uphill battle for torture survivors being granted asylum in Europe and ensuring the perpetrators pay

Jan Ole Haagensen, PhD*

Three Dutch organisations, Pharos, Amnesty International, and the Council for Refugees, have published Care Full – Medico-Legal Reports and the Istanbul Protocol in Asylum Procedures[1] which gives a comprehensive and very detailed background on the pertinent need in asylum procedures for medical-legal reports based on the Istanbul protocol. The book is an important contribution to the European debate on asylum policies and the fate of the most vulnerable refugee groups coming to Europe. This article will explore why it is now required to use medical-legal reports in asylum procedures.

Changes in asylum and asylum seeking procedures

During the Cold War era, people from the East could hardly travel to the West. Furthermore, people's geographic mobility was severely limited by the high costs of airfares. Therefore, the asylum policies in Europe were much more lenient, in general, the number of asylum seekers was fewer and the political discourses were narrowly linked to the East-West conflict. After the political changes in 1989, the situation shifted and the inflow of refugees applying for asylum status gradually increased. This trend was exacerbated by the lowered travel costs, which brought asylum seekers to the doorsteps of the territories of the European Union (EU) more easily[b].

Today, the asylum policies in most EU countries do not appear to be about protecting people in need but about reducing the influx of refugees to the EU. This tendency has been accentuated after the event of September 11, 2001[c]. Today it is extremely difficult for an asylum seeker to come to the EU countries, which keep people from their shores with archaic policies and pro-

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a) Office of the United Nations' High Commissioner for Human Rights, Geneva (2004): The Istanbul Protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment. Professional Training Series No. 8 Rev. 1. United Nations, New York and Geneva.

b) Not to mention the growth of the business of human trafficking.

c) Paradoxically, while it is mainly the rich affluent countries that put up these restrictions, the vast majority of refugees stay in poor neighbouring countries. Considering their large numbers, we hear very little about these refugees.

cedures covered by a continuously thinning humanitarian layer. The strict policies have spread from one European country to another[d], and the forthcoming adoption of common policies on asylum procedures of the EU is continuing along these lines. To get to the EU and to acquire asylum today has become a rat race – a modern version of the survival of the fittest – where the asylum seeker has to be economically, physically and mentally resourceful to come to the shores of its member countries. Needless to say, the weaker groups loose out in this process, among them torture survivors.

Torture survivors at a loss

Torture survivors constitute a significant group among the asylum seekers[e]. Myrthe Wijnkoop's[3] thorough country assessments on asylum procedures towards vulnerable groups show great differences from one European state to another. Some states have formal procedures that may provide special treatment for torture survivors and other vulnerable groups. Nevertheless, Wenzel and Kjaer[4] found that torture experiences often are neglected in the asylum process. Torture survivors do not have easier access to asylum than other groups. Several studies seem to show that, on the contrary, they have more difficulties in getting asylum.[5] Bloemen, Vloeberghs & Smits[1] give ample evidence that interviewed torture survivors applying for asylum due to their experience of being tortured often conceal or forget to forward important information (see also the Istanbul Protocol paragraphs 167 and 141 and 142) that could have a positive influence on their asylum application. The recently introduced so-called accelerated asylum procedures adopted by more and more European countries, do not even include special considerations towards vulnerable groups like torture survivors.

Furthermore, a Common European Asylum System is expected to be in place by 2010[f]. This will be based on a harmonisation of the individual states' policies and it is therefore not expected to constitute an improvement for asylum seeking torture survivors.

To counter the fact that torture survivors loose out in the asylum processes, European organisations dealing with treatment of torture survivors or offering legal assistance to these have come up with some principles and recommendations for the role and use of medico-legal reports in European asylum procedures.[g] These are on the verge of being adopted by organisations in Europe dealing with the treatment of torture survivors. The organisations are trying to rectify today's fundamentally unfair system by smoothening the new EU asylum policies so that the vulnerable asylum seekers, such as torture survivors, are not on the loosing side. It is about giving torture survivors a decent chance. However, it can also be seen as making minor technical corrections (by ensuring more valid information) to a system that

d) This has often taken place along with all too familiar populist xenophobic political discourses.

e) I.e. in Denmark studies have shown one third of refugees to be torture survivors (2), although this number obviously changes with the societal context of the refugees.

f) The European Commission (2006): The European Union Policy towards a Common European Asylum System, See http://ec.europa.eu/justice_home/fsj/asylum/fsj_asylum_intro_en.htm Accessed 9th July 2007.

g) This was the outcome of a meeting 14-15 October and it is part of the Care Full Initiative. A draft was discussed by the European Network of Treatment and Rehabilitation Centres for Victims of Torture and Human Right Violations.

is a reflection of global injustices. To focus on a refinement of the asylum system is an acceptance of the overall policy framework intended to keep as many refugees out of Europe as possible.

The Istanbul Protocol – a standard in need of adaptations and updating

The main purpose of the Istanbul Protocol was to develop an instrument in the documentation of torture to counter impunity, which is still flourishing and a central impediment for freedom from torture. The Protocol is about how to prove torture to such an extent that it can stand up in courts. The rather comprehensive Istanbul Protocol was made with the involvement of a substantial number of professionals with medical and legal expertise in the field of rehabilitation and prevention. The protocol has become an UN document, but it is not an internationally legally binding document, as Hemme Batje[6] is at a pain to show in her article.[h] It has nevertheless become a standard covering the state of the art in medical-legal documentation of torture. Although the document is important and should be taken as a standard it must also be seen as a dynamic product that needs to be adapted to local circumstances[7] as well as updated according to the continuing scientific advancements in the field.

The focus on the continued struggle against impunity and ensuring the perpetrators pay

Using the Istanbul Protocol in medico-legal documentation to help torture survivors provide more valid information in the asylum process will cost salaries, and ceteris paribus, be more time consuming. Nowadays, torture survivors often do not get asylum due to their torture experiences; there must be hard evidence that he/she will be personally at risk of being tortured again if sent back. Nevertheless, a more systematic introduction of medico-legal reports to the asylum process offers a great opportunity for strengthening the struggle against impunity of torture. If the data collected using the Protocol during the asylum process is systematically and properly stored it can be used to have the perpetrators, and the countries that condone torture, persecuted. They will then pay for the asylum procedures as well as for any treatment needed by the torture survivor.

In other words, the perpetrators and the countries that produce the problem should one way or another pay for the costs – thereby further discouraging the practices. Such a move could help to substantially reduce impunity in the future. Along the same lines, RCT will now, after pilot testing,[8] be introducing a system where client data will be collected parallel to, and stored separately from, its treatment records, for legal and research purposes. Needless to say, it will only take place upon consent from the individual torture survivors, but the pilot test showed that clients were more than willing, as it was seen to be a chance for getting justice.[i] This is further supported by the experience of many organisations in the South that testimonials and justice can be seen as an important part of the healing process as well.[j]

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h) Torture is a multidisciplinary problem involving many different professions and disciplines. This sometimes creates some misunderstandings and confusions as the same words may have different meanings in different disciplines. The word protocol may be such one.

i) It is some time called psycho-legal counselling (see for instance Agger et al., forthcoming): both in therapeutic jurisprudence as well as the testimony methods, justice is seen as having a healing effect (see also Agger & Buus, 1990, 1995) and Weine, 2006).

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Sir,

Prisoners of war and torture need more attention

According to the definition of torture by the U.N.,[1] torture is defined as "the intentional infliction of severe mental or physical pain or suffering by or with the consent of the state authorities for a specific purpose". In the literature, specific groups are mentioned as victims of torture, such as political, religious, or ethnic groups. In detail, it includes groups that challenge governments, mainly in developing countries, so politicians, union leaders, journalists, health professionals, human rights defenders, people in detention or prison, members of ethnic minorities, and student leaders are frequently mentioned.[2]

Military conflicts are actually an important source of torture.[3] In the 20th century, 72 million deaths occurred in 25 conflicts worldwide.[4] In terms of loss of disability-adjusted life years (DALYs), war was ranked sixteenth by the World Health Organization in the global burden of disease in 1990, and by the year 2020 it is expected to rank in eighth place.[5] Among victims of war, prisoners of war (POWs) are the group that is heard from less than others and are rarely considered as victims of torture. They are often subjected to extreme physical and psychosocial stressors (during capture, or internment), so it is strongly believed that the surviving ex-POWs are fragile persons and more prone to suffer from a variety of physical, psychiatric and social disorders than the so-called normal members of the general population.[6-8]

Physical trauma and psychosocial stressors can arise. One of these stressors is prolonged and indefinite captivity that is itself the greatest source of hardship for POWs. For example, during the Iraq-Iran war, the longest military conflict in the 20th century (1980 to 1988), nearly 21,000 of the prisoners were registered by delegations from the International Committee of the Red Cross (ICRC), but others (55%) went undetected (some for ten years or more) until the exchange of prisoners in August 1990. Subsequently, many of them were in this situation for 16 years. This was apart from the poor health conditions in the detention camps[9] and restriction of physiological needs (food, water, sleep, toilet and ...). This situation is very harmful and destructive for anyone in the world, regardless of nationality, language and religion.

We seldom hear about the POWs even though they have suffered lengthy times of captivity. In conclusion, the POW is subjected to various physical and psychological violence from which they and their families experience the consequences for years. It seems that it is necessary to bring special attention to prisoners of war as victims of torture.

Ali Khaji, MD*

Sir,

Balkan immigrants

The United States contains a large concentration of immigrants from the Balkans and Former Yugoslavia. These immigrants represent numerous ethnic groups including Bosnian, Serbian and Croatian people and their families. In a country, that has a long history of ethnic challenges and civil rights demands, I am dismayed that the victims of the 1992-1995 holocaust in Bosnia-Herzegovina are rarely seen in the media, hardly ever have their history and culture presented in a non-hateful or fascist way and are basically non-represented in the daily news.

It is as if the mass killing and torture, death camps and mass raping committed by the Serbians never happened, as far as the world is concerned. Unfortunately for the affected Bosnian community the Serbian and Croatian crimes did occur in truly massive numbers. The Bosnian people suffer from a similar fate that the African Americans, American Indians and other ethnic minorities suffered from in our otherwise great nation. The Bosnians are underrepresented both here in America and back in their former nation as well. If you can't get proper treatment in the land of the free, since you can't go back to your own destroyed nation, where discrimination is even worse and more dangerous, then where can you go?

Does the United States offer a place where people can live in peace, freedom and safety? Evidently it does offer a chance at the great American dream. However you just will not hear about these people in the papers, except from hate mongers and insane barbarians, who killed often and brutally back in the mountains of Yugoslavia. You be the judge on this one.

Kevin Beck*

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