

# Chronic pain and PTSD: the Perpetual Avoidance Model and its treatment implications

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## Abstract

Posttraumatic Stress Disorder (PTSD) and chronic pain are frequently seen in the aftermath of a traumatic experience. Torture survivors have an increased risk to suffer from these two disorders. Although many studies report high comorbidity, there is still insufficient knowledge on the mechanisms of the development and maintenance of PTSD and chronic pain.

After providing an overview of the current literature concerning the comorbidity of these two disorders, we will present the “Perpetual Avoidance Model” (PAM). This model provides an explanation of the reciprocal maintenance of both disorders and offers treatment implications.

*Keywords:* torture survivors, chronic pain, PTSD, comorbidity, Perpetual Avoidance Model

## Introduction

*Chronic pain as a posttraumatic disorder in torture survivors*

The experience of torture is related to a wide array of psychological and somatic

consequences. A frequently diagnosed disorder in the aftermath of these man-made traumatic experiences is Posttraumatic Stress Disorder (PTSD). PTSD is characterized by symptoms of reexperiencing the traumatic event, avoiding reminders of the trauma and hyperarousal. According to a review of PTSD in civilian adult survivors of war trauma and torture from Johnson and Thompson,<sup>1</sup> the prevalence of PTSD in refugee torture victims ranges from 14 to 92%.

Besides PTSD, the experience of pain is one of the most frequent complaint of torture survivors. In a study with Buthanese refugees Van Ommeren et al.<sup>2</sup> found that 84% of the tortured group reported one or more somatic complaints. The most common pain is headache, from 39%<sup>3</sup> to 93%<sup>4</sup> and back/neck pain from 60%<sup>5</sup> to 87%.<sup>3</sup> Frequently, patients suffer from multiple pain sensations<sup>6</sup> lasting over decades. In a follow-up study with torture survivors in Denmark, Olsen et al.<sup>7</sup> even showed an increase of prevalence over 10 years: 58% still reported pain in the head (compared to 48% at baseline) and 76% in the back (compared to 48% at baseline).

For an understanding of the high prevalence of chronic pain in torture survivors, several factors have to be taken into account. Rasmussen et al.<sup>8</sup> examined in their study the chronic pain and associated symptoms

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and the possible torture techniques causing them. One typical consequence from suspension by the arms, for example, is pain in the shoulder, upper arms and neck. Not surprisingly, pain is a direct result of the pain-inflicting torture experiences. Besides pain as a direct sequel of torture, many survivors suffer from another type of chronic pain. Due to their traumatic experiences they live with a persistent state of high arousal, because of flashbacks (also nightmares) and memories of the traumatic event. In addition, the health status of tortured refugees is influenced by multiple stressors such as leaving family members behind, an insecure asylum status and the exile situation. Clinical experience has shown that these persons respond with a heightened psychophysiological response (e.g. heart rate, muscle tension) to trauma-related as well as more general environmental stimuli. This contributes to increased pain mainly in the neck, shoulders or in the back.

As many traumatized suffer from both disorders, we will now give an overview of the comorbidity-rates of PTSD and chronic pain.

#### *Comorbidity of chronic pain and PTSD*

The comorbidity of chronic pain and PTSD was repeatedly shown across different populations. In studies with war veterans up to 80% of those suffering from PTSD also reported symptoms of chronic pain.<sup>9,10</sup> In a study with psychiatric outpatients Villano et al.<sup>11</sup> found that 46% met the criteria for PTSD (according to DSM IV), 40% reported chronic severe pain and 24% had both disorders.

In a large community sample with N = 36,984 Sareen et al.<sup>12</sup> showed a considerable discrepancy with regard to chronic pain between patients with and without a PTSD diagnosis. In patients suffering from PTSD

46% also reported chronic back pain (compared to 21% without PTSD) and 33% reported migraine (compared to 10%).

The prevalence of pain in PTSD samples is, according to Otis, Keane and Kerns,<sup>13</sup> 34-80% substantially higher than the PTSD prevalence in pain patients ranging between 10% and 50%. This difference may be explained by the fact that many traumatic events are associated with physical injury. Norman et al.<sup>14</sup> examined 115 patients at the Trauma Center of the University of California San Diego. It emerged that peritraumatic pain is a risk factor for PTSD. According to the authors, the relationship can be explained by a mediation effect: peritraumatic pain may lead to more negative evaluations of the trauma memory and more distress associated with the traumatic event.

Dirkzwager et al.<sup>15</sup> investigated the way in which PTSD may influence the development and the chronification of pain symptoms. With a longitudinal study on survivors of a firework disaster in the Netherlands, the authors conclude that PTSD may be a potential risk-factor in the development of physical health problems: 18 months in the aftermath of the disaster PTSD survivors reported more pain symptoms and more restrictions in their daily life because of physical problems compared to those who show no PTSD symptoms.

For a better understanding of the relationship and the reciprocal maintenance of PTSD and chronic pain it is necessary to take a closer look at the risk factors for the development of the two disorders.

#### *Risk factors for PTSD and chronic pain*

Brewin et al.<sup>16</sup> identified in a meta-analysis with 85 studies the following variables as predictors for PTSD: the intensity of the traumatic event and posttraumatic factors like missing social support and additional

life stress. In addition being female, prior trauma and history of psychopathology emerged as risk factors. Empirical evidence shows that the substantial discrepancy between the lifetime-prevalence of a traumatic experience (over 50%) and the lifetime-prevalence of PTSD (about 7%) can be largely explained by the nature of the traumatic event: individuals who experience a man-made traumatic event (e.g. rape) are more likely to develop PTSD than victims of natural disasters (e.g. earthquake or hurricane).<sup>17</sup>

Furthermore, individuals who experience a trauma that included bodily injury like torture survivors show an eight times higher risk for development of PTSD than individuals who experienced traumatic events without physical injury.<sup>18</sup> Similar results were found in a study with Iraq war veterans.<sup>19</sup> Of those veterans who were wounded or injured 32% met PTSD criteria, compared to only 14% of those who were not injured. Besides the aforementioned trauma related aspects, cognitive factors have become a key focus in the development of PTSD: the perceived uncontrollability, negative appraisals of the trauma and its consequences and inadaptable control strategies such as avoidance are of crucial importance.<sup>20,21</sup>

As in PTSD, cognitive processes prove to play an important role in the development and maintenance of chronic pain. Empirical evidence suggests that pain related fear is a significant predictor for chronification in pain symptoms. Picavet, Vlaeyen and Schouten<sup>22</sup> investigated the influence of catastrophizing and kinesiophobia (fear of movement/fear avoidance beliefs) on chronic back pain. It emerged that high levels of catastrophizing and fear-avoidance beliefs predicted lower back pain with significant disability at a six months follow up. Woby et al.<sup>23</sup> examined the influence of cognitive fac-

tors on perceived pain intensity in chronic pain patients. It turned out that self-efficacy and catastrophizing explained 30% of the variance in pain intensity. In addition, research revealed that it was not the severity of injury which was associated with back pain but rather psychological and social factors such as stress that predicted chronic pain. These aspects increase the likelihood for the development of pain up to 13 times.<sup>24, 25</sup> As refugees have a higher risk for psychosocial problems, these results may be especially relevant to this group.

The fact that all studies mentioned above are cross-sectional implicates that the direction of causality stays ambiguous. Although the chronification of pain is a very complex and multifactorial problem with interrelationships of somatic, psychological and social factors, cognitive factors and the avoidance aspect emerged as crucial aspects in the development of chronic pain and PTSD.

To specify the mechanisms of PTSD and chronic pain development after a traumatic event, below we will discuss the most important models concerning PTSD and pain development. Furthermore empirical data examining the development of pain after traumatic events will be presented.

#### *Development and maintenance of PTSD and chronic pain*

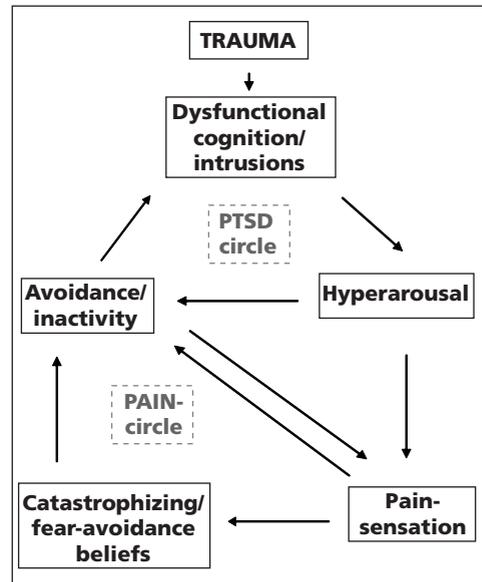
One of the most cited PTSD models is the well-established and validated model of Ehlers and Clark<sup>21</sup> which attributes cognitive processes a crucial role. According to this model, negative appraisals of the trauma and its consequences and certain characteristics of the trauma memory (such as poor elaboration and integration, strong priming and associative learning) predict the development of PTSD in the aftermath of a traumatic event. For the maintenance of PTSD, the authors suggest cognitive and behavioural

aspects such as avoidance of trauma reminders or safety behaviours that individuals use to control the threat and symptoms.

For chronic pain, the fear avoidance model<sup>26</sup> is one of the most important models. It offers a mechanism of how the development from acute pain to chronic pain can be explained and how the avoidance aspect plays a crucial role. The model stresses the role of catastrophic interpretations following a pain experience and subsequent fear and hypervigilance. The fear that physical activity will cause harm and therefore worsen the pain problem leads to avoidance of activity. Research supports that fear avoidance beliefs are strongly related to chronic pain and disability.<sup>27</sup>

Concerning the development of pain in the aftermath of a traumatic event, it is important to note that the crucial factor, and a better predictor for the development of pain, is not the trauma alone but PTSD.<sup>24,28</sup> Tagay et al.<sup>29</sup> found in a study (N=483), that patients suffering from PTSD showed significantly more somatoform symptoms than traumatized patients without a PTSD diagnosis. Hoge et al.<sup>19</sup> examined the association of PTSD with somatic symptoms among Iraq war veterans and found that all health measures (e.g. poor self related health, two or more sick call visits, somatic symptoms) were strongly associated with PTSD, even after controlling injury sustained in combat. One third of the soldiers who screened positive for PTSD had high somatic symptom severity. Campbell and colleagues<sup>30</sup> revealed in their study with female veterans (N=268) that PTSD fully mediated the relationship between violence and physical health symptomatology.

On the basis of the well-established models and the aforementioned findings, we developed the Perpetual Avoidance Model (PAM)<sup>31</sup> which provides an explanation for



**Figure 1.** *The Perpetual Avoidance Model (Liedl & Knaevelsrud).*

the development and mutual maintenance of PTSD and chronic pain. The single components and their interaction will be presented in the following section.

#### *The Perpetual Avoidance Model*

As can be seen in Figure 1, the PAM consists of two circles: the PTSD and the PAIN circle.

According to the PTSD model of Ehlers and Clark<sup>21</sup> cognitive, affective and behavioural aspects are taken into consideration in the PTSD circle. Dysfunctional cognitive processing during and in the aftermath of the traumatic event leads to an increase of psychological and physical arousal. Flashbacks or intrusive memories with a “here and now” quality increase the (bodily) arousal in form of increased heart rate, blood pressure, muscle tension and gastrointestinal activity. These physiological

symptoms result in avoidance. Moreover, hyperarousal may directly increase pain sensation and reinforce negative beliefs and fears that activities will be painful. The consequence of these misinterpretations (fear avoidance beliefs) is the avoidance of movements or activities. The inactivity responds on the perceived pain sensation and vice versa. The PAIN circle results in increased avoidance and eventually leads to inactivity and depression.

To empirically validate the PAM, we will subsequently present a number of studies which examine the interactions of the different components of the PAM.

The link between PTSD and psychophysiological variables such as hyperarousal indicated by muscle tension, heart rate, skin conductance or blood pressure is well proven (for a review see Pole<sup>32</sup>). According to Blechert et al.<sup>33</sup> PTSD related hyperarousal is significantly related to high sympathetic activity (e.g. increased heart rate) with parallel low parasympathetic cardiac control. The important role of the sympathetic nervous system in pain patients is also well known. A study with chronic back pain patients (N=39) conducted by Gockel et al.<sup>34</sup> revealed a significant association between heart rate variability and perceived physical impairment. As McFarlane<sup>35</sup> pointed out in his article about stress related musculoskeletal pain, protective muscular activity can emerge after a traumatic event and escalate into a cycle of neck pain and headaches. Wall & Melzack<sup>36</sup> argued that the association between emotional stress and increased pain severity can be explained by increasing activity in the central nervous system, autonomic nervous system and musculoskeletal system.

The key aspect of avoidance in the development and maintenance of PTSD is discussed in the review by Nemeroff et al.<sup>37</sup> on the basis of a study conducted by North et

al.: North and colleagues examined psychiatric disorders among survivors of the Oklahoma City bombing (N=182). They showed that despite the fact that only 36% met the criteria for avoidance symptoms (over the first six months after the disaster), 94% of those had a diagnosis of PTSD.

Taking into consideration the dysfunctional cognitions, there is much evidence for their influence on pain-sensation (for review see Tunks, Weir & Cook<sup>38</sup>). In a study with chronic pain patients (N=156) Turner et al.<sup>39</sup> found that cognitive variables such as changes in pain beliefs, catastrophizing, pain self-efficacy and perceived controllability turned out as mediators for the improvement in pain and activity one year after a cognitive behavioural therapy. Furthermore a substantial body of empirical evidence emphasizes the crucial role of fear avoidance beliefs in chronic pain patients (e.g. Leeuw et al., 2007). Grotle, Vollestad & Brox<sup>40</sup> showed in a prospective cohort study (N=173) of acute and low back pain that patients with chronic low back pain had more fear avoidance beliefs than patients with acute low back pain.

The Perpetual Avoidance Model offers different treatment implications. Based on these components of the PAM that are assumed to be responsible for the maintenance of both disorders the authors propose specific interventions that might be useful to integrate into the treatment of PTSD and chronic pain.

#### *Treatment implications*

An important and one of the first components in treating traumatized patients with chronic pain should be a theoretical model educating them about the relationship between chronic pain and PTSD. The understanding of the function of cognitive and behavioural avoidance and the interaction of

hyperarousal, catastrophizing, avoidance and pain perception is of crucial importance.

Cognitive and behavioural avoidance/inactivity as part of the PTSD circle and as part of the PAIN circle play a significant role in the PAM. Therefore an important aim in treating PTSD and chronic pain should be to break the vicious circle of mutual maintenance by reducing the avoidance. Well-tested and standard treatment methods for PTSD are exposure strategies. In confronting patients with their traumatic and feared experiences patients learn to reinterpret the situation and see it as part of their past. The “here and now” quality of the reminders will be changed and integrated in the autobiographical memory.

Exposure strategies are also helpful in treating chronic pain: pain patients are invited to engage in physical activities that were previously avoided because of fear of causing more pain. The exercises should be designed to help patients focus and cope with uncomfortable physiological sensations and reduce fear avoidance beliefs (e.g. “Physical activity might harm my back”). These experiences help patients to restructure misinterpretations and catastrophizing and get out of the inactivity. Maquet and colleagues<sup>41</sup> highlighted in their review the vicious cycle of pain and avoidance/inactivity behaviours. Based on several studies they affirmed the benefits of physical exercises for pain patients on parameters like pain-threshold, well-being, self-confidence and feelings of helplessness. Consequently physical activity can help to break the vicious circle of chronic pain and inactivity.

For reducing the general high somatic arousal, relaxation techniques such as Progressive Muscle Relaxation or diaphragmatic breathing are helpful treatment approaches. In combination with biofeedback, a well established treatment method with pain

patients, patients learn to influence internal physiological responses. Thereby they gain control over their body and increase the sense of self-efficacy. One of the most common types of biofeedback is Electromyography (EMG): the muscle tension in the pain area is measured and recorded back (visual or auditory) to the patients. In a first step they become aware of internal biological activity such as muscle tension and body reactions in different situations (stressful/trauma situations versus relaxed situations). In a second step, patients learn to reduce their high tension and thus to control their pain experience. Moreover the positive effects should be supported by physical activation: fitness exercises can help patients to improve body awareness and general well being.

With these treatment methods all crucial elements of the PAM PAIN circle will be addressed: hyperarousal and pain sensation (relaxation techniques), catastrophizing and avoidance (biofeedback, physical activation). Because of the overlapping elements in the PTSD and PAIN circle (hyperarousal and avoidance) the aforementioned treatment methods are also helpful for the improvement of the PTSD symptomatic.

An effective therapy for traumatized patients suffering from PTSD and chronic pain should therefore combine psychoeducation of the development and maintenance of PTSD and chronic pain and biofeedback with exposure-strategies, relaxation techniques and physical activation.

The advantage of a physiologically oriented intervention such as biofeedback can be very helpful in treating refugees from non-Western cultures. These patients tend to have a rather somatic understanding of illness. It is essential to take this into account by applying a physiologically oriented intervention. The presented treatment methods

– a combination of biofeedback, exposure strategies and relaxation techniques – is therefore a very promising therapy for tortured refugees, suffering from PTSD and chronic pain. The Treatment Center for Torture Victims in Berlin – in cooperation with the University of Zurich, the University of Dresden and the University of Southampton – is examining a biofeedback-based cognitive behavioral therapy for traumatised refugees with chronic pain that combines the mentioned components.<sup>42</sup> Preliminary data of a pilot study show promising results.<sup>43</sup>

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# Asylum seekers in Denmark

*A study of health status and grade of traumatization of newly arrived asylum seekers*

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## Abstract

**Background:** An unknown number of asylum seekers arriving in Denmark have been exposed to torture or have experienced other traumatising events in their country of origin. The health of traumatised asylum seekers, both physically and mentally, is affected upon arrival to Denmark, and time in asylum centres leads to further deterioration in health.

**Methods:** One hundred forty-two (N=142) newly arrived asylum seekers were examined at Center Sandholm by Amnesty International Danish Medical Group from the 1st of September until the 31st of December 2007.

**Findings:** The asylum seekers came from 33 different countries, primarily representing Afghanistan, Iraq, Iran, Syria, and Chechnya. Of the asylum seekers, 45% had been exposed to torture – approximately one-third within the year of ar-

rival to Denmark. Unsystematic blows, personal threats or threats to family, degrading treatment, isolation, and witnessing torture of others were the main torture methods reported. The majority of the asylum seekers had witnessed armed conflict, persecution, and imprisonment. The study showed that physical symptoms were approximately twice as frequent and psychological symptoms were approximately two to three times as frequent among torture survivors as among non-tortured asylum seekers. However, even the health of non-tortured asylum seekers was affected. Among the torture survivors, 63% fulfilled the criteria for post-traumatic stress disorder, and 30-40% of the torture survivors were depressed, in anguish, anxious, and tearful in comparison to 5-10% of the non-tortured asylum seekers. Further, 42% of torture survivors had torture-related scars.

**Interpretation:** Torture survivors amid newly arrived asylum seekers are an extremely vulnerable group, hence examination and inquiry about the torture history is extremely important in order to identify this population to initiate the necessary medical treatment and social assistance. Amnesty International Danish Medical group is currently planning a follow-up study of the present population which will focus on changes in health status during their time in Denmark.

**Keywords:** torture; health status; post-traumatic stress disorder; physical examinations; interview; Denmark; survivors

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## Introduction

In recent years, the number of asylum seekers arriving in Denmark has decreased. Currently, around 2,000 asylum seekers come to Denmark each year.<sup>1</sup> An unknown number of these asylum seekers has been tortured or experienced other traumatising events in their country of origin. Several studies show that the health of traumatised asylum seekers, both physically and mentally, is affected upon arrival in Denmark, and that the waiting time in asylum centres leads to further deterioration of their health.<sup>2-8</sup>

As a result of this knowledge, Amnesty International Danish Medical Group conducted a study, where all newly arrived asylum seekers, who arrived at Center Sandholm, were offered a health examination within the first few days after arrival. The study had two objectives, one was to identify the number of asylum seekers having been exposed to torture, severe war trauma, or other traumatising events prior to their arrival. The second objective was to assess the asylum seekers general health status upon arrival and the health related consequences of exposure to torture. Amnesty International Danish Medical Group consists of doctors, who document torture, both nationally and internationally. The Medical Group has more than 30 years of experience and its members have received specific training enabling them to examine potential torture survivors. The project was conducted in collaboration with the Danish Red Cross. All medical examinations were performed at Center Sandholm.

## Materials and methods

From the 1st of September until the 31st of December 2007, Amnesty International Danish Medical Group offered a health examination to all newly arrived asylum seekers at Center Sandholm. Center Sandholm

is responsible for the registration of all newly arrived asylum seekers in Denmark, except for unaccompanied children under the age of 18 years. Two project coordinators were employed by Amnesty International and worked at Center Sandholm. The project coordinators were responsible for making contact with the newly arrived asylum seekers and for providing general information about the project including information about voluntary participation, anonymity of identity, and confidentiality of data collected by Amnesty International Danish Medical Group. Written information about the project had been prepared in seven different languages (available on request), with the intention that most asylum seekers should be able to read the information in their mother tongue. During the medical examination the asylum seeker received additional information about the project and if they wished to participate they gave their written informed consent.

If written material or consent form was not available in the mother tongue of the asylum seekers, a translator was used and an English or Danish consent form was used. The routinely used Red Cross' telephone translators in the Center Sandholm were used during the vast majority of the medical examinations. Translators were not used if the asylum seeker and the examiner were able to communicate in the same language. The study intended to include all newly arrived asylum seekers regardless of age, however all children under the age of 18 were required to have a parent or a guardian present during information and examination. Unaccompanied children were not examined.

The medical examination lasted on average one hour and took place in Center Sandholm's medical examination rooms. The medical examination consisted of a structured interview (questionnaire available

on request), which sought to disclose the following information:

- Background (age, country of origin etc.)
- Imprisonment, torture and other traumatizing events
- Health status prior to traumatizing event
- Current physical and psychological symptoms
- Self rated psychological health status
- Current use of medicine and abuse
- Objective physical and psychological health status

The definition of torture and the medical examination were based on the principles described in the United Nation's "Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment".<sup>9</sup> The World Health Organization's (WHO) International Classification of Disease Codes (ICD-10)<sup>10</sup> was used for diagnosing Posttraumatic Stress Disorder (PTSD).

The WHO's General Health Questionnaire was used for the self-judged psychological health status.<sup>11,12</sup> Scores vary by study population. Scores about 11-12 are typical. A score >15 is evidence of distress. A score >20 suggests severe problems and psychological distress.

In both the physical and psychological examination of the asylum seekers, emphasis was placed on finding a connection to torture sequel.

No advanced investigations, such as for example gynaecological examinations or radiological examinations, were carried out.

#### *Ethics*

The project was reported to the local ethical committee in June 2007. The committee had no objection to the execution of the project.

The project was also reported to the Danish Data Protection Agency. The considerations of Amnesty International Danish Medical Group in relation to the present project are based on the following ethical codes and protocols: The International Code of Medical Ethics,<sup>13</sup> the Helsinki Declaration,<sup>14</sup> and the ethical protocol described in the United Nation's "Istanbul Protocol".<sup>9</sup>

The medical interview conducted by the doctors within Amnesty International Danish Medical Group had no curative purpose, however, if during an examination the doctor found that an asylum seeker needed medical treatment, the doctor contacted the health personnel at the Red Cross after having received verbal consent from the asylum seeker in order to let the Red Cross initiate the appropriate diagnostic and treatment.

All asylum seekers exposed to torture can free of charge have a more detailed medical examination done by the Amnesty International Danish Medical Group. The medical report can be used as documentation in their asylum case.

The Amnesty International Danish Medical Group is financially independent and all asylum seekers and doctors have participated voluntarily in this study.

The asylum seekers were informed that Amnesty International and Danish Red Cross are politically independent organizations and that participation in the project would have no consequences for the asylum seekers' asylum case in Denmark.

#### **Results**

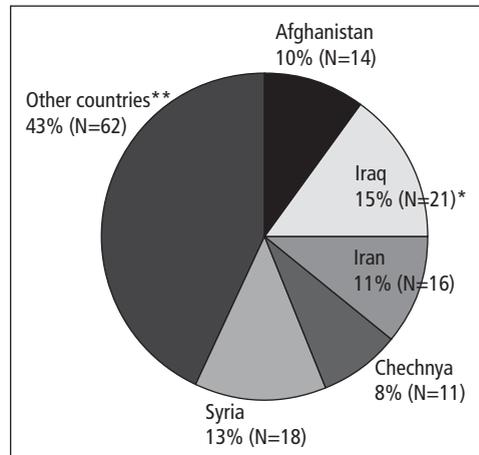
According to The Ministry of Refugee, Immigration and Integration Affairs in Denmark, 720 asylum seekers arrived in Denmark during the project period.<sup>1</sup> Amnesty International's project coordinators were in contact with 164 asylum seekers at Center Sandholm during the project period. Four

of these did not wish to participate in the project and 18 asylum seekers had agreed to participate, but did not show up for the medical examination. Consequently, a total of 142 people were included in the project. Ten of the 142 asylum seekers were Iraqi asylum seekers, who had been granted asylum due to their work for the Danish armed forces in Iraq.

The asylum seekers in the study population came from 33 different countries, mainly Afghanistan, Iraq, Iran, Syria and Chechnya (Figure 1). The average age of the included asylum seekers at the time of the examination was 32 years (16-73 years), among these were 29% (N=41) women and 71% (N=101) men. As for education, 17% (N=24) had 5 years, 41% (N=58) had 5-10 years, and 42% (N=60) had more than 10 years of schooling. At the time of the medical examination, 44% (N=63) of the asylum seekers were married, 48% (N=68) were unmarried and 7% (N=10) were divorced or widowers. One asylum seeker did not disclose his civil status.

A total of 45% (N=64) of the asylum seekers stated that they had been exposed to torture, of these 14% (N=9) were women, and 86% (N=55) were men. They will in the following be referred to as torture survivors. Among the torture survivors, 31% (N=20) had been tortured within the year that they arrived to Denmark, 36% (N=23) in the period of 2002 to 2006, and 22% (N=14) before 2002. In 11% (N=7) of the cases the year of the torture was not disclosed.

In 81% (N=49) of the cases of torture survivors the examining doctor evaluated that there was a strong correlation between the stated torture history, the symptoms, and the objective findings. In 13% (N=8) of the cases the examining doctor found that there was some correlation between the stated torture history, the symptoms, and the ob-



**Figure 1.** Nationality of the asylum seekers (N=142).

\*) Among the asylum seekers there were 10 Iraqi asylum seekers, who had been granted asylum, due to their work for the Danish armed forces in Iraq.

\*\*\*) "Other countries" cover the following 28 countries: Algeria (1%), Angola (1%), Armenia (1%), Azerbaijan (2%), Bhutan (1%), Bosnia (3%), Democratic Republic of Congo (1%), Eritrea (1%), Gambia (1%), India (3%), Kina (1%), Kosovo (3%), Croatia (1%), Lebanon (3%), Macedonia (1%), Marocco (1%), Montenegro (1%), Nigeria (2%), Pakistan (2%), Palestine (1%), Russia (1%), Serbia (1%), Senegal (1%), Somalia (2%), Sri Lanka (4%), Sudan (1%), Turkey (1%), Zimbabwe (1%).

jective findings of the torture survivor, and in 5% (N=3) it was evaluated that there was no correlation between the stated torture history, the symptoms, and the objective findings.

Of the entire population, 44% (N=62) had been imprisoned prior to their arrival in Denmark, 59% (N=83) had witnessed armed conflicts, and 68% (N=97) had experienced persecution (Table 1).

#### Methods of torture

Among the 64 torture survivors, 91% (N=58) had been subject to unsystematic blows, 88% (N=56) to personal threats or

**Table 1.** Types of traumatisations of the asylum seekers prior to arrival in Denmark.

Trauma	All asylum seekers (N=142) N (%)	All torture survivors (N=64) N (%)	Female torture survivors (N=9) N (%)	Male torture survivors (N=55) N (%)	Non-tortured asylum seekers (N=78) N (%)	Female non-tortured asylum seekers (N=32) N (%)	Male non-tortured asylum seekers (N=46) N (%)
Torture	64 (45)	64 (100)	9 (100)	55 (100)	0 (0)	0 (0)	0 (0)
Imprisonment	62 (44)	52 (81)	5 (56)	47 (85)	10 (13)	1 (3)	9 (20)
Armed conflict	83 (59)	40 (63)	7 (78)	33 (60)	43 (56)	16 (50)	27 (59)
Persecution	97 (68)	58 (91)	9 (100)	49 (89)	39 (50)	16 (50)	23 (50)

**Table 2.** Applied methods of torture.

Torture methods	All torture survivors (N=64) N (%)	Female torture survivors (N=9) N (%)	Male torture survivors (N=55) N (%)
Unsystematic blows, incl. with object	58 (91)	7 (78)	51 (93)
Falanga	25 (40)	4 (50)	21 (38)
Suspension	19 (30)	2 (25)	17 (31)
Electric torture	16 (25)	1 (13)	15 (27)
Forced positions	25 (40)	2 (29)	23 (42)
Isolation	41 (65)	5 (56)	36 (67)
Personal threats or threats to family	56 (88)	8 (89)	48 (87)
Witness to torture of others	40 (63)	7 (88)	33 (60)
Mock execution	18 (29)	2 (25)	16 (29)
Degrading treatment	56 (88)	8 (89)	48 (87)
Sexual abuse	6 (10)	4 (44)	2 (4)

In addition to the above methods the following methods were also used: Sleep deprivation, forced confessions, witness to hanging of fellow prisoners, threats with knives to cut out organs (eyes, liver, heart), being forced to drink urine, denial of food and water, forced labour incl. in bad weather, being kept in a hole, stabbing with knives and needles, blindfolding and being pushed around, burning on hands and feet, being forced to look directly at the sun, being placed into ice-cold water, ligation of penis, fixation to bench with stick in between legs.

threats to family, 88% (N=56) were subjected to degrading and inhuman treatment, 65% (N=41) had been put into isolation, and 63% (N=40) had witnessed torture of others (Table 2).

The torture survivors were most frequently from Afghanistan, Iran, Syria and Chechnya. Only 1% (N=1) of the asylum seekers from Iraq had been tortured, while 57% (N=8) of the asylum seekers from Af-

ghanistan, 44% (N=7) of the asylum seekers from Iran, 78% (N=14) of the asylum seekers from Syria, and 45% (N=5) of the asylum seekers from Chechnya had been tortured. Among the Syrian torture survivors 12 of the 14 persons were of Kurdish origin.

The level of education and civil status among the torture survivors was comparable to the rest of the study population.

**Table 3.** Physical and psychological symptoms present in the study population upon arrival in Denmark (i.e. symptoms within two weeks of the medical examination).

Symptoms	All asylum seekers (N=142) N (%)	Torture survivors (N=64) N (%)	Non-tortured asylum seekers (N=78) N (%)
<i>Physical symptoms</i>			
Headache	76 (54)	48 (75)	28 (37)
Pain or loss of sensibility in the sole of feet	26 (19)	21 (33)	5 (7)
Pain in back and/or neck	66 (48)	44 (69)	22 (30)
Pain in pelvis and/or legs	50 (36)	31 (48)	19 (25)
Pain in arms	41 (30)	26 (41)	15 (20)
Loss of hearing/buzzing in ears/dizziness	42 (30)	26 (41)	16 (21)
Symptoms from the gastrointestinal system	40 (29)	24 (38)	16 (21)
Symptoms from the urinary tract/system	18 (13)	11 (17)	7 (9)
Sexual problems*	16 (13)	10 (17)	6 (9)
<i>Psychological symptoms**</i>			
Recurring bad memories, flashbacks, nightmares	74 (61)	55 (86)	19 (33)
Discomfort in circumstances resembling the traumatic events	68 (57)	53 (84)	15 (27)
Avoidance of situations resembling the traumatic events	54 (45)	44 (71)	10 (18)
Loss of memory of parts of the traumatic events	23 (19)	22 (35)	1 (2)
Sleeping difficulties	77 (63)	51 (80)	26 (45)
Heightened irritability	60 (50)	42 (67)	18 (32)
Difficulty in concentration	65 (53)	45 (70)	20 (34)
Alertness	61 (51)	48 (76)	13 (23)
Increased vigilance	53 (45)	40 (63)	13 (24)

\*) 13 % of the asylum seekers were not asked about sexual problems, as it seemed inappropriate and too insisting to ask.

\*\*) Only about 85% of the asylum seekers answered questions about psychological symptoms.

### Health

A total of 32% (N=45) of the asylum seekers had prior to their arrival in Denmark and independently of exposure to torture, experienced relatively chronic health-related problems. The health problems were generally related to diseases of arms/legs/back, cardio-vascular diseases and bowel-diseases. Among the torture survivors, 38% (N=24) had health issues, in comparison to only 27% (N=21) of the non-tortured asylum seekers.

The distribution of symptoms present in the study population upon arrival in

Denmark (i.e. symptoms within two weeks prior to the medical examination) is illustrated in Table 3. Physical symptoms are approximately twice as frequent among torture survivors as among asylum seekers who had not been tortured, whereas psychological symptoms were two-three times more frequent. Of the physical symptoms, headaches, pain in extremities and back/neck were most frequent, whereas recurring memories, discomfort in circumstances resembling the traumatic event, nightmares, and sleeping difficulties were the most frequent psychological symptoms among the torture survi-

**Table 4.** Objective physical findings among the torture survivors.

Objective physical examination	Torture survivors (N=64) N (%)
Scars compatible with torture	26 (42)
Facial/head injuries compatible with torture	7 (11)
Injuries to eyes/ears/nose/throat compatible with torture	4 (6)
Injuries to mouth/teeth compatible with torture	4 (7)
Pathological alterations of heart and lungs	3 (5)
Pathological alterations of abdomen	7 (11)
Impaired mobility of musculoskeletal system compatible with torture	15 (24)
Sequel of fractures of arms/legs/back compatible with torture	7 (11)
Neurological injuries compatible with torture	5 (8)

**Table 5.** Objective psychological findings of all asylum seekers.

Objective psychological examination	All asylum seekers (N=142) N (%)	Torture survivors (N=64) N (%)	Non-tortured asylum seekers (N=78) N (%)
Anxious	20 (14)	17 (27)	3 (4)
Depressive	35 (25)	27 (42)	8 (11)
Tearful	24 (17)	16 (25)	8 (11)
Confused	5 (4)	5 (8)	0 (0)
In anguish	28 (20)	25 (39)	3 (4)
Psychotic	5 (4)	4 (6)	1 (1)

vors. In the entire study population, 34% (N=48) fulfilled the criteria of PTSD, 51% (N=72) did not fulfil the criteria, and 15% (N=22) had not answered all questions pertaining to the PTSD diagnosis.

Among the torture survivors 63% (N=40) fulfilled the criteria for PTSD, whereas only 10% (N=8) of the asylum seekers who had not been tortured were diagnosed with PTSD. The WHO's General Health Questionnaire was completed by 128 of the 142 asylum seekers. The average score within the entire study population was 17 (range 3-36). The torture survivors had an average score of 20 (range 5-36), in comparison to asylum seekers who had not been tortured, who had an average score of 14 (range 3-28).

In total, 6% (N=9) of the asylum seekers were receiving antidepressants. Among the

torture survivors, 11% (N=7) took antidepressants in comparison to only 3% (N=2) among the non-tortured asylum seekers. In the whole study population, 20% (N=29) took painkillers; the distribution among torture survivors and non-tortured asylum seekers was 28% (N=18) and 14% (N=11) respectively.

Only one of the asylum seekers indicated having an alcohol abuse problem, this asylum seeker had been tortured.

The most common objective physical findings among torture survivors were tissue injuries (scars) and impaired mobility in the musculoskeletal system as a consequence of the torture (Table 4). There were also many objective psychological findings among the torture survivors in comparison to the non-tortured asylum seekers (Table 5). Depressed mood, tension/uneasiness, anxiety,

and tendency to cry were the most common objective psychological findings among the torture survivors. In four cases the examining doctor diagnosed the torture survivors with psychoses.

### Discussion

During a four-month period in 2007, 142 of 720 newly arrived asylum seekers to Denmark were medically examined by Amnesty International in collaboration with the Danish Red Cross. The objective of the project was to determine the share of asylum seekers having been exposed to torture and other traumatising events, as well as to assess the asylum seekers' general health status. To achieve this objective a medical examination of newly arrived asylum seekers was conducted. However, it was not possible to make contact with all the newly arrived asylum seekers, because not all of them passed through the Center Sandholm. Women travelling on their own were moved to Center Fasan, children without a parent or guardian were moved to Center Gribskov, and other refugees continued to other countries in order to seek asylum there. In addition to this, the time spent at Center Sandholm was often short before the asylum seekers were moved to other centres or living areas in Denmark. Only a limited number of asylum seekers decided not to participate or did not show up for the medical examination. The reasons for this could be miscommunication or cultural misunderstandings. The asylum seekers who did participate in the project came from countries that Denmark primarily has been receiving asylum seekers from over the recent years.<sup>1</sup> The asylum seekers who participated in the project were predominantly young men with more than pre-school education, with equal distribution between married or single. This distribution of the above mentioned parameters is com-

parable to the distribution of these parameters among all newly arrived asylum seekers in Denmark when considering the recent statistical survey published by The Ministry of Refugee, Immigration and Integration Affairs.<sup>1</sup>

This project showed that almost half (45%) of the medically examined asylum seekers had been tortured in various degrees and in most cases this had happened within the past years. The study showed that the torture survivors were primarily men from the Middle East and Chechnya. The methods of torture were common and previously well described from many parts of the world. This project showed that unsystematic blows and kicking, isolation, threats, witness to torture and degrading treatment were the most frequent types of torture. In a Norwegian study from 2007, 85 relatively newly arrived asylum seekers filled out a questionnaire concerning among other things traumatising events and psychological well-being. Among the person interviewed, 57.5% indicated that they had been tortured.<sup>15</sup>

Previous reports from Denmark have also indicated relatively high frequencies of torture survivors among asylum seekers, but in more selective populations.<sup>16,17</sup> In a cohort of asylum seekers from the 1990's from the Middle East approximately half the male asylum seekers had been tortured<sup>17</sup> and 28% of parents with children.<sup>16</sup> A study, published in 1996, based on an unselected material of newly arrived male asylum seekers from various countries, found that approximately 20% had been tortured.<sup>18</sup>

The prevalence of torture survivors seeking asylum will always reflect the existing national and international political situation. This study demonstrated a relatively high prevalence of torture survivors, considering that this was an unselected population of asylum seekers. As previously mentioned,

the number of asylum seekers arriving in Denmark has decreased over the past years, however the prevalence of torture survivors remains high among the asylum seekers in this study. The high number of torture survivors among asylum seekers to Denmark has to be taken into consideration by the political, legal, social, and health professional systems dealing with asylum seekers on a daily basis.

The high frequency of physical and psychological symptoms among all the asylum seekers is a clear indication that their health is affected. Furthermore, torture survivors as an especially vulnerable group among the asylum seekers had a much higher prevalence of psychological symptoms. Many fulfilled the PTSD diagnosis and in general they had a high score in the General Health Questionnaire.

The various health-related symptoms among the asylum seekers in Denmark may have been caused by other traumatising events than torture, such as the flight, the armed conflict and the separation from family, although exposure to torture still seemed to be one of the most crucial factors for the many health-related problems of newly arrived asylum seekers. This is also supported by the prevalent finding of 34% PTSD among all newly arrived asylum seekers, but with a marked difference in the prevalence of the diagnosis between torture survivors and non-tortured asylum seekers. Medical examination and questioning about torture is therefore essential in the identification of asylum seekers who have an increased need for professional and social assistance.

The findings from the objective medical examination were dominated by psychological findings among torture survivors. In this project there was a high degree of correlation between the stated torture history, the symptoms, and the objective findings of

the torture survivors. Objective findings can be of both physical and psychological nature and both are considered in the overall evaluation of the history of the torture survivors. Among some torture survivors objective physical finding cannot be identified. This may be due to the fact that certain methods of torture do not leave visible or lasting signs or scars. Thus a lack of objective findings does not exclude exposure to torture.

Several studies have shown that long waiting periods before being granted or rejected asylum have a negative impact on health status, especially on mental health status.<sup>5,7,19</sup> Amnesty International Danish Medical Group is currently planning a follow up study of the population of the present project in order to examine how the health of the asylum seekers is affected during their stay in Denmark, and furthermore to investigate if there is any correlation between having been exposed to torture and being granted asylum in Denmark.

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# A follow-up study of allegations of ill-treatment/torture in incommunicado detainees in Spain

*Failure of international preventive mechanisms*

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## Abstract

**Background:** Proper documentation is an important factor in torture prevention, thus making systematic research studies necessary. According to international reports, torture/ill-treatment continues to exist in Spain in relation to Basque people arrested under anti-terrorist legislation (incommunicado detention). To improve the safeguards of these detainees, the European Committee for the Prevention of Torture (CPT) has visited Spain and published recommendations. However, the Spanish Government has not implemented these recommendations. The primary aims of this study were to analyze the methods of torture claimed by Basque incommunicado detainees during 2000-2005 and to compare them with the findings of a previous study (1992-1993), as well as to evaluate the impact of the CPT recommendations. The influence of variables related to police ill-treatment were also studied.

**Methods:** This retrospective study is based on the testimonies given voluntarily by 112 Basques held incommunicado during 2000-2005. Testimonies were collected by a non-governmental organisation.

**Findings:** Threats (91%) and beatings (89%) were the most frequent alleged methods, followed by suffocation, deprivation methods, forced body position, undressing and physical exercises (percentage between 49% and 29%). The frequency of suffocation, electricity, visual input reduced and threats was lower in 2000-2005 than in the 1992-1993 period. Different patterns of torture related to each police force were detected. The group arrested by the Guardia Civil alleged more severe torture methods, while the detainees arrested by Ertzantza alleged less severe ill-treatment. The prevalence of sexual torture was higher for women than for men. The present data are in consonance with the findings described for international organisations after their visits to Spain.

**Interpretation:** These findings, in addition to other evidence, suggest that torture is still a serious problem in Spain in relation with Basque incommunicado detainees. This fact shows that national and international (mainly based on CPT visits) measures of control/prevention have failed. This study supports the importance of scientific statistical analysis in the documentation of human rights violations and its potential use in order to improve the forensic evaluation of torture victims.

**Keywords:** torture; ill-treatment; prevalence; prevention; forensic medicine

## Introduction

Torture is one of the most severe forms of the violation of human rights. Proper documentation and assessment are considered

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to be important strategies in the prevention of torture.<sup>1,2</sup> However, systematic data on national and regional variations in torture practices are scarce because epidemiological reports of cases of violations of human rights are, by their very nature, extremely difficult to carry out. Several studies have shown that the methods of torture may vary a great deal between countries and regions. However, systematic research studies are necessary in order to improve the assessment of torture.<sup>3</sup>

As in other regions with political conflicts, torture/ill-treatment continues to exist in Spanish police stations in relation to Basque people arrested under anti-terrorist legislation.<sup>4-12</sup> Such persons, to whom a highly specific legal framework is applied (incommunicado detention with suspension of some rights), constitute a very small minority of persons deprived of their liberty in Spain. In a previous study in the period 1992-1993 we analyzed the prevalence and methods of torture claimed in the Basque Country (Spain).<sup>5</sup> Since 1990 much attention has been paid to the situation of persons deprived of their liberty in connection with terrorist offences by several international bodies. These organizations have assessed the situation in Spain and have issued recommendations to improve the safeguards of the Basque detainees under the anti-terrorist legislation.<sup>4,6-12</sup> However, the Spanish Government has not implemented these recommendation.<sup>11</sup>

The primary aims of this study were to analyze the methods of torture claimed by Basque detainees arrested under the Spanish anti-terrorist legislation during 2000-2005 and to compare them with the findings of the previous study of the period 1992-1993. Through this comparison we wanted to examine whether international visits to detention centres have been effective. As far as we are aware, no previous scientific analysis

has been done. The influence of variables which have been demonstrated to be factors of importance in police ill-treatment were also studied. In addition, the implications of these findings in forensic documentation are outlined.

### Methods

This retrospective study was based on the testimonies given voluntarily by 112 persons who were arrested in the Basque Country (Spain) during the 2000-2005 period under the Spanish anti-terrorist legislation. This legislation allows incommunicado detention (solitary confinement) for a period of five days. The police forces taking part in the "anti-terrorist fight" in this period were "Guardia Civil" (GC; Spanish military corp), "Policía Nacional" (PN, Spanish civil police force) and Ertzantza (Basque civil police force).

The group against torture, Euskal Herria (known as "Torturaren Aurkako Taldea" [TAT]), has worked since 1992 as a non-governmental organization whose principal objective is the eradication of torture and other cruel, inhuman or degrading punishments.<sup>13</sup> Testimonies were collected by trained members of TAT according to a previously described methodology.<sup>5</sup> In brief, the interview was individual and open on the character of the torture claimed, avoiding leading questions. TAT members gave details to the ex-detainees about the objective of the interview and, if they accepted, signed or oral informed consent was obtained.<sup>13</sup>

The presented material represents all TAT collected testimonies from the period in question, in which there were also official forensic documents related to the detention.

The term "torture" is used in accordance with the definition of the World Medical Association (Declaration of Tokyo, 1975): "Torture is defined as the deliberate, system-

atic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason". The definition of the different methods of torture can be found in other previous publications.<sup>14-16</sup>

In order to monitor data, a simplified version of the protocol of the Rehabilitation and Research Center for Torture Victims (RCT/IRCT)<sup>17</sup> was used. The following methods of physical torture were analyzed: beatings; forced abnormal positions (including standing for prolonged periods), forced gymnastic exercises, electricity, asphyxia methods (obstruction of airway "bolsa", drowning/near drowning "bañera"). These methods were the most frequently used in this region according to our previous report.<sup>5</sup> Only the following methods of psychological torture/ill-treatment were included: detention in isolation cell and its duration (less or more than 96 hours [4 days]), visual input reduced as deprivation; threats as coercion techniques; and forced undressing as sexual torture, which is, in our opinion, representative of the overall psychological methods. Thus, in total, 10 methods of torture were analyzed.

The following demographic and criminological variables were also noted for this study: sex, age, police force which realized the arrest and legal status after the arrest.

The results are expressed as means (standard deviation) of individual values or as percentages. The  $\chi^2$  test with and without Yates' correction, and Fisher's exact test were used in the statistical study in order to evaluate the association between period of time, sex, police force and legal situation after arrest. They were also employed to compare the frequency of the different methods of torture in relation to demographic and

criminological variables. In this analysis, the age variable was coded into three groups: 18-23 years, 24-30 years and over 30. The quantitative variables (age and total number of torture methods alleged by each subject) were compared using Student's t test or Univariate Analysis of Variance. All analyses were carried out using the SPSS (Statistical Package for Social Sciences) program. The level of significance was chosen as  $p < 0.05$ . Only the methods with a frequency higher than 10% were considered in the statistical analysis.

## Results

### *Findings of the 2000-2005 period*

The sample of the 2000-2005 period was made up of 112 incomunicado detainees. The demographic and criminological characteristics are shown in Table 1: there was a high frequency of males (76%) and a relatively low average age (27 years; SD 7 years). The police force most commonly involved in the arrest was the GC and after detention the majority of the detainees were in prison.

The number and frequency of the different types of ill-treatment are shown in Table 2. On the basis of allegations made by detainees, the pattern of ill-treatment was a combination of physical and coercion methods, associated frequently with deprivation and sexual ill-treatment. In relation to beatings, 10 detainees of the GC alleged the method named "sandwich" (the detainee is wrapped with a blanket before being beaten in order to avoid or minimize the physical marks of the beating). Detention time in incomunicado regimen had an average of 4.1 days, being longer than four days (96 hours) for 42% of the detainees (Table 2).

### *Comparison between 2000-2005 and 1992-1993 periods*

The comparison between the two periods

**Table 1.** Demographic and legal variables of the two periods

	<b>2000-2005 period (N = 112) n (%)</b>	<b>1992-1993 period (N = 87) n (%)</b>	<b>Statistical value</b>
Sex			n.s.
Male	85 (76)	70 (80)	
Female	27 (24)	17 (19)	
Age (years)			
18-23	37 (34)	27 (42)	
24-30	49 (45)	20 (31)	
> 30	23 (21)	17 (27)	
Not indicated	3	23	
Media (DS)	27.2 (6.9)	27.4 (8.4)	n.s.
Police force			p < 0.001
Guardia Civil	60 (54)	64 (74)	
Policia Nacional	35 (31)	23 (26)	
Ertzantza	17 (15)	0	
Legal situation after detention			p < 0.001
Freedom	22 (20)	44 (51)	
Imprisonment	86 (80)	42 (49)	

N represents the absolute number of persons in each period of time. The percentage in each group is calculated as percentage ( $n \times 100 / N$ ) of the total number of subjects of each period of time. Missing values were not included in the percentage analysis. The statistical difference between groups was calculated using  $\chi^2$  test and Student's t test. n.s. = not significant.

in relation to demographic and criminological variables showed statistically significant differences in relation to which police force undertook the arrest and the legal situation after detention (Table 1). Regarding the methods of torture, statistically significant differences between the two periods were obtained for the following methods: suffocation with plastic bag, electricity, visual input reduced and threats (Table 2). All of them had a higher frequency during the first period of time, the difference being especially high in electric torture.

*Variables related to the methods of torture in the two periods of time*

In a preliminary analysis the possible inter-relations between the demographic and criminological variables were evaluated.

With regard to significant statistical differences between police forces, the average age of detainees by GC (29; DS 8.3 years) was significantly higher than with the PN (25 years; DS 5.3) and Ertzantza (24 years; DS 4.7 years old) ( $p = 0.001$ ). There were no other significant differences between these variables.

The different methods of torture were compared in relation to the demographic and criminological variables. This study showed that the police force was the most decisive variable (including period of time variable) in practically all methods of ill-treatment. In fact, except for the method of awkward body position (no significant differences), and for threats ( $p < 0.01$ ), all the other types of torture showed statistical significance differences with  $p$  value < 0.001.

**Table 2.** *Methods of alleged torture\**

	<b>2000-2005 period (N = 112) n (%)</b>	<b>1992-1993 period (N = 87) n (%)</b>	<b>Statistical value</b>
<i>Physical torture</i>			
Beating	100 (89)	83 (95)	n.s.
Suffocation with plastic bag, "la bolsa"	55 (49)	55 (63)	p < 0.05
Keeping an awkward body position for an extended period of time	46 (41)	42 (48)	n.s.
Forced physical exercise	32 (29)	30 (34)	n.s.
Electricity	6 (5)	26 (30)	p < 0.001
Suffocation with water "la bañera"			
<i>Deprivation torture</i>			
Isolation cell longer than four days (96 hours) <sup>1</sup>	47 (42)	33 (38)	n.s.
Visual input reduced ("capucha")	48 (43)	55 (63)	p < 0.01
<i>Coercion ill-treatment</i>			
Threats	102 (91)	86 (99)	p < 0.05
<i>Sexual torture</i>			
Forced undressing	36 (32)	32 (37)	n.s.

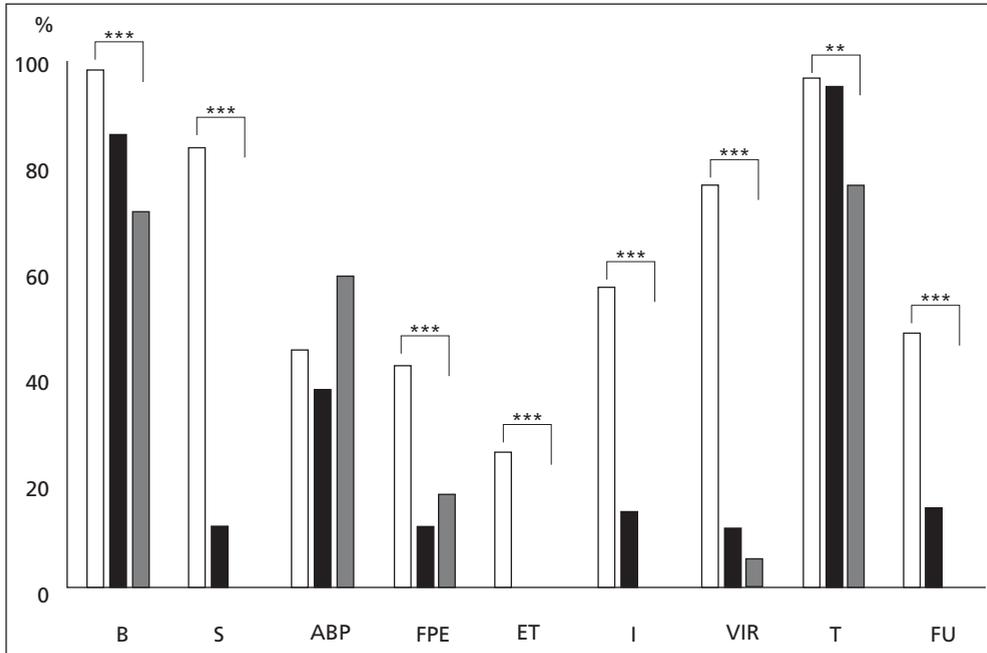
Data are expressed as percentage (%) of total number of subjects of each period of time. The methods of torture were examined using a simplified version of the RCT/IRCT protocol. The statistical difference between groups was calculated using  $\chi^2$  test. n.s. = not significant.

The existence of a harder physical and psychological ill-treatment on the group arrested by GC was demonstrated by a higher frequency in the use of the majority of methods (Figure 1). Electricity was exclusive in the GC group; and suffocation with

a plastic bag, visual input reduced, forced undressing and incommunicado duration longer than 4 days was nearly exclusive to this police force. The pattern of ill-treatment of the Ertzantza group was the least. Some methods (suffocation with plastic bag,

\*) The protocol of the Rehabilitation and Research Center for Torture Victims (RCT/IRCT)<sup>17</sup> includes "isolation" as a form of torture. Moreover, one of the recommendations on the Report of the Special Rapporteur on the question of torture in the visit to Spain<sup>12</sup> was that "Since incommunicado detention creates conditions that facilitate the perpetration of torture and can in itself constitute a form of cruel, inhuman or degrading treatment or even torture, the incommunicado regime should be abrogated". On the other hand the duration of the incommunicado detention has been evaluated in the CPT reports. In the Report on the visit to Spain in 1991<sup>16</sup> is said that: "It is

highly undesirable for a detainee to have contact practically exclusively with law enforcement officials<sup>5</sup> for a period of up to five days, especially when the period in question is that during which the risk of ill-treatment is the greatest. The CPT recommends the Spanish authorities to reduce the length of time during which a person in the custody of the police or the Civil Guard can be held incommunicado". In the light of all these findings, we decided to include the duration of the incommunication longer than four days (96 hours) as a method of psychological ill-treatment.



**Figure 1.** Methods of torture in relation to the police force.

Representation of the percentage rates in types of torture alleged by detainees arrested by the GC (white columns;  $N = 124$ ); the PN (black columns;  $N = 58$ ); and Ertzantza (hatched columns;  $N = 17$ ). B beating; S suffocation with plastic bag; ABP awkward body position for an extended period of time; FPE forced physical exercise; ET electric torture; I isolation cell longer than four days; VIR visual input reduced; T threats; FU forced undressing.

\*\*\*)  $p < 0.001$

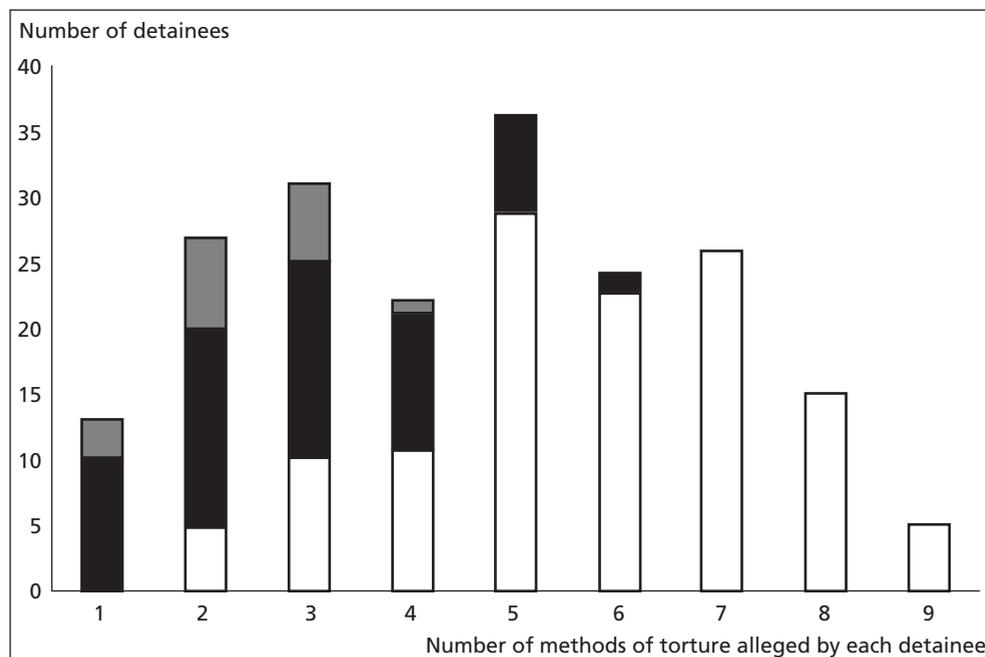
\*\*\*)  $p < 0.01$

electricity, forced undressing and incommunicado duration longer than 4 days) were never alleged by the detainees of Ertzantza group.

The analysis of the distribution of methods of torture in relation to age showed significant statistical differences for incommunicado duration longer than 4 days (18-23 years old = 25%; 24-30 years old = 35%; and more than 30 years = 65%;  $p < 0.001$ ); forced undressing (17%, 30% and 47%, respectively;  $p < 0.001$ ); asphyxia by bag (41%, 55%, 72%, respectively;  $p < 0.01$ ); and visual input reduced (37%, 48% and 67%, respectively;  $p < 0.05$ ).

The sex variable was only associated with forced undressing (male = 27%; female 59%;  $p < 0.001$ ). Statistically significant differences were also obtained between legal situation after detention and incommunicado duration longer than 4 days (freedom = 26%; prison = 49%;  $p < 0.01$ ); and visual input reduced (67 and 44%, respectively;  $p < 0.01$ ).

With a view to examining if the differences observed in the variables period of time, age group, sex and situation legal after the detention were due to an association between these variables and the police force variable, we carried out a subsequent strati-



**Figure 2.** Number of methods of torture alleged by each detainee in relation to the police force in the two periods of time.

Representation of the number of the methods of torture alleged by each detainee. White portions of the columns correspond to the detainees arrested by the GC (N = 124); black portions of the columns correspond to the detainees arrested by the PN (N = 58); and hatched portions of the columns correspond to the detainees arrested by the Ertzantza (N = 17). In the present article we codified ten methods of torture using a simplified version of the RCT/IRCT protocol.

fication analysis controlling the police force variable.

In the GC group the most important findings were: the decrease in the use of electricity (41% vs 10%;  $p < 0.001$ ) and awkward body position (56% vs 33%;  $p < 0.05$ ) from the first to the second period; the increase in the percentage of detainees arrested without communication for more than four days from the first to the second period (68% vs 47%;  $p < 0.05$ ); the higher frequency of forced undressing between woman than between men (73 vs 38%;  $p < 0.001$ ); the higher percentage of detainees arrested without communication for more

than 4 days between the detainees who were to prison (69% vs 40%;  $p < 0.01$ ); and the higher percentage of visual input reduced between the persons who were freed after the arrest (93% vs. 68%;  $p < 0.01$ ).

*Number of torture methods alleged by each detainee in the two periods of time*  
The 199 detainees alleged a total of 919 methods of torture (average of 4.62 [SD = 2.14]). The number of torture methods alleged by each detainee is shown in Figure 2. The main variable associated with the number of methods per person was the police force. This figure was noticeably higher

among the GC group than among the PN group and Ertzantza group (5.75, SD 1.72; 2.86, SD 1.33; 2.29, SD 0.84, respectively). It is worth noting that subjects of the GC group represented 99% (69/70) of detainees who alleged more than five different methods. Significant differences were not encountered on the basis of sex, age group, period of time or legal situation after the arrest.

### Discussion

There is a solid body of evidence, including the present study, to assure that the torture and ill-treatment continue to be a serious problem in Basques detained under the anti-terrorist legislation in Spain.<sup>4-13</sup> This is especially relevant as Spain is a democratic European country that has signed and ratified the international instruments against the torture. The comparison between the two periods of time shows little improvements in the last 15 years, even though CPT and the United Nations Special Rapporteur on the question of torture have visited Spain on several occasions, giving clear recommendations to improve human rights. The overwhelming number of allegations must be seen as a problem itself, indicating that the internal and international measures of control of torture have failed.

According to TAT, 793 persons from the Basque Country were held under the anti-terrorist legislation in 2000–2005; 486 (61%) alleged ill-treatment and 364 of them were collected in TAT annual reports.<sup>18-22</sup> So, our sample (112/364) represents 31% of them. This percentage was quite similar in 1992-1993 period (87/216; 40%). Our material was large, thereby researching at least a significant part of the people from the Basque Country arrested under the anti-terrorist legislation in the study period. The documents analyzed in the two periods of

this study were collected by the same human rights organization and in the same manner. We therefore assume that the two samples are comparable. The difficulties inherent in epidemiological studies tend to be particularly pronounced in research concerning human rights violations;<sup>23</sup> in our sample a selection bias cannot be excluded.

According to the above data of the TAT, about 88 Basque persons detained under anti-terrorist legislation alleged ill-treatment/torture each year. Taking into account that the population of the Basque Country is near 2,700,000 habitants, the incidence of ill-treatment/torture would be about 3 cases/100,000 habitants/year. Given that 66% of our sample was young people aged 20 to 29 years; the estimated incidence of alleged torture in such age would be 14 cases/100,000 habitants/year (59 cases each year/415,999 habitants). This figure seems quite lower than these found in other studies in populations affected by war, conflict, and violence, such as Ethiopia, Gaza, Cambodia or Algeria,<sup>24</sup> although the methodological differences do not permit a reliable comparison. However, the data about Spain has to be considered as worrying. In consonance with other populations of torture victims the demographic characteristics of the present sample show a clear dominance of young adult males.<sup>3,24,25</sup>

#### *Type of ill-treatment and related variables*

Our findings are in consonance with other articles, showing that torture exposure is highly complex and that a large number of physical and psychological methods are simultaneously or successively used on the same person.

Some of the main findings were the identification of specific patterns of torture per police force and the differences in the types of torture in relation to the periods of time.

The GC group was the most severely damaged. Some of the torture methods were exclusive to the GC; while others were almost exclusive. On the contrary, the detainees of the Ertzantza group alleged a pattern of less severe ill-treatment, and some methods were never alleged by them.

Another factor related with the methods of torture was the *period of time*. With the data available in the medical literature we were able to compare three periods of time in relation to Basque detainees in Spain: 1973–1978;<sup>14</sup> 1992–1993<sup>5</sup> and 2000–2005. From the first to the second period it could be observed that some methods alleged in the 1970s, such as alanga, finger torture or suspension from “barra” had fallen out of use; the frequency of other methods such as “wet submarine” (“bañera”) had gone down. However, suffocation by “bolsa”, forced gymnastics and sexual verbal assault were more often used in the 1992–1993.<sup>5</sup> The comparison between 1992–1993 and 2000–2005 shows less changes, principally the diminution of the use of the electricity by the GC. As a consequence, it can be concluded that the practice of torture has changed in order to leave minimal visible marks.

The methods of torture vary over countries and regions. It has been suggested that the evaluation of self-reported torture can be facilitated by this fact.<sup>3</sup> Some types of physical torture seem to be universal, principally blunt force. On the contrary, other methods of torture are quite specific for a region. In some places sharp weapons, whippings or burns with cigarettes have been used with a frequency of about 50%.<sup>3,25</sup> In other places, as observed in this study, methods which do not leave external injuries are more frequently alleged.

The prevalence of sexual torture in our sample of the period 1992–1993 was high,<sup>5</sup>

though it was similar to the prevalence reported in other studies.<sup>26,27</sup> The results of the period 2000–2005 show again a preference of sexual torture on women, as has been reported in previous articles.<sup>26,28</sup>

#### *Comparison with other sources of information about torture in Basque Country*

During the period of time involved in this study, the CPT and the United Nations Special Rapporteur on the question of torture have visited Spain on several occasions, and in some of the visits they interviewed Basque persons arrested under anti-terrorist legislation.<sup>6–12</sup> Descriptive findings of six reports (April 1991, April 1994, June 1994, January 1997, July 2001, and October 2003) are in consonance with our results about methods of torture on the whole (the most frequent methods being described as beatings, asphyxiation by the placing of a plastic bag over the head and threats; followed by electric shocks, standing for prolonged periods, physical exercises, hooding and forced nudity), and also in relation to some findings with regard to police force and changes over the time.

With regard to internal reliability of individual testimonies, these two international organisms have concluded that there is ample evidence, including of a medical nature, consistent with allegations of ill-treatment and that the allegations of torture and ill-treatment could not be considered to be fabrications in light of the internal consistency and the precision of factual details.

In agreement with the CPT, we are aware that persons arrested under anti-terrorist legislation may make false allegations of ill-treatment with a view, inter alia, to undermining the reputation of the law enforcement agencies. However, we think that the validity and reliability of the allegations is supported by different variables:

- a) Data about internal consistency of the individual allegations
- b) Data about consistency amongst the information gathered by different sources
- c) The significant statistical differences observed in relation to the different variables in the analysis of torture.

#### *Forensic and scientific implications*

The role of the forensic doctors can be of great importance in documentation and prevention of torture. However, in some countries, including Spain, the quality of the work of the medical doctors employed by the state has been questioned.<sup>29-32</sup> Several reasons, for example lack of a proper formation and lack of a formal protocol, could explain the low quality of the work. In 1997, the Spanish Government published a standardised form for the recording of findings of forensic doctors. However, the form did not include allegations of ill-treatment and the doctor's conclusions.<sup>33</sup> Moreover, this insufficient format<sup>11</sup> has been used only in a few cases.

In this context, it has been proposed that the medico-legal examination of survivors of torture should ideally be done by a doctor with knowledge of the prison conditions and torture methods in use in the particular region and their common after-effects.<sup>34</sup> Today, the Istanbul Protocol is one of the most important tools in the investigation and effective documentation of torture, and it would be recommended that the Spanish Government put it into practice. Protocol trainings, as has been done in other countries, should also be organized in Spain.<sup>35</sup>

The findings of the present study should be interesting for Spanish forensic doctors, in relation to a proper evaluation of individual cases of allegations of torture – and for Spanish Government, in relation to designing a uniform protocol in the examination of

detainees in consonance with the principles of the Istanbul Protocol.

In addition, our findings also indicate the importance of statistical analysis in the study of human rights violations.

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# Medical students' attitudes toward torture

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## Abstract

Torture, whether it be domestic or war related, is a public health issue of current concern. It is the position of the American Medical Association (AMA), The World Medical Association (WMA), the United Nations Declaration and the Geneva Convention, that torture is unethical, “morally wrong” and never to be condoned. The attitudes of medical students, our future physicians, will be critical in reducing the incidence of torture.

The purpose of this investigation was to assess medical student's attitudes regarding the permissibility and ethics of the use of torture.

A University of Illinois at Chicago College of Medicine's Institutional Review Board approved torture questionnaire was administered to 336 students of the University of Illinois College of Medicine.

35% of students agreed that torture could be “condoned” under some circumstances. Moreover, 24% of respondents disagreed that torture should “be prohibited” as a matter of state policy and a similar 24% disagreed that torture was “intrinsically wrong.”

It is concluded that most students felt that

torture was “not permissible” and “intrinsically wrong”, a disturbing 27%-35% felt that it could be permitted or condoned at times. Moreover, 27% felt that torture was not unethical. Given the strong condemnation of torture by the AMA, the WMA and the Geneva Convention these medical student attitudes, albeit by a minority of students, are disturbing. It is suggested that medical school curriculum committees review this matter.

*Keywords:* ethics to torture, questionnaire technique, medical students, Hippocratic oath

## Introduction

The American Medical Association (AMA) defines torture as “the deliberate, systematic, or wanton administration of cruel, inhumane, and degrading treatments or punishments during imprisonment or detainment.”<sup>1</sup> Torture has been condemned not only by the American Medical Association<sup>2</sup> but also the World Medical Association and the United Nations Universal Declaration of Human Rights,<sup>3</sup> and Convention Against Torture.<sup>4</sup> Moreover, Article 3 of the Geneva Convention<sup>5</sup> states that torture is “morally wrong”. Indeed it categorically states that torture “should remain prohibited at any time and in any place whatsoever.”

Given these strong condemnations of torture, it is surprising that physicians have been implicated in torture in a variety of settings, including Chile, the Soviet Union,

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and South Africa, but most recently and notoriously at Abu Ghraib.<sup>6-8</sup> Relatively little is known about medical student's attitudes about torture. Given the presumed idealism of medical students one might assume that they would subscribe to the Hippocratic idea of "primum non nocere", or do no harm.

The purpose of this investigation was to assess the attitudes of medical students regarding torture. To focus the inquiry, two issues were addressed: 1) is it permissible to torture to obtain information, and 2) are there ethical imperatives that always forbid certain behavior, in this instance, torture?

### Methods

Three hundred and thirty-six M-1 through M-4 medical students were asked to voluntarily complete a six item questionnaire that was University of Illinois-College of Medicine (UIC-COM) IRB (#2006-02681) approved (Table 1). There were no identifiers of participants on the questionnaires. The M-1 and M-2 (classroom years) student questionnaires were completed in the lecture rooms. The M-3 and M-4 (clinical years) student questionnaires were mailed to the students with a prepaid return envelope. The selection of the students was somewhat uneven because it was done at postgraduate levels and many of the clinical year students were on off-campus rotations. This should not constitute a bias because these students were randomly distributed. The 336 students represent approximately one-half (49%) of 690 students of the College of Medicine student population. While the options were "strongly agree", "agree", "undecided", "disagree", "strongly disagree", for the purposes of this analysis, "strongly agree" and "agree" were reported as "agree", and "disagree" and "strongly disagree" were reported as "disagree".

The six questions were in two categories:

**Table 1.** *Torture questionnaire*

Question	
1	The use of torture should be prohibited as a matter of state policy – PERIOD
2	Rare exceptions for the use of torture can be condoned under extreme circumstances by legitimate state agents
3	The use of torture to elicit information from captives is immoral and intrinsically wrong
4	If there is the "slightest belief" that life-saving information can be obtained, it is permissible to use torture
5	Under extreme conditions, it is permissible for interrogators to yell at prisoners and to use psychological intimidation
6	It is permissible for physicians to treat individuals to verify their health so that torture could begin or continue

Q1 and Q3 asked if the students thought torture "should be prohibited" and was "immoral." Questions 2, 4, 5, and 6 asked if torture was "permissible" or could be "condoned" under some circumstances.

Our research hypothesis was that more than 20% of medical students would either 1) disagree that torture was immoral and/or intrinsically wrong, or 2) agree that torture was permissible under some circumstances. An arbitrary 20% cut-off point was chosen because it was midway between an ideal 0% tolerance for torture and the 37% tolerance expressed in the ABC poll of the American public.<sup>9</sup> Analysis performed was a one sample z test for proportion.

### Results

Twenty-four percent of students disagreed that torture "should be prohibited" (Q1) and a similar 24% disagreed that torture was "intrinsically wrong" (Q3) (Table 2). The proportion of students who agreed that torture was sometimes permissible was 35%, 27%, 50%, and 22% for Q 2,4,5, and

**Table 2.** Medical student responses

	# Agree (Percentage)	# Disagree (Percentage)	# Undecided (Percentage)	Hypothesis	z-value	p-value
Q-1	216 (64%)	80 (24%)	40 (12%)	More than 20% disagree	3.02	0.001
Q-2	119 (35%)	163 (49%)	54 (16%)	More than 20% agree	9.32	<0.001
Q-3	213 (63%)	80 (24%)	43 (13%)	More than 20% disagree	3.03	0.001
Q-4	91 (27%)	170 (51%)	75 (22%)	More than 20% agree	6.00	<0.001
Q-5	170 (50%)	100 (30%)	66 (20%)	More than 20% agree	7.00	<0.001
Q-6	73 (22%)	195 (58%)	68 (20%)	More than 20% agree	1.96	0.002

6 respectively (Table 2). The results shown in Table 2 indicate that our research hypotheses are substantiated by the data (all p-values are less than 0.05).

### Discussion

Torture is a broad and complex subject. There is a vigorous debate, in and out of the government, as to what constitutes torture. This was highlighted in a recent (November 2007) senate confirmation of the United States Attorney General. For the purpose of this study the AMA's definition: "the deliberate, systematic, or wanton administration of cruel, inhumane, and degrading treatments during imprisonment or detainment" will be used.

As mentioned before we will focus on two issues. 1) Is there an ethical imperative that always forbids certain behavior: in this instance, torture? 2) Can torture ever be permitted to obtain information?

Relatively little is known about medical student's (or physician's, for that matter), attitudes regarding torture. Verma,<sup>10</sup> using a questionnaire technique, evaluated the attitudes about torture of 98 Indian medical students. Fifty-seven percent of the students responding to a question about employing torture to obtain information or a confession thought that it was acceptable. In another questionnaire study, this time of Indian physicians, a similar 57% (of 843 respond-

ents) felt that torture was justified to elicit information.<sup>11</sup> A more recent e-mail survey of American medical students suggested that they were deficient in knowledge about the Geneva Convention as well as military medical ethics. They were not specifically asked about the ethics of torture.<sup>12</sup>

Given the clear-cut and repeated blanket condemnations of torture by not only the United Nations Declaration of Human Rights, but particularly international medical organizations such as the World Medical Association, the Geneva Convention and our own American Medical Association these, admittedly few, reports of doctors approving of torture, or in rare cases participating in it, are of concern.

Medical ethics and the Hippocratic admonition of "do no harm" are assumed to be ingrained in the medical profession and have contributed to the public perception of medicine as an honorable and moral profession. But if torture is "morally wrong" (as stated in the Geneva Convention), these literature reports are troubling.

The results of this study suggest that while most students disapprove of torture, many (35% in question #2 and 27% in question #4 and 22% in question #6) would still allow it under some circumstances. No question addressed actual physician participation in torture and such a question might have elicited a stronger negative response.

Of interest is the recent United States Army report “Attitudes Regarding the Treatment of Insurgents and Non-Combatants.”<sup>13</sup> This survey of combat soldiers and marines in Iraq revealed that 41% of the soldiers and 44% of marines would torture to “save the life of a soldier/marine.” One might have expected combat soldiers to be more approving of torture to save the life of a comrade. It is disturbing that 27% of medical students would allow torture to obtain “life saving information” (question 4). The medical students are not that much less accepting of torture than soldiers.

Given the strong absolute prohibition of torture by virtually all medical organizations it is noteworthy that about one quarter of the students (24% in question #1) did not agree that torture should “be prohibited” or that torture is “immoral and intrinsically wrong” (24% in question #3). Putting it another way, more than one-fourth could approve of torture.

There are limitations to this study that must be noted. Some of the questions are less than focused by allowing two interpretations, making the participants answers to those questions somewhat ambiguous. Collapsing “strongly agree” and “agree,” and “strongly disagree,” and “disagree” into single choices of “agree” and “disagree” erases a range of opinions that could be informative. It was assumed that no systematic trends exist among students whose response was “undecided” as to approving or disapproving torture under some circumstances. In other words, little or no discernible bias was assumed to occur, and “undecided” responses were likely to follow the trends among participants who chose “agree” or “disagree,” if they were forced to choose another option.

This study brings to the ethics community’s attention an issue that tends to

be ignored – that is intrinsically unethical actions. As mentioned in the introduction, the Geneva Convention states that torture is “morally wrong,” and continues that it is “always intrinsically wrong.” At a time when relativists question whether any human action can always be intrinsically unethical, the case of torture might be the issue that we all can agree is morally evil.

Given the findings of the Boyd Report<sup>12</sup> it would appear that torture receives little attention (less than 1 hour for 94.2% of respondents) in the curriculum of many medical schools. Perhaps our medical educators might want to emphasize the relationship between the ethics of torture and medical practice.

In summary, this survey of 336 M-1 through M-4 medical students suggest that a majority of students agreed that torture was unacceptable. However, a troubling minority, perhaps as many as one third, were ambiguous or even approving of torture. If one believes that torture is intrinsically unethical, this acceptance rate is too high.

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# Pharmacological treatment to prevent and treat post-traumatic stress disorder

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## Abstract

Pharmacological treatments do have a role to play in the treatment of PTSD. Several agents have been shown to be superior to a placebo and many PTSD sufferers do appear to benefit from medication. The overall effect sizes are relatively small. It is to be hoped that in the future better pharmacological agents will be developed.

*Introduction:* In recent years there has been a large increase in the amount of research looking at the neurobiology of post-traumatic stress disorder (PTSD). We now know that certain areas of the brain become active at the time of trauma, resulting in emotional and behavioural responses, and changes in neurochemicals and hormones. The amygdala, for example, is involved in the normal fear response, determines the significance of external stimuli and triggers responses such as fight, flight and freezing. These responses lead to alterations in stress hormones, neurochemicals and activity in other parts of the brain, such as the hippocampus and medial prefrontal cortex. One hypothesis is that in PTSD there is a failure of other networks to regulate amygdala reactivity, resulting in hyper reactivity to threat commonly seen in PTSD sufferers.<sup>1</sup> Some, but not all studies have suggested that cortisol levels are lower in PTSD sufferers than in individuals without PTSD,<sup>2</sup> and that there is adrenergic overactivity shortly after traumatic events.

Our current knowledge of the neurobiology of PTSD, although not complete, suggests that certain drugs should be able to prevent its development and reduce its symptoms.

*Keywords:* Neurobiology, PTSD, controller trials, guidelines

## Pharmacological prevention

Few studies have considered administration of pharmacological treatments shortly after a traumatic event. Schelling et al<sup>3</sup> compared intravenous hydrocortisone with a placebo in 20 septic shock victims on an intensive care unit. They found evidence that those who received hydrocortisone were less likely to suffer from PTSD at 31 month follow-up than those who did not. Pitman et al<sup>4</sup> randomised individuals to receive a short course of Propranolol, a drug that reduces adrenergic activity, starting within six hours of a traumatic event, or a placebo. They found no significant difference in the rates of PTSD at follow up. However, there was some evidence that individuals who received Propranolol showed less physiological reactivity on being reminded of what had happened. Melman et al<sup>5</sup> conducted a randomised controlled trial of Temazepam, a hypnotic benzodiazepine, an average of 14 days after attendance at an emergency unit following a traumatic event. At six weeks follow up there was no significant difference between the

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groups but there was a trend for those in the Temazepam group to be more likely to have PTSD than the placebo group despite the Temazepam group reporting improved initial sleep. Another study by Stein et al<sup>6</sup> found no difference between Propranolol, Gabapentin and the placebo when started 24 to 48 hours after a traumatic event.

With the evidence available at present there is no evidence that any pharmacological agent can prevent PTSD. Therefore, routine administration is not indicated. The United Kingdom's National Institute of Clinical and Health Excellence's (NICE) guidelines<sup>7</sup> recommend that, given the absence of evidence, pharmacological treatment should only be offered, if at all, for acute phase symptomatic management, for example if an individual has marked insomnia.

### Pharmacological treatment

The published randomised controlled trials to date have considered treatment of chronic PTSD. Research suggests that around 80% of individuals attending mental health services for treatment of PTSD are currently being prescribed medication.<sup>8</sup> Antidepressants, in particular selective serotonin reuptake inhibitors, are the most commonly prescribed drugs but other medications such as atypical antipsychotics and benzodiazepines are also widely used. A large number of randomised controlled trials have now been conducted with drugs, the majority with antidepressants but the atypical antipsychotics Olanzapine and Risperidone have also been subjected to randomised controlled trials. Overall the effect sizes are relatively small although the placebo response rates have been very high. For example, in randomised controlled trials of the serotonin and noradrenaline reuptake inhibitor Venlafaxine the placebo group have reported experiencing symptom reductions

of around 50%.<sup>9</sup> This means that individuals who take medication, be it placebo or Venlafaxine, reported significant symptom reductions but those in the Venlafaxine group only did slightly better than those in the placebo group.

Paroxetine is the drug that has been most researched and shows a highly statistically significant small positive effect on symptoms of PTSD overall.<sup>7</sup> The NICE guidelines' meta-analysis of drug treatment found that Mirtazapine, Amitriptyline and Phenelzine were the only other three drugs that fared statistically significantly better than a placebo, although the number of individuals included in those studies was relatively low, particularly in the case of Mirtazapine.<sup>7</sup>

As a result of a priori determined rules regarding effect sizes, the NICE guidelines recommended drug treatment as a second line treatment for PTSD. The Australian Guidelines also recommended that drug treatments for PTSD should not be used as a routine first line treatment.<sup>10</sup> Given the current evidence, the NICE guidelines recommend a limited role for Paroxetine and Mirtazapine to be prescribed by non-specialists and Amitriptyline and Phenelzine by mental health specialists. They are likely to be indicated when a patient has a clear preference for a pharmacological rather than a psychological approach, when there is serious ongoing threat that will prevent an individual fully engaging with evidence psychological treatment, and to augment psychological treatment that has not been effective on its own. In many countries the limited availability of psychological therapists who are able to provide evidence psychological treatments means long waits to access such treatments. It is therefore likely that many individuals will be prescribed medication because of the lack of availability of psychological treatment.

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# Secondary trauma in the legal professions, a clinical perspective

Yael Fischman, PhD\*

## Abstract

This article describes the importance of being aware of secondary trauma in lawyers, interpreters, judges, police, forensic physicians and other professionals that work with traumatized clients. In addition, it presents a psycho-educational model developed by the author to address secondary trauma among those associated with the legal and clinical professions.

## Introduction

The Institute for Study of Psychosocial Trauma (ISPT) is a non-profit organization based in California, providing psychological treatment to refugees affected by war trauma and the aftermath of torture since the early 1980's. ISPT has trained clinicians and other health personnel throughout the U.S., South and Central America, staff in an International Court, and international human rights lawyers and field workers. Also, we provide training and consultation on secondary trauma to graduate students at the Law Schools of the University of Santa Clara, Stanford University and the University of California at Berkeley.

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We work with human-induced trauma caused by experiencing or witnessing acts of war, genocide, religious, political or ethnic persecution, domestic abuse, incest, rape, genital mutilation, and human trafficking. Our main emphasis, however, has been serving survivors of war and physical, psychological and sexual torture.

Our initial work with secondary trauma was focused exclusively on primary responders and clinicians. In the past eight years, it has expanded to include interpreters and members of the legal profession, including lawyers.

It is now well established that interpreters are among those vulnerable to experiencing secondary trauma, just as associates of trauma survivors, primary responders, disaster workers, victim assistance specialists, nurses, physicians, psychotherapists, and others.

## Psychological trauma

Psychological trauma may originate from natural disasters such as earthquakes, wildfires, tornadoes, floods and hurricanes. The aftermath of natural disasters can include death, destruction, loss, infectious diseases, homelessness and psychological distress. Trauma may also be caused by experiencing or witnessing human violence, such as acts

of war, genocide, religious, political or ethnic persecution, torture, domestic abuse, incest, rape, genital mutilation, and human trafficking. Most clinicians believe that it is harder to recover from a human-induced trauma, since it implies intentionality.

Psychological trauma refers to an experience that is emotionally painful, distressful, or shocking. It creates a psychological wound that may lead to substantial negative impact to a person's physiological, psychosocial and family systems. According to the Diagnostic Manual published by the American Psychiatric Association, Posttraumatic Stress Disorder (PTSD) may occur when "a person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of others; and the person's response involved intense fear, helplessness or horror".<sup>1</sup>

The consequences of trauma and PTSD vary widely according to diverse variables, such as the victim's age, the pre-trauma psychosocial context, the nature and severity of the trauma, and the support received following the trauma. Some common symptoms of trauma and PTSD include fear, helplessness, horror, anger, rage, sleep disturbances, alterations in memory, irritability, difficulty concentrating, re-experiencing traumatic events, avoidance or numbing to avoid thoughts and feelings connected with the traumatic events, detachment, and estrangement from others.

Psychological trauma creates an emotional wound that may harm a person's physiological and psychological systems. Severe traumatic events involve extreme stress that overwhelms the ability to cope, and shatters habitual categories of perception and understanding. Trauma may entail different losses, such as those of sense of self, meaning and hope. This experience of

loss often varies according to ethnic, cultural and religious differences and the national or sociopolitical context in which it occurs. These losses usually lead to feelings of depression. If interviewed superficially, a traumatized person may be diagnosed with a major depressive disorder, and the trauma symptoms may be overlooked.

### **Secondary trauma**

Many of the experiences and symptoms described above, are also commonly reported by caregivers and other providers that interact with traumatized patients or clients. Therefore, Figley,<sup>2,3</sup> and others introduced the concept of secondary trauma, also known as vicarious traumatization,<sup>4</sup> event countertransference,<sup>5</sup> and compassion fatigue.<sup>6</sup>

Secondary trauma refers to the psychological signs and symptoms that result from ongoing involvement with traumatized clients. Professionals that engage with empathy and care with people that have endured severe trauma may experience psychological difficulties produced by the survivors' account of their traumatic experience and the professional's reactions to such accounts. By becoming a witness to these atrocities, these may become part of the providers' consciousness, leading to a potential incorporation of their clients' traumatic experiences.

Therefore, professionals may experience, to a lesser degree, some of the same symptoms as those impacted by primary trauma. As stated above, these may include fear, helplessness, horror, anger, rage, sleep disturbances, alterations in memory, irritability, difficulty concentrating, avoidance or numbing to avoid thoughts and feelings connected with traumatic events, detachment, and estrangement from others.

In addition, they may undergo intense emotional reactions, ranging from denial

to over-identification. The delineation of a model to address secondary trauma (see below) will allow for a more detailed description of symptoms, behaviors, feelings and concerns associated with secondary trauma.

Smith et al<sup>7</sup> evaluated results of their studies on the effect of secondary trauma on psychotherapists, and concluded that experience with particularly severely traumatized clients, combined with frequent confrontations may influence therapists' in-session reactions. They oppose the view that long-term trauma therapy experience exerts prolonged negative influences on therapist's well-being or in-therapy behaviour. They add, however, that given the exploratory nature of their studies thus far, these results need to be tested in a controlled quantitative design.

A significant part of the clinical literature shows that "wounded healers" are less effective in helping traumatized clients.<sup>6</sup> At the same time, they may show particular strengths in working with survivors. A wounded healer may attain a deeper understanding of the dynamics of a specific trauma as a direct result of having endured a comparable traumatic experience.

Clinicians dealing with human-induced trauma have long understood the usefulness of psychotherapy with victims of primary trauma. More recently, they have recognized their own vulnerability to secondary trauma while working with traumatized individuals, including victims and witnesses at war crimes tribunals. Conversely, the secondary trauma of the legal professional has hardly been addressed. Those working in war crime tribunals, or with political asylum applicants that are victims of war, torture, trafficking, domestic violence, etc. are clearly vulnerable to secondary trauma. Being exposed daily to detailed traumatic narratives is extremely demanding and adds an important emotional dimension to legal work.

However, lawyers are not traditionally trained to address work-related emotions or acknowledge the potentially traumatic impact that their work may have on them and, by extension, on their clients. In some instances, they may feel overwhelmed by unidentified emotions. Legal professionals may experience symptoms such as those described above, and may also undergo intense emotional reactions, ranging from denial to over-identification.

These feelings are particularly conflicting when they are neither labeled nor voiced and may lead them, for example, to unknowingly detach. In such cases they distance themselves from their clients, withdrawing empathy and a supportive stance. Continued distress may even lead them to abandon work with victims, thus depriving from legal representation an already underserved population.

There are very few published articles about secondary trauma in the legal profession, and we hope that this article may stimulate further interest in the subject.

### **Secondary trauma: examples**

The following examples included in this section might be helpful to readers unfamiliar with the actual experience of secondary trauma.

Literal statements from interpreters in group processes which I developed and co-lead include: "How do I get out of the feeling that I didn't help the client?"; "How can I cope when I feel overwhelmed by the narrative that I have to translate?"; "Can you give me tools to deal with my sadness?"

When interpreters have themselves been victims of primary trauma, their risk of re-traumatization is very high.<sup>8</sup> Interpreters still affected by primary trauma have reported stomach aches, "heartache", feeling exhausted after a session translating for a hu-

man rights attorney, inability to stop thinking about the reported trauma several hours or even days after interpreting, increased intake of alcohol or “junk food” following a work session. Statements recorded include: “I feel flooded by memories of what went on in my country”; “I get scared of what information will come up next and what I will have to deal with in the following session”.

Our experience addressing the secondary trauma of attorneys and field workers that document situations of genocide and human rights violations in conflict areas and refugee camps, of immigration attorneys that deal frequently with extremely traumatized refugees, and those assigned to interview war prisoners in detention camps, indicates that the potential for secondary trauma in that professional population deserves serious attention. In individual psychotherapy work with legal professionals, we have frequently encountered feelings of anger, rage, fear, guilt, identification with the client, and internalization of their clients’ pain.

In group work with legal advocates, common statements include: “I never suspected that documenting these human rights violations would affect me so deeply”; “I have had so many nightmares since interviewing a client that was brutally tortured, that now I am afraid of going to sleep”.

Concern about retraumatizing the client appears with increased frequency among legal professionals that are starting to learn about retraumatization. In the past year I have been addressing the subject through frequent phone consultations with attorneys throughout the United States, as well as in training events for law students.

Levin and Greisberg<sup>9</sup> conducted a study to evaluate secondary trauma in attorneys, and stated that “The major finding of our study was that attorneys working with traumatized clients experience significant symp-

toms of secondary trauma and burnout”. They further point to the need for identifying effective interventions to reduce secondary trauma among legal professionals in order to enhance the delivery of legal services to victims of trauma.

Parker<sup>10</sup> argues that law students working with traumatized clients must be trained to identify trauma issues that may affect the client-law student relationship, and states that some students identify with the client and internalize their pain, while others close off and block out emotions.

### **A psycho-educational model to address secondary trauma**

Williams & Sommer,<sup>11</sup> Pearlman<sup>12</sup> and others have used specific approaches to address secondary trauma. Most share some basic principles such as the importance of self care, the need to develop awareness of signs of excessive stress, and the need to identify personal triggers for secondary trauma. Some clinicians also propose debriefing following particularly painful trauma-related interviews, to facilitate the provider’s release of thoughts and feelings that might not otherwise be expressed.

Understanding that education and accurate information are important elements in the prevention of secondary trauma, I developed a psycho-educational model for prevention and early intervention for legal professionals, primary responders, psychotherapists, and others that may be vulnerable to secondary trauma.

When working with providers who live and work in societies where war, terrorism or human rights violations are occurring, we need to be aware that they commonly share an experience of primary trauma with their clients. It is important to understand that this creates unique difficulties in the provision of services. For example, in situations

such as those of primary responders, human rights lawyers or psychotherapists, they might be facing their own primary trauma, while also incorporating their clients' traumatic experiences. This creates problems such as blurring of boundaries, potential exacerbation of emotional responses and issues of personal safety. Such problems may hinder the lawyer or clinicians' ability to set limits in their work, take care of their own physical and emotional health, and even allow themselves to be mindful of their personal reactions to trauma. It is therefore crucial to focus on the physical and mental well-being of providers, explore creative means for self-care and the release of emotions and personal feelings, and provide supervision to help minimize the blurring of boundaries. Group training or supervision may also function as a support system.

What follows is an attempt to present a step-by-step description of the topics addressed in lectures, discussions or process sessions and small groups. These are introduced below in the order in which they take place.

1. The training starts with lectures and interactive sessions to teach the concepts of trauma, retraumatization and secondary trauma; this is followed by a discussion of individual, family, and community effects of traumatic events and how these interact with the work of providers.

2. The next step is a lecture and open discussion of the process through which caretakers develop symptoms that parallel those of their clients and of the way in which their behavior is impacted by such symptoms; consideration of emotional changes and their impact on their outlook on life; attention to behavioral changes following secondary traumatization, including disruption in relations

with spouses or partners, children, co-workers, supervisors, and friends. The exact number of hours devoted to each topic varies according to the number of days prearranged for each program.

3. The previous topics are followed by a discussion of common secondary trauma symptoms such as irritability, hypervigilance and numbing as well as of the potential for dangerous behaviors such as reckless driving, alcohol or drug abuse. All the information discussed is based on an understanding of the cultural meaning of trauma and healing within the group with which we work, and awareness of culturally appropriate ways to develop and foster resilience whenever that is possible. Although our team is not completely multicultural, we actively try to educate ourselves within possibilities on the meaning ascribed to trauma in different cultures. In addition, our experience in individual psychotherapy with traumatized individuals from many different cultures has taught us to request their help to explain to us the meaning of concepts such as trauma and healing in their specific culture.

4. Following the examination of the impact of secondary traumatization on the individual caregiver we lead a discussion about the ethical responsibility of traumatized professionals to address personal healing needs. This is necessary to avoid distortion of the interview, interpretation or treatment process when a professional is unable to act according to each profession's convention of "do no harm". Awareness of potential counterproductive responses ranging all the way from excessive distancing to over-identifying with their clients<sup>13</sup> contribute to a better understanding of how secondary trauma may affect a provider's decision-making process, lead to inhibited listening, ameliorate the

ability to maintain appropriate boundaries and to render effective services.

5. Subsequent to such analysis, we offer education to facilitate early identification of symptoms of secondary traumatization, and approaches to prevent further traumatization. Examples that lead to a “mentality of prevention” include suggestions such as:

“Learn to identify changes in your mood. Are you feeling angry very frequently? Do you often feel that you are about to cry? Given the work you are currently doing, these may be signs of secondary trauma; do not ignore them. Try to make some time for activities that distract you from your everyday routine, such as spending time outdoors, playing with friends, children or pets, engaging in some artistic pursuit, etc. Also, practice observing your mood changes. The more you observe these changes, the more control you will eventually acquire over your moods.”

“Learn to identify changes in your behavior. Do you get frustrated very frequently? Are you becoming impatient with your family, friends, co-workers? Have you increased your alcohol intake? Are you fighting a lot with your spouse or significant other? Do you have a desire to attack them physically or feel that you cannot control your temper when you are around them? In your present circumstances, these also might be signs of secondary trauma. They may indicate that you need to take time out, get support from friends, or talk to a psychotherapist.”

6. This is followed by a lecture on diverse approaches to self-care which contribute to both prevent secondary traumatization and attempt to reverse its effects as needed. Some of these approaches emphasize the importance of incorporating balanced nutri-

tion, physical exercise and a short, interesting, inspiring, or relaxing activity into everyday life. Also, we highlight the importance of obtaining supervision from someone that understands the dynamics of work with traumatized clients, as well as ongoing discussion groups with peers whenever possible. The support of professional peers provides non-judgmental listening, objective feedback, and additional professional perspectives.

A central aspect of our presentation on the topic of self-care involves organizing small process groups to recapitulate the reasons that lead each professional to trauma work. This is followed by questioning whether such reasons are still valid, in order to evaluate potential occupations in a related field that does not necessarily involve trauma. For those who decide to continue their employment in the field of trauma, we strongly recommend to limit direct involvement with survivors of trauma and to attempt to combine it with other lines of work. Ideally, this recommendation should apply to everybody in this field, in order to prevent burnout and secondary traumatization.

If the original motivation to choose this line of professional work remains in place, participants are invited to reflect on the two sides of trauma work. On the one hand, it deals with the “dark side of life”. On the other, it grants us the privilege to bring light into darkness, challenge those in power who adhere to a worldview that creates horror and despair, fight injustice, or to try to fulfill an inner commitment of healing the world. It also allows us to appreciate the courage and resilience of those who have endured harrowing experiences.

7. At this stage the amount of exposure to the subject usually allows us to safely move into small process groups to consider individual variables that may increase the vulner-

ability to secondary trauma. These include personal trauma history, degree of integration of traumatic experiences, and lack of necessary support from the social and family milieu. A respectful and concerned discussion of personal trauma history sometimes leads to an appropriate referral for individual or group psychotherapy.

When there is acknowledgement of lack of social or family support, we try to decrease feelings of frustration and loneliness by clarifying that it is not realistic to expect immediate support or understanding from family and friends. It may take them some time to acknowledge the pain involved in trauma work, and people who are not familiar with trauma need help to gradually understand and develop the ability to process the information that is shared with them. (Confidentiality regarding identification and specific circumstances of clients is always emphasized).

In addition, we attempt to normalize expected reactions such as anger, outrage and hopelessness that result from continued exposure to the helplessness of traumatized victims. When these emotions emerge, we put forward the option of joining local organizations that focus on preventing the specific crimes that cause major negative impact in each provider. This offers a positive channel to express anger and helps counteract feelings of hopelessness.

8. In the following meeting we bring up the possibility of considering spiritual support to provide holding and thus complement the encouragement given by colleagues, family and friends. Through my experience lecturing on the spiritual dimensions of trauma I have learned that a significant percentage of professionals interacting with trauma are open to exploring a mind-body-spirit paradigm. For many, trauma work demands

new frames of meaning, since traditional intellectual constructs cannot easily incorporate the traumatic wounds with which we are confronted. The need to find additional ways of relating to these traumatic wounds sometimes leads providers into exploring a spiritual path. For some, spirituality suggests therapeutic avenues that encourage the transformation of traumatic experiences.

As stated earlier, this psycho educational program takes place in the form of lectures, small group discussions, process sessions and individual meetings as needed. These different formats are designed to promote personal and professional connections and peer support, which contribute to counteract isolation, a common element of secondary trauma. Group interactions emphasize safety, thus allowing for discussion of fears, frustrations, and feelings of anxiety and inadequacy due to the difficulties involved in work with a severely traumatized population. In addition, safe groups encourage examination of the desire to distance oneself from the trauma, associated with feelings of guilt for wanting to abandon the client; and of issues of mistrust and betrayal, which parallel the client's experience.

Peer groups also provide a helpful forum to address ethical dilemmas generated by coming face to face with the hate and violence in the world. For many providers, witnessing the unspeakable may seriously challenge belief systems. These challenges often lead to questions of purpose and meaning that affect victims as well as those who work with them. It is valuable for providers to discuss these questions, as well as dilemmas regarding faith or religion if they seem important. Even if there are no universal answers to these questions, it helps to have an opportunity to reflect on, and access the spiritual, ethical or moral resources congruent with each individual's belief systems.

Providers that struggle with these questions without giving them a voice make themselves more vulnerable to isolation and existential loneliness.

### Conclusions

Even though secondary trauma is not a universal phenomenon that impacts all professionals interacting with trauma, the problem is frequent enough to merit serious attention. Secondary trauma may affect a provider's decision-making process, lead to inhibited listening, decrease the ability to maintain appropriate boundaries and to render effective services. Also, many professionals burdened by secondary trauma abandon their work with trauma survivors in order to avoid serious emotional distress.

It is important to keep in mind that particularly vulnerable individuals, such as those with a history of unresolved primary trauma, may need individual or group psychotherapy in addition to education and self care.

Prevention and education appear as a very cost-effective approach to avoid the negative consequences of secondary trauma affecting providers, and by extension, service users. Education is also a simple way to remind legal and clinical professionals about the risks of retraumatization, and to bring into focus the dangers involved in retraumatizing clients through inadequate, untimely or insensitive questions.

Our emphasis on group work provides a safe forum to discuss important practical issues as well as existential dilemmas that may intensify symptoms of secondary trauma.

The psycho-educational model described above has proved to be a valuable method to identify, prevent or diminish the effects of secondary trauma. A central focus of this model is the clarification of personal motivations leading professionals to trauma work

and its connection to purpose, meaning, worldview and the spiritual dimensions of trauma.<sup>14</sup> It also allows us to remind providers that while we cannot undo what happened to those we serve, we can attempt to heal and restore.

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# Justification Doctrine in the Prohibition on Torture, Cruel, Inhuman or Degrading Treatment

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‘The notion of inhuman treatment covers at least such treatment as deliberately causes severe suffering, mental or physical, *which, in the particular situation is unjustified*’<sup>1</sup>

## Abstract

This paper looks at the legacy of a justification doctrine evident in early international jurisprudence that set the threshold for treatment prohibited under international law as torture, cruel, inhuman or degrading treatment or punishment [hereafter the *prohibition*], excusing from its reach deliberately inflicted, potentially severe, suffering proportionately inflicted for a legitimate purpose.

Debates over a ‘threshold’ at which point the prohibition engages, or at which point ‘inhuman’ treatment reaches a level sufficient to be deemed ‘torture’, typically invoke an implicit ‘severity’ threshold. This paper is not primarily concerned with severity or the instrumentality of any ‘severity threshold’ either in engaging the prohibition or in distinguishing categories of prohibited treatment. Neither is the article concerned directly with the legal distinction between categories of prohibited treatment (i.e. the distinction between ‘torture’, other ‘inhuman’, or even any subcategory ‘degrading’ treatment). Rather the article focuses on the

distinction between (i) treatment prohibited, as either torture or other cruel, inhuman or degrading, and (ii) treatment prima facie ‘justified’. What the article looks at is the operation of a ‘justification’ threshold in triggering the prohibition, one that understands ‘justified’ treatment as never reaching the level of, or never amounting to inhuman, cruel or degrading treatment under the prohibition.

The article interprets the current prohibition on torture, cruel, inhuman or degrading treatment as one on ‘unjustified’ inflicted suffering, suggesting that the notion of ‘justifiability’ active in this definition is problematic in encouraging arguments seeking to circumvent the protection afforded under the prohibition. In the absence of a clearly defined notion of the ‘victim’, or circumscribed class afforded protection, this paper both identifies and addresses a correlation between (i) a broadly inclusive contextual scope for the prohibition’s applicability – one that contemplates a broad notion of the potential victim – and (ii) an enhanced role for a justification doctrine in excusing the infliction of [potentially severe] suffering where necessary and proportionate. In light of identified dangers associated with a role for justification doctrine in the definition of prohibited treatment, an alternative is put forward that would

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1) [emphasis added] European Commission on Human Rights in the *Greek Case*, Report of November 1969, (1969) 12 Yearbook 186-510 at para. 186.

redefine the prohibition as one, not on 'unjustified' but one on 'all' suffering deliberately inflicted restricted to contexts of detention, custody, control or other deprivation of liberty.

A brief disclaimer and clarification should also be made at the outset: The article addresses balancing exercises, active in determining the justifiability of treatment, that draw on the nature of its purpose and the degree of its severity. However the author wishes to make clear that the article *in no way means to suggest that proportionality is, or should ever be, active in excusing treatment deemed cruel, inhuman, degrading or even torture*; the article does not, in referring to 'balancing exercises', 'justification' or 'proportionality', mean to invoke, and much less to argue for, any justification doctrine or proportionality that would balance the prohibition against, for example, national security concerns. What the article is concerned with is a degree of balancing between the severity of suffering inflicted and a potentially legitimate purpose, operating *in certain circumstances* either to determine treatment as prohibited as torture, cruel, inhuman or degrading or alternatively to excuse it as 'justified'. It is not, then, balancing exercises which might mitigate (notwithstanding the absolute nature of the prohibition) the infliction of treatment deemed 'cruel, inhuman or degrading', or even that amounting to 'torture', but those balancing exercises which '*precondition*' the triggering of the prohibition that are the subject of the article and of which will be attempted as lucid an analysis as possible. It is in this context that any reference to 'proportionality' in the article is made.

Lastly the author wishes to clarify that anything presented or put forward by the article is done so solely in the interest of securing the maximum protection for the most vulnerable.

*Keywords:* torture, cruel, inhuman or degrading treatment, definition of, inflicted suffering, justification, threshold, purpose, context

## History

The European Commission on Human Rights, in the *Greek case*, found that: 'the notion of inhuman treatment covers at least such treatment as deliberately causes severe suffering, mental or physical, which, in the particular situation is *unjustifiable*';<sup>2</sup> the notion of 'unjustified treatment', then, setting the threshold for treatment prohibited as torture, cruel, inhuman or degrading.

The European Court of Human Rights [ECtHR] in *Ireland* later found that: 'ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3',<sup>3</sup> further considering the 'assessment of this minimum [to be]..., in the nature of things, relative;... depend[ing] on all the circumstances of the case, such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim, etc.'<sup>4</sup> The Court's focus on the severity of the treatment, both in setting the entry threshold for treatment prohibited under the Convention, and in distinguishing lesser forms of prohibited treatment from 'torture',<sup>5</sup> suggested, in relation to the threshold for prohibited treatment, a focus very much on the subjective effect, rather than the [un-]justifiability, of the treatment.

Although *Ireland* might have suggested

2) [emphasis added] *The Greek case*, supra note. 1; see also UN Special Rapporteur on Torture, Manfred Nowak: '...there may be some purposes for which deliberately causing severe suffering is justified and, therefore, is not inhuman...' Manfred Nowak, *What Practices Constitute Torture?: US and UN Standards*, 28 (no. 4) *Human Rights Quarterly* 809 (2006), at 821.

3) *Ireland v. The United Kingdom* (Application no. 5310/71), Judgment 18 January 1978, para. 162.

4) *Ibid.* para.162.

a shift away from any centrality of purpose in determining the legal nature of the treatment, and despite reference to the ‘...potential justifiability of inhuman treatment... [having since] been abandoned by the European Court of Human Rights and rejected elsewhere’,<sup>6</sup> subsequent international and domestic jurisprudence suggests that purpose (under the justification doctrine) still plays a central role in determining the legal nature of treatment inflicting suffering, not only in distinguishing torture from other forms of ill-treatment, but in distinguishing prohibited from ‘justified’ treatment, consistently reflecting the possibility for, in certain circumstances, ‘justified’ deliberately inflicted [and potentially severe] suffering,<sup>7</sup> so that while the notion of ‘justified inhuman’ treatment has been abandoned, the potential for ‘justified, deliberately inflicted and po-

tentially severe suffering’ survives; the notion of treatment as ‘un-justified’ still central as a pre-condition in engaging the prohibition. ‘Justification doctrine’ does, then, operate, at least along side ‘severity’, to set the entry threshold for prohibited ill-treatment.

### **Justifiability and the absolute prohibition**

It is accepted that as the prohibition is currently understood, a degree of justification or proportionality active in determining the *scope or reach* of what would still be an absolute prohibition (rather than excusing treatment within that category) is not itself necessarily incompatible with an absolute prohibition where that prohibition incorporates the notion of justifiability in to the definition of what it absolutely prohibits.<sup>8</sup> However, the introduction of a justifica-

5) ‘... the Court must have regard to the distinction, embodied in Article 3 (art. 3), between this notion and that of inhuman or degrading treatment. In the Court’s view, this distinction derives principally from a difference in the intensity of the suffering inflicted ... The Court considers ... that it was the intention that the Convention, with its distinction between “torture” and “inhuman or degrading treatment”, should by the first of these terms attach a special stigma to deliberate inhuman treatment causing very serious and cruel suffering’, para. 167; see also, ‘[though] the acts complained of often occurred during interrogation and, to this extent, were aimed at extracting confessions, the naming of others and/or information, ... the severity of the suffering that they were capable of causing did not attain the particular level inherent in the notion of torture as understood by the Court’, *Ibid.* at. 174.

6) Nigel Rodley, *The Definition(s) of Torture in International Law*, 2002 55 *Current Legal Problems* (Oxford University Press), pp.467-493, at 471.

7) For example in formulations to the effect that ‘... a measure which is of therapeutic necessity...cannot in principle be regarded as inhuman and degrading.

The same can be said about force-feeding that is aimed at saving the life of a particular detainee who consciously refuses to take food’, *Nevmerzhitsky v. Ukraine* (Application no. 54825/00) judgment 5 April 2005, para. 98. See also ‘[a]ny use of force that is not strictly necessary to ensure proper behavior on the part of the detainee constitutes an assault on the dignity of the person... in violation of Article 5 of the American Convention’ [emphasis added], *Loayza Tamayo*, 1997, *Inter-Am.Ct.H.R. Series C No.33*, para. 57; *Castillo-Petruzzi*, Judgment of May 30, 1999, *Inter-Am. Ct. H.R. (Ser. C) No. 52* (1999) para.197; *Cantoral-Benavides*, Judgment of August 18, 2000, *Inter-Am. Ct. H.R., (Ser. C) No. 69* (2000) para. 96; also ‘in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3’ [emphasis added], *Bati and Others v. Turkey*, nos. 33097/96 and 57834/00, judgment of 3 June 2004 at para. 118.

8) so that, for example, it ‘...does not mean that a little CIDT [cruel, inhuman or degrading treatment] may be applied for a legitimate purpose’, *Nowak*, *supra* note. 2, at 836.

tion threshold, simultaneously defining a category of treatment deemed particularly abhorrent, to be absolutely prohibited, and potentially excusing the deliberate infliction of severe suffering, has seen what in the context of an 'absolute' prohibition might be referred to as an unnatural, and uncomfortable significance attached to the nature of the pro-offered purpose for which suffering is inflicted and the relative severity of that suffering in the determination of scope of the prohibition. So that although the prohibition is proclaimed absolute and non-derogable<sup>9</sup> proportionality and purpose nonetheless distinguish 'legitimate' from 'prohibited' inflicted suffering.

Such a prohibition sees torture, cruel, inhuman and degrading treatment and punishment defined as the 'unjustified infliction of suffering' of relative severity or purpose; what is prohibited is *not* the deliberate infliction of even severe suffering but the *unjustified* infliction of suffering. This, it is suggested, has left the protection afforded under the prohibition vulnerable to arguments, in the current context of the war on terror, that certain forms of treatment, particularly those not reaching levels sufficient to trigger the definition of torture under the Convention (and with it the only reference to suffering inflicted in the extraction of information or a confession), might be 'justified' in the inter-

ests of national security and so excused from the reach of the prohibition.

### Limits to the operation of justification

Though jurisprudence demonstrates that a justification doctrine is operational, at least along side 'severity', to set the entry threshold for prohibited ill-treatment, and potentially excusing deliberately inflicted suffering, jurisprudence also demonstrates that it is at most of restricted significance in that only in limited situations have courts been willing to entertain any balance in considering the legal nature of treatment inflicting even lesser suffering. Instead there is a reluctance<sup>10</sup> to entertain any balance that might excuse as justified the deliberate infliction of suffering beyond a number of circumstances addressed below.

Most situations found to involve a proportionality or justifiability to excuse inflicted suffering fall outside, or beyond, contexts of direct control [e.g. in the affecting of an arrest, quelling a riot etc]; suggesting notions of justification and the balancing of competing interests to be relevant considerations only outside that context. It is a reasonable proposition that once an individual is under 'direct control', in very few situations can any inflicted suffering ever be legitimate.<sup>11</sup>

However (and it is suggested that the following is the current understanding of the

9) The prohibition on torture is also a *jus cogens* norm; see International Criminal Tribunal for the Former Yugoslavia in Prosecutor v. Furundžija IT-95-17/1, Judgment 10 December 1998 para. 153, and Prosecutor v. Delalic, Case No. IT-96-21-T, Judgment, 16 Nov. 1998, para. 454.

The prohibition on cruel, inhuman and degrading treatment has also been found to amount to a norm *jus cogens* under US Restatement of Foreign Relations law (see section 702(n) and federal court cases involving the Alien Torts Claim Act (see eg, *xuncax v, Gramajo*). The Berlin Declara-

tion on Counter Terrorism and Human Rights, adopted by the entire ICJ Biennial also affirmed CID as *jus cogens*.

10) This might be understood as a reluctance informed by the greater deference to utilitarian arguments – antithetical to human rights – represented by a greater role for any justification doctrine that would balance between the inviolability of the human person or the right to human dignity (their protection from inflicted suffering) and any wider concerns.

operation of justification doctrine in relation to the prohibition), while most situations in which exercises considering the justifiability of treatment operate do fall outside detention situations, a willingness to entertain balancing, or the 'justifiability' of the treatment, can alternatively be understood triggered not by the context in which the treatment takes place, but by the *nature of the purpose* being pursued – affecting an arrest, quelling a riot, administering medical aid, securing of information, extracting a confession, safeguarding national security, etc., with certain purposes, rather than contexts, understood to have been put *beyond* proportionality. So that as currently understood, then, the prohibition operates framed *conceptually*; the scope defined by the operation of justification rather than the existence or absence of context.

Justification doctrine can be understood to operate similar to limitations inherent in rights to freedom of thought, conscience and religion, to freedom of expression and association and to respect for private and family life.<sup>12</sup> A degree of interference with these rights *is* entertained, but that interference will depend for its acceptability, firstly on *the nature of the purpose being pursued* and only secondly on the degree of the interference relative to that aim. In other words, as in the case of any justification for inflicted suffering, only certain purposes entertain the *possibility* of legitimate interference.

### **Purpose and those 'beyond proportionality'**

The defining characteristic of 'torture', distinguishing treatment inflicting suffer-

11) See for example Nowak; 'when the person has been arrested, handcuffed, detained, or otherwise bought under the direct control of the official, *no further use of force or infliction of pain is permitted*' *supra note*. 2, at 837 [emphasis added]. Under international humanitarian law, applicable in the most extreme of situations, it is clear that any suffering inflicted on detainees [right down even to a very low threshold] is prohibited without recourse to proportionality. See, e.g. the Geneva Conventions: 'No physical or moral coercion shall be exercised against protected persons, in particular to obtain information from them or from third parties' Geneva Convention IV, Art. 31; and 'Protected persons...shall at all times be humanely treated, and shall be protected especially against all acts of violence or threats thereof and against insults and public curiosity.' Geneva Convention IV, Art. 27; also [T]he term 'cruel, inhuman or degrading treatment or punishment' should be interpreted so as to extend the widest possible protection against abuses." UN Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, adopted by General Assembly resolution 43/173 of 9 December 1988, Principle 7.

12) The ICCPR, in article 18(3), provides for restriction of the rights of thought, conscience and religion 'as are prescribed by law' and only to the

extent 'necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others', and under article 19(3) for restriction to freedom of expression to the extent necessary '(a) for respect of the rights or reputations of others [and] (b) for the protection of national security or of public order (ordre public), or of public health or morals.

International Covenant on Civil and Political Rights, GA res. 2200A (XXI) 16 December 1966 entry into force 23 March 1976. The ECHR provides for curtailment of these freedoms only as far as necessary 'in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others' art. 9 [thought, conscience and religion], or in the 'interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or rights of others, for preventing the disclosure of information received in confidence, or for maintaining the authority and impartiality of the judiciary' art. 10 [freedom of expression], *Convention for the Protection of Human Rights and Fundamental Freedoms* 1953 ETS 5 [ECHR], the Inter American Convention on Human Rights 1978, O.A.S. Treaty Series No. 36, 1144 U.N.T.S. 123, provide similar exceptions under art. 12 and 13.

ing of comparable severity,<sup>13</sup> is the presence of a ‘purposive’ element;<sup>14</sup> the purposive element then, rather than relative severity, informing the abhorrent nature of treatment understood under international law as ‘torture’. An absolute prohibition on suffering inflicted in the course of e.g. interrogation, regardless of its severity, sees that purposive element the abhorrent characteristic of treatment deemed ‘torture’ similarly inform the reprehensible, and so prohibited, character of treatment inflicted for the same purpose resulting in suffering of a lesser severity. The listed purposes found in the definition of ‘torture’ under article 1 of the UN Convention against Torture<sup>15</sup> [hereafter *the Convention*] all, with the exception of ‘for discrimination of any kind’, presuppose a context of detention, custody or control. It has been suggested elsewhere that the ‘powerlessness’ of the victim in these situations justifies the aggravated stigma attaching to inflicted suffering to deem that ‘torture’.<sup>16</sup> It is suggested *here* that the ‘powerlessness’ of the

victims in these situations – contexts of ‘control’ – justifies [in addition to justifying the label torture where the severity is sufficiently ‘severe’] the irrelevance of balancing to determine the reprehensible, and so prohibited, nature of treatment for one of these purposes regardless of its severity; justifying its prohibition without recourse to balancing.

A review of the effect the inclusion of a ‘purposive’ element in the definition of torture has, seems to support their having been put ‘beyond proportionality’, beyond ‘justifiability’. ‘Purpose’ is both a category of *mens rea* and a factor in attribution.<sup>17</sup> The inclusion of purpose therefore serves to affect a narrowing of either the required *mens rea* [as the listed purposes do not exhaust the possibilities of intentional infliction] or the rules of attribution [leaving only the infliction of severe suffering as state policy or state sanctioned]. The scale or degree of this narrowing effect is determined by the adopted interpretation of the listed purposes. Interpreted widely to encompass sadistic

13) While it is accepted that both *severity* and *purpose* might distinguish ‘torture’ from ‘other acts of cruel, inhuman or degrading treatment’, the reference here is to the distinguishing factor of treatment of ‘comparable severity’.

14) Article. 1 of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment Adopted and opened for signature, ratification and accession by General Assembly resolution 39/46 of 10 December 1984 entry into force 26 June 1987, (and accepted elsewhere as customary law elements of the crime of torture, see, for example, the appeal chamber of the International Criminal Tribunal for the former Yugoslavia [ICTY] in *Prosecutor v. Anto Furundzija*, No. IT-95-17/1-A, (ICTY Appeals Chamber July 21, 1999) at para. 111; see also; *Prosecutor v Delalic and Others*, Case IT-96-21-T, Judgement, 16 Nov 1998, para. 459, and; *Prosecutor v. Kunarac et al.*, Case No.IT-96-23-T & IT-96-23/1-T, Judgement, ICTY TC, 22 February 2001, at para. 469). See, also Nowak, supra note 2.

15) Being ‘such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind’, Article. 1 of the UN Convention against Torture, supra note 14.

16) Nowak, supra note 2, at 832.

17) ‘...the purposes referred to in article.1 must be understood as having some connection with the interests or policies of the State and its organs’, Burgers and Danelius, *The United Nations Convention against Torture: A Handbook on the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (M. Nijhoff Publishers, 1988), at 119.

infliction of pain,<sup>18</sup> the effect on either the rules of attribution or the required *mens rea* is negligible and the purposive requirement seems *de trop*. Interpreted narrowly it sees a corollary narrowing of the rules of attribution and of the required *mens rea*, raising the burden and making a violation harder to establish [something unlikely to have been intended given the nature of human rights protection being focused on achieving maximum protection rather than establishing ‘guilt’]. Given authoritative interpretation of purpose in the wide sense,<sup>19</sup> it is suggested that the rationale of their inclusion is then to indicate the reprehensible nature of treatment inflicted for these purposes and excluding, as policy, these specific purposes from those which should be subject to any balancing even when resulting in less than severe suffering. The list of purposes is then a policy statement as to those having been put ‘beyond justifiability’ and the manifest unacceptability of inflicted suffering for these specific purposes without recourse to severity.

### Other purposes

The Convention then, in its specific reference to purposes associated with ‘torture’, establishes the *irrelevance* of any notion of justifiability in relation to the prohibition of treatment inflicted for those purposes. But in relation to suffering inflicted for other purposes, the Convention can also be seen to implicitly establish a justification threshold

to excuse categories of potentially legitimate inflicted suffering. Article 16 prohibited treatment [defined as ‘other acts of cruel, inhuman or degrading treatment which do not amount to torture’<sup>20</sup>] would seem to cover a broad range of treatment not amounting to ‘torture’, including; treatment inflicted for a listed purpose though not meeting the requisite level of ‘severity’; treatment resulting in both severe and less than severe suffering inflicted for purposes other than those under article 1, and; as well as non-purposive suffering. However the reach of article 16 can not have intended to catch [or excuse] *all* forms of suffering inflicted for any other purpose than those listed in article 1, as there are some circumstances, for example in the effecting of an arrest, in which a measure of inflicted suffering, without being in anyway reprehensible, is inherent in, or collateral to a justified act. Instead the article must contemplate, and must contain, an implied threshold distinguishing ‘cruel, inhuman or degrading [prohibited] treatment’, from all forms of inflicted suffering not amounting to torture. Although the Convention says nothing explicitly about suffering inflicted for any other purpose, or about proportionate suffering in relation to those purposes being excusable, the language used by article 16 (referring to ‘other acts of *cruel, inhuman or degrading treatment or punishment* which do not amount to torture’ rather than ‘other acts of *inflicted suffering* not amounting to torture’) sets up the distinction between

18) The wide reading suggests that ‘...even where a sadistic motive is predominating, there is normally also an element of punishment or intimidation which would bring the act under the definition in article.1 [of the UN Convention]’, or alternatively ‘where a public official performs such an act [sadistic], there is also to some extent a public policy to tolerate or to acquiesce in such

acts’, such policy would there by be driven by intimidation motives.’ Burgers and Danelius, *supra* note 17, at 119.

19) *Ibid.*

20) Article 16 UN Convention Against Torture, *supra* note 14.

all acts of inflicted suffering and those prohibited; demonstrating that the Convention did not seek to prohibit *all* acts of inflicted suffering, instead distinguishing collaterally inflicted, or proportionate, suffering incidental to the pursuit of a legitimate purpose.

### The danger of justification

Assertions that '[t]he absolute prohibition proclaimed in article 5 [of the 1948 Universal Declaration of Human Rights] has rarely been questioned',<sup>21</sup> seem to overstate the infallibility of the protection afforded under the prohibition and fail to acknowledge the threat that a 'justification' doctrine represents to the protection afforded against deliberately inflicted, potentially severe, suffering. That the absolute prohibition on inhuman treatment 'has rarely been questioned' maybe so; but exactly when justification might engage to excuse inflicted suffering as not 'inhuman' is *constantly* questioned. Qualifying terms like 'severe' or 'unjustified' in the definition of what is absolutely prohibited allow for... No, *encourage* a targeted exploitation – creative interpretation – by states of those terms, seeing a proliferation of arguments that, for example, 'the treatment is justified, and so never amounts to prohibited ill-treatment'.

As set out above, it is recognised that at present the potential for justification to excuse inflicted suffering is entertained only for certain and limited purposes. However

there is a danger in a signalled willingness by courts to engage in balancing exercises in certain situations being 'co-opted' either in support of direct arguments for the appropriateness of balancing in other, or all, situations [seeking to erode the list of purposes deemed 'beyond proportionality']; for example, in support of arguments that call for courts to balance the degree of inflicted suffering against the 'purpose' in, e.g. the extraction of information], or at least contributing to a 'fog of ambiguity' surrounding 'justification' and its applicability, exactly when it is relevant and when not.<sup>22</sup> This ambiguity is then targeted in the U.S. 'torture papers' and requests and authorisation for enhanced interrogation techniques for use on 'high-value' Guantanamo detainees including Khalid Sheikh Mohammed,<sup>23</sup> thus seeking to effectively circumvent the protection afforded by what is an absolute prohibition.

Arguments put before the European Court of Human Rights by respondent and intervening governments in the case of *Ramzy*<sup>24</sup> directly asked the Court for either a broader justification or higher severity threshold in the context of national security, either expanding the contemplated 'justifications' for inflicted suffering to include national security, or raising the entry threshold for Article 3 prohibited treatment so that lower end suffering, inflicted either in the course of refoulement, or even during interrogation would fall beneath that threshold;

21) Edouard Delaplace & Matt Pollard, *Torture prevention in practice*, Torture Volume 16, No. 3, 2006.

22) The term 'fog of ambiguity' used here is taken from 'Taxi to the Dark Side', Alex Gibney [2007] referring to a confusion designed to conceal the nature of rules expressly prohibiting 'coercive interrogation techniques' used on detainees – leading directly to Abu Ghraib.

23) Compiled in *The Torture Papers; The Road to Abu Ghraib*, edited by Karen J. Greenberg Joshua L. Dratel, 2005, Cambridge University Press (ISBN-13: 9780521853248 | ISBN-10: 0521853249).

24) *Ramzy v. Netherlands* App. no.25424/05.

‘...the greater the reach or coverage of Article 3, the more pressing becomes the issue whether a terrorist threat should be wholly left out of account’.<sup>25</sup>

While these arguments do not argue for an exception to, or directly threaten the absolute status of the prohibition on ill-treatment, they instead argue for a broader justification threshold for what would still be an absolute prohibition, and if accepted would represent a considerable circumvention to the effective protection afforded detainees against deliberately inflicted suffering.

### **The alternative – a contextually bounded prohibition on all inflicted suffering**

The above has attempted (i) to set out current understanding of the operation of justification in excusing proportionate, intentionally inflicted suffering for certain purposes, (ii) to explain other purposes as having been put beyond proportionality, and (iii) to draw attention to the potential for circumvention of a prohibition defined as ‘unjustified inflicted suffering’. This has focused on the role of a justification doctrine currently instrumental in excusing certain forms of deliberately inflicted; a target for arguments

that seek to undermine the level of protection afforded detainees.

What follows suggests an alternative interpretation for the prohibition’s applicability, one that, by restricting the prohibition to contexts of control and at the same time reinterpreting it as one not on ‘unjustified-inflicted suffering’ but one prohibiting all inflicted suffering in a context of control, might effectively ‘purge’ the law of any remnants of ‘justification’ and so avoid ambiguities over its relevance.

Support for such a reinterpretation can already be found. As set out above, the UN Convention does not explicitly refer to prohibited treatment inflicted for other than one of the listed purposes [referring only to ‘other acts of cruel, inhuman or degrading treatment which do not amount to torture’]. And the majority of those listed purposes do presuppose a context of detention or at least control; something interpreted to justify the label ‘torture’ attaching to severe suffering inflicted for one of those purposes.<sup>26</sup>

In addition, commentary to the drafting of the 1975 UN Declaration against Torture [*Declaration*] and the UN Convention against Torture [Convention] persuasively suggest that,

25) Ramzy v. Netherlands App. no.25424/05, Observations of the intervening governments para. 19.

26) See Nowak on ‘powerlessness’ supra notes 2 & 16.

27) Burgers and Danelius, supra note 17 p. 120. ‘The 1975 Declaration was drawn up by the Fifth UN Congress on the Prevention of Crime and the Treatment of Offenders in response to a request from the General Assembly ‘to include, in the elaboration of the Standard Minimum Rules for the Treatment of Prisoners, rules for the protection of all persons subject to any form of detention or imprisonment against torture and other cruel,

inhuman or degrading treatment or punishment’. Two years later the General Assembly requested the Commission on Human Rights to draw up a draft convention in ‘light of the principles embodied in the declaration.’ All work undertaken in the framework of the Commission for preparing the present Convention was performed under an agenda item reading ‘Question of Human Rights of all persons subjected to any form of detention or imprisonment (italics added)’. The connection between the phenomenon of torture as dealt with in the Convention and deprivation of liberty is also apparent from articles 10 and 11 which explicitly refer to persons ‘subjected to any form of arrest, detention or imprisonment’.

‘... the history of the Declaration and the Convention make it clear that victims [for the purposes of the Convention] must be understood to be persons who are deprived of their liberty or who are at least under the factual power or control of the persons responsible for the treatment or punishment.’<sup>27</sup>

Against such an interpretation, subsequent international jurisprudence has, however, seen the prohibition progressively applied beyond contexts of direct control, custody or detention, to e.g.; relatives of disappeared,<sup>28</sup> house demolitions<sup>29</sup> and to discriminatory policies exercised against minorities.<sup>30</sup> These, which *prima facie* appear outside or beyond any context of control, and which cannot be ignored, are situations which would have to be re-interpreted as ones, while not amounting to ‘direct’ control, might amount to ‘factual’ or ‘effective’ control, were an interpretation of the prohibition as one contextually bounded to be adopted.

Conversely, utilitarian exercises in the justifiability of inflicted suffering, for example against rioting prisoners, would have to be interpreted as falling *outside* or *beyond*

the absolute sphere of prohibited inflicted suffering; as situations *not* amounting to ‘direct’, ‘factual’ or ‘effective’ control. The forced used, the subject of an exercised balancing of its relative severity and purpose, would need to be understood as having been applied, beyond the contextual scope of the absolute prohibition; the use of force acceptable to the extent exercised outside, and with a view to ‘returning’ someone to, or [re-]establishing a context of, ‘direct control’. This is instrumental in establishing a context for the law’s *subsequent* applicability.

The adoption of ‘direct’, ‘factual’ or at least ‘effective’ control would, then, have to both (i) explain the application of the prohibition to e.g.; relatives of the disappeared and house demolitions as situations of ‘factual’ or ‘effective’ control, and (ii) exclude those situations in which a degree of justification is employed to determine prohibited from legitimate inflicted suffering; understood as ones other than ‘direct’ or ‘effective’ control, and so falling outside the scope of the prohibition. Semantically, however, the adoption of an ‘*effective*’ control formulation – to see treatment of relatives of disappeared included – might be seen

28) *Cakici v. Turkey* (App.23657/94), judgment of 8 July 1998 (2001) at para. 98

29) *Hajrizi Dzemajl et al. v. Yugoslavia* CAT Complaint No. 161/1999, UN Doc. CAT/C/29/D/161/2000.

30) The ECtHR has interpreted art.3 broadly, not being restricted to contexts of deprivation of liberty; ‘The Convention does not contain any provision relating specifically to the situation of persons deprived of their liberty...’ *Mouisel v. France* (App.67263/01) judgment 14 November 2002, para.38; this is consistently reinforced by the application of article.3 to monitories’ subject to discriminatory policies, *Moldovan and others v. Romania*, judgment no. 2 12 July 2005 (Apps. 41138/98 64320/01), at para.113. The case

concerns the razing of Roma houses in Romania [prior to ratification of the Convention] and the subsequent plight of the Roma applicants; leading to a finding of a violation of article.8 on account of the applicants living conditions aggravated by a general attitude of the authorities which perpetuated the applicants’ feelings of insecurity after razing of the their houses and constituted in itself a hindrance of the applicants’ rights to respect for their private and family life and their homes, going on to find violation of article.3. See also *Cyprus v. Turkey*, (Apps.25781/94), judgment of 10 May 2001, (2001) 35 EhRR 731; concerning the discriminatory treatment of Greek Cypriots in Northern Cyprus; para.305 et.seq. and *East African Asians v. the United Kingdom* adopted on 14 December 1973 (Decisions and Reports 78-A, p. 62...) at para. 207.

to conflict with the adoption of a narrower ‘direct’ control formulation necessary in having rioting prisoners, having been subject to an ‘acceptable’ measure of force, excluded from protection. That is, the expansion of the notion of ‘control’ from ‘direct’ to ‘effective’ to accommodate the prohibitions application to either relatives of disappeared or minority groups subject to discriminatory policies, might see rioting prisoners collaterally subsumed; a collateral subsumation that would then bring back within the sphere of an absolute prohibition on inflicted suffering examples and situations of an accepted/able measure of inflicted suffering.

Secondly, such an interpretation, applied to established jurisprudence, risks defining ‘control’ – ‘direct’, ‘factual’ or ‘effective’ – out of meaningful existence. Jurisprudence [especially that of the ECtHR on degrading treatment] suggests that appropriate contexts for the prohibition’s application actually bridge from custodial situations of direct control, through those of ‘powerlessness’ of the victim, almost to the inevitable unequal position of power of the State to the individual. Cases involving the razing of property where a state’s involvement is limited to a power of intervention not having been exercised,<sup>31</sup> developments regarding positive obligations,<sup>32</sup> and situations in which article 3 of the European Convention on Human Rights has been invoked as a particularly severe violation of article 8,<sup>33</sup> are not easily

comparable to that of a powerless prisoner in ‘direct’, or any other type of subjugation to state officials.

Pre-empting criticism that such a narrow interpretation for the prohibition’s scope – one restricted to contexts of direct control – might see vulnerable groups denied protection, e.g. where disproportionate, violent force is exercised against protestors, such a situation – seeing an immediate inequality of power between the state and its citizens – arguably comes under force used in a situation of control. Situations which would provide the opportunity for such an inequality in power to be exploited are at least suggestive of a measure of control sufficient to engage protection.

### The role of ‘proportionality’

Reconciliation of an exercised proportionality with a contextually bounded prohibition on any inflicted suffering, necessitates then both; (i) the re-classification, addressed above, of those situations in which proportionality has been exercised as ones *outside* the scope of the prohibition [adoption of the ‘direct’, ‘factual’ or ‘effective’ control formulation] *and*; (ii) a corollary re-clarification as to the ‘role’ of proportionality – to be instrumental in determining the point at which control is established, and beyond which force [which can then be called excessive or ‘cruel, inhuman or degrading’] is caught by the prohibition. That is, force used

31) Hajrizi Dzemajl et al. v. Yugoslavia No. 161/1999, UN Doc. CAT/C/29/D/161/2000 (2002).

32) For example, where States have been found under obligation to provide methods by which protection can be ensured, to provide effective channels for redress and to have in place an effective criminal justice system capable of prosecut-

ing acts of ill-treatment and torture, regardless of whether the conduct is that of State agents or private parties. Aksoy v. Turkey, (App. 21987/93), Judgement 18 December 1996, para. 98.

33) Moldovan et al. v. Romania, No.2 (Apps. 41138/98 and 64329/01) Judgment 12 July 2005 para. 109-113.

in situations initially outside ones of ‘direct control’ being acceptable only to the extent required to establish, and only up until the point it has in fact established, control. Force used *beyond* that necessary to establish control, or subsequent to the establishment of control, would then be subject to the prohibition. This seems to be an understanding of the role of, and limits to, ‘acceptable’ force supported by the Council of Europe’s Committee for the Prevention of Torture; having suggested that force used beyond that necessary to *return the victim to a situation of ‘direct control’* cannot be justified:

‘...the CPT fully recognises that the apprehension of a suspect may often be hazardous, particularly if the individual concerned resists and/or the police have reason to believe that the person might be armed and dangerous. The circumstances may be such that the apprehended person, and possibly also the police, suffer injuries, without this being the result of an intention to inflict ill-treatment. However, no more force than is reasonably necessary must be used. Furthermore, *once apprehended persons have been brought under control, there can never be any justification for their being struck by police officers.*’<sup>34</sup>

Current understanding is for proportionality to apply in ‘defining the scope of th[e] right’<sup>35</sup> as one not to be subject to ‘unjusti-

fied inflicted suffering’ regardless of context, with UN Committee against Torture jurisprudence on excessive use of force by law enforcement officers interpreted as supporting the application of Art.16 CAT ‘... outside the situation of detention or similar control’<sup>36</sup>. The alternative, set out here, is an interpretation that sees the use of force by security personnel as instrumental in the establishment of ‘direct control’ and the disproportionate measure of force as having been exercised subsequent to the establishment of control; the context for it’s absolute prohibition. As much as force used subsequent to the establishment of control is subject to the prohibition, force *beyond that necessary* to establish control – excessive force – is equally subject to Art. 16. This suggests that only through establishment of the relevant context [‘direct control’] is proportionality instrumental in defining the scope of the prohibition. Interpretations bypassing this role for proportionality open up the possibility for, and indeed expressly endorse, expansion of the scope beyond situations of ‘direct control’ and a corollary enhanced role for proportionality and justification. The re-interpretation equates suffering inflicted within a context of detention, or a wider degree of ‘control’ with unjustified inflicted suffering.

## Conclusion

Detainees, those under direct control, or

34) [emphasis added] CPT - Bulgaria, 1995, CPT/Inf (97) 1, para. 31. Near-identical language is used elsewhere, e.g. in CPT - Norway, 1999, CPT/Inf (2000) 15, para. 11; CPT-UK, 2003, CPT/Inf (2005) 1, para. 148. A similar point is made by the CPT regarding the use of force in effecting the expulsion of aliens, see CPT - Spain, 1997, CPT/Inf (98) 9, para. 11. The author ac-

knowledges Yuval Ginbar for drawing attention to these references which, while made in a different context, support the current argument.

35) Nowak, *supra* note 2 at. 836.

36) *Ibid.* at. 834.

those subject to an immediate inequality of power affording the opportunity for such a disproportionate level force are most vulnerable and most at risk from inflicted suffering. Contrasted with a prohibition on ‘unjustified’ inflicted suffering, a contextually restricted prohibition applicable only in situations of control and on ‘any’ rather than only ‘unjustified’ inflicted suffering seems to avoid identified dangers associated with a justification doctrine that necessarily plays an enhanced role in a broader or broadly inclusive prohibition. An absolute prohibition on any inflicted suffering, made possible only by restriction of the prohibition to contexts of control, would see any notion of justifiability excusing inflicted suffering otherwise falling within the sphere of the prohibition’s applicability finally abandoned.

However, two outstanding issues – beyond the semantic strain outlined above in reconciling established jurisprudence with such an interpretation – betray any ‘contextual’ understanding of the prohibition. Firstly, there *are* justifications advanced, and accepted, for the infliction of suffering in situations that cannot realistically be considered other than ones of ‘direct control’; e.g. those of ‘medical necessity’. Only justifications legitimising inflicted suffering as ‘a necessary response to the victim’s own conduct’ or otherwise in regaining or establishing control, fit with an understanding of ‘proportionate’ inflicted suffering as having

been exercised other than under a situation of ‘direct control’. Medical necessity, the ‘potential’ justification contemplated in *Nevmerzhtsky*, and elsewhere, would be an exception, though possibly the only, exception to the rule.<sup>37</sup>

‘...a measure which is of therapeutic necessity...cannot in principle be regarded as inhuman and degrading’<sup>38</sup>

This clearly says nothing about ‘returning’ the victim to a situation of ‘direct control’, and would instead support an understanding of the justifiability of treatment relevant, not by the context but by the *purpose* invoked.

However, and this must be the material consideration in whether the re-interpretation of the law is favoured, it is suggested that an exception – possibly the *only* exception to a prohibition on inflicted suffering in control contexts – is not fatal to the exercise in the prohibition’s re-interpretation. Exploitation of an exception that would have to permit the infliction of suffering in the course of a therapeutic measure of medical necessity does not represent, or encourage, the same level of potential for circumvention of the prohibition as the operation of a justification threshold. Re-interpretation of the prohibition as applicable to any inflicted suffering in control contexts, subject to a single exception, provides less opportunity for exploitation of the exception than does the

37) Although the position taken by the government in *Herczegfalvy* might bring such a justification within this type of reasoning; there the government claimed ‘the measures were essentially the consequence of the applicant’s behaviour, as he had refused medical treatment which was urgent in view of the deterioration in his physical and mental health ... *it was only his resistance to all treatment, his extreme aggressiveness and the threats and acts of violence on his part* [emphasis added]

against the hospital staff which explained why the staff had used coercive measures including the intramuscular injection of sedatives and the use of handcuffs and the security bed.’ *Herczegfalvy v. Austria*, (App. 10533/83) 24 September 1992 para. 81.

38) *Nevmerzhtsky v. Ukraine* ECtHR (App. 54825/00) Judgment 5 April 2005, para. 98.

current operation of a justification threshold. As noted, the incorporation of notions of ‘severity’ or ‘unjustified’ into the definition of what is prohibited encourage targeted erosion of the total protection afforded detainees.

Secondly, and it is accepted that this might be more problematic, the revised role for proportionality, active in interpreting the establishment of the context for the prohibition’s subsequent applicability, contemplates use of force acceptable only, and to the extent exercised, to bring the subject [not yet a ‘victim’] under ‘direct control’; suggesting that it might be possible to identify the precise point at which such control is established, force becomes ‘disproportionate’, the prohibition is engaged, and beyond which further force [which can then be called unlawful] is caught by the prohibition. However, such a point is *not* always identifiable. Rather disproportionate force might take the form of a single disproportionate act - not the series of actions leading up to and passing a point at which control is established. This argument, however, is also not fatal, as it is at least arguable that the requisite immediate unequal position of power for such an excessive, disproportionate single act, *would* suggest a degree of control. A single disproportionate act, disguising the point at which control is established, implies the pre-existence of an unequal position of power, the exploitation of which resulting in the infliction of suffering would be prohibited. It might also amount to force used beyond that necessary to establish control – and equally subject to the prohibition.

Finally, the author acknowledges that to root the irrelevance of proportionality in the purpose for which treatment is inflicted, as the current understanding of the law does, rather than the context in which it is inflicted, has the benefit which should not

be abandoned of seeing an irrelevance of severity for determining treatment as *prima facie* prohibited when inflicted for a prohibited purpose. Thus, a very low severity ‘entry-threshold’ is set, arguably maximising protection.

### Manuals

Guidelines and manuals addressed to health professionals and other interdisciplinary workers helping to provide practical advice, recommendations and tools in therapy for rehabilitation for victims of torture, organized violence and suffering after traumatic assaults have been developed from many institutions, clinics and rehabilitation units.

These guides and manuals are not textbooks, and should not be, but rather offer information and knowledge taken from consensus-based experience material, more or less supplied with a focus adapted to the specific organisation.

In order to give attention to such manuals in general, and specifically on how they can be expanded upon, a chapter from a French guide titled "Treating torture victims: a guide for practitioners" is presented here. It is published in an English translation from the rehabilitation centre AVRE with support from the French Ministry of Solidarity, Health and the Family. From this guide follows chapter 5 "How to deal with torture victims".

## How to deal with torture victims

Hélène Jaffé, MD\*

### Definitions

"Torture victims are not only ashamed to confess their fear, their cries of pain and their pleas for mercy, they are also ashamed to admit what they have suffered ..."

*Paul Ricœur – Preface to "L'interdit ou la torture en procès", ACAT, CERF*

Torture should be seen as the cause of unease, the origin of which is difficult to identify for some patients. It is always difficult for victims to talk about their experience. It is therefore necessary to create a situation where they feel properly listened to and at

ease. Other members of the family should also be taken into consideration: their partner and children will also have been shaken by the horror of what has happened. It is important to give them the time they require, or else to refer them to another specialist if you are unable to deal with them yourself.

### I – Identification

Some patients who attend a consultation are suffering the after-effects of torture or highly traumatic experiences, in particular those who have come from foreign countries and have only recently arrived in France. It should be remembered that as torture victims they will have been harshly interrogated many times. It is therefore necessary to conduct this "new interrogation" with tact, and to know when to stop if the patient is unwilling to answer.

\*) Former head of AVRE (Association pour les Victimes de la Répression en Exil)

Torture victims may only request a consultation because they have some other ailment. But very often they reveal their suffering through indirect complaints such as insomnia, headaches and diffuse and ill-defined pains. They are ashamed to admit that they have been tortured.

However, by asking a few questions you will show your patient that you are also interested in his/her past:

- Where do you come from?
- What was it like there?  
And now
- What is your status in France?
- Are you a refugee or asylum-seeker or do you have another status?
- Why did you leave your country?
- You must have experienced difficulties?
- Did you have financial difficulties or come into conflict with the authorities?

In the latter case:

- Were you arrested/imprisoned/mistreated/badly mistreated?  
Allow the patient to speak.

Perhaps (s)he will start to tell his/her story, which may be long and distressing for both you and him/her.

- If the waiting room is full or if you have to make a visit, try to interrupt him/her by explaining that you need a further consultation to be able to discuss the matter properly, and offer to deal with the patient's most pressing need.
- According to the patient, is the reason for the consultation linked to any mistreatment received or is it unrelated? Did the symptoms already exist earlier?

By showing an interest in his/her past you will very quickly enable the patient to feel

that (s)he has found someone who will listen, either now or in the future.

- During a second consultation, after further investigation of the patient's experience, you may manage to relate it to the symptoms presented.
- This is not always easy: the complaints may change from one visit to the next in a disconcerting manner. You must not allow yourself to be taken in: a clinical examination will make it possible to rule out an organic disorder. Ask the patient the reason for the problem: (s)he perhaps has an explanation that a clinical examination does not reveal! The complaint may be seen as an expression of past suffering and often of depression, as is the case for all patients in fact.

Leila had been tortured ten years earlier. She said that one of her fingers was very painful, and pointed to a small scar parallel to the edge of the nail. After the torturer had put a needle under her nail she had suffered a whitlow which had been lanced. Whenever she saw the small scar she felt the pain she had suffered while being tortured.

- What if the patient has language difficulties?

The patient will probably come with a friend or a child to act as interpreter. Allow the interpreter to stay at first but ask him/her to go out for a few minutes before the end of the consultation. You may find that the patient is good enough at the new language to say things that (s)he was unable to say in front of too close a friend or relative, or someone very young. Otherwise the patient may at least make it clear to you that (s)he does not wish to speak in their presence. In this case, if possible you must request the as-

sistance of a suitably neutral interpreter for the next consultation. If you have no interpreter, you could show the patient a diagram of the human body so that (s)he can show you where the problem is. The head and the genitals will indicate difficulties that cannot be mentioned in front of a third party and which it is so difficult to talk about, even in the patient's own language.

*Do not forget!*

60% of the survivors of the Holocaust examined by a psychiatrist said that they did not believe they were listened to properly by the doctor they consulted, when they told him/her of their experience in the Nazi concentration camps.

## II – Treatment

It will then be necessary to implement a strategy for examinations and treatment based on the following approach:

- Arrange the complaints by order of importance:  
What bothers you most?  
What do you want me to treat first?
- Arrange the therapeutic requirements by order of importance, as revealed by the clinical examination.
- Reach a compromise between the complaints and the therapeutic requirements.

You will of course treat the critical pathology from the outset, but your patient will know that (s)he can count on your ability to listen if necessary. Alternatively you may have understood that a number of major physical and psychological traumas are involved that will take time to treat. You will need to plan how to provide the treatment, or if necessary refer the patient to another specialist.

## III – Referral

Depending on the clinical symptoms, the circumstances and the wishes of the patient, specialist treatment may prove necessary.

### *Somatic disorders*

It may be advisable to refer the patient to a specialist. You must then decide how to help the patient to do this, and what information to pass on to the specialist or team that the patient is referred to.

### *Mental disorders*

A psychiatric consultation may prove essential in order to determine which symptoms are linked to the trauma caused by torture, and which belong, for example, to a psychotic-type pathology, given that these patients may also have been tortured.

Psychological help may prevent or cure disorders linked both to the after-effects of the abuse suffered and/or to the family or environment of the refugee.

You must also decide whether the patient should be accompanied: By an interpreter? Which interpreter? A family member?

## IV – Administrative and social problems

The improvement in the health of torture victims will partly depend on the results of the steps taken to resolve administrative and financial problems that they face, like any asylum-seeker or refugee. The complexity of these procedures, discouraging periods of waiting and the importance of the anticipated outcome will have an impact on any treatment provided.

Before obtaining refugee status, asylum-seekers have to go through a real obstacle course, in particular in order to:

- Obtain the right of residency within France, granted by the police headquarters.

- Establish their status as refugee, which is awarded by the French Office for the Protection of Refugees and Stateless Persons (OFPRA), which centralizes all applications.
- Refer their case to the Refugee Appeals Board (CRR) if their application is rejected by the OFPRA.
- Obtain entitlement to social welfare.
- Obtain payment of a small amount from the French unemployment benefit office (Assedic) for a period of one year, from the time that the OFPRA acknowledges receipt of their application.
- Find accommodation.
- Possibly bring their family to France.

In addition, most torture victims also face difficulties of accommodation and financial problems once their savings have run out, and once the hospitality of their fellow countrymen has reached its limit, even if they were willing to put them up for a certain time.

It is essential to work in partnership with such bodies so that the physical and psychological improvement achieved is accompanied by access to rights in a way that is as reassuring as possible.

## V – Specific situations

*How to deal with children*

A few points to remember:

### 1. *They always know more than their parents think*

By allowing them to talk about their experience and the way they lived through the events you will enable them to bring a taboo subject out into the open. The parents often think that the reality is too difficult for their children to bear, and will be relieved to be able to talk openly about their experiences, and the children will also benefit.

2. *Roles may well be reversed within the family*  
Children become their parents' guardians. For example, young people learn to speak the new language more quickly, making parents dependent on their young translators who are thereby able to prematurely take the role of head of the family.

### 3. *The presence of a mental trauma should be investigated*

This will be revealed in regressive, anxious or depressive personality disorders (enuresis, night terror, stammering, aloneness, or on the contrary hyperactivity etc.). In this case psychological care, possibly involving other family members, is essential.

4. *Adolescents want to be treated like adults and frequently oppose all discipline imposed by their close relatives. They may show addictive behaviour, as a means of coping with their anxiety.*

They suddenly find themselves in a consumer society surrounded by temptations and will make demands that their parents cannot satisfy. This leads to tensions within the family that further damage the father's self-esteem.

One solution would be to encourage them to take part in sports activities where the instructor may provide a role model for a certain time.

But it is often necessary to seek psychological support from a specialist for the age group concerned. A few sessions will be sufficient to defuse the situation and the young people will be able to devote their often surprising abilities to building their future.

### 5. *Even if they are doing very well at school, there may be deeper problems*

For example, over-investment in academic activities may be a way of compensating for feelings of guilt or emotional difficulties.

*How to deal with women*

Rape is increasingly common and in certain cultures the women are then ostracized by their family, although this is less severe when they are outside their country, away from the shame imposed by their society. It is understandable that they have great difficulty talking about what happened. You can reassure them by saying that they are perfectly entitled to have their own private secrets, and that they can speak about it to their husband when they feel ready, and when their husband is ready to listen. Time may be needed.

Fear of HIV infection may also cause women to keep silent about rape: a test for sexually transmitted infections must be systematically proposed.\* In a number of cases this will reassure them, or if the test is positive will make it possible to take the preventive measures required and provide appropriate therapy if necessary.

Finally it should be remembered that very often female torture victims are told that they will no longer be able to have children or satisfactory sexual intercourse. They need to know whether this is true.

In this case too, a clinical examination is generally reassuring. With or without a physical element however, sexual difficulties must be taken into account to avoid weakening a couple that is already suffering, among other difficulties, the trials of exile.

One must be careful however not to see all female torture victims as rape victims who are unwilling to admit that they have been raped. Although some women may hide the truth, not all women have been raped.

\*) Objects used by the torturers may also cause infection!

Women who have come alone, who are widows or who are faced with the disappearance of their husband have a heavy weight to carry. In addition to being physically exhausted, they are often suffering from depression which will be felt by their children, who themselves show the symptoms of their mother's pathology.

These symptoms will disappear as their mother's condition improves.

*How to deal with men*

Contrary to common belief, men also suffer sexual abuse, almost as much as women. They have even greater difficulty talking about it because their male pride has been shaken, the abuse of the torturers has affected them deeply, and because they are not encouraged to speak about such things. In addition, in some societies homosexuality is very harshly condemned, which further encourages them to remain silent.

They often complain of haemorrhoids, anal fissure or pain in the lower abdomen, but refuse to be examined. This is often a plea for help.

Without being insistent, it is necessary to:

- Provide relief by treating the symptoms first.
- Say that you can imagine what happened to them, and that they can talk about it if they want to.
- Suggest tests for sexually transmitted infections which are essential for them and their wives.
- Treat any depression which leads to a drop in libido or even impotence.
- Deny the claims of the torturers by stating the facts (e.g. "As a doctor, I know more than they do, I assure you this will not stop you having children").

*How to deal with the family*

If the family has arrived together or within a short space of time, they will all need to come to terms with reality. Some will do so by falling into an even deeper state of depression, some will flee from their family, brought closer together by the ordeals and seen as stifling, and some will show behavioural disorders, for example with addictive behaviours. For a certain time however, their curiosity for their new environment may lead to remission of their psychological difficulties.

But the failure to discuss what each person has experienced will negatively affect relations within the family. It may be necessary to propose psychological help in the short term, usually for a brief period. This will make it possible to see who needs greater support.

If the family has been reunited after a separation of several years, the members will have to learn to live together again.

It is therefore necessary to prepare for this: Tell your patients not to be surprised at how much their children have grown and how independent they are, and that their partner has grown used to having to cope alone.

Their anxiety and depression will be made worse by the feeling that they have changed, that they have aged prematurely and have a poor quality of life. They should be treated during the period that the family is reunited, which may also lead to the return of episodes of revivication that may be distressing for one or other family members.

## Recommendation

- Speak as simply as possible about the different experiences of each family member.
- Review the positive achievements e.g.

their increased safety, to help the family to get over the first few weeks. Similarly, more frequent consultations will make it possible to deal with difficulties as soon as they arise.

Under such circumstances the help of a marriage guidance counsellor or psychologist specializing in family therapy is advisable.

**VI – Coping with difficult situations***Be aware*

That the patient may be reluctant to undress, because that is how the torture sessions began. You must take this into account. After all, you can simply slide the stethoscope under the shirt ...

That the complaints may change from one visit to the next – which is simply a means for the patient to say that (s)he has been hurt everywhere – and that each time you go over a painful experience you remind him/her of the torture, which will bring back other pains etc.

That giving pills “to help you sleep” to someone who has nowhere to sleep may well not be very effective ...

That care is required when prescribing psychotropic drugs and any side effects must be clearly explained. Such patients are wary of anything that may reproduce the feeling of depersonalization that they experienced earlier.

That pictures, sculptures and written texts may help to express things that are too difficult to say, or for which words are inadequate to describe what one has suffered.

That an articulated model (such as are used by art students) can be used by the patient to show where the pain is, or to show what position (s)he was put in while being tortured.

Difficulty	Solution
Language	<p>"Everything is language" – Françoise Dolto</p> <p>Drawing and mime can be used to communicate</p> <p>The term "police" can be understood in any language</p> <p>Observe the patient's movements, clenched or trembling hands that betray the apparent calm of his/her face etc.</p>
The patient has a mental block (S)he is beset by strong emotions, starts to cry and can no longer speak	<p>Do not allow an oppressive silence to take over, suggest that the patient tells this difficult story later and ask what (s)he would like you to deal with first</p> <p>Do not go any further for the time being. Ask the patient if something in your surgery reminds him/her of what (s)he suffered (an electrocardiograph may remind him/her of the electric shocks)</p>
If you do not have enough time If you do not want to get involved in a case that you are afraid you will not be able to handle If you have reservations, perhaps linked to your own personal or, family experiences	Do not be ashamed to delegate, but carry out a sympathetic and careful clinical examination, according to the complaints expressed. The patient perhaps wants nothing more than to start the healing process
If the patient faces welfare or administrative difficulties	This refers to an appendix elsewhere

### A few statistics concerning after-effects

No comprehensive studies have been carried out on a worldwide scale. They are all fragmented and generally concern a specific country.

It should be remembered that many patients who are torture victims have no other way of expressing their mental suffering other than through somatic complaints, both here and elsewhere.

It is therefore of interest to investigate the complaints rather than the symptoms.

A study of the most common complaints within a population of torture victims from the same country reveals that this also applies to most of our patients. In extreme situations there seems to be a universal response, regardless of the sociocultural level or geographic origin.

Physical complaints:

- headaches

- diffuse pain
- gastrointestinal pain
- specific articular pains (mainly lumbar and back)

Psychological complaints:

- sleep disorders
- attention and memory disorders
- behavioural disorders
- panic attacks

Fear of being diagnosed as mad leads such patients not to mention pseudo-hallucinatory disorders which are very common. They only refer to them later on, once a relationship of trust has been built up. The doctor may mention these him/herself and will be able to reassure the patient since we know that such symptoms are sparked by events that are themselves crazy, and that they can be treated.

### A few cases

Mr A... D... was referred to us due to epileptic-type fits that were taxing for those around him and for the doctor of the hostel where they were staying.

These fits were not mentioned during our first meeting. He complained that he could not sleep for more than three hours because of fear of the nightmares in which he was being tortured again. He also complained of pain in his left hip which he said was due to the electric shocks, and of headaches, "especially when I think". Finally, he could no longer remember things and could not concentrate on a book: he kept forgetting what he had read.

All of the examinations carried out showed clearly that there was no epileptogenic source.

Photographs of his hips show a small circular mark on the head of the femur that is non-progressive and proves to be not related to the trauma described.

On the other hand, the rheumatologist whose opinion we asked thought it might be paroxysmal meralgia, which improved after a few months.

His wife said that their relationship had been transformed: he had become infantile, quick-tempered and at times almost became violent.

We learn that he had very often been on long hunger strikes which must have played a part in his mental disorders.

One day, on regaining his composure after yet another fit, he told us that while he was being tortured he had gone through a whole period when he did not know if he was dead or alive ... What exactly did he tell his torturers during that time?

The fits enable him to attract the attention and help of others, freeing him for a time from the unbearable question that he has been asking himself ever since.

The marriage ends in divorce. He has to learn a new trade suited to his physical and psychological abilities, the latter having certainly been impaired by the long periods of hypoglycaemia.

This union official was severely affected by the torture he suffered.

S.V..., a young lad, was referred by the hostel where he was staying due to his timid attitude and his screams in the night that disturbed his neighbours.

He presented himself to us after having postponed his appointment twice. He appeared terrified, jumped at the slightest noise and whispered between his teeth.

He explained to us that he had been subjected to a form of torture that involved being pricked with a needle throughout his body, which he said lasted for hours. He said that he still had the feeling that he was going to be pricked again, hence his constant vigilance and nervous tension.

He was treated with tranquilizers and gentle massage, at first only on the parts of his body he could see, and then little by little, as his confidence returned, throughout his body. His sleep improved and he learned to relax. In the space of a few months he regained his peace of mind.

Mrs. D. G... was arrested and subjected to falaka, i.e. repeated blows to the soles of the feet.

On leaving prison she had to undergo a skin graft due to skin necrosis on the soles of both feet.

In addition to insomnia she complains of pains in the knees and back as soon as she walks a little.

She refused to let us examine her feet.

At the following consultation she explained to us that she cannot look at them,

that it is too difficult for her because it reminds her of when she was tortured.

She walks on the outside edge of her feet to avoid pressing on her soles and consequently damages the heels and outside edge of her shoes.

She was provided with orthopaedic soles to support the soles of the feet, together with a few foot-massage sessions undertaken with great sensitivity and a non-aggressive approach. This relieved her pain to the extent that she was able to envisage resuming her work as a dentist, which she had previously considered impossible as it involves a standing position.

During interrogation, Mr. M. N... was subjected to "jaguar" torture\*.

Since then he suffers pain in one shoulder and in the chest.

He believes that it has given him a heart condition. The ECG result was normal, but pain recurred when tensing of the pectoral muscles was antagonized: he had tendinitis which responded to anti-inflammatory drugs. In the shoulder he has the beginning of a rupture of the rotator cuff.

He tells us that a possible operation is planned, but for later: he is still too afraid of anaesthesia, "when you don't know what you might say".

Referred to a psychologist, he is able to come to terms with the meaning of this fear, which haunts him in fact.

Mr. X. D..., a young Frenchman aged about twenty, undertook psychoanalysis due to difficulties in his relationships with others.

He asked us for a consultation as he had just learned from a member of his family that his father had been tortured by the Nazis in front of his grandparents who were members of the Resistance.

His father was about ten years old at the time. His grandparents died in a Nazi concentration camp.

X. D's childhood was marked by the violent outbursts of his father, who never mentioned what had happened to him when he was a child. X. D. believes that this provides an explanation of his own unease, and we suggest that he tells his father that he has been told about the suffering he was subjected to.

A new, peaceful relationship is established between him and his father, and X. D. was invited to take part in a pilgrimage that the children of deported members of the Resistance carry out each year.

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\*) Jaguar torture involves tying the feet and hands to a stick, as is done by hunters to transport large animals they have caught. Blows and electric shocks can be inflicted in this position.

# Inter-Agency Standing Committee guidelines for mental health and psychosocial support in emergency settings

Margriet Blaauw, MD\*

Psychological and social suffering caused by armed conflicts and disasters can have a serious impact on the well-being and recovery of the affected populations. Protecting and improving mental health and psychosocial well-being should have a priority in emergency settings, however, the field is relatively new, and guidelines on good practices were lacking until recently.

The September 2007 launch of the “Guidelines for Mental Health and Psychosocial Support in Emergency Settings” by the Inter-Agency Standing Committee (IASC) is an important milestone. Developed through consultation with UN organisations, NGOs and universities representing different regions and disciplines, the Guidelines aim to strengthen the humanitarian response in the field of mental health and psychosocial support in emergency settings.

The Guidelines have been developed for all actors doing humanitarian relief work, including local organisations. The Guidelines address mental health problems and the psychosocial impact of emergencies and the people at risk, including torture survivors. They also focus on the resilience of affected

populations and the importance of: recognising skills and resources of people affected by emergencies, inclusion of the affected population in the emergency response, and building on existing ways to deal with difficulties. Though not directly targeted at those working with torture survivors, the Guidelines can be an important tool for rehabilitation centres operating in emergency situations.

Twenty-five action sheets are included with the Guidelines which cover, among other topics, minimum responses related to coordination of the establishment of inter-sectoral mental health and psychosocial support, assessment, monitoring and evaluation, human resources, community mobilisation, health services and education. For each action sheet additional resource material is recommended.

The IASC was established in 1992 to strengthen coordination of humanitarian assistance. It consists of UN- and non-UN humanitarian organisations. Other IASC Guidelines include “Operational Guidelines on Human Rights and Natural Disasters” and “Guidelines on Gender-Based Violence Interventions in Humanitarian Settings”.

The Guidelines can be downloaded in English, French, Spanish and Arabic on the following website: [www.humanitarianinfo.org/iasc/content/subsidi/tf\\_mhps/default.asp?bodyID=5&publish=0](http://www.humanitarianinfo.org/iasc/content/subsidi/tf_mhps/default.asp?bodyID=5&publish=0)

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# Sir,

## **Detainees in Saudi Arabia**

In *Jones v. Ministry of Interior of the Kingdom of Saudi Arabia and others*,\* a case brought in the High Court of Justice in London, four British citizens who had been living and working in Riyadh, were arrested by the Saudi secret police in late 2000 and 2001. They were falsely accused of involvement in a bombing campaign in the country and were detained in Saudi jails for periods of up to nearly three years. They all allege that they were repeatedly tortured and there is compelling medical evidence to support their claims as pointed out in TORTURE 2007,<sup>1</sup> All continue to endure severe psychological and physical harm as a result of torture. They sought to bring a claim against Saudi Arabia and the officials who tortured them but were denied this opportunity by the House of Lords which found the State Immunity Act 1978 to be applicable. The Redress Trust (REDRESS) intervened, along with other organisations, on behalf of the survivors.

REDRESS is an international human rights organisation based in London with a mandate to assist torture survivors to obtain

justice and reparation. It was founded by Keith Carmichael, a UK national who was imprisoned and tortured in Saudi Arabia for two and a half years without any formal charge or court appearance. Since he was released in 1984 Keith has been trying to pursue a claim for compensation for his arbitrary detention and torture. He has petitioned King Fahd and sought espousal of his claim by the Foreign and Commonwealth Office. He has pursued a remedy in the courts of Saudi Arabia and in the United States. All his attempts at seeking a remedy have been unsuccessful. He founded REDRESS over fifteen years ago with the objective of helping torture survivors to gain access to justice.

REDRESS pursues its mission through a combination of casework, research, advocacy and capacity building. One of its advocacy projects is the promotion of the Torture (Damages) Bill through the British Parliamentary system. The Bill is a private member's bill which, if enacted, would enable victims of torture to access the courts of England and Wales to bring a civil claim for compensation against the state and the officials responsible for their torture. This route to justice would only be available when effective redress is not possible in the courts of the state where the torture took place. The Bill was introduced in the House of Lords

\*<sup>1</sup>) [2006] UKHL 26.

on 5th February 2008 by Lord Archer of Sandwell Q.C., the former Solicitor General, and has the support of many human rights, medical, psychosocial and refugee organisations both in UK and around the world. It received its Second Reading on 16 May 2008.\*

### **Torture victims in the UK**

There are many torture survivors who live in the UK and face enormous challenges as a result of having been tortured. They usually require extensive medical treatment for their physical injuries for the rest of their lives. For example, a British man tortured in Saudi Arabia with no previous heart conditions collapsed with a heart attack during interrogation, required heart surgery (throughout the hospital stay he was chained to the bed) and continues to suffer serious heart problems today.

Many torture survivors also require counselling and psychological treatment by trauma specialists for post traumatic stress disorder. They find it difficult to reintegrate into society and to be around groups of people.

As a result of their physical and psychological scars, a large proportion of individuals, who prior to their ordeal had successful professional careers, are now unable to work and are only able to survive on state benefits. A survivor tortured in Ecuador, and another tortured in Bahrain, became homeless on their return to the UK. This increases torture survivors' suffering and feeling of marginalisation.

\*) A transcript of the debate can be obtained through the REDRESS website: [www.redress.org/torture\\_bill.html](http://www.redress.org/torture_bill.html).

### **Access to justice for torture survivors**

For torture survivors, moving on with their lives is never easy, but obtaining justice is very often a crucial factor in their rehabilitation. Justice is as much about the process as it is about obtaining a successful result. For victims, having the opportunity to tell their story and for the truth to be recognised by an impartial court and wider society can help them reclaim their dignity and legitimise their suffering. The validation of their experience can help victims restore a sense of trust and re-establish relationships with others. It can provide victims with a sense of closure over past events and allow them to move on with their lives.

The financial elements of a civil award can help assist survivors with their day-to-day needs, and prevent torture survivors from living on the streets or on state benefits.

### **The problem of access to justice in the country where the torture occurred and at the international level**

Under the present law, individuals who have suffered torture must first pursue a claim in the national court where the torture took place. In many cases this will be an appropriate forum for the complaint. However, REDRESS has found that it can be very difficult for torture survivors to obtain justice at the national level; for example, criminal investigations into alleged acts of torture may not be carried out effectively, if at all, sometimes because the very official or department responsible for the torture is asked to carry out the investigation. This makes it difficult for an individual to substantiate the evidence required to bring a successful civil claim. Claimants can face other hurdles such as the existence of relatively short limitation periods to lodge claims, together with domestic immunities and amnesties for the

prosecution of serious human rights violations.

Sometimes the local judiciary is not independent and follows a policy of not pursuing torturers through the criminal justice system. This creates a culture of impunity where torture is not investigated and so becomes more commonly practiced. This has been the case with individuals whom REDRESS has spoken to.\*

### **The problem of access to justice in the UK**

Where it is not possible to make a claim in the country where the torture was committed, victims living in the UK have sought to bring a claim in the English courts. However, they are also denied a route to justice in the UK: they are prevented from initiating proceedings in the English courts as a result of the provisions of the State Immunity Act 1978. This provides as a general rule that a foreign state is immune from the jurisdiction of the UK courts. In this context, the principle of state immunity acts as a procedural bar to access to justice in the UK. Historically, the principle is borne out of customary international law on the basis of sovereign equality, non-intervention in the internal affairs of another state and international relations.

States used to enjoy *absolute immunity* before the courts of another state, but states have long since moved away from this practice in order, for example, to allow commer-

cial enterprises to sue foreign governments in respect of commercial transactions. This is reflected in exceptions to the general principle of immunity in the UK State Immunity Act and similar legislation in other countries. There is also a “tort” exception where a state commits an act of personal injury in the UK. This exception is also found in the legislation of most common law countries.

Particularly upsetting for the four above-mentioned British citizens arrested in Saudi Arabia was the fact that the UK Government actually intervened in their case, arguing that the application of state immunity was not inconsistent with the prohibition of torture. They had thought that as British nationals, the Government would be supportive of their case but the intervention suggested that it was more concerned with preserving the principle of state immunity and its relationship with Saudi Arabia. The case is currently on appeal to the European Court of Human Rights. However, whatever the outcome at the European Court, the law in the UK needs to be changed if victims of torture are to gain effective access to justice and reparation for the harm they have suffered.\*\*

### **The Torture (Damages) Bill**

The Torture (Damages) Bill seeks to address the problems outlined above, by providing an exception to the State Immunity Act to the effect that states and officials who perpetrate torture will no longer be immune from

\*) For example, Sulaiman Al-Adsani, who was tortured in Kuwait in 1991, was informed that if he returned to Kuwait he would be killed. A Compilation of Evidence on the Torture (Damages) Bill 2007-08, received following the Call for Evidence launched by Lord Archer of Sandwell QC is available at: [www.redress.org/reports.html](http://www.redress.org/reports.html).

\*\*) This would be consistent with the wishes of the UN General Assembly, see Basic Principles and guidelines on the right to a remedy and reparation for victims of gross violations of international human rights law and serious violations of international humanitarian law. Available: [www2.ohchr.org/english/law/remedy.htm](http://www2.ohchr.org/english/law/remedy.htm).

the jurisdiction of the English courts in civil claims for compensation for torture. Providing an exception to the State Immunity Act for torture is not an extraordinary measure, given the restricted immunity afforded states today. The principle of state immunity should be updated in light of the absolute prohibition of torture.

If the Bill were enacted, immunity from jurisdiction would no longer be a barrier to claimants, however, there would still be other procedural conditions to satisfy, such as demonstrating that the UK is the most appropriate forum for the claim. In addition, in order to be successful, the survivors will still have to prove through the court process that they had been tortured. All they seek is this opportunity.\*

Jehangir Jilani, Solicitor \*\*

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\*) For more information on the Bill and how you can support the Bill: [www.redress.org/torture\\_bill.html](http://www.redress.org/torture_bill.html). You can follow the progress of the Bill at: <http://services.parliament.uk/bills/2007-08/torture-damages.html> (June 25th, 2008).

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# Silent healers

*On medical complicity in torture*

Kenneth Mostad, Psychologist\* & Eva Moati, MA\*

## Abstract

*Objective:* To shed light on a large but neglected human rights issue that can be termed passive participation in torture. This is a response to the rising number of statements from torture victims who claim that during their incarceration, medical personnel cooperated with the interrogators by sharing medical documents, giving false statements, and providing other indirect assistance to the interrogator.

*Method:* Cases studies are used to demonstrate the existence of passive participation, as well as situations where the passivity has been addressed and improved.

Extracts of international instruments and actions undertaken by associations are used to help the reader address issues around the passive participation in torture.

*Result:* By reading this article medical professionals will be made aware that action can be undertaken with the help of existing international laws and policies.

*Conclusion:* In the conclusion of the article a range of bullet-points is made available for medical professionals who want to address the issue of passive participation.

*Keywords:* active and passive participation of health personnel in torture, medical professional, universal declaration, medical ethics, AMA, APA, Israel, U.S.A, South Africa, Chile, dual loyalty, international law, human rights

## Introduction

When we commonly think about the involvement of doctors or other health care personnel in torture, cruel, inhuman or degrading treatment, or punishment, we usually think about the atrocities performed during the Second World War by health personnel in the name of medicine. It is for this reason that characters such as Joseph Mengele<sup>1</sup> are famous. As with other health personnel, he conducted medical experiments on Jews in Birkenau concentration camp in Auschwitz. Among other things Mengele introduced grass into detainees' bodies, with the intention of understanding how an infection worked. Even though this murderer escaped, his fellow colleagues were charged and condemned in the Nuremberg trial<sup>2</sup>. Modern international law regarding health professionals is based on the human rights issues that were addressed during the Nuremberg trial. Justice and society agree today to condemn health personnel who are involved in atrocities. At times it is suggested to condemn them to an even larger sentencing, due to their medical responsibility, which will be demonstrated later on.

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It is easy to recognise that someone who purposefully injected a virus or performed a forced sex-change operation is guilty of cruel and inhuman treatment. It may be less easy to condemn, with the same conviction, someone whose only action was not to oppose the torture of her or his patient. Nevertheless, in many cases, medical professionals who participate passively in these actions possibly join the same category as the torturers. For example, a circumstance might arise in which a state-agent requests a doctor to make a diagnosis of a detainee. If the doctor identifies symptoms of torture and does not demand an immediate end to the procedure, the doctor is indirectly legitimising the action of torture (see for instance the Tokyo and Hamburg declarations).

A medical professional working in a state prison might lose a patient's medical history on purpose, knowing that the information inside could be used by international organisations like Amnesty International or the Red Cross. In the two examples above, the doctor is not seen as directly involved, but does comply with a third party, often a state agent, that does not have in mind the best interest of the patient. The main purpose of this paper is to bring to light this invisible complicity, namely *passive participation*, in contrast to *active participation*. The reasons behind this silent acceptance might be manifold, such as believing that the state has the right to torture people that represent potential security threats<sup>3</sup>, resignation due to an overwhelming problem or simply the fear of getting hurt.

According to Steven H. Miles, author of "Oath Betrayed,"<sup>4</sup> somewhere between 20 and 50 percent of torture survivors report "... seeing physicians serving as active accomplices during the abuse". These numbers, Miles explains, do not contain any figures regarding physicians who falsify medical

records or detainees' death certificates, nor do the figures take into account torture techniques designed by medical professionals. Another reason for why there is little data on this issue is that there is more focus on human rights in general, and less on torture<sup>5</sup> in particular. Reports of passive participation are therefore almost impossible to find.

### Grounds for accepting torture

#### *The case of doctors*

A major factor for the medical professional to comply with passive participation in torture is probably dual loyalty. Physicians for Human Rights (PHR) and the University of Cape Town (UCT) in South Africa defines this situation as "a clinical role conflict between professional duties to a patient and perceived or real obligations to the interest of a third party, and focuses on instances where the human rights are in jeopardy".<sup>6</sup> The effect can be that a doctor turns a blind eye to a criminal offence at work, such as torture, and by doing this becomes a passive part of the involuntary extraction of information from a patient. See the 2002 report from Physicians for Human Rights on the six types of dual loyalty:<sup>7</sup>

- A Using medical skills or expertise on behalf of the state or other third party to inflict pain or physical or psychological harm on an individual that is not a legitimate part of medical treatment.
- B Subordinating independent judgement, whether in evaluative or treatment settings, to support conclusions favouring the state or other third party.
- C Limiting or denying medical treatment or information related to treatment of an individual in order to effectuate policy or practice of the state or other third party.
- D Disclosing confidential patient information to state authorities or other third

parties in circumstances that violate human rights.

- E Performing evaluations for state or private purposes in a manner that facilitates violations of human rights.
- F Remaining silent in the face of human rights abuses committed against individuals in the care of health professionals.

These are common situations that we can qualify as passive participation in torture, cruel, inhuman or degrading treatment, or punishment. Unlike other kinds of more active participation, these last cases are rarely revealed, nor punished. The passive participation of health care personnel in torture and other cruel treatment is far less recognized and punished compared to cases of active participation. This difference is embedded in the nature of torture, which forces the victim to remain in the shadow of society and requires him or her to remain silent about the abuse. The nature of passive participation itself also contributes to the difference between prosecution of its agents and those who participate more actively.

Since the doctors who participate passively are actually guilty of not reporting any data, it remains very difficult to document a passive act. It is also very difficult to find the guilty medical professional, since the victims may not even get to see them. A case example is Amin Shqirat, who was in detention on 28th December, 2004. He explained that “They brought me to a doctor who examined me and then returned me to the interrogation blindfolded and handcuffed.”<sup>8</sup> As he was blindfolded, it would not be possible to prosecute anyone without written evidence.

The program director of the working-group between PHR and UCT (see the above section), Leonard Rubenstein, has identified four circumstances in which health

professionals can find themselves in a situation of dual loyalty, and accordingly where the human rights of the client can be violated.<sup>9</sup> A situation of dual loyalty can, first of all, be explained by a *lower quality of care*. This might be due to a variety of reasons such as the culture at the institution, local pressure, or national laws demanding sub-treatment of certain ethnicities. Confronted with dual loyalty, doctors employed in a prison might *remain silent*. They sometimes do not report to authorities, or other institutions or organizations that might help to improve the human rights of the patient. The health personnel might also have to *impose medical procedures to serve state interests*. One example can be the use of chemicals in a torture related situation, as well as supervision and injection during an execution. Finally, there are cases of *compromising one’s medical judgment*, for example when a medical forensic expert overlooks compromising evidence of torture for the benefit of a third party, often the state.

Dual loyalty is not the only reason for health professionals to accept being implicated in torture. Amnesty International (AI), in their report called “Doctors and Torture”,<sup>10</sup> lists five reasons for why medical professionals might be involved in torture: *Bureaucratic necessity* is equivalent to a situation of dual loyalty since this relates to medical professionals who find it difficult to go against the wishes of their employer. Persuasion might work with the use of ideology, for instance claiming the importance of the security of the state, and the significance of the health professional’s help. Health personnel can, for instance, be *pressured or threatened* not to tell anyone what is going on, they can lose their job, or receive threats to their family. *Workplace pressures* are similar to the last point, and are also a part of the dual loyalty problem. Pressure is put on the med-

ical personnel, by the use of expectations or threats, to stay loyal to the institution that they work for. *Lack of awareness of medical ethics* is a problem when medical personnel think that if they do not participate in the actual torturing, they are not in breach of medical ethics. This is of course incorrect.

AI, in "Prescription for Change Health professionals and the exposure of human rights violations",<sup>11</sup> also gives 11 more examples for why medical professionals may fail in reporting human right violations.

*The case of medical organisations and institutions*

Another major issue that needs attention is the institutional acceptance of passive participation. An example of an organisation that indirectly supports torture is the American Psychological Association (APA). On the surface APA seems to be following the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT). The statement on their Web-Pages declares that the "APA has made absolutely clear that it is always unethical for a psychologist to participate in torture or cruel, inhuman or degrading treatment in any setting for any purpose".<sup>12</sup> This declaration is written in its full length under the APA resolutions, and is an adoption of the UNCAT.

When the APA, in their reaffirmation 19th August 2007, defines torture or cruel, inhuman, or degrading treatment, or punishment, it is not in the lines of the UNCAT definition. The policy is instead founded on the (John) McCain Amendment<sup>13</sup> that rests on the 5th, 8th and 14th amendments of the Constitution of the United States of America.<sup>14</sup> The problem with using these amendments is that they are not clear about the exact definition of torture and cruel, inhuman, or degrading treatment, or punish-

ment. The amendments demand that the detainee has been charged for a criminal act, and they do not apply to non-U.S. citizens located outside the U.S.<sup>15</sup> It is through the application of this policy that health professionals such as John Leso, a behavioural psychologist, can be a member of the APA and still design interrogative techniques to be used in the detention facilities at Guantanamo Bay.<sup>16</sup> In the drafting of an APA ethical report in 2006, no less than six of the ten board members had "close ties"<sup>17</sup> with the army of the United States. Four of the six had also served in American detention centres in either Guantanamo, Abu Grahیب or in Afghanistan. The relationship between psychologists and the army of the United States has a long history<sup>18</sup> and is, for this reason, an example of dual loyalty on an organisational level. It is not surprising that the APA has not taken stronger measures to ban torture and other cruel, inhuman, degrading treatment, and punishment, since this would have grave repercussions on the financial income of this institution.<sup>a</sup>

Physicians for Human Rights-Israel (PHRI) state in their paper "Physicians and Torture-The Case of Israel"<sup>19</sup> that the Israeli Medical Association (IMA) was far too lenient in its definition of torture and other cruel, inhuman, degrading treatment, and punishment. Much like the APA, the IMA had financial interests in maintaining a bond with the Israeli Security Agency (ISA, formerly known as GSS, General Security Service). Although the IMA board has on several occasions promised PHRI to improve the definition, it remains to be seen. PHRI

a. More about the role of the APA, the response from this organisation and its commitment can be found in the Appendix of this issue of TORTURE.

believe that all physicians in Israel should take a stand against any form of torture and other cruel, inhuman, degrading treatment and punishment, since physicians in Israel, like in the U.S., “do not face any threat to their lives.”

*Expected higher moral standard*

The latter paragraph raises another critical issue: What is expected by the medical professional? If the medical professional is threatened with direct violence, should she or he yield? The case of Gerard Ntakirutimana<sup>20</sup> is an example of a doctor who was eventually imprisoned for 25 years as a result of his actions during the Rwandan genocide. The importance of this case here is the emphasis that the International Criminal Tribunal of Rwanda (ICTR-96-10-1) put on his position as a medical professional when they gave him his sentence. Not long after the conflict ended, Doctor Gerard Ntakirutimana was found guilty of genocide and crimes against humanity by the tribunal. The Court emphasized that: “As a doctor, he was one of the few individuals in his area of origin to have achieved a higher education and one of the rare schooled in Western universities. It is particularly egregious that, as a medical doctor, he took lives instead of saving them. He was accordingly found to have abused the trust placed in him in committing the crimes of which he was found guilty.”<sup>21</sup> The case of Gerard Ntakirutimana

is extreme in its contents, and also a rare juridical example of how the medical profession is expected to uphold an even higher standard than that of non-medical professionals.

**Instruments and Institutions that help to counter torture**

*The contributions of the WMA and other associations*

Despite the regrettable position of a few medical organizations, many others have created guidelines that concern how medical professionals are somehow implicated in torture. These guidelines and policies address what is expected of medical professionals, as well as what the medical professionals can expect of the international community. In this context, the Tokyo Declaration from 1975,<sup>b</sup> adopted by the World Medical Association (WMA), aims specifically at medical personnel and condemns all actions that could passively or actively harm a patient. This declaration is today internationally recognised and available for any medical professional.

In addition, in its Hamburg Declaration of 1997,<sup>c</sup> the WMA details the rights and duties that can be expected from a medical doctor in a torture-related situation. It is also reaffirmed that there is never any excuse for violating human rights.

A few years later, in a 2002 resolution,<sup>d</sup> the WMA asked medical professionals to

b. Adopted by the WMA during their 29th Assembly in Tokyo, the declaration was revised in 2005 and in 2006. [www.cirp.org/library/ethics/tokyo](http://www.cirp.org/library/ethics/tokyo).

c. World Medical Association declaration concerning support for medical doctors refusing to participate in, or to condone, the use of torture or other forms of cruel, inhuman or degrading treatment. Adopted by the 49th WMA General Assembly Hamburg, Germany, November 1997.

d. World Medical Association resolution on the responsibility of physicians in the documentation and denunciation of acts of torture or cruel or inhuman or degrading treatment. Initiated: September 2002. Adopted by the WMA General Assembly, Helsinki 2003 and amended by the WMA General Assembly, Copenhagen, Denmark, October 2007.

report cases of torture, as well as to report individual healthcare personnel involved or affiliated with torture, to the proper authorities. It calls for medical professionals to avoid any affiliation with torture.

Some other protocols are results of a wide collaboration of many actors. The Istanbul Protocol<sup>e</sup> was initiated by the Human Rights Foundation of Turkey (HRFT) and the Physicians for Human Rights U.S.A. (PHR U.S.A.) and involved more than 40 different organisations. It became an official U.N. document in 1999.

Regarding the position adopted by other medical professions, the International Council of Nurses (ICN)<sup>f</sup> states that the primary concern for a nurse is the patient who needs nursing.<sup>g</sup> The ICN endorses the 1948 Universal Declaration of Human Rights and the 1949 Geneva Convention.

#### *International law*

After the atrocities during the Second World War, torture has, for the first time, become part of an international declaration. The Universal Declaration of Human Rights (UDHR) states, in its article 5, that “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment”.<sup>22</sup> After the Declaration of 1948, there was a codification process of torture, reflecting a global concern for condemning this practice.

e. Manual to assist the researcher while gathering information regarding accusations of torture. It is a tool for collecting evidence and shows how to report any findings.

f. Federation with 124 local nurses' associations worldwide.

g. Nurses' Role in the Care of Detainees and Prisoners, Position Statement adopted in 1998 and revised in 2006.

The first regional treaty to denounce torture was the European Convention of 1950<sup>23</sup> which states that “No one shall be subjected to torture or to inhuman or degrading treatment or punishment.” The European Convention is also the only one to allow an individual to take a state party to court.

Soon after, in 1948, the United Nations found the need to fit the human rights, mentioned in the UDHR, into an enforceable international instrument. Facing the difficulty of creating a single treaty that would include the 30 articles of the UDHR, the General Assembly ended up adopting two distinct covenants in 1966: the International Covenant on Civil and Political Rights (ICCPR), and the International Covenant on Economic, Social and Cultural Rights (ICESCR). Both of these came into force in 1976. The two covenants were made separately, so as to bypass the problem of differing perceptions expressed by the states involved. This way, states with different concepts of, for instance, economic rights could still agree on political issues, and sign a joint covenant. ICCPR devotes its article 7 to the prohibition of torture, saying that: “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.”<sup>24</sup>

The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) came into force in 1987. Ratified by 144 states, the UNCAT is the first international treaty entirely devoted to the prohibition of torture, which expresses the increasing international concern for this issue. It states that the State Party shall take effective measures to prevent torture and that no exceptional circumstances may be invoked as a justification of torture.<sup>25</sup> In order to look at all questions

regarding this topic, the UN also appointed a Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. This Special Rapporteur has a mandate for all countries.

Torture is banned at all time, and there are no exceptions. In the area of humanitarian law, the Third Geneva Convention, states that “No physical or mental torture, nor any other form of coercion, may be inflicted on prisoners of war to secure from them information of any kind whatever. Prisoners of war who refuse to answer may not be threatened, insulted, or exposed to any unpleasant or disadvantageous treatment of any kind”.<sup>26</sup>

Several other specialized international conventions mention the prohibition of torture, like the Convention on the Rights of the Child, in its article 37.<sup>27</sup> The High Commissioner for Human Rights has also recalled that the passive participation of medical professionals in torture was a “gross contravention of medical ethics”. In one document it states six principles that physicians should follow at all time.<sup>28</sup>

It is therefore illegal to be implicated with torture and other cruel, inhuman or degrading treatment or punishment under any circumstance and medical professionals should take action to comply with international law. On this point, the Council of Europe has made a list of recommendations which addresses the responsibilities of medical professionals to act in accordance with international law.<sup>29</sup>

### **Obstacles to stopping passive participation in torture**

There are deeper issues that need to be addressed in the process of eliminating passive participation in torture. These are created by a flawed system and can be corrected when addressed. The purpose of this section is therefore to point out six issues that need to

be addressed in the interest of stopping passive participation in torture.

The first issue is the negligence by society as a whole. There is an automatic belief that the torture victim “had it coming” and that the governing state is flawless. Medical professionals are in no way excluded from thinking like this, and may use it as an excuse not to act. More information regarding reasons for getting tortured should be easily available to read. Some examples of reasons to perform torture may be to suppress political activists, forcing false testimonies on scapegoats, and using the threat of torture to suppress an entire population.

The second issue is the need for more mandatory classes on medical ethics. All faculties dealing with any form of medical professionals should have mandatory classes on medical ethics. In doing this it will be easy for any medical association to exclude a member, since the member will know that she or he has breached a human right. This would create an even larger space for ethical reinforcement.

The third issue is the pressure stemming from issues of dual loyalty. Dual loyalty puts an immense expectation on the individual medical professional to act in accordance with a third party. Any change of internal procedures of hospitals, jails and other work stations for medical professionals could help prevent possible situations of dual loyalty.

The fourth issue is the lack of transparency. All organisations and institutions should have open records at all times. If there is a request to see if a medical professional worked at a specific time, this information should be available. In this manner it would be possible to verify or disprove an accusation from a torture victim. The public should have access to all information related to financial affiliations, work locations and staff records, as long as this does not affect

the confidentiality of a patient. To achieve this in the workplace, it is important that medical professionals ask for the implementation of such a system.

The fifth issue is the role of the state and the police. Torture is often performed under state regulation. That means, like in the South African case, that health care professionals are expected to obey a third party, and not the best interests of their patient. This has a grave effect on those that have had their human rights violated. Documents that can prove an act of torture are very hard to find, since the local government does not want to expose itself as torturous. The medical professionals that are implicated in torture are therefore often protected by the state and the police. However, if the medical professional should want to protect the torture victim, then she or he would possibly have to rely on international policies and laws.

The sixth issue is the lack of enforcement in international law. There has not been much action taken on the issue of passive participation, and the only way to change this is a heightened interest from the international court to address the problem, which can be addressed by signing petitions supporting this view.

### **A case of successful fight for human rights**

*The Medical College in Chile, and its struggle for human rights*

The Chilean Medical College can serve as an example of a medical institution that fights, both in the past and present, for human rights. Unlike the APA and IMA, this struggle does not depend on the severe threats that have been given to the people involved in the conflict. The Chilean Interior Minister writes that from 11th September 1973 until 10th March 1990, no less than

28,459 people were victims of political imprisonment or torture in Chile. Of these 1,244 were younger than 18, and 176 were younger than 13.<sup>30</sup> The period from 1973 until 1990 was marked by the dictatorship of Pinochet, the commander of the Chilean army, and leader of a rebellion that took control of the country.<sup>31</sup> The number of victims during this period is likely to be much higher than reported, since the police that helped gather this information after the end of the rule of Pinochet were the same police-officers that helped him during his rule.

The Medical College of Chile (MCC) is, like the Turkish Medical Association (TMA), willing to use their influence to change the behaviour of their members. The MCC and TMA stress human rights and enforcement of medical ethics in societies where opposing the authorities could hold grave outcomes on the lives of the protesters. The MCC has already expelled Dr Vittorio Orvieto Tiplitzky in September 2005, Dr Hernán Horacio Taricco Lavín in 1989, Dr Osvaldo Leyton Bahamondes in 1991, and currently Dr Pedro Valdivia Soto is under investigation. The four doctors have been expelled, or are under investigation, due to their complicity in the kidnapping and murder of Manuel Leyton. The first of the four doctors involved in this particular case was expelled from MCC as early as 1989, and though it has taken some time, the effects of the MCC policy can now be seen to have an influence on the Chilean legal system. On 24th July 2007, Chilean Judge Alejandro Madrid started the process of prosecuting 13 health professionals, doctors and nurses for their involvement in the murder of Manuel Leyton.<sup>32</sup> All of the above-mentioned doctors form a part of the implicated 13, as well as the chief nurse of the Londres clinic Eliana Carlota Bolumburu Taboada, who has now been expelled from the Chilean College for Nurses.<sup>33</sup>

*The South African grassroots movement of medical practitioners*

In Chile and Turkey it was the medical associations that drove the legal system into taking action. In South Africa it was, to the contrary, a grassroots movement of health professionals, who, with the help of the court, in the end forced the national medical association to take action against two of their members. The two health professionals were Doctors Benjamin Tucker and Ivor Lang, both accomplices to the death of Stephen (Steve) Bantu Biko. Steve Biko was a human rights activist working against the South African apartheid, and he died while being in detention in 1977. Dr. Tucker and Dr. Lang both stated that the physical condition of Steve Biko was good enough to allow a transport from Port Elizabeth to Pretoria, some 800 miles away.<sup>34</sup> The doctors were accused of not having performed a proper medical examination, as well as falsifying medical documents. On the 17th of October 1985, the South African Medical and Dental Council stripped Dr. Tucker of his medical license for three months, and gave Dr. Lang a reprimand. Dr. Tucker was treated harsher, as he was the district surgeon, and had been Dr. Lang's supervisor.

The road to the ruling in 1985 was long, and had been pushed forward by both individual health professionals, as well as the South African Supreme Court (SASC). South Africa's Medical and Dental Council (SAMDC) had first ruled, in 1980, that the two doctors had done nothing wrong, when they had been excused on all points. This led to a protest to the Medical Association of South Africa (MASA), which retained the verdict by the SAMDC in 1980. The ruling first changed after protests from individual doctors pleading with SASC, which subsequently concurred with the protests, and told the SAMDC to make a new inquiry.<sup>35</sup> In this

latter judgment, the ruling changed<sup>436</sup> One of the most infamous cases involving inappropriate and negligent care of a detainee by district surgeons was the death of Stephen Bantu Biko.<sup>37</sup> In the case of Biko, TRC found six points to demonstrate the failures made by the doctors Tucker and Lang:

"1) maintain patient-doctor confidentiality norms; 2) treat their patient with dignity and respect; 3) examine the patient thoroughly; 4) record and report injuries accurately; 5) diagnose illnesses and prescribe appropriate medication; 6) register complaints (particularly pertaining to assault and torture)."<sup>38</sup>

**Actions that can help prevent the passive participation in torture**

*What doctors can do*

- Be prepared to work in a situation that is highly influenced by a culture of dual loyalty, and always remember the law requires duty to their clients and not to a third party.
- Promote and reinforce human rights by warning international authorities or human rights organisations about any irregularities.
- Demand that all treatment is done without a third party in the room (see the Istanbul protocol, for proper procedure<sup>39</sup>).
- Follow at all times the ethical principles designed for health care professionals in both ancient guidelines and modern international law.

*What the medical institutions and organizations can do*

- Promote transparency in all records.
- Reinforce human rights by expelling and prosecuting members that are proven to be in breach of human rights.
- Stay financially independent from any governmental institution.

- The faculties for health care professionals should provide a class of Human Rights, in order for the future health staff to be more aware of their duties and obligations regarding International Human Rights.
- Work on a clear definition of torture. Not to mistake torture for other cruel, inhuman or degrading treatment or punishment.
- Not use the word torture excessively, since this weakens the meaning.

*What can be done in international law*

- Search and punish examples of passive participation, to reinforce the existing laws.
- Demand more from institutions and organisations, and create a checklist of minimum responsibility.
- Implement preventive systems to search in institutions and organisations for signs of dual loyalty.
- More norms regarding health personnel's obligation to their patients.
- Dual loyalty should not be allowed as an excuse for the participation in torture. Human Rights should be, by nature and in essence, superior to any governmental policy.
- The court should be less lenient with the accused that does not have any hard evidence against them. However, this trend is turning. International courts are starting to take the stand that should there be no evidence to the contrary, it is the victim that should be believed.

*What you can do as a private person*

- Help society to understand the reality of torture by bringing it up in debates.
- Help victims of torture to be reinserted into society by supporting and helping them to give their testimony.

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