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Preface

Torture Journal published a desk study *Approaches to torture rehabilitation* by Roger Gurr and José Quiroga in 2001 (Torture 2001, 11: Supplement 1: 1-35). It covered the scientific literature within the global medical work against torture collected in 1997-98. Already back then the editors of Torture Journal invoked for the need of corrections in respect to the evolution in service programmes for rehabilitation of torture survivors. It is therefore a great pleasure now, in co-operation with the Rehabilitation and Research Centre for Torture Victims (RCT) who initiated and financed the follow up study, to be able to publish Politically-motivated torture and its survivors by José Quiroga and James M. Jaranson since this study reviews the most recent literature.

This second desk study updates and complements the first one and covers the scientific literature from about 1998 to 2004. As a supplement to the review of the literature on health, which forms the core of the study, an appendix covering essential legal aspects of interest to the rehabilitation professional is included. Together the two desk studies provide a comprehensive up-to-date overview of the scientific basis for the work with the rehabilitation of torture survivors worldwide.

One great challenge remains, namely to prevent torture; but as long as torture exists - and it does - there is a need for new knowledge on and acquaintance with the various kinds of rehabilitation practices. It is our wish that Politically-motivated torture and its survivors in this context will serve as a useful source with recent and upgradet knowledge on rehabilitation, treatment interventions, and legal aspects in connection with the fight against torture.

TORTURE has like in desk study one: *Approaches to torture rehabilitation*, departed from the normal requirements for manuscripts - the Vancouver system, regarding appropriate use of an extensive alphabetical arranged reference list.

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Politically-motivated torture and its survivors:

A desk study review of the literature

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1. introduction

Objective

This desk study intends to update and complement the desk study review of the torture rehabilitation literature completed in 1998 (Gurr and Quiroga, 2001), emphasizing areas not covered by the original study but updating the torture rehabilitation literature from the publication of the original desk study. Some selected earlier references have been retained, but the focus remains primarily on the published literature from 1998 through mid-2004. This paper intends to stand alone but will refer back to original study. The target audience is those working in or interested in the field of rehabilitation of politically motivated torture survivors.

Findings since 1998

Perhaps the most important finding is that either torture has increased worldwide or the exposure of torture events has improved.

Publications: Much has been written about trauma and torture, especially since the terrorist attacks on New York City and Washington, D.C. on September 11, 2001 (9/11) and the Abu Ghraib prison abuses in Iraq. The print and visual media has fostered a virtual explosion of information about torture and terrorism. Even in the professional literature, the relevant books are too numerous to catalogue here and beyond our scope. Research on PTSD and on the prevalence of torture has been notable. In addition, much information is more readily available with the increased access and availability of internet resources and publications.

Changing Nature of Torture: After 9/11, terrorism and its relationship to torture became an issue. The use of torture methods to extract information from suspected terrorists became controversial. Evidence of torture by

“civilized” western countries was uncovered. Worldwide, the context of torture has broadened to include many aspects of organized violence, often occurring during war. Anti-immigrant sentiment has not improved and, if anything, has worsened in the US Europe, and in many other Western countries.

Methods: The Abu Ghraib prison abuses and alleged torture by coalition forces in Iraq has fueled an international discussion about what methods constitute torture.

Assessment: Progress has been made on the legal and forensic evaluation of torture survivors, notably publication of the Istanbul Protocol. Questions raised regarding the validity of memory recall have implications for assessment of torture survivors.

Prevention: Passage of the UN Optional Protocol and formation of the International Criminal Court are significant advances in the effort to prevent and eradicate torture.

Gaps in the literature since 1998

After a quarter of a century and dramatic expansion of rehabilitation efforts worldwide, there is still no consensus about the efficacy of treatment interventions for torture survivors.

There is little additional literature about treatment outcome, models and structure of rehabilitation services, design of services, cost-effectiveness, or sustainability of services. General principles of assessment and treatment remain virtually unchanged. Controversies over PTSD applicability for torture survivors persist.

Restructuring of the desk study

New Structure: In order to focus the desk study on health issues, the sections with this emphasis will be presented as chapters while

the remaining topics, which are more political, research, or prevention oriented will be included as appendices.

New sections/topics: These include Perpetrators; Special Populations (e.g., Elderly, Children and Adolescents); new Assessment Tools (e.g., the Istanbul Protocol); Comparison of Traumatized with Tortured Refugees; Community-based and Psychosocial Interventions; and the concept of Reparation.

Updates: Sections with a more complete review of the literature include: Definitions; Methods of Torture; Prevalence; Sequelae; Assessment; Rehabilitation; International Law; Prevention; Impunity; and Research.

2. Definitions

A. Amnesty International's definition of torture
Amnesty International was the first organization that defined torture from a political and operational point of view to be used in eligibility for care, human rights advocacy, and for surveys and epidemiological research. The initial simple and broad definition of torture was used in the "Report on Torture" in 1973:

"Torture is the systematic and deliberate infliction of acute pain by one person on another, or on a third person, in order to accomplish the purpose of the former against the will of the latter" (Amnesty International, 1973).

B. World Medical Association's definition of torture

Later, the World Medical Association (WMA), in its Tokyo Declaration in 1975, adopted a similar definition:

"Torture is defined as the deliberate, systematic or wanton infliction of physical or men-

tal 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" (Amnesty International, 1994).

C. United Nations' definition of torture

The United Nations (UN), in the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) in 1984, adopted the following definition:

"For the purpose of this Convention, the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purpose 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, when such pain or suffering is inflicted by, or at the instigation of, or with the consent or acquiescence of, a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions" (United Nations, 1984).

The definition of torture from the CAT is the official definition for the 210 countries that had ratified the convention as of April 23, 2004.

This legal definition does not include cases of torture practiced in some countries as a lawful punishment, such as mutilations, whippings or canings, nor does it include torture practiced by gangs or hate groups.

The Convention reintroduced the concept of grades, when it defined torture as severe pain or suffering, the other level being cruel, inhuman or degrading treatment (also

called maltreatment). For an experienced clinician, there is less of a problem distinguishing a true torture survivor from a malingering case in the clinical setting. If we accept the possibility of a difference, it is almost impossible to define this difference from a subjective or an objective point of view. "However, given that cruel and inhuman treatment is itself also contrary to international law, attempting to set clear borders between the two is probably a futile and potentially misleading task" (Welsh and Rayner, 1997).

D. World Health Organization's definition of organized violence

The WHO working group in 1986 introduced the concept of organized violence, defined as:

"The inter-human infliction of significant, avoidable pain and suffering by an organized group according to a declared or implied strategy and/or system of ideas and attitudes. It comprises any violent action that is unacceptable by general human standards, and relates to the victims' feelings. Organized violence includes 'torture, cruel, inhuman or degrading treatment or punishment' as in Article 5 of the United Nations Universal Declaration of Human Rights (1948). Imprisonment without trial, mock executions, hostage-taking, or any other form of violent deprivation of liberty, also fall under the heading of organized violence" (WHO, 1986; Geuns, 1987).

This broader definition includes not only other perpetrators, but also other victims of violence in addition to survivors of torture. The definition includes government repression and terrorist group violence. While some torture rehabilitation services provide care only to torture survivors, others also provide care to survivors of organized violence.

WHO and regional offices have been very concerned with the impact of violence on health. In a recent publication, WHO developed the concept of "Collective Violence" that has been defined as:

"The instrumental use of violence by people who identify themselves as members of a group – whether this group is transitory or has a more permanent identity – against another group or set of individuals, in order to achieve political, economical, or social objective" (World Health Organization, 2002).

This definition covers a broad range of forms of violence including conflicts within and between countries, organized violent crime, and various forms of structural violence that may or may not be state perpetrated. Structural violence means economic, political, or social discrimination directed at one or more groups in society (World Health Organization, 2002).

Because torture occurs in the environment of organized violence and collective violence, many torture rehabilitation programs give care not only to torture survivors but also to victims of collective violence.

E. Problems using definitions

The problem is more difficult in an epidemiological study of torture, which requires a definition with clear operational limits to classify each torture event as present or absent. Another possibility is to consider three categories of torture as Possible, Probable, and Definitive, with clear definitions for each subcategory.

The National Institute of Health funded several torture prevalence studies in the United States in 1998. Each of them had to adopt an operational definition. The first of these papers was published in April 2004 (Jaranson, 2004). The authors follows the CAT definition but from the operational point of view the participants were classified

as torture survivors if they: 1) responded in the positive to any of the three items directly asking whether they have been tortured (Have you been tortured in prison? [Y/N]; Was tortured [marked off on a checklist]; Were you tortured in prison or jail? [Y/N]; and reported experiencing at least one identified torture techniques item (details available from author)) or 2) reported experiencing one of the subset of torture techniques that investigators considered could be used only during torture sessions. This example illustrates the problems that an epidemiologist has to resolve in choosing an acceptable definition.

Maltreatment was used for the first time in the European Court of Human Rights in the case *Ireland vs. Great Britain* in 1971. The Court decided that interrogation of a prisoner while blindfolded, with food and sleep deprivation, was maltreatment, but not torture. Amnesty International used maltreatment instead of torture in the report of an international mission to Northern Ireland in 1977.

3. Prevalence

A. National random samples

A random selection from a national sample in four countries showed a prevalence of torture of 8% in Algeria; 9% in Cambodia; 15% in Gaza, Palestine; and 26% in Ethiopia (de Jong et al., 2001). A prevalence of torture of 39% was found in a national random sample of 1,033 representative households in 13 districts of East Timor (Modvig, 2001).

B. Detainees in their countries of origin

The most accurate method to measure the magnitude of a problem is to use a rate that measures an event, in this case torture, in relation to a unit of a population at risk, in this case detainees. The ideal situation would de-

termine the number of torture victims among a population of detainees during the same period of time in an identified country. Unfortunately, this information is unknown.

Chile could help give light to this problem very soon. The Chilean government, as part of Program for Human Rights, created an organism called "National Commission on Political Prisoners and Torture". Any Chilean detained and/or tortured between September 11, 1973 and March 10, 1990 (the period of Pinochet's military dictatorship) had the opportunity to register in the Commission roster, filling a form and requesting a personal interview. The registration was open for six months and, at that moment, 35,000 had registered. These numbers are incomplete because members of the Chilean Diaspora, who comprised the largest number of tortured, did not have the opportunity to register because they had left the country. In spite of this problem the analysis of this data will give more precise information about the prevalence of torture among the detained population in Chile. This is a unique experience. No other country in the world has done anything comparable following an experience of collective violence.

One study published calculated this information in retrospect with a select population. Paker studied the prevalence of torture in 246 detainees in a Turkish prison. He found that 208 (85%) had been tortured (Paker et al., 1992).

C. Refugees

Studies on prevalence of torture in refugee populations are very rare. There were only two prevalence studies published in the 1980s. A study of a random sample of 3,000 refugees from the 10,000 asylum seekers who arrived in Denmark in 1986 showed a 20% prevalence (Jepsen, 1980). A Swedish

group from the Red Cross found a torture prevalence of 23% in refugees requesting asylum in Sweden. These two studies did not specify the diagnostic definition of torture used (Bamber, 1988).

Several studies have recently been published and more studies are in the fieldwork stage. The prevalence of torture in refugees varies from 2.74 to 100%, depending upon the composition of the sample in relation to age and sex. The most important variables are the nationality of the group in relation to the magnitude of collective violence in the country of origin and the history of the past political activism of the members of that community.

Prevalence in a general population of refugee camps

A United Nations High Commission for Refugees (UNHCR) camp in Southern Nepal, by the end of 1994, had 85,078 Bhutanese refugees. With the help of human rights organizations and collaborating agencies, 2,331 torture survivors were identified. The prevalence of torture in this population was 2.74% (Shresta et al., 1998). A prevalence of 3% was found in a random sample of households (1,180 refugees) in Macedonian and Albanian refugee camps for Kosovars (Iacopino et al., 2001). In a random sample of 242 Senegalese in two refugee camps in Gambia, the prevalence of torture survivors was 16% (Tang and Fox, 2001).

Prevalence in clinics

The lowest torture prevalence rates were found in selected samples of refugees consulting a general medicine outpatient clinic in New York in 1996 (6.6%) (Eisenman and Keller, 2000) and in three primary care clinics in Los Angeles (8%) (Eisenman et al., 2003). In contrast, the prevalence of torture was 70% in males and 31% in females in a

selected outpatient refugee psychiatric clinic in Oslo between 1991 and 1995 (Lavik et al., 1996).

Prevalence in a select group of refugees and asylees in the US and Europe

A prevalence of 6% of torture survivors was found among resettled refugees that arrived in 20 municipalities in Norway from May, 1994, to December, 1995. Of the 791 invited to participate, 462 accepted (Lie, 2002). A prevalence of 30% was found in a small sample of 74 Middle Eastern asylum-seeking refugees in Denmark in 1992 (Montgomery and Foldspang, 1994).

A prevalence of 51% was found in a random selection of 2,930 people from an airline list of accepted refugees arriving in Sweden. 402 refugees were sampled and 218 participated in the study (Ekblad et al., 2002). The most recent prevalence study was of population sample of Somali and Oromo refugee residents in Minnesota. It found a prevalence of 36% among Somali and 55% among Oromo refugees (Jaranson et al., 2004). The highest prevalence rate (100%) was found among a group of Chilean refugees in the United States. All of them were selected by the US embassy from jail and detention centers during the Pinochet dictatorship to be given asylum in the US, and all of them were torture survivors (Quiroga, 1985, unpublished).

4. Perpetrators

A. Background

Torture has been practiced since ancient times but the interest in knowing more about torturers and the training of torturers is very recent. Manuals on interrogation techniques and curriculum of training schools for intelligence officers have been kept as secret and classified documents. Information or studies on torturers are scarce.

Several studies of Nazi perpetrators and torturers during WWII indicate that most of them were normal people. Kelly interviewed and did Rorschach tests on 8 Nazi criminals and 8 American control subjects. There were no differences in the results between these two groups (cited by Gibson, 1990).

Robert Lifton studied Nazi doctors involved in human experimentation and killings via extensive interviews with them and their victims. The physicians involved were normal professionals who were transformed from healers to killers through a process of medical justification for the killings. The physicians involved were also able, through a dissociative process, to “double”. They were able to form a second and relatively autonomous self that enabled them to remain sane in a mad world (Lifton, 1986).

Stanley Milgram performed an already classic study in experimental social psychology when he was working at Yale University between 1960-1963. Experimental subjects (teachers) were asked to participate in a study to measure the effect of punishment on learning. The teacher was told to administer the learning test to the man (student) in the other room. When the student answered correctly he moved to the next item, if he answered incorrectly the teacher gave him an electric shock ordered by another person in the room. The intensity of electric shock was indicated on a scale in an impressive shock generator, with a horizontal line of 30 switches ranging from 30 to 450 volts in 15 volts increments. The switches were also marked with a range of severity that ranged from slight to danger and severe shock. The student was an actor who did not receive any shock but simulated discomfort and pain. Sixty five percent ordered electric shocks above the level marked as severe and dangerous, despite thinking that the student

was suffering. Experimental subjects responded similarly regardless of their age, sex, religion, or political orientation (Milgram, 1974).

The Stanford University prison experiment is another psychological experiment important to analyze in this context. Twenty-four normal college students were selected from a group of volunteers to participate in a paid psychological study of prison life. Half of the students were selected at random for the role of guards and the other half for the role of prisoners. Neither group received any specific training in these roles. Prisoners were arrested at home by local police, finger printed, and brought to this simulated cell block in a police car. Guards were given uniforms. The experiment was suspended after six days. Prisoners experienced a loss of personal identity, became passive, dependent, depressive, and helpless. Guards experienced a gain in social power and status and became aggressive and abusive towards the prisoners (Haney, 1973).

Mika Haritos-Fatouros has provided a most significant contribution to the subject of psychology and training of torturers. She had the opportunity to interview several torturers and victims of torture after the military dictatorship that lasted from 1967 to 1974 in Greece. The first trials of torturers took place in August and September of 1975 when 14 officers and 18 soldiers were brought before Athens Permanent Court Martial on charges of torture during detention and interrogation (Amnesty International, 1977).

Haritos-Fatouros described the steps followed by the armed forces in Greece to train the interrogators and torturers (Gibson, 1986; Haritos-Fatouros, 1988; Gibson, 1990; Gibson, 1991; Haritos-Fatouros, 1995). The training of torturers in Greece followed a systematic method. The entire

training was a type of brainwashing, which completely breaks down the recruit and his personal identity (Wagner, 1983):

1. *Selection of the candidates*

Candidates were selected from among army recruits because they obeyed even senseless orders and they came from well-known anti-communist families. Recruits had to endure a brutal training. None of the candidates was told of the purpose of their training.

2. *Training techniques*

Recruits during training were isolated from their normal social support, such as family and friends. They were trained to build new fidelities and relationships. They had an initiation rite, a different subculture, and a vocabulary that banded them psychologically. They were told they belonged to a very select group that was elite. They were also told that the government was based on their fidelity and that they were the saviors of Western civilization from communism.

3. *Reduction of guilt techniques*

Recruits underwent a slow process of brainwashing to dehumanize their victims and to blame them for the need to torture and to obtain valuable information. They were told that the communists want to destroy the government and that they are the enemy.

During and after training the recruits were under constant harassment and tension. The authorities rewarded obedience and severely punished non-cooperation. The training followed a social modeling of violence. During training the recruits were brutally abused.

They had to endure many of the same methods of torture they later had to apply during interrogations. They were slowly introduced to the violence of torture through a

process of systematic desensitization. They first acted as guards of a detention torture center. Later they participated in the process of detaining political dissidents. With time they came to witness torture and eventually tortured the victims themselves.

This military model of training torturers is very similar to the training followed in other third world countries such as in Latin America (Wagner, 1983). This Greek experience of training has been described in other articles related to torturers (Wagner, 1983; Williams, 2002; Crelinstein, 1993), and interviews of Dr. Haritos-Fatouros (Holm, 1999). A Danish filmmaker, using the information made public during the trials, made a documentary on the training of torturers in Greece. The film, called "Your Neighbour's Son", was produced at the initiative of the Danish Amnesty International prevention of torture group and premiered in 1982.

B. Military torture resistant training

After the Korean War, the US military was concerned that some of the American prisoners of war were used in anti American propaganda. It was interpreted as a successful brainwash of prisoners into undue acts of compliance after "deep interrogation" and reeducation techniques.

Most of the NATO countries (US, Great Britain, France) began training their troops in survival and torture resistant techniques in the event that they become prisoners of war. The rationale for the training was to prepare the person because "if he is captured unusual forces may be focused upon him, not only pressing him to give up valuable military information, but to abandon well-loved ideals, to adhere to strange concepts, to sign false confessions, to participate in propaganda activities through which the enemy will seek to exploit him" (West, 1958).

The training included participation in “deep interrogation” sessions and enduring physical and psychological maltreatment, such as hooding, wall standing, sleep deprivation, having a restricted diet, and exposure to noise machines, which are techniques now considered torture. These were the same techniques that these countries were using against dissidents in counter-insurgency operations in their colonial wars. Some journalist articles called attention to these training courses. The Navy secretary of US admitted that some students had been injured and two had died (cited by Amnesty International, 1979). Apparently this type of training continues. In May 2004, a newspaper reported the case of Sean Baker, a former military police officer who, as part of his training drill, was given an orange detainee jumpsuit to wear and asked to act the part of a resistant detainee. Four guards (soldiers) at Guantanamo Base beat and choked him, stopping only when they saw that he was wearing an army uniform underneath his jumpsuit. He suffered traumatic brain injury and seizures. Later, he was medically discharged from the army (Associated Press, May 24, 2004).

All this training has involved the infliction of pain not only to facilitate resistance of torture if they are captured, but also to make it psychologically easier to apply if necessary.

Additional information became known when some torturers decided to desert from the armed forces and made public testimony or brought documents to a human rights organization. A torturer can only escape by deserting and leaving the country. One of the best known was the statement of a Uruguayan first lieutenant, Julio Cooper, who, in 1979, brought several photographs of victims who had been tortured. These photographs were shown around the world (Am-

nesty International, June, 1979). Sedat Caner from Turkey and Andres Valenzuela from Chile have also given information regarding to torture in their countries. (Caner 1986; Crelinstein, 1993). A good review is found in other articles by Crelinsten (e.g., 1995).

Many torturers confessed their crimes when looking for amnesty before “The Truth Commission” in South Africa (Strudsholm, 1999).

A sadistic unrepentant torturer from Chile, Romo Mena, gave an extensive interview to a journalist who published the interview in a book. Mena said that the training of the Chilean military officers was done through specific courses and that they used two CIA manuals, entitled Kubark “Counterintelligence Interrogation” and the “Human Resources Exploitation Training Manual”. He learned physical torture at the side of other torturers (Guzman, 2000, pp. 112-116). Luz Arce, a leftist survivor of torture in Chile, began to cooperate with her torturer. She became an important member of the repressive apparatus of the Pinochet dictatorship in Chile. Later, she gave names of perpetrators, victims, and an account of the organization of the torture system in Chile in biographic testimony (Arce, 1993).

John Conroy, a journalist who investigated three incidents of torture in the Western world: in a Chicago police station, the Israeli acceptance of torture as “moderate physical pressure”, and the “hooded men” torture by the British army in Northern Ireland. He interviewed victims and torturers and also described the torturers’ training, impunity to prosecution, and coping mechanisms (Conroy, 2000).

In summary, all these investigations show that, with the right training and adequate environment, ordinary persons can be transformed into torturers.

5. Physical sequelae

Only recently has it been recognized that the most important physical sequelae in torture survivors involve pain. Pain is experienced in multiple sites, is long-lasting, and chronic. In a preliminary investigation, Amris found that in a sample of 48 torture survivors from Middle East countries, the most frequent pains, categorized by body region, were in the head, neck, shoulder girdle, lower back, lower extremities, and in multiple locations (Roche, 1992; Amris, 2000a; Williams, 2003; Amris, 2004). See Table 1.

Pain in torture victims could be nociceptive, visceral, or neurogenic (Thomsen, 1997; Amris, 2000b):

- Nociceptive pain is a condition caused by tissue damage where the pain has been elicited by nociceptors. The pain resolves after tissue healing.
- Neurogenic pain is a condition caused by a lesion or dysfunction of the nervous system, secondary to trauma or other causes, such as vascular, infectious, toxic, metabolic, or degenerative conditions.
- Psychological mechanisms should be considered after other causes have been ruled out.

Scientific knowledge of chronic pain is limited, as well as the knowledge and training of general physicians in the diagnosis and treatment of pain. Torture survivors with chronic pain are under-diagnosed and under-treated. Physicians taking care of torture survivors must learn to ask about pain symptoms systematically by regions. Pain is an expression of distress and it has a personal meaning, and is part of the biography and trauma history that needs to be investigated. Questions regarding pain in each region should probe for localization, intensity, radiation, frequency, factors that trigger or control the

pain, and change over time. A very important question to ask whether the pain began before or after torture trauma. Chronic pain in torture survivors is a complex clinical problem that needs a multidisciplinary approach. In addition to the primary care physician, other personnel that should be involved include psychologists, psychiatrists, pain specialists in persistent cases of pain, neurologists in severe non-tension headaches and/or pain in the spine, and maybe even anthropologists to interpret certain cultural expressions of pain (Roche, 1992; Kleinman, 1992; Thomsen, 1997; Amris, 2000a; Amris and Roche, 2002; Jacobsen, 2003).

Bennett describes the development and validation of a new pain scale for identifying patients for whom neuropathic mechanisms dominate their pain experience.

The "LANSS Pain Scale", or Leeds Assessment of Neuropathic Symptoms and Signs, is based on analysis of sensory descriptions at a bedside examination of sensory dysfunction and provides immediate information in clinical settings. The study demonstrates that the LANSS scale can distinguish patients with neuropathic pain from those with nociceptive pain (Bennet, 2001).

Because most torture victims do not volunteer their trauma history when they request medical care, unexplained neuralgia and musculo-skeletal pain may help to identify torture victims.

Body region	Percentage
Headaches	93
Neck and shoulder girdle	93
Upper extremity	54
Thorax including spine	38
Lower back	87
Lower extremity	71
Feet	53
3 or more regions	63

Table 1. Chronic pain in torture victims by body region. 48 survivors of torture from the Middle East (Amris, 2004).

Torture survivors present a variety of other symptoms in different body systems that have been reviewed in several publications (Cathcart et al., 1979; Rasmussen, 1980; Petersen et al., 1985; Allodi et al., 1985; Goldfeld et al., 1988; Rasmussen, 1990; Skylv 1992; Cunningham and Cunningham, 1997). Most of these papers have a listing of symptoms and signs, but few diagnostic categories.

Only a few of the physical sequelae of torture have been clearly identified and well documented. Falanga, the beating of the soles of the feet with a wooden or metallic baton, for example, is one of the few methods of torture that has been studied extensively. Victims complain of chronic, dull, cramping pain, which intensifies with weight-bearing and muscle activity. They also experience a burning, stinging pain that is spontaneous or that can be evoked in the soles at examination with a flat wide heel pad. A case-control study was done using magnetic resonance of the foot. The MRI shows a significant thickness in the central portion of the plantar aponeurosis (Skylv, 1995; Amris and Prip, 2001).

Rhabdomyolysis, secondary to a beating, has been well documented in India. Malik gave medical care to 34 victims of torture who presented acute renal failure secondary to rhabdomyolysis, due to severe beatings involving muscles. These victims would have died without emergency dialysis. In spite of the treatment, 5 of the 34 died, with a lethality of 15% for this group (Malik et al., 1993; Malik et al., 1995). Two other victims with a similar medical problem were diagnosed in Israel (Bloom et al., 1995).

Moreno and Grodin (2002) reviewed the neurological sequelae of torture. For example, beatings (especially blunt trauma), the most common form of physical torture, and crushing may produce intracranial and

spinal cord bleeding, intracranial edema, CSF fistulas, and seizures. Shaking may cause retinal and subdural hemorrhages, and axonal injury. Bone fractures may affect peripheral nerves, while gunshots and stab wounds may destroy a large amount of nerve tissue. The authors found that seizures after head trauma were associated with brain lesions, such as subdural and intracranial hemorrhages, and intracranial edema. Cervical spine fracture with spinal cord compression may result in quadriparesis.

Few cases have been published that relate specifically to torture. The film "Your Neighbour's Son" shows a Greek survivor of torture with a right hemiplegia as a result of brain trauma.

Shaking is a frequent method of torture. Documentation indicates that shaking produces cerebral edema, subdural hematomas, and retinal hemorrhage, similar to the findings in the "shaken baby syndrome" (Physicians for Human Rights, 1995; Moreno and Grodin, 2002).

Peripheral neuropathies in arms have been documented in prisoners who have been suspended by their arms during disciplinary punishment in jails. A winged scapula, as consequence of a brachial plexus injury, was found in a torture survivor who was suspended by the arms (Moreno and Grodin, 2002; Hargreaves, 2002). A hand-cuff neuropathy has been described in four US prisoners of war from Operation Desert Storm. Compression of peripheral nerves at the wrist is a recognized complication of overzealous handcuffing. This syndrome has not been described in torture survivors, but it is important to keep in mind because most torture survivors are handcuffed during detention and imprisonment (Cook, 1993).

Sinding reviewed her experience with 63 torture survivors who had been referred to ear, nose, and throat specialists because of

their symptoms. The most common symptoms were tinnitus (75%), decreased hearing (46%), impaired air passage through the nose (41), and dizziness (40%). There was a significant association between telephone torture and tinnitus (Sinding, 2000).

In 2003 Kinzie reported an increased prevalence of hypertension (ca. 43%) and diabetes (ca. 15%) in a Cambodian refugee population (Kinzie, personal communication)

Thirty-five years after liberation, victims of the holocaust and concentration camps were dying at a higher rate than was expected. The survivors examined were more often and more seriously ill than the control groups who had not been exposed to the maltreatment of the camps. Victims of trauma are at increased risk of infectious diseases, cancer, cerebrovascular accidents, and heart problems. We do not have similar studies on survivors of torture (Goldman and Goldston, 1985; Ettinger and Strom, 1973; Eitinger, 1991).

6. Mental sequelae

Historically, studies of torture and its sequelae have been conducted in refugee clinics and in other treatment settings. In recent years, the literature has included more samples of specific groups of refugees, asylees, torture victims, and other immigrants not receiving treatment. Several studies have now compared torture survivors with refugees and others who have not suffered torture.

Research and clinical judgment over many years have established that the mental health consequences of torture to the individual are usually more persistent and protracted than the physical aftereffects, although, for much torture, there is considerable overlap of the physical and psychiatric sequelae (Engdahl and Eberly, 1990). For

some types of torture, such as rape, head trauma, malnutrition, and many others, diagnosticians have difficulty determining whether the origin of the sequelae is physical, psychological, or a combination. Due to the complexity of diagnosing and choosing the best treatment, the sequelae may be more long-lasting and the treatment less successful. This section will review the literature on psychiatric/psychological sequelae to the individual torture survivors, predominantly any new findings since completion of the first desk study (Gurr and Quiroga, 2001).

A. *Psychological symptoms in selected populations*

The following will attempt to review the recent literature about specific groups of refugees, asylees, torture victims, and other immigrants whether they were studied in their countries of origin, in refugee camps, or in resettlement countries.

The response to systematic persecution, torture, other severe traumas of conflict, and exile is determined by many factors, from the person's genetic vulnerabilities or resilience, to personal psychology and the social environment. Many very emotionally charged processes, chiefly concerned with loss, are intimately involved with the experience of torture. Survivors of torture may have lost physical health, employment, status, family, and identity. The meaning of torture and trauma, shaped by religious, cultural, and political beliefs, partially determines the effect on an individual (Holtz, 1998).

However, there are similarities in the psychological symptoms that emerge. In studies that did not use control groups, the psychological problems most often reported were psychological symptoms (anxiety, depression, irritability/aggressiveness, emo-

tional lability, self-isolation/social withdrawal), cognitive symptoms (confusion/ disorientation, memory and concentration impairment, impaired reading ability), and neurovegetative symptoms (lack of energy, insomnia, nightmares, sexual dysfunction). These symptoms can change over time, often because dissociative reactions suppress symptoms until immediate survival or resettlement needs are met and the person is safe enough to cope with memories of the trauma. An extensive review of the controlled and uncontrolled studies can be found in Basoglu et al. (2001) and will not be repeated here.

The following groups, organized by general geographic area, have been selected based on their frequent representation in the published literature. This is not intended to be a complete review and will highlight articles published since 1998.

Southeast Asians: Southeast Asians are among the most frequently represented in published studies. Steel et al. (2002) studied 1,161 adult Vietnamese refugees resettled in Australia for an average of 11.2 years. Using a population-based strategy with trained bilingual workers, 7-8% of participants had psychiatric diagnoses, but trauma exposure increased this risk to 12%. Trauma experience and exposure to more than three trauma events negatively predicted mental health status. Mental illness was associated with impaired physical function and high demand for health services. Risk of mental illness fell across time. Mollica et al. (1993), in a study of 993 displaced Cambodians living in a Thai border camp, showed that the prevalence of depression was as high as 82%, while 15% of the study participants had symptoms that were consistent with criteria for PTSD. In a study of asylum-seekers in Australia, Silove et al. (1997)

found 36.8% PTSD, up to 47% among those exposed to traumatic events including torture. High rates of PTSD and depression were also reported in earlier studies of Cambodian refugees (Kinzie et al., 1986; Kinzie et al., 1989).

Asians: Holtz (1998) compared refugee trauma with the torture trauma in Tibetan nuns and lay students tortured in Tibet but living in India (54% anxiety vs. 29% in controls). Shrestha et al. (1998) compared 526 Bhutanese refugee survivors of torture in Nepal with 526 non-tortured refugees matched by age and sex, the largest published study of tortured refugees using matched controls. The study group was selected randomly from among the Bhutanese refugee community in the UN refugee camps in eastern Nepal. Torture survivors had more PTSD symptoms, higher anxiety and depression scores, and more musculoskeletal and respiratory system complaints. The authors concluded that torture may increase the risk for mental health problems among refugees displaced within the developing world, and that PTSD symptoms appear to be part of a universal reaction to torture. They also pointed to the need for an increase in services for tortured refugees. Other studies by the same group of researchers describe the treatment and prevention methods of CVICT, the Center for the Victims of Torture, Nepal (Sharma and van Ommeren, 1998). Van Ommeren et al. (2001) compared 418 tortured and 392 non-tortured Bhutanese refugees for ICD-10 disorders, finding that those tortured reported more PTSD symptoms, somatoform pain disorder, and dissociative disorders in the preceding year, more lifetime PTSD, somatoform pain, affective, generalized anxiety, and dissociative disorders. Although men were more likely to report torture,

women who were tortured reported more lifetime anxiety, somatoform pain, affective, and dissociative disorders. Van Ommeren et al. (2002) studied whether their previously documented relationship between PTSD and somatic complaints resulted from shared co-morbidity with anxiety and depression. Using the sample described in Shrestha (1998) above, they found that PTSD symptoms, independently of depression and anxiety, were correlated with high numbers of somatic complaints and high number of organ systems involving these somatic complaints. Agrawal and Srikar (2000), from the Shubhodaya Center for Rehabilitation of Victims of Torture and Violence (SCRVTV), studied 230 Burmese refugees in the western part of India. Of those tortured, 89% felt they had suffered mentally or physically, 81% had probable psychiatric disorders according to the Goldberg Health Questionnaire, and 36% had PTSD according to the Harvard Trauma Questionnaire.

Steel, Silove, and others have studied Tamil refugees, immigrants, and asylum seekers in Australia. Steel et al. (1999) mailed a questionnaire completed by 62 asylum-seekers, 30 refugees, and 104 immigrants. Using path analysis, premigration trauma accounted for 20% and postmigration stress 14% of posttraumatic stress symptoms. Silove et al. (2002) examined predictors of PTSD in a sample of 107 Tamils, finding that, controlling for overall trauma exposure, those tortured had higher PTSD scores compared with other war trauma survivors.

Middle Easterners: Laban (2005, in press) compared two groups of Iraqi asylum-seekers in the based upon length of time in the Netherlands (<6 months, N=143, and >2 years, N=151). Thirty per cent of the sample had been tortured. Overall prevalence of

psychiatric disorders was 42% in the recently arrived group and 66.2% in those staying more than two years. Women and elderly were at particular risk for psychiatric disorder. PTSD was diagnosed by the Composite International Diagnostic Interview (CIDI) in 36.7% and did not differ significantly between groups, while depression was found in 34.7% of the total sample, higher in the group staying longer. A lengthy asylum process was an important risk factor for psychiatric disorder, showing a higher odds ratio than those from life events in Iraq. In another epidemiological study, conducted in 2002 (unpublished) by the Gaza Community Mental Health Program (GCMHP), prevalence of mental symptoms, such as anxiety and depression, was 73% for patients seeking medical treatment at the primary health care centers. Only 11% of these cases were detected by the general practitioners at the primary health care centers. This demonstrates the pressing need to train health professionals, especially physicians to better detect cases of mental health nature that seek medical services.

Hondius et al. (2000) conducted two studies of Latin American or Middle Eastern (N=480) and Turkish and Iranian (N=156) refugees resettled in the Netherlands. Turkish refugees comprised 41% (Study 1) and 55% (Study 2) of participants. High frequencies were reported for torture events, but PTSD was diagnosed infrequently (6-11%) primarily because Criterion C (avoidance) was not met. While 40% attributed their worries to postmigration stressors, only 29% attributed their somatic and psychological complaints to their experiences of torture. Priebe and Esmali (1997) examined 34 Iranian torture victims living in Germany and diagnosed depression, anxiety, and somatoform disorders (frequently co-morbid with the most common diagnosis, PTSD).

The level of pathology was higher in the treatment group. Gorst-Unsworth and Goldenberg (1998) interviewed 84 male Iraqi refugees at the Medical Foundation in London, finding a total of 45 of the 84 diagnosed as cases of major depression or PTSD. In a controlled study, Paker et al., (1992) studied 246 inmates of a prison in Turkey, 208 of whom were tortured for non-political reasons. Some homogeneity of non-torture stressors was present. Multiple regression analyses controlled for some of the confounding variables. Using DSM-III-R criteria for PTSD, torture survivors had significantly more PTSD and higher scores on measures of general psychopathology than did the non-tortured prisoners. However, the length of time since the last torture was not however taken into account and non-torture stressors during imprisonment and other stressful life events were not controlled for. Basoglu et al. (1994a) used semi-structured interviews based on DSM-III-R and other standardized assessor- and self-rated instruments in comparing 55 tortured political activists in Turkey with 55 non-tortured political activists and 55 non-tortured individuals who had no history of political activity or involvement. All groups were closely matched for age, sex, marital and socio-cultural status. The first two groups were also matched for political ideology (left-wing), and extent of political involvement. The study involved non-refugee survivors of torture, thereby avoiding confounding by refugee status. The torture survivors had significantly more lifetime and current PTSD than did the controls (33% vs. 11% and 18% vs. 4%, respectively) and had higher anxiety and depression (but the scores in both groups were within normal range). Among the factors related to long-term psychological status were secondary impact of captivity/torture on family, family history of psychiatric ill-

ness, and post-captivity psychosocial stressors (Basoglu et al., 1994b). Age at trauma, sex, and marital and socio-economic status did not predict post-torture psychological functioning.

Former Yugoslavians: Suli and Como (2002) assessed the prevalence of PTSD in a sample of 840 refugees from Kosovo in an Albanian village. More than 50% reported physical torture, and, in addition, 79% had property destroyed, 19% were robbed, 17% were imprisoned, while 49% experienced the killing of a loved one and 33% the disappearance of a family member. PTSD prevalence was 59%, higher in women and with increasing age. Grzeta et al. (2001) compared traumatized refugees in Croatia with experiences of combat, imprisonment, and torture (N=50), refugees with combat experience only (N=29), and 30 local persons with no trauma experience. All examinees (N=79) had PTSD, and torture survivors showed significantly more clinical depression than either the combat experience refugees or the control group. Arcel (1998) has edited an extensive volume on the sequelae and treatment approaches based upon research and clinicians' experiences in the former Yugoslavia. The problems of children and caregivers in war receive special emphasis in this work. Weine et al. (1998) assessed PTSD symptoms in 34 Bosnian refugees in the US at resettlement and one year later. Older refugees were at greatest risk. At initial assessment 25 (74%) were diagnosed with PTSD and 15 (44%) on follow up, with severity of posttraumatic symptoms decreasing over time. Kivling-Boden and Sundbom (2001) assessed 27 traumatized refugees from the former Yugoslavia seen in psychiatric treatment initially and three years later. On follow-up the authors found no significant change in average symptom level. Ek-

blad et al. (2002) completed a three month follow-up of 131 adult Kosovars mass-displaced to Sweden and found that torture was associated with poor coping, while PTSD was associated with depression, anxiety, and aggression. Women had more psychiatric symptoms and demonstrated poor coping. Porter and Haslam (2001) conducted a meta-analysis comparing knowledge about differences in mental health of former Yugoslavian refugees and non-refugees. The authors found that refugees had more mental health impairment. Iacopino et al. (2001) studied 1,180 ethnic Albanians from Kosovo who had taken refuge in camps in Macedonia and Albania. Most (68%) were forcibly expelled by Serbian forces. The findings of multiple human rights abuses provided support for a systematic and brutal campaign by Serb forces. Cardozo et al. (2000) conducted a cross-sectional cluster sample survey among 1,358 Kosovar Albanians age 15 or older in 558 randomly selected households in Kosovo. Seventeen per cent met criteria for PTSD. The high prevalence of traumatic events was related to decreased mental health status and social function. Those 65 years or older, internally displaced, or with prior psychiatric illness or chronic health problems, had the most psychiatric morbidity. Those living in rural areas, unemployed, or with chronic illness had poorer social function. Approximately 90% had strong feelings of hatred toward Serbs. Mollica et al. (1999), in a cross-sectional survey of 534 Bosnian adults living in a Croatian camp, found 39% depression, 26% PTSD, and 21% co-morbidity for both. In follow-up (Mollica et al., 2001a), 78% of the original sample were re-interviewed and 45% continued to have depression, PTSD, or both, while another 16% who were originally asymptomatic had developed one or both disorders.

Africans: Youngmann et al. (1999) studied emotional distress of Ethiopian immigrants in Israel and found that emotional distress was primarily expressed through somatic symptoms (especially head, heart, and stomach) and that external factors such as “supernatural powers” and acculturation stress were identified as the causes. Depression symptoms were the most frequently identified sequelae of emotional distress. Peltzer (1997) studied the psychological effects of torture in 120 political detainees and 60 non-political prisoners in Malawi. Despite the similarity of torture methods across cultures, specific forms of torture differed between the two groups. Unpredictable and uncontrollable torture resulted in greater perception of distress, female and single status predicted greater vulnerability, and emotion-focused coping and social support were related to increased pathology. Tang and Fox (2001) studied Senegalese refugees in refugee camps in Gambia, finding high prevalence rates of anxiety, depression, and PTSD, as well as a large number of traumatic experiences (11.28 of 16 possible). Musisi et al. (2000) reviewed 310 patient records at a torture treatment center in Kampala, Uganda, finding prevalence rates of 75% PTSD, 28% depression, 17% anxiety, 32% somatoform, and 83% chronic pain. The army accounted for 86% of the perpetrators who most commonly used kicking and beating (80%) and forcing victims to witness the torture of others (48%).

Latin Americans: Eisenman et al. (2003) studied 638 Latino patients in three primary care settings in the US, finding that 8% reported torture experiences while 54% reported experiences of political violence. Of the latter, 36% had depressive symptoms and 18% posttraumatic stress symptoms compared with 20% and 8% of those with-

out political violence history. Those who had experienced political violence more frequently had PTSD, depressive and panic disorder symptoms, chronic pain, physical disability, and lower perceptions of their general health.

Methodological Issues

Reviews (Somnier et al., 1992; Goldfeld et al., 1988; Basoglu et al., 2001) have drawn attention to the methodological problems in studies of torture survivors. These include insufficient description of the interview procedures, assessment instruments, diagnostic criteria, and medical diagnoses; inadequate reporting of neurological and neuropsychological findings to rule out the possible etiological role of head trauma; failure to report the length of time between torture and assessment, relationship between the symptoms and the diagnosis of PTSD, or how factors such as gender, age, education, cultural traits, and personality factors relate to post-torture symptoms.

B. Psychiatric diagnoses and symptom constellations

Data from studies in treated and untreated populations, in resettlement countries, refugee camps, and countries of origin, indicate that PTSD and depression are the most common diagnoses. Neuropsychiatric symptoms are often difficult to diagnose correctly because the multiplicity of symptoms is great and co-morbidity occurs frequently. Most studies focus on PTSD, which will consequently receive the most attention in this review. However, this emphasis may have obscured the finding that depression is the most common psychiatric disorder diagnosed in torture survivors, according to Mollica (2004).

Sleep disturbances: Insomnia and nightmares are among the most common and distressing

sequelae reported by torture survivors (White, 2001). Astrom et al. (1989) reported abnormal sleep patterns compared with controls in seven young, previously healthy, torture survivors in Denmark examined by polysomnography. These included disturbance of REM (dream) sleep, absence of the deepest (Stage 4) sleep, reduced sleep, and poor sleep efficiency. In a review of sleep disturbances after a traumatic event, Lavie (2001) found that trauma-related anxiety dreams are the most consistent sleep problem reported by PTSD patients. PTSD patients, who suffer from hyperarousal, paradoxically have deep sleep and lower rate of dream recall than normals, even when awakened from REM sleep. Lavie also found that immediate sleep problems after the traumatic event predict future symptoms, both physical and psychiatric. Koren et al. (2002) also found that insomnia and daytime sleepiness in motor vehicle accident survivors predicted PTSD a year later.

Neurocognitive: Traumatic brain injury (TBI) has long been suggested as a factor associated with psychiatric co-morbidity in survivors of mass violence and torture. Head trauma is frequent during beatings in torture. Mollica (1993) has stated that, in his sample of Cambodians, most torture has involved beatings to the head. The traumatic stress literature from other populations (Gerrity et al., 2001) and head injury literature (McFarlane, 1995) can assist our understanding of these effects.

Basoglu et al. (2001) have reviewed earlier findings, beginning with the studies of Holocaust survivors in 1954, showing abnormal neurologic exams and EEGs, but questionable cerebral atrophy using computerized tomography and other techniques. Some recent studies have suggested an association between head trauma and neuro-psy-

chiatric symptoms, such as cognitive deficits, and a lifetime risk of PTSD and depression (Williams et al., 2002; Holsinger et al., 2002; Robinson and Jorge, 2002). Holsinger et al. (2002) studied lifetime rates of depression 50 years after closed head injury in a sample of 1,422 head injured World War II veterans using a chart review methodology. Veterans with head injury had more major depression, unexplained by potential confounders of heart disease, stroke, or alcoholism. The lifetime risk of depression increased with the severity of the head injury and remained elevated for decades following the injury. Joseph and Masterson (1999) studied PTSD and traumatic brain injury to determine whether they were mutually exclusive. These authors reviewed research studies and concluded that PTSD does occur rarely among the TBI population, but that the true prevalence remains unknown. Williams et al. (2002) studied the relationship between PTSD symptom reporting by 66 survivors of TBI in a community sample, measuring injury severity, memory, insight, and index-event attributions. Reporting of PTSD symptoms was only related to insight, and severity of PTSD symptoms was associated with external attribution of causality for the event.

Strong (2003) reported that 10% of US soldiers with a traumatic brain injury and PTSD had more psychiatric co-morbidity and disability. Bryant and Harvey (1998) reported a high frequency of PTSD following mild traumatic brain injury after a motor vehicle accident. Gurvits et al. (1993) reported significantly more neurological soft signs in outpatient Vietnam veterans with PTSD than in a control group. Vasterling et al. (2000) studied 171 male combat veterans and found that head injury was associated with severe depression but not PTSD.

Moreno and Grodin (2002) noted that

techniques which prevent breathing can cause cerebral anoxia, causing long-lasting memory or cognitive impairment. A study by Fann et al. (1995) showed that more than half of the outpatients in a brain injury clinic had major depression, either at the time of exam or first onset after the injury had resolved, and reported severe post-concussion symptoms. Depression and anxiety were frequently found in the more disabled and those who perceived their injuries and cognitive impairments as severe.

Depression and suicide: Depression and PTSD are widely acknowledged as the most common psychiatric diagnoses in refugees and torture survivors. Suicide is more closely correlated with major depression than with any other psychiatric diagnosis, but reports of suicide are rare in the torture rehabilitation literature. Suicidal ideation and attempts have been reported significantly higher among women who have been victims of assault (Koss and Kilpatrick, 2001). Rates of attempted suicide for those with PTSD have been reported as high as 19% (Davidson et al., 1991; Davidson, 2001). Ferrada-Noli et al. (1998) studied 65 refugees with PTSD and suicidal behavior, finding that the choice of method was related to the main stressors. Blunt force to the head and body was associated with jumping, water torture with drowning, sharp force torture with self-inflicted stabbing or cutting.

Substance abuse: PTSD and substance abuse are very common in soldiers and veterans of combat, but relatively uncommon in torture survivors who are refugees. Among refugees, Asians tend to have lower rates of alcoholism, but substance abuse is fairly common among Central American refugee males (Farias, 1991). This co-morbidity appears to

be gender-related, more often seen in men than women (Kastrup and Arcel, 2004).

C. Posttraumatic stress disorder (PTSD)

PTSD was first introduced in the Western diagnostic manuals in 1980. Torture certainly qualifies as one of the most, if not the most, extreme traumatic stressors meeting diagnostic criteria for PTSD. PTSD is classified as a subcategory of anxiety disorders in the DSM-IV (309.81) (American Psychiatric Association, 1994) and ICD-10 (F43.1) (World Health Organization, 1992). The DSM-IV now includes for the stressor (Criterion A) not only those who have experienced torture and other extreme trauma, but those who have witnessed or been confronted with actual death or serious injury, threatened death or serious injury, either to themselves or to someone else. Other criteria include symptom clusters of re-experiencing the traumatic event (Criterion B), avoidance (Criterion C), increased arousal (Criterion D), as well as duration greater than one month (Criterion E) and significant distress or impairment (Criterion F). Specifiers may be used to identify onset and duration of the symptoms: Acute-duration of symptoms is less than 3 months; Chronic-symptoms last 3 months or more; With Delayed Onset-at least 6 months have passed between the trauma and the symptom onset. The DSM-IV only includes one related diagnosis in response to an extremely traumatic stress, Acute Stress Disorder (308.3), which occurs within a month after exposure. Disorders of Extreme Stress Not Otherwise Specified (DESNOS) was considered for inclusion in the manual but not accepted for DSM-IV. It is under discussion again for DSM-V.

In ICD-10, PTSD arises as a delayed and protracted response to a stressful event or situation (either short- or long-lasting) of an exceptionally threatening or catastrophic

nature, which is likely to cause pervasive distress in almost anyone; predisposing factors such as personality traits or previous history of neurotic illness may lower the threshold for the development of the syndrome or aggravate its course, but they are neither necessary nor sufficient to explain its occurrence. PTSD should not generally be diagnosed unless there is evidence that it arose within 6 months of the trauma. Probable diagnosis might be possible if the delay between the event and the onset was longer than 6 months if the clinical picture is typical and no alternative disorders are plausible. In addition to evidence of trauma of exceptional severity, there must be repetitive, intrusive recollection or re-enactment of the event in memories, daytime imagery, or dreams. Conspicuous emotional detachment, numbing of feeling, and avoidance of stimuli that might arouse recollection of the trauma are often present, but are not essential for the diagnosis. The autonomic disturbances, mood disorder, and behavioral abnormalities all contribute to the diagnosis but are not of prime importance. The chronic sequelae of devastating stress manifesting decades after the trauma, should be classified elsewhere. Under F62.0 ICD-10 has to some extent partially solved the problem of changes occurring outside of the diagnosis of PTSD by adding the diagnostic category of "enduring personality change after catastrophic experience".

These two major diagnostic systems differ in many ways. The ICD is integrated with somatic diagnostic codes used in clinical practice in many countries, is the official WHO instrument, contains some categories such as postconcussional syndrome for sequelae, and has open categories for PTSD in the clinical version manual. The DSM is supported by abundant research data, is clearly operationalized, but also limited since

criteria intended for research might be too restrictive for clinical work. Many research and diagnostic instruments in multiple languages have been based on the DSM.

These system differences may affect how PTSD is diagnosed by DSM-IV and ICD-10. When symptoms were mapped to both diagnostic criteria using the computerized CIDI in a major epidemiological survey, the groups were not identical (Andrews et al., 1994).

There has been a continuing narrowing of the diagnosis for medico-legal purposes, at least in the United States. The concept of “partial PTSD” or a cluster of posttraumatic stress symptoms has been proposed since many trauma survivors have posttraumatic stress symptoms, but do not fulfill the criteria for diagnosis. Even though the term “posttraumatic” implies that the torture was a single isolated trauma, most survivors of torture have a history of cumulative traumas.

Validity of the PTSD construct

Kinzie and Goetz (1996) reviewed clinical antecedents as early as the 1860s leading to the development of the PTSD criteria in DSM-IV. The authors state that the role of trauma in PTSD was accepted only after WWII and the controversy over the validity of the PTSD diagnosis continues today. Opponents of the PTSD formulation have stated that torture survivors are experiencing a normal reaction to an abnormal stressor or societal pathology (Reeler, 1994). Labelling torture symptoms as a mental disorder, implying personal pathology and the stigma of mental illness, can be viewed as medicalizing a socio-political problem (Lira, 1998). Especially in countries where torture is routinely practiced, PTSD is often viewed as a Western ethnocentric (Chakraborty, 1991) and very limited diagnostic category which fails to capture the magnitude of torture as a trauma.

Survivors have suffered from a life-threatening event and are often concerned about being labeled with diagnoses such as PTSD. Allodi (1991) defines two categories of torture treatment settings geographically, the “North” and the “South”. Countries of final resettlement, such as the industrialized nations in the continents of Europe, North America, and Australia, fall into the former category, while totalitarian “Third World” countries where torture is practiced, as well as countries of initial refuge, comprise the latter. The North has developed diagnostic systems, i.e., DSM-IV and ICD-10, based upon the medical model or syndrome approach to diagnosis. Clinicians in the South more frequently question this approach and the applicability of PTSD to survivors of torture and extreme trauma.

Re-definition of PTSD as a need for assistance rather than a pathology is one solution to this dilemma. On the other hand, the PTSD construct can be defended as important in identifying syndromes for medical research and treatment. There is also an increasing body of evidence concerning the biological correlates of PTSD, and many symptoms of posttraumatic stress have a biological basis. This makes a compelling argument for the existence of the disorder, but not necessarily classified precisely according to the Western diagnostic systems (Friedman and Jaranson, 1994). In Basoglu’s controlled study (1994a) of non-refugee survivors, 33% had lifetime PTSD while 18% had current PTSD after an average of five years, suggesting a chronic course of illness. These figures suggest that PTSD, although not extremely common after torture, occurs in a substantial proportion of cases. Such chronic and disabling psychological responses cannot be regarded as a normal response to trauma. In an earlier study (1992), Basoglu and Minetka found that PTSD and depression,

which are often overlapping features in trauma survivors, were independent in his study group, another finding supporting the validity of PTSD as a diagnostic entity. Smith Fawzi et al. (1997), studying 74 Vietnamese in Boston, found support for the symptom clusters of PTSD but found two separate dimensions of avoidance, attributing this to the confounding effect of depression as a consequence of trauma. The argument that PTSD is prevalent, and therefore normal, can also be refuted (Jaranson, 1998) by a public health analogy. The fact that posttraumatic stress may be statistically frequent in traumatic situations does not exclude it as a disorder or illness. Posttraumatic stress can be considered a pathogen not unlike, for example, the cholera bacterium, which causes illness in many of those exposed to a contaminated water supply. Like cholera, PTSD causes illness in many (but not usually most) of those exposed, but this does not make PTSD either normal or untreatable (Jaranson, 1998).

Complex PTSD

There is no doubt that simply to label survivors as having PTSD is inadequate to describe the magnitude and complexity of torture's effects. However, PTSD was never intended to encompass the entire range of sequelae following torture, which is always severe, and usually repeated (Friedman and Jaranson, 1994). The socio-political aspects, as well as cultural considerations, cannot be ignored. Based upon clinical experience, torture appears to be such an extreme stressor that it reduces many of the cultural differences. The symptoms of posttraumatic stress appear in individuals from many different countries fairly consistently (Jaranson, 1995). This does not mean, of course, that cultural factors are unimportant. In fact, cultural differences have been identified as

important factors in PTSD (Marsella et al., 1994). When cultural differences occur, they are predominantly in the way that the symptoms are expressed and in the ways the individual either interprets what has happened or views the world (Friedman and Jaranson, 1994; Jaranson et al., 2001).

Other concepts have been proposed to classify the longer term effects in personality and world view, including Complex PTSD (Herman, 1992, 1993), Continuous Traumatic Stress Response (Dowdall, 1992), Disorders of Extreme Stress Not Otherwise Specified (DESNOS), or Enduring Personality Change after Catastrophic Experience (ICD-10). Especially when torture is prolonged over many years or when the survivor is young when tortured, many other changes may occur. Long-term sequelae often include somatization, multiplicity of symptoms, dissociation, lability of affect, difficulty with relationships, inability to trust, changes in the way one looks at oneself or the world, and repetition of harm. Once again, however, most studies have not been controlled for the potential confounding factor of refugee trauma.

Torture syndrome

A number of practitioners have proposed a torture syndrome, broader than PTSD but including most of the PTSD symptoms (e.g., Genefke and Vesti, 1998). Elsass (1997, 1998) cites distinguishing features of torture compared with other forms of severe trauma. Since torture is both mental and physical and "has an explicit political aim in a specific sociopolitical context" (1998, p. 35), i.e., torture intends harm to individuals and groups in a political context. Therefore, A) Torture differs from the Holocaust, which was impersonal genocide; B) Certain posttraumatic symptoms may be associated only with specific types of torture; and C) Four

themes have been considered unique to torture survivors: “1) incomplete emotional processing, 2) depressive reactions, 3) somatoform reactions, and 4) existential dilemmas” (1998, p. 36). More recently, Wenzel et al. (2000) argued for continuing to look for a broader conceptualization for the traumatic aftereffects of torture, including feelings such as shame and guilt, and existential rumination. Peel et al. (2001) continue to suggest that torture victims probably have different distress patterns from those traumatized in other ways. Much of the research on torture survivors, using control or comparison groups, has not provided support for the separate existence of a torture syndrome (Basoglu et al., 1994b; Westermeyer and Williams, 1998). Evidence for a torture-specific syndrome would require a) evidence of a causal connection between the torture and subsequent symptoms, b) a meaningful grouping of symptoms, validated across samples and cultures, and c) comparison of symptoms with established diagnoses such as PTSD (Basoglu, 1997). The torture syndrome has not yet been validated with qualitative empirical studies, but clinical descriptions have generated the hypothetical syndrome. It remains to be seen whether future research will provide that validation.

PTSD prevalence

Although the knowledge about PTSD has increased, the prevalence still remains unknown. PTSD prevalence was considered to be low (1.3%) in the general population (Davidson et al., 1991) until the National Co-morbidity Survey in the USA (Kessler et al., 1995) estimated a lifetime prevalence of PTSD of 7.8%. Women are four times as likely to develop PTSD as men exposed to the same trauma, and lifetime prevalence rates of PTSD after civilian trauma are

higher for women (10.4%) than for men (5%) (Breslau et al., 1998). In veterans of the Vietnam war, prevalence has been reported as 30-38% (Reeler, 1994).

PTSD occurs in a minority of those exposed to mass conflict, with prevalence rates varying between 4% and 20% (Silove, 1999; Silove et al., 2000) or between 9% and 37% (Modvig and Jaranson, 2004). Only a few large studies (N>500) examining PTSD rates have been reported. From national samples, de Jong et al. (2001) studied post-conflict populations in Algeria, Cambodia, Gaza, and Ethiopia, finding rates of post-traumatic stress disorder (PTSD) ranging from 16% to 37%. Symptom levels tend to be higher in refugee camps than in resettlement populations (e.g., Modvig et al., 2000). Mollica et al. (1993,1998) studying 993 Cambodians in a Thai refugee camp, found that a third had posttraumatic stress. Comparing 526 Bhutanese torture survivors in a Nepalese refugee camp with matched controls, Shrestha et al. (1998) found higher posttraumatic stress and anxiety. Van Ommeren et al. (2001) subsequently randomly sampled 810 (418 tortured and 392 non-tortured Bhutanese refugees) from the same frame, finding that torture survivors had more PTSD symptoms (43% vs. 4%). In Western resettlement populations, Jaranson et al. (2004) found that, among a community sample of 1,134 Somalis and Ethiopians (Oromo) in Minnesota, 25% of the torture survivors had suspected PTSD compared with only 4% of those not tortured. Maercker and Schutzwohl (1997), investigating the long-term effects of political imprisonment in the former German Democratic Republic, compared 146 former political prisoners with 75 controls matched for age and sex. Assessment of psychological status was carried out using a semi-structured diagnostic interview based on DSM-III-R. In com-

parison with controls, the former political prisoners had significantly higher rates of lifetime (59.6%) and current PTSD (30.1%).

Table 2 shows, by descending order of sample size, the percentages of traumatized persons having posttraumatic stress diagnosis or significant symptoms in population-based surveys and case-control studies with samples larger than 200.

Co-morbidity: Many studies have found a high level of co-morbidity (e.g. Cunningham and Cunningham, 1997; Somnier et al., 1992), especially between depression and

PTSD. Basoglu et al. (1994a) have found PTSD the most common diagnosis among torture survivors, while depression, anxiety, and substance abuse were less common. Co-morbidity seems to be gender-related, with men more likely to have PTSD associated with substance abuse and women to have a history of depression or anxiety (Kastrup and Arcel, 2004). However, co-morbidity in refugees may be the result of refugee trauma rather than torture trauma.

Dose-effect relationships: Rundell et al. (1989) reviewed the literature about psychiatric re-

Primary author	Population sample	Trauma type	Sample size	Country of origin/study	Prevalence, percentage		
					Total sample	Non-tortured	Tortured
De Jong	Postconflict	Torture & war	1.200	Ethiopia/ Ethiopia/	16	Lower	LT higher ($p < .001$)
Steel	Resettled refugees	Torture & war	1.161	Vietnam/ Australia	7-8 with psych dx		
Jaranson	Resettled refugees	Torture & war	1.134	Somalia & Ethiopia/US	13	4	25
Shrestha	Refugees in camp*	Torture & War	1.052	Bhutan/Nepal	9	4	14
Mollica	Refugees in camp	Torture & war	993	Cambodia/ Thailand	33	N/A	N/A
Van Ommeren	Refugees in camp*	Torture & war	810	Bhutan/Nepal	N/A	4 (C) 15 (LT)	43 (C) 74 (LT)
De Jong	Postconflict	Torture & war	653	Algeria/Algeria	37	Lower	LT Higher ($p = .003$)
De Jong	Postconflict	Torture & war	610	Cambodia/ Cambodia	28	Lower	LT Higher ($p < .001$)
De Jong	Postconflict	Torture & war	585	Gaza/Gaza	18	Lower	LT Higher ($p < .001$)
Mollica	Refugees in camp	Torture & war	534	Bosnia/Croatia	26	N/A	N/A
Paker	Prisoners	Torture & prison	246	Turkey/Turkey	33	0	39
Maercker	Former political prisoners	Torture & prison	221	GDR			60 (LT) 30 (C)

C = Current or within past year

LT = Lifetime

* = Case-control study

Table 2. Traumatized samples with posttraumatic symptoms ($N_s > 200$)

sponses to trauma and found a positive dose-response correlation between PTSD symptom severity and the amount of trauma in four studies of Vietnam veterans and one of disaster victims. PTSD showed the greatest additive effect of torture in the study of East Africans resettled in the United States by Jaranson et al. (2004). Silove et al. (2002) previously found an additive effect of PTSD in Tamil torture survivors in Australia after accounting for other traumatic events. Mollica et al. (1998), who studied Vietnamese ex-political prisoners in the United States, found a positive association between cumulative torture experience and symptoms, especially the increased arousal symptoms of PTSD. On the other hand, Basoglu and Paker (1995), in studying torture survivors, found that the frequency of experiencing torture did not predict posttraumatic stress responses, suggesting that repeated torture did not have an additional impact beyond a certain threshold. Although the published literature is contradictory, these findings support a possible dose-response relationship between torture and PTSD.

D. Traumatized refugees compared with torture survivors

Usually the torture survivor has suffered from many traumatic episodes and the trauma can be ongoing in exile, including countries of final resettlement. However, most studies of torture survivors use an uncontrolled design and do not control for the additional effects of refugee trauma, while studies of non-refugee survivors have failed to control for other non-torture, potentially traumatic, life events. Torture is only one of the many traumatic stressors in an environment characterized by political repression and such stressors are associated with increased psychiatric morbidity.

Den Velde (2000), comparing Dutch sur-

vivors of WWIIs in the Netherlands with Dutch who immigrated to Australia, provided support for the concept that severe stress rather than migration was a major factor in PTSD. Lie (2002) found that pre-flight and post-flight trauma (in both Norway and in the home country) correlated significantly with symptoms. Lie found that PTSD symptoms increased during a three-year resettlement period in Norway for 240 refugees. Roth and Ekblad (2002) found that PTSD rates increased from 45% to 78% at 18-month follow-up in Kosovars resettled in Sweden. These findings suggest that additional stressors such as refugee trauma, which involves deprivation of social support networks, may contribute to traumatic stress responses. However, Bhui et al. (2003) found that anxiety and depression were increasingly prevalent with each pre-migration stressor for Somali refugee in the UK. A study by Jaranson et al. (2004) found that social problems of East African refugees in Minnesota were no greater for torture survivors than for refugees traumatized in other ways. PTSD was found in 25% of those tortured but only 4% of those refugees otherwise traumatized, and this increase for torture survivors was found when controlling for total trauma events in the sample population. Silove et al. (1997) studied association with pre-migration and post-migration stressors of 40 asylum-seekers attending a center in Australia. Of the 37% who met full criteria for PTSD, associations were found with exposure to pre-migration trauma, delays in processing applications, problems with immigration officials, employment obstacles, racial discrimination, as well as loneliness and boredom.

In earlier work, Somnier et al. (1992) reported that the rates of psychological problems in studies of refugee survivors of torture appeared to be higher than those found

in studies of non-refugee torture survivors, perhaps a result of additional trauma from stressors in the refugee experience. At least two lines of evidence support this. First, Basoglu et al. (1994b) found that post-torture psychosocial stressors contributed independently to traumatic stress reactions, supporting the notion of “sequential” traumatization. Secondly, post-captivity lack of social support predicted depression. Basoglu and Mineka (1992) have reported the multiplicity of psychological problems associated with torture and refugee trauma. They found that perceived severity of torture related to PTSD but not to depression, while lack of social support was associated with depression but not with PTSD. They concluded that the connection between torture and PTSD symptoms such as re-experiencing, increased physiological arousal, and avoidance of reminders of trauma may reflect conditioning effects of torture. Lack of social support, on the other hand, may lead to depression by reducing sense of control over subsequent stressors and precipitating helplessness and hopelessness. Basoglu and Paker (1995) found a differential relationship between stressors and symptoms: perceived severity of torture predicted PTSD but not depression, while lack of social support after captivity related to depression but not to PTSD. Post-captivity non-torture stressors, however, related to both PTSD and anxiety/depression. These findings suggest that both torture and post-torture psychosocial stressors are associated with traumatic stress symptoms in torture survivors.

E. Predictors and coping

Relatively little is known about the factors that determine psychological response to torture in studies of non-refugee survivors of torture. Furthermore, prediction studies require the use of special statistical techniques

(e.g. multiple regression analysis) to examine the unique or independent effects, and few studies have employed such analytic methods.

Brune et al. (2002) studied the role of belief systems in the outcome of 141 traumatized refugees in Hamburg, Germany, using chart review methodology, and found that a strong belief systems predicted better therapy outcome. Emmelkamp et al. (2002) found that, in 315 Bhutanese refugees from a database set, findings were verified in a second sample of 57 Nepalese torture survivors seeking help. In both samples negative coping, compared with positive coping, was related to increased symptoms on all outcome measures. Received social support was more strongly related to these symptoms than was perceived social support. Kanninen et al. (2002) examined 103 male former political prisoners primarily from refugee camps and urban areas in the Gaza Strip in Palestine. The goal was to examine the mediating effects of trauma-specific appraisals and coping efforts. High levels of posttraumatic symptoms were associated with acuteness of trauma, negative appraisal of the prison experience, and use of both emotion-focused and problem-focused coping. Torture and ill-treatment were directly associated with intrusive symptoms. Recent release from prison was associated with PTSD avoidance symptoms. Lower levels of post-traumatic symptoms were associated with emotion-focused coping in the long run and problem-focused coping in the short run.

Basoglu has published extensive earlier work on predictors and coping. Basoglu et al. (1994a), comparing tortured political activists with non-tortured political activists in Turkey, pointed to the possible protective role of a strong belief system, commitment to a cause, prior knowledge and expectations of torture, and prior immunization to trau-

matic stress. In this study, the majority of the torture survivors were highly committed political activists with prior expectations of torture and psychological preparedness for it. Later, Basoglu et al. (1997) compared 34 “psychologically prepared” torture survivors who had no history of political activity, commitment to a political cause, or expectations of arrest and torture with the 55 tortured political activists.

Less psychological preparedness for trauma was by far the strongest predictor of greater perceived distress during torture and more severe psychological problems afterwards. These findings supported both the role of prior immunization in reducing the effects of traumatic stress and the role of unpredictability and uncontrollability of stressors in exacerbating the effect.

Many survivors reported using elaborate coping strategies in order to avoid total loss of control during torture, a factor that may play a role in the development of traumatic stress symptoms (Basoglu and Mineka, 1992). Basoglu et al. (1996) also examined some of the cognitive factors that may have protected the survivors against the traumatic effects of torture. Three groups were compared in their appraisal of self, others, and state authority. No remarkable differences between tortured and non-tortured political activists were found, and both groups differed from non-activist controls in having a more negative appraisal of state authority. The study concluded that pre-trauma lack of beliefs concerning a benevolent state may have protected the survivors from the traumatic effects of torture.

7. Social, familial, and societal sequelae

A. Social and economic consequences of torture on the survivor and the family

The social and economic consequences of torture have rarely been systematically

studied. This is important for the less industrialized countries as well as for host countries providing asylum to large numbers of tortured refugees.

Even though torture is intended to damage the person’s self-esteem and personality and to destroy trust in fellow humans (Genefke, 1994), there is also the loss of normal life development due to lost time in prison or waiting for final resettlement. Delays may occur in education, marriage, or accumulation of wealth. Torture, therefore, must be seen not only as a very important life event, but also as the cause of many others (Turner and Gorst-Unsworth, 1993). Several factors may account for the social and economic consequences of torture and associated life events. Loss of social/occupational status or educational opportunities as a result of prolonged imprisonment and difficulty finding employment after release may contribute to social and economic disability. The physical and psychological effects of torture may compound the latter. Physical disability may arise from permanent bodily injury (Skylv, 1992) or head trauma leading to cognitive impairment.

Psychological problems, including PTSD and depression, may cause significant social disability and undermine the chances of finding employment. Irritability and rage reactions may impair interpersonal relationships. Memory and concentration difficulties may reduce the capacity for learning and impair work performance. Symptoms of impulsivity and irritability may lead to problems with the law (Jaranson et al., 2001). Silove (1999) proposed an integrated psychosocial framework suggesting that torture challenges five core adaptive systems: safety, attachment, justice, identity-role, and existential-meaning. This framework was elaborated with respect to PTSD by Ekblad and Jaranson (2004).

Steel et al. (2002) found that mental illness in a large sample of Vietnamese refugees resettled in Australia was associated with impaired physical function and high demand for health services. Kivling-Boden and Sundbom (2001) assessed 27 traumatized refugees from the former Yugoslavia seen in psychiatric treatment initially and on follow-up three years later. On follow-up, social welfare dependence was high and unemployment at 32% was sixfold the mainstream Swedish labor force. Positive factors were housing and a reasonable knowledge of the Swedish language. Mollica et al. (1999) found that a sample of Bosnian refugees with psychiatric co-morbidity for depression and PTSD were five times more likely to report disability, independent of age, trauma, and health. In a follow-up study three years later (Mollica et al., 2001), the Bosnian refugees who remained living in the Croatian camp region still showed psychiatric disorder and disability. Many of the healthier and educated refugees had emigrated. Mollica et al. (1987) found that Cambodian widows, who had experienced at least two of three trauma experiences (rape, loss of spouse, or loss of children), had very high levels of depressive symptoms. They perceived themselves as socially isolated and living in a hostile social world, even among their own cultural group. Gorst-Unsworth and Goldenberg (1998) interviewed 84 male Iraqi refugees at the Medical Foundation in London, finding that good social support ameliorated the severity of both depressive and posttraumatic symptoms. Poor social support more strongly predicted depressive than traumatic morbidity.

Another common psychological problem influencing economic costs of torture is the development of somatic symptoms and pre-occupation with bodily complaints (Somnier et al., 1992; Mollica et al., 1987). Torture

survivors with a tendency to somatize symptoms often seek costly medical investigations and treatments that are not always necessary and in their own best interest.

Evidence suggests that avoidance of trauma reminders in PTSD needs special attention in understanding the causes of social and economic disability in torture survivors. Anxiety disorders research shows that avoidance of feared situations is the primary cause of disability in work, social, and family functioning (Basoglu et al., 1994) and that global clinical improvement is most closely associated with improvement in avoidance of feared situations (Basoglu et al., 1994b). Basoglu et al. (1994a) found that 33% of tortured political activists had significant avoidance of trauma reminders, despite their resilience to torture. This symptom occurred even more commonly (53%) among non-activist survivors of torture (Basoglu et al., 1997). Furthermore, some case studies (Basoglu and Aker, 1996) suggest that interventions aimed at reducing avoidance behavior lead to a significant improvement in social disability.

The family is intimately involved and may need assistance for indirect trauma and for dealing with the survivor. There have been relatively few systematic studies of the effects of torture on family. Separation from family, loss of social and occupational status, deprivation of social support networks and physical needs, uncertainty about the future (Witterholt and Jaranson, 1998), problems in settlement in a new country and adaptation to a new culture, and housing and economic problems are among the many problems faced by refugee survivors of torture. Basoglu et al. (1994b) showed that the presence of additional stressors for the family was a more significant predictor of PTSD than the actual trauma of torture itself. Other studies have reported a number of

factors that may disrupt family functioning. The survivor's family may come under further strain by additional stressors such as unemployment, poverty, and various social stigmata (e.g., being labelled as terrorist) as a result of involvement in dissident political activity. Effects on the immediate families of torture survivors include increased irritability and domestic violence, frequently with destruction of the intimacy of marriage and the sexual relationship. Where "disappearances" have occurred, there can be tragic effects on the surviving relatives, who do not know whether their loved one is dead, tortured, or kept alive in secret. These relatives cannot work through their feelings of grief unless they know the reality (Turner and Gorst-Unsworth, 1993). Kordon et al. (1998) supported this in their review of the consequences of political repression and impunity in Argentina.

Flight into exile, asylum-seeking, and settlement in a new country are additional events that aggravate the social and economic consequences of political persecution and torture. Mollica (2004) estimates that 60% of asylum-seekers in the US have been tortured. Adjustment to a new country and unclear legal status have been shown to increase symptoms (Steel and Silove, 1997).

In addition, there appears to be a rising anti-immigrant bias and increasing racism in much of the Western world, initially documented by Baker (1992), even for those who have already been granted permanent residency in a host country. Those who have escaped to a host country without proper documents may face the risk of being summarily deported back to their home country or placed in detention. These problems persist and, in some countries, have become even worse. This has implications for treatment, since granting of asylum usually provides security, permission to work, family re-

unification, and recognition of the trauma history.

B. Intergenerational trauma

Danieli (1998) has compiled an extensive handbook of 38 contributed papers providing support for the effects of intergenerational trauma including but not limited to the violence of holocausts, genocide, war, political change, and repressive regimes. Danieli concludes that at least three components explain the psychological effect of parents' trauma on their children: 1) the trauma itself; 2) the conspiracy of silence surrounding this trauma; and 3) the adaptation of the parents following the trauma. Yehuda et al. (1998) found that children of Holocaust survivors may be biologically vulnerable to stress. The issue is complex and multidimensional, with physiological, social, political, cultural, and even economic dimensions.

Among the specific examples are discussions of the effects on second and third generation Armenians persecuted by the Turks during the 1915-23 genocide. An older cohort of the third generation had the highest psychopathology scores, contrary to the authors' expectations. The denial of the Turks and disinformation about the history of the genocide continues this historic persecution (Kupelian et al., 1998). Kinzie et al. (1998) found that Cambodian children during the Pol Pot repression had higher rates if a parent had PTSD, even higher if both parents had PTSD. Although systematic effects are difficult to determine, parents' PTSD significantly impairs their parenting ability. Edelman et al. (1998) describe the effects of terror in Argentina during the military dictatorship from 1976-83, when many children were born in captivity or abducted while young and adopted by families of repressors who did not reveal their true identity. Identity problems have persisted for more than

20 years since the dictatorship. In another Latin American study published outside of Danieli's book, Locke et al. (1996) found that the mothers' PTSD adversely predicted their children's mental health in Central American refugees.

Contrary to the findings of intergenerational transmission described above, Bilanakis et al. (1998) studied 254 Albanians ages 8 through 22 studying in Greek schools. By comparing the mental health of these students who came from families victimized by political suppression and torture with a control group without such experiences, the authors found no difference in the mental health status of the groups.

C. The effect of torture on societies

Torture is intended to terrorize the population represented by the individual (Genefke, 1994) and, in countries subjected to repression and torture on a very large scale, whole communities may be affected. Torture may have a dramatic effect on the social and political life of a country or region. The political action of the opposition is paralyzed and the price of being a political activist is very high, with harassment, arbitrary detention, torture, and possibly death. Societies may remain highly polarized, suspicious, and angry, which requires a process of reconciliation for national healing. Social reparation needs several sequential steps: truth, justice, and pardon. Social reconciliation requires that society acknowledges what has happened. Truth is the mechanism, because it is the end of the social denial and silence. Truth commissions have been created in several countries to investigate the atrocities of past regimes, such as in Argentina, Chile, Uruguay, Brazil, and South Africa. Social reparation also needs compensation to the victims of the organized violence, and this subject will be expanded later in this report.

Justice is the logical next step after the truth is known. Pardon comes after justice, if society accepts it (Jaranson et al., 2001).

8. Assessment

A. Istanbul Protocol

The right to be free from torture is clearly stated under international law and domestic law in most countries of the world. Despite this, legally prohibited torture is practiced by 75% of the countries of the world (Amnesty International, 2000). An important element in the prevention of torture and fight against impunity is the effective investigation of torture and other cruel, inhuman, or degrading treatment. Amnesty International adopted a set of principles in January, 1996, as part of the Amnesty International worldwide campaign for a more effective role for health professionals in the exposure and investigation of torture.

All persons who allege to be victims of torture, regardless of the length of time since torture, should undergo a medical and psychological assessment.

States under international law are required to investigate reported incidents of torture and other cruel, inhuman, or degrading treatment, promptly and impartially.

Amnesty International calls on governments to ensure that all allegations of torture are investigated and that medical investigations of torture are carried out in conformity with the principles set out below:

1. *Access:* A detainee should have prompt access to a doctor.
2. *Independence:* The examining doctor should be independent of authorities.
3. *Confidentiality of medical exam:* The examination should take place in a private room.
4. *Consent:* The subject should give consent to the examination.

5. *Access to medical records*: The doctor should have access to previous medical records.
6. *Full examination*: The doctor should do a full medical examination.
7. *Report*: The doctor should promptly prepare an accurate written report.
8. *Confidentiality of the report*: The report should not be made available except with the consent of the victim.
9. *Second examination* by an independent physician should be permitted if requested.
10. *Ethical duties*: The primary duty of a physician is to promote the well-being of a patient.

Gifford, from the University of Essex, published a handbook in 2000 that was oriented to helping NGOs working at a national and community level to become more involved in torture reporting. The handbook not only assisted NGOs in the production of higher quality information both on individuals and at the community level, but allowed them to uncover local patterns of torture and report this to the most appropriate international body (Gifford, 2000).

The United Nations has been very active in the development of international standards for the effective prevention of human rights abuses. The General Assembly adopted resolution 35/172 in December, 1980, on arbitrary or summary executions. Ten years later they adopted the "Manual on the effective prevention and investigation of extra-legal, arbitrary and summary executions". This manual (the Minnesota Protocol) contains a model of necropsy protocol and guidelines for cases of deaths in the hands of authorities. Examples of such abuses are political assassinations, deaths resulting from torture or ill-treatment in prison or in detention, deaths resulting from

enforced "disappearances", deaths resulting from the excessive use of force by law enforcement personnel, executions without due process, and acts of genocide (United Nations, 1991).

Following a similar pattern, the UN Commission on Human Rights in April, 2000, and the General Assembly on December, 2000, adopted resolution 55/89, the "Principles on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment" (the Istanbul Protocol). This document was written to provide international guidelines for the assessment of victims who alleged torture and ill-treatment and describes the fundamental principles of any viable investigation into incidents of torture. The investigation must be competent, impartial, independent, prompt and thorough. The manual was the result of three years of work of more than 75 experts in law, health and human rights, representing 40 organizations or institutions from 15 countries. This manual was not written as a fixed protocol, but represents the minimum standards to be used by governments and human rights organizations. This manual is a summary of the accumulated experience on the evaluation of torture survivors and should be implemented in the training of health professionals involved in the care of torture survivors (OHCHR, 2001). The Istanbul Protocol includes extensive information on relevant international legal standards, ethical codes for lawyers and health professionals, and legal investigation principles and standards. The manual has also extensive description of physical and psychological evidence of torture and guidelines for the health professionals on the assessment and reporting of an examination of a torture survivor.

The final objectives of an effective inves-

tigation and documentation of torture or ill-treatment are: to establish the facts of the alleged cases of torture, to identify who is responsible, and to facilitate their prosecution. Medical and psychological experts involved in the investigation should behave with the highest ethical standards. The fundamental principles of any investigation into incidents of torture are competence, impartiality, independence, promptness, and thoroughness.

The experts should prepare an accurate written report. This report should include at least the following:

- a. The name of the subject and those present in the examination, exact date and time, location and address of the institution, and the circumstances at the time of the examination specially if has been done in a detention center.
- b. Qualifications and experience of the medical and psychological experts in documenting evidence of torture, with attached curriculum vitae.
- c. A detailed history of the trauma and methods of torture and all physical and psychological symptoms.
- d. A record (drawing, measure, and photographs) of all the physical evidence of torture and a psychological assessment including appropriate tests if necessary.
- e. Diagnosis and interpretation of findings and statements on the probable relationship of the physical and psychological findings to torture methods applied to the survivor.
- f. Conclusions and recommendations.
- g. Statement of truthfulness.
- h. Names and signatures of the experts who carry out the examination with date and place conducted.

The report should be confidential and sent to the legal representative of the survivor of

torture. A complete detailed guideline for the medical evaluation report is included in the Annex IV of the Istanbul Protocol (United Nations, 2001).

The physician and psychologist, in formulating their clinical impressions, should be able to answer six important questions of legal interest:

1. Are the physical and psychological findings consistent with the alleged report of torture?
2. What physical conditions contribute to the clinical picture?
3. Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?
4. Given the fluctuating course of trauma-related mental disorder over time, what is the time frame in relation to the torture event? Where in the course of recovery is the individual?
5. What other stressful factors are affecting the individual (e.g., ongoing persecution, forced migration, exile, loss of family and social role, etc.)? What impact do these have on the victim?
6. Does the clinical picture suggest a false allegation of torture?

The US organization, Physicians for Human Rights (PHR) wrote a manual for health professionals on the medical and psychological evaluation of torture survivors seeking political asylum in the US. The manual is based on the Istanbul Protocol with an emphasis on US asylum law, expanding the medical and psychological evaluations of asylum seekers (Physicians for Human Rights, 2001).

The International Rehabilitation Council for Torture Victims (IRCT), in partnership with the Human Rights Foundation of

Turkey (HRFT), World Medical Association (WMA), Physicians for Human Rights (PHR, USA), with the legal support of redress and economic support from the European Commission has embarked upon a project for the global implementation of the Istanbul Protocol. The Istanbul Protocol Implementation Project (IPIP) aims to increase awareness, national endorsement, and tangible implementation in five countries representing five different regions of the world. Training manuals, medical, psychological, legal, and audiovisual materials have been prepared in English, French, and Spanish. Five target countries were identified: Morocco, Uganda, Georgia, Sri Lanka, and Mexico. A training seminar oriented to train future trainers has been conducted in each of these countries. Mexico has had two previous seminars.

B. Medical assessment

Interviewing in general medical settings

Many survivors initially seek help from a general medical clinic, whether in the home country, in the refugee camp, or in countries of resettlement. Often, however, the doctor may recognize the depression in a patient, yet not recognize the patient as a survivor of torture. The primary care practitioner needs to know whether the patient belongs to a population at risk for torture or extreme trauma, e.g., refugees, asylum seekers, or those involved in radical political activity in their own countries. Presumably innocuous situations, such as a visit to the doctor, may precipitate re-experiencing symptoms in a torture survivor. Survivors may be reluctant to talk about their lives. Sometimes they have physical evidence of trauma or, more likely, may have somatic symptoms with no known physical cause. Many times torture survivors are fearful of being touched or examined. Merely sitting in a waiting room

might remind the torture survivor of periods of enforced waiting. A doctor wearing a white coat may have been responsible for assisting torturers. Dental work may trigger recollections of dental extractions during torture. Reasons to refer to more specialized services, if they are available, include a need for expertise in physical and psychological trauma, sensitivity to cross-cultural issues, special knowledge of the multiplicity of needs of refugees or other survivors, and the availability of interpreters who can bridge the language barriers.

Physical assessment

Torture survivors need a comprehensive medical assessment to investigate all these potential problems. The assessment should include:

- Trauma history
- Medical history
- Family history
- Review of systems
- Review of the vaccination history
- Nutritional assessment

With the exception of trauma history and nutritional assessment, these areas are part of a comprehensive medical evaluation conducted during routine medical care. Trauma history is a new problem for primary practitioners but is a central issue in the care of refugees. Sometimes the trauma history has to wait until a trusting relationship has been established (Mollica, 2001b). In some torture rehabilitation programs the trauma history is taken by the physician and psychologist together in order to avoid repetition.

Physical exam should include:

- Complete physical examination
- Vision and hearing screening if indicated

- PPD in all and chest x-rays if the test is positive
- Vaccination as needed
- Stool ova/parasite if client has gastrointestinal symptoms
- HIV, RPR, Hepatitis B antigen, and a gynecological examination, preferably with a female physician in all cases where women have been raped
- Forensic evaluation if the torture survivor presents torture sequelae
- Treatment of all medical conditions, acute or chronic, related or not related to torture and referring the client to other medical facilities if the program cannot provide the necessary medical care

The laboratory tests most frequently requested for the care of torture survivors and refugees are:

- Urinalysis, chemical and microscopic
- CBC
- Chem. 12
- Liver function test
- Lipid profile
- Pregnancy test
- HIV
- RPR
- Hepatitis panel
- H. pylori
- Stool ova/parasite
- Stool occult blood
- PSA for men over 50 years old
- All other tests or procedures if they are indicated

At the end of the medical work up the medical problems can be separated into those related to torture and those not related to the trauma. From the medical point of view, all medical problems need to be detected and treated from a humanitarian perspective.

C. Psychiatric/psychological assessment

Assessment approaches and techniques can be used in research studies, in screening of high risk populations such as refugees for possible referral by public health, immigration, or education personnel, or as the first part of the intervention strategy in treatment. However, many survivors live in countries where health professionals and specialized services may be in short supply or where access to the health care system is limited. Friends, family, teachers, lawyers, community or religious leaders, and traditional healers may be their only perceived source of help (Jaranson et al., 2001).

Interviewing by mental health professionals

The most problematic aspect of diagnosis is the interview process itself, which can stimulate memory of traumatic events and reactivate posttraumatic stress symptoms to the point where, for the first time, the survivor exhibits the full spectrum of PTSD. Consequently, in the interview process, the survivor should be allowed to tell his or her story at a pace that is comfortable. Interviewers who are too aggressive may cause re-traumatization or re-experiencing of the symptoms. The interview should be interactive in the manner in which the interviewer supports probes and questions the patient. The interviewer needs to monitor the patient's non-verbal communication and expressed language, observing whether the questions are too sensitive or painful and whether the patient wants to explain or clarify. When survivors are reticent to tell their stories or seem less upset than expected following horrible torture experiences, interviewers might become cynical or disbelieve the survivor's story (Jaranson, 1995). Mainstream professional staff often do not know how to ask the difficult questions or wish to know the answers. The bond that develops

between the therapist and the patient begins during the initial interview and therapy can begin at that time with a good explanation of the reason and/or origin of the symptoms. Certain aspects of the evaluation process must be emphasized when assisting survivors of extreme interpersonal trauma. Professionals must be well-acquainted with key elements of the survivor's world, since lack of this knowledge will almost certainly lead to significant errors in assessment and evaluation. The establishment of rapport between the specialist and the survivor is crucial, based partly on the fact that the survivor is an active participant. Assessment and diagnosis, as well as any subsequent intervention, must cultivate the trust of the survivor, who must feel safe. If these conditions are not met, the survivor is unlikely to continue with intervention or may terminate intervention prematurely (Jaranson et al., 2001).

Assessment challenges for the professional
From the professional's perspective, the task of assessing patients who have been victims of severe interpersonal trauma is extremely complicated. At least partly because of difficulties at the initial assessment, it has been shown that systematic reevaluation of established patients may increase case findings (Kinzie et al., 1990). Jaranson et al. (2001) have identified the following difficulties even in trauma sensitive programs: 1) Survivors may have multiple concurrent psychiatric disorders or longer term personality changes; 2) Symptoms of PTSD, particularly the intrusive symptoms, wax and wane over time and may not be present at the time of the interview; 3) Symptoms of avoidance, numbing, and amnesia may prevent the patient from remembering information about the trauma and other symptoms; 4) The information may be so disturbing that the interviewer reacts, preventing objective data

gathering; 5) The interviewer may correctly feel that the patient is decompensating and that the clinical situation precludes pursuing relevant information (Kinzie and Jaranson, 2001); 6) Survivors may expect rapid improvement in symptoms and leave treatment early unless this happens.

Assessment principles

In the most well equipped settings, the best assessment is done as part of a treatment program and by professionals who can treat the patient both biologically and psychologically immediately after the evaluation. The assessment should include a thorough mental status examination, physical examination, and laboratory tests, in addition to details the survivor is willing to share about the trauma experience. In addition, historical data preceding and following the trauma needs to be gathered. Not only the survivor's symptoms but also the level of function before and after the trauma experience is important. Pre-existing psychiatric and physical conditions, personality maladjustment, and prior trauma experience (as victim or perpetrator) need to be assessed. Active psychiatric disorders or other more mundane psycho-social trauma increase vulnerability (Kinzie et al., 1990). Also of importance is the history of head trauma, with or without loss of consciousness, at any time in the survivor's past. In particular for refugees and asylum-seekers, post-migration factors need to be explored. Treatment plans, accompanied by responsibility for carrying out these plans over time, must be formulated at the initial interview (Jaranson et al., 2001).

Cultural issues in assessment

Cultural differences are found in the willingness and need for detail recall and recollection of the torture experience. Indochinese tend to minimize the problems and are re-

luctant to talk about the events. South American refugees seem to be more eager and perhaps even helped by the experience of going through the trauma in detail (Morris and Silove, 1992; Jaranson et al., 2001).

Cultural understanding is essential in choosing the methodology of the assessment. A standard Western psychiatric interview can be toxic (Mollica and Son, 1989). An assessment of the individual's larger life experiences, personal values, current life situation, family situation, and external social support are of equal importance to the medical assessments.

Questionnaires and rating scales

Use of structured interviews and diagnostic instruments as part of the assessment process can have several advantages, such as systematically recording symptoms in a way that elicits more than would be spontaneously volunteered by survivors. Some can be self-administered or administered by even briefly trained non-professionals, to give reasonably accurate diagnoses, and to provide information for research purposes. Many of these are now in versions that have been translated and validated for increasing numbers of cultural groups and new measures are being developed specifically for assessing refugees and torture survivors. These tools are also useful for repeat assessments for comparison purposes. A complete review of these is beyond the scope of this paper. Selected instruments which could be used in initial assessment are listed in Appendix VI, B.

Accuracy of memory recall

Accurate recall of the experience of torture is critically important in documenting support for asylum claims, as well as in assessment and rehabilitation. A review of these issues is beyond the scope of this desk study, but will be briefly discussed here. The

strength of the traumatic memory relates to the degree to which particular neuromodulatory systems are activated. Some of the acute neurobiological responses to trauma may facilitate the encoding of traumatic memories. The memories of traumatic experiences remain indelible for many decades and are easily reawakened by all sorts of stimuli and stressors (Charney, 1993). These traumatic experiences are encoded by the brain in the amygdala, which connects and integrates information of the five senses, the cortical sensory systems, and the emotional reactions from the thalamus and hypothalamus (Southwick, 1994; Charney, 1993).

Issues of memory recall are important for accurate assessment, diagnosis, treatment, and research of torture survivors. Traumatic stress may cause amnesia for events or distortion of the memories. Later, a survivor may remember details initially repressed, either through psychotherapy or under other circumstances. For example, some survivors of childhood sexual assault only retrieve and deal with the memories once they have developed a stronger ego and a stable support system. Herlihy et al. (2002) investigated the consistency of autobiographical memory of 27 Kosovan and 12 Bosnian asylum-seekers in England, finding that discrepancies were common but that the inconsistencies did not necessarily indicate poor credibility.

In recent years, concern about the validity of memories of childhood trauma has led to considerable discussion which has relevance for torture survivors. The debate centers around whether it is common for adults to forget, then later remember traumatic experiences which happened to them in childhood. According to Roth and Friedman (1997), evidence suggests that these memories can be "recovered" after periods in which they were forgotten.

On the other hand, evidence has also shown that inaccurate memories can be “strongly believed and convincingly described” (Roth and Friedman, 1997, p. 8). In laboratory research, subjects can be persuaded to believe that they experienced events which they did not. Findings suggest that situation and personality characteristics may increase suggestibility and, consequently, some people may report false or inaccurate memories of trauma.

Layton and Krikorian (2002) have proposed a new theory of the neurobiology which mediates memory in PTSD. The comprehensive model argues that the amygdala is where consolidation of the traumatic experience occurs, but that the amygdala also inhibits the hippocampus at high levels of emotional arousal, causing a reduction in conscious memory for events surrounding the trauma. Southwick et al. (2002) have suggested that enhanced memory for arousing events is associated with an increase in norepinephrine when memory is consolidated.

Forensic evaluations

Several authors have written articles communicating their experiences on medical, psychological, or forensic assessment of torture survivors requesting medical or psychological care or an evaluation for political asylum (Oemichen, 1999; Pounder, 1999; Thomsen, 2000; Jacobs et al., 2001, Part 1; Jacobs et al., 2001, Part II).

Physical evidence is often more readily accepted by the legal systems in many countries than is psychological evidence. The dual role of documentation and treatment becomes potentially problematic because the goal of acquiring safe legal status may be a more powerful motive than receiving other necessary treatment services. A conflict may exist between provision of treatment and

providing support for social security disability, asylum, or workers compensation applications. On the other hand, since there are relatively few skilled professionals available, these roles are difficult to separate.

These dilemmas are discussed in depth in recent issues of the *Torture Journal* and further elaborated below.

Jacobs (2000) argues for the central role that psychological evidence must have in documenting torture, since many sequelae of torture cannot be directly addressed by physical evidence. Jacobs conceptualizes resistance to properly recognizing psychological evidence as a psycho-political constriction of psychic space for both examiners and survivors. Certain basic assumptions, psycho-political in nature, may negatively affect evaluators' attempts to effectively document torture, including the overvaluation of physical evidence, acceptance of the burden of proof, the medicalization of mental health into symptoms, syndromes, and diagnoses, and the perpetuation of mind-body dualism. Although the mainly subjective nature of psychological evidence cannot claim the objective validity of physical evidence, psychological evidence can nonetheless claim legitimacy. Even when physical evidence is primary, the survivor's psychological impairment can interfere with accurate narrative, and assessment can clarify these impairments for the legal system and, hopefully, for benefit of the survivor.

Jacobs et al. (2001, part I) discusses the effective principles of documenting psychological evidence for immigration courts. This is a difficult task, requiring special treatment beyond the usual clinical, psychological, or psychiatric evaluation. The contradiction of the evaluator as an advocate or as independent examiner needs resolution. While the evaluator needs to render an independent expert opinion based predominantly on ob-

jective findings, clinicians generally view themselves as survivor advocates. When clinicians are examiners, they must establish rapport with the survivor without judging and also probe for inconsistencies in the survivor's story. This is often the case if clinicians in torture treatment centers write affidavits for their patients. This can have negative consequences when medico-legal evaluations do not occur outside the treatment context. Ideally the examiner should not be the treating clinician, but the clinician's input is important in a larger, more independent and comprehensive evaluation which includes third party sources of information. Nonetheless, the specific role of the examiner needs to be explained to the survivor.

Although objectivity, independence, and neutrality are required in forensic work, excessive removal and critical approaches by the evaluator can compromise the vulnerability of torture survivors. Jacobs cites Haenel's (2001, part II, p. 41) description of the ideal as "the greatest possible empathy combined with the greatest possible distance". As an evaluator, the job is to focus on the facts rather than on the psychic reality of the survivor, while the reverse is often true in therapy. The evaluator must offer an opinion about the probability of whether torture occurred and might occur again. The court wants the expert to provide evidence to corroborate the claim based on detailed history, to assess the claimant's credibility, to describe the psychological problems, and to discuss the "nexus" issue, or whether torture rather than other factors caused the problems. Specifics about the structure of taking the forensic history incorporates many of the sensitive approaches discussed elsewhere in interviewing torture survivors, but highlights include using a non-adversarial approach, establishing a sense of safety, and under-

standing the reluctance to disclose sensitive, but crucial, information. Often the interview begins with psychosocial and family history predating the trauma and persecution history, explaining this approach to the survivor before beginning the interview. The assessment of possible malingering and deception depends upon the assessment described above. Credibility is subject to the consistency of the history, the consistency of symptoms, behavioral observations, and validity indicators in psychological assessment procedures. If an application is not granted, it is important to find out the reason for denying the claim.

Jacobs et al. (2001, part II) continues in the second section to discuss data gathering from behavioral observations, mental status exams, structured interviews and questionnaires, and psychological test results. The observations should not be limited to psychological distress but to the way in which the narrative is told. When selecting questions for the evaluation of the mental status, education level of the survivor and linguistic barriers must be considered. Questionnaires and interviews are limited by cross-cultural factors, and must be used with caution. Selecting those available in the survivor's language, including those widely translated such as the HTQ and HSCL 25. PTSD scales, mood and anxiety disorders modules of the SCID, and depression scales such as the Beck have high face validity. For greater in-depth testing, Jacobs recommends the MMPI-2 which is widely used, translated, and validated, and the TSI, which is shorter and includes validity scales (See Appendix VI).

In conclusion, the examiner must determine whether the history was detailed and consistent, that the findings suggested trauma, and that there was no evidence of malingering or deception. Finally, the exam-

iner must answer where and where not causes other than torture could have caused the psychological symptoms. Since torture survivors usually suffer additional trauma and distress, the examiner should identify these events as contributors in order to assure the courts of the completeness and independence of the examination. If properly explained, this will support torture as the primary cause.

Herlihy, Scragg, and Turner (2002) investigated the consistency of autobiographical memory of refugees in the United Kingdom. All participants in the study had been granted political asylum under the United High Commission for Refugee program to avoid the secondary gain factor in people seeking political asylum. Discrepancies between the two accounts were found for all participants. Discrepancies increased with length of time between interviews and in refugees showing symptoms of PTSD. More discrepancies occurred in details peripheral to the account than in details that were central to the account. (Herlihy, Scragg, and Turner, 2002)

Haenel (2001, I and II) uses case examples to elaborate the principles and procedures described by Jacobs and colleagues. Examples of programs which include forensic evaluations are recently described at the Medical Foundation of London (Peel et al., 2001; Peel et al., 2000) and at the Human Rights Clinic in the Bronx, New York, by Shenson and Silver (1997). Heisler et al. (2003) have surveyed forensic physicians in Mexico, finding not only that torture and ill-treatment of detainees is problematic, but that additional training, protocols, and procedures are required to improve the documentation.

9. Rehabilitation

A. Service programs worldwide

Medical and psychological service programs working with victims of political or other forms of organized violence have continued to expand in the last 5 years. The precise number is unknown, because some programs are new, small, and without international connections.

The Secretariat of the International Rehabilitation Council for Torture Victims (IRCT) has identified 235 centers and programs whose existence was known through activities such as the 26 of June campaign. IRCT publishes periodically the most complete Global Directory of Centers and Programs. The 2003-2004 Directory provides detailed information of 177 rehabilitation centers and programs in 75 countries worldwide. Ninety-four of these centers and programs have been accredited by IRCT, the largest international umbrella organization of centers and programs world wide (IRCT 2003 b).

The United Nations Voluntary Fund for Victims of Torture received application for grants amounting to approximately US\$ 13 millions for considerations by the Board of Trustees at its 23rd session in October 2004. The Board approved grants for 172 centers and programs in 61 countries for a total of 6.7 millions for 2004.

B. Physical rehabilitation:

Health needs of torture victims

General needs

Torture survivors living as displaced persons in the country of origin or as a migrant in a host country have multiple medical, psychological and social needs. The mixes of these needs are different in each individual or each family. For some people, all of their needs are equally important, while other people have needs with higher priorities.

The most urgent needs of torture survivors and refugees are:

- Shelter or house
- Food support
- Income support
- Employment
- Medical care for individual and/or family
- Mental health care for individual and/or family
- Advice on legal or migration matters
- Child care
- Schooling for children
- Local language classes
- Social support

Some torture rehabilitation centers have programs to fulfill some of these needs, such as medical care, or they may refer the clients to migrant resource centers, community health clinics, hospitals, or other facilities that can cover these services.

Medical needs

When torture survivors request medical care, most of them do not volunteer their history of trauma. As mentioned previously, Eisenman and Keller (2000) have found a 6.6% prevalence of survivors of torture and Eisenman et al. (2003) of 8% in adult ambulatory care clinics.

The medical problems of torture survivors and refugees are complex because psychological symptoms and multiple social problems compound them (Silove, 1994; Kennedy et al., 1999; Piwowarczyk et al., 2000; Harris et al., 2001; Burnett and Peel, 2001). Asylum seekers living in immersed communities in a host country have restricted access to work, education, housing, welfare, and basic health care. In addition, the post-migration stress facing asylum seekers increases the risk of PTSD and other psychiatric symptoms (Silove, 2000). The lack of

medical and preventive care in refugee and torture survivor populations results in hospitalizations for conditions that would have been treatable on an outpatient basis in earlier stages of disease, consequently increasing the cost of care (Harris et al., 2001).

Some refugee populations have shown a higher prevalence of certain diseases compared with the host population. Nelson et al. (1997) studied a population of 99 recent Vietnamese immigrants and found that 51% had positive ova parasite in their stools, 70% were PPD positive, 83% were exposed to Hepatitis B, and 14% of them were chronic Hepatitis B carriers. Walker and Jaranson found that 5% of Korean and 15% of Cambodian refugees were positive for the Hepatitis B surface antigen (Walker and Jaranson, 1999).

All active or high risk medical problems are going to influence a person's emotional life.

Some survivors of torture have very urgent medical problems and psychotherapy is not possible until the medical problems are under control. Mental health care may be needed for an individual and/or the family.

The final aim of a rehabilitation program is to enable torture survivors to become productive community members. To reach this objective, good physical health is as important as mental health. Most of the rehabilitation programs have a very strong mental health programs but a weak or non-existent medical component.

The principal reason for this deficit is the high cost of the medical care in all countries of the world. If the country has universal medical care, the local torture survivors or refugee will be covered, as is the case in the United Kingdom and Australia. The problem in those countries is to educate the physicians of the local national health service or community to give adequate medical care

to these special populations, which have additional needs.

To provide medical care to torture victims and refugees, additional training is needed for physicians, medical students, and other medical personnel to help avoid the frustration that many physicians experience when treating immigrant populations (Kamath, 2003).

Most populations are no longer homogeneous and include a wide array of races, ethnicities, nationalities, religions, and languages. In most countries, physicians are challenged to understand the health needs of culturally diverse clients and the practitioners and health services are not prepared for this diversity. Culture has a major influence on how we understand, express, and resolve mental distress and medical symptoms. To resolve these problems we need to develop "culturally competent" health care system and providers (Kinzie et al., 1980; Slomka, 1998; Pumariega, 2001; Diaz et al., 2000).

The Royal Australian College of General Practitioners, the Victoria Foundation for the Survivors of Torture (VFTS), the NSW Refugee Health Services in Australia, the British Medical Association, and the National Health Service in the United Kingdom have been very active in educating their members. They have developed several manuals to educate the general practitioner (New South Wales Refugee Health Service, 2000; National Health Service, 2001; British Medical Association, 2002; VFTS, 2002).

Guidelines for general practitioners

The New South Wales Health Service of Sydney, Australia, developed guidelines for general practitioners (GPs) for care in managing the trauma of survivors. The aims of the training and management are to emphasize some basic guidelines that are relevant for the care of survivors of torture:

Guideline 1: GP is able to identify patients who may have experienced torture and/or a traumatic experience.

Patients who have experienced trauma and torture are frequently reluctant to tell their trauma history. The physician should suspect that the client is a torture survivor if the patient is:

- A refugee, in a refugee-like situation, or a political asylee from a country that has experienced war, invasion, civil war, military dictatorship, oppressive government, or political unrest for any other reason.
- A member of a minority that has been discriminated or persecuted for political or religious reasons, or because of sexual orientation.

Present at the medical examination:

- Chronic, multiple sites, pain difficult to treat
- Multiple psychosomatic problems
- Evidence of multiple physical scars on physical examination
- Complex injuries

Guideline 2: GP understands the context in which torture and refugee trauma may have occurred, and the impact on the individual, family, and community.

The physician would find it useful to learn about the political and social history, causes of conflict, ethnic and cross-cultural issues and consequences of trauma in individual, family, and society of the region or country from which the patient originates.

Guideline 3: GP is able to assess the physical and mental health problems of torture and refugee trauma survivors.

The physician should be aware of the most common medical and psychological symptoms in survivors of torture and be able

to do a comprehensive medical evaluation that includes a physical examination, an assessment of psychological symptoms, and, if necessary, a forensic evaluation as described previously in this desk study.

Guideline 4: GP is able to work with the patient to develop a management plan.

The physician should develop jointly with the survivor a treatment plan. The physician has the responsibility to explain the medical components of the treatment and answer the questions of the patient. The patient should have control of the prevention and management of the health problems, including the implementation of the pharmacological and non-pharmacological or alternative treatments.

Guideline 5: GP is aware of and confident in referring patients to appropriate services.

Torture survivors frequently need assessment and treatment from a specialist not available in a community clinic. The most frequent needs have been described earlier in the chapter on physical rehabilitation: health needs of torture survivors. The physician should identify those services locally and refer the survivors to those clinics. The referral is most effective when the service provider can provide a culturally appropriate service, and the survivor has the choice of a female or male practitioner. Information about the patient problems should be given to the referral service.

Guideline 6: GP is aware of the impact of these issues on the GP's personality.

Treating survivors of torture may have an impact on the health care provider when not emotionally prepared to listen to this type of trauma experience, as has been described in the vicarious traumatization section.

The guidelines were published in Torture

magazine in 1998. The last edition can be found in the Internet at: (http://www.swsahs.nsw.gov.au/areaser/refugeehs/resources_guide.s.asp) (New South Wales Refugee Health Services, 1998; New South Wales Refugee Health Services, 2000).

Physical therapy

Chronic pain, musculo-skeletal symptoms, and physical functional limitations are the most significant medical complaints from torture survivors. Physical therapy, conducted by a specially trained physiotherapist, can help patients with these symptoms. RCT has developed a Manual for Physiotherapy with the purpose of securing a standard physical assessment and treatment (Amris, 2000, Amris, 2001).

The survivor's physical capacity is evaluated at the beginning, during, and at the end of the treatment. The physical assessment is done using self-report scales and objective measurements such as:

- Disability rating index (DRI)
- Disability rating by physiotherapist
- Balance test
- Ergometric bicycle test
- Walking distance on a treadmill

Individual treatment may include one or more of the following modalities: manual therapy, including soft tissue treatment and mobilization of joints; neuromuscular training; resource-oriented therapy; relaxation; or apparatus treatment. Individual treatment is offered once or twice a week for 2 or 3 months. Later the client continues in a group treatment once a week for an additional 16 sessions.

Physiotherapists using sensitive physical techniques can relieve chronic severe pain, improve physical fitness, posture and body balance (Prip and Tived, 1995), and relieve

stress. Physiotherapy can form a vital link in rebuilding the personality of the survivor because trust can be fostered in the context of physical contact (Hough, 1992). There are no systematic studies, nor controlled studies, addressing the effects of physiotherapy provided to torture victims.

C. Psychiatric rehabilitation:

General principles in therapy

There are good arguments for a bio-psychosocial approach to caring for torture survivors and for a comprehensive treatment and rehabilitative approach that provides long-term flexible involvement to cope with relapses. Systems thinking and hierarchies of care are needed for torture survivors (Gurr and Quiroga, 2001). Since treatment programs often include clients from many cultures of both developed and developing countries, needs include resources, flexibility in psychotherapeutic approach, and a differentiated approach to problem-solving interventions. It is unethical not to provide treatment, and this is mandated under international conventions.

Torture and subsequent refugee trauma may have differential psychological effects and important implications for treatment. For example, rehabilitation programs with a focus on providing social support for refugees may be helpful in preventing or alleviating depression but not effective in reducing PTSD symptoms. Indeed, over 80% of the non-refugee torture survivors studied by Basoglu and his associates (1994) had strong social and psychological support from their community but nevertheless many of them had chronic PTSD symptoms. Rehabilitation programs may therefore need to add specific psychological interventions to effectively reduce PTSD symptoms.

Long-standing alteration of the neurobiological response could explain the extended

duration of the symptoms of PTSD, and why current treatments are only partially effective. Torture treatment programs should include prolonged follow-up, and an open door for care during periods of reactivation of symptoms. Spontaneous recovery is not likely.

The context in which survivors of torture and extreme trauma have suffered, and then in which they receive help, partially determines both their perceptions of the experience and the treatment intervention. Treatment of torture survivors occurs in their countries of origin, and well as in countries both of initial and final resettlement.

A medical-psychological treatment approach empowers the individual by validating his or her experiences, facilitating effective reprocessing of the experience, and encouraging active engagement in living. Empowerment of the larger society or community has more explicit goals of reintegrating the individual into the political process as evidence of healing (van der Veer, 2002). Equally important goals are documenting torture and extreme trauma in order to record the truth, provide the survivors with validation of their own experiences, and expose the perpetrators. Returning the survivor to more effective participation in society becomes a priority in therapy whether the survivor remains in the country of origin, is returning from exile, or has escaped to a country of first or of final resettlement.

The stressors of seeking asylum have implications for treatment of tortured refugees in countries of final resettlement. Birck (1999) discusses the content of psychotherapy with asylum-seekers, stating that, in a content analysis of 20 psychotherapy records at BZFO in Berlin, problems in seeking asylum were more frequently discussed in therapy than the original torture. Frequently the asylum issues aggravated symptoms and re-

traumatized the survivors. She observed that torture was prominent in the first phase of therapy, while later the insecurity of waiting for the asylum decision subsequently interfered with re-framing the torture experience. Van der Veer (1999), from Pharos in the Netherlands, discusses how the adverse effects of the poor social position of refugees and asylum seekers become a major source of their psychological problems.

In the early stages of treatment, torture survivors need safety, since symptoms are often suppressed for months or longer until immediate needs are met and the survivor feels safe. If loss of control is a critical factor in the development of traumatic stress symptoms, then effective treatment would need to involve strategies that focus on helping the torture survivor gain sense of control. Survivors need to find work and secure their legal status. Trust must be regained, physical illnesses stabilized, and symptoms reduced. Medications often reduce symptoms to the point where psychotherapy can progress. Often victims are initially much more ready to talk about their physical symptoms and their social needs than about their psychological symptoms. Psychotherapy may proceed with difficulty unless the survivor's basic need for safety is met. That may be particularly so in countries in transition, such as South Africa, where, despite disappearance of the initial threat of torture and extreme trauma, high crime and ineffective criminal justice continue to threaten safety.

In the later stages, as survivors begin a new life and can help family members still in the country of origin, they may have a different set of social needs. They need to accept physical limitations that may have occurred as a result of the torture and, psychologically, they need to reframe or put the torture experience into perspective so that they can go on with their lives. They need to learn

about sequelae from their torture, mourn their losses, and integrate with their families once again.

Marotta (2003) more recently summarizes this as sequenced models of trauma treatment for tortured refugees, including the stages of safety, reconstruction, and reconnection, not necessarily in a linear fashion.

For survivors to receive help from clinicians who have experience treating other torture survivors reassures them that they are understood. While treatment issues are relatively consistent across groups of torture survivors, obviously there are cultural and linguistic differences. Treatment plans need to focus on the individual survivor of torture rather than assuming that members of a particular group all share the same trauma experiences.

Responses to various types of trauma vary but certain standard treatments may help trauma survivors. Foa et al. (2000), from the International Society for Traumatic Stress Studies, have developed practice guidelines for PTSD. Treatment approaches often reflect relatively more the individual clinician's experiences with survivors, and professional or societal biases. Most professionals have used the knowledge and experience acquired from the treatment of survivors traumatized in a non-political context and then adapted these treatment modalities for the special needs of the survivors they help. Accurate identification and diagnosis of these sequelae dictates the appropriate care for torture survivors, whatever their demographic background and personal experiences. Treatment for torture survivors ideally requires a multidisciplinary approach, since the sequelae of torture are acute and chronic, and may include physical, psychological, cognitive, and socio-political problems. Treatment also requires a long-term

approach. The approaches are many, little consensus exists, and treatment effectiveness has not been scientifically validated by treatment outcome studies.

Jaranson et al. (2001) propose the following general principles in the treatment of severely traumatized patients: 1) Do no harm. A) Aggressive treatment and evaluation can exacerbate patients' symptoms; B) Surveys of trauma patients can increase the patients' utilization of health care services; C) Pressing for catharsis and ventilation instead of allowing formulation of the story at a rate comfortable for the survivor may be harmful. 2) Focus treatment on the individual treatment needs, whether this means reducing symptoms, limiting disability, increasing understanding of PTSD, or encouraging personal freedom; 3) Have a single professional act as case manager, taking responsibility over time for the patient and integrating a variety of treatment and services; 4) Aggressively treat pharmacologically the intrusive symptoms of impaired sleep, nightmares, hyperarousal, startle reaction, and irritability; 5) Provide supportive therapy using consistent and predictable meetings in which there is continuity, warmth, and modeling of positive and negative emotions; 6) Support the physical, social, and medical needs of patients; 7) Do not refocus on the trauma until after intrusive symptoms are decreased and the survivor is ready; 8) Do not encourage or discourage political activities or public activism until the survivor, if ever, is willing and ready; 9) Use groups for socializing and supportive activities to reestablish a sense of family and cultural values for refugees; 10) Support the traditional religious beliefs, which may provide an explanation or an acceptance of life. The search for existential meaning after severe trauma may be a therapy goal, including recognition that life has been changed

after severe trauma; 11) Do not prevent patients from returning to treatment after termination. Severe PTSD requires long-term support rather than a cure.

D. Psychiatric rehabilitation: Psychotherapies

Many authors have discussed the applicability of particular therapy modalities for survivors of torture. Therapy modalities have been reviewed previously (Gurr and Quiroga, 2001; Jaranson et al., 2001; Jaranson and Popkin, 1998) and will not be repeated here. This review will discuss some complexities and overlap among psychotherapies, and cite references to the psychotherapies which have received the most attention in the recent literature.

General cultural issues in psychotherapies have been discussed by Gurr and Quiroga (2001). Barhoum (1998) provides such an example of an Arabic case using alternative methods of behavior therapy when the concept of torture could not be discussed openly because of cultural constraints. Mercer et al. (2004) describe integration of traditional beliefs and practice with Western approaches in a sample of twenty Tibetan leaders and torture survivors exiled to North India, as well as staff of the psychosocial care project. The subjects considered mental health to be important, felt that the project was necessary and improved the mental health in the community, and that it effectively accomplished the goal of combining Western and traditional approaches. However, the leaders felt that mental health issues were not the top priority and that traditional or local health services were adequate to deal with mental health problems.

In the literature, psychosocial treatment has varying definitions. Ekblad and Jaranson (2004), in their review of psychosocial rehabilitation, state, "Reviews of the scientific lit-

erature tend to be limited in scope, focusing on particular techniques that have been validated as effective for individuals. The content of these reviews seldom includes the broader social context in which these techniques are used ..." p. 611). For example, Hembree (2002) states that the psychosocial treatment with empirical support for PTSD is cognitive-behaviorial, such as exposure and cognitive therapies, stress-inoculation training, and Eye Movement Desensitization and Reprocessing (EMDR). In this current review, psychosocial interventions will be considered those which are community-based rather than individually-based. Cognitive behavioral therapies are reviewed in this section on psychotherapies, while a separate section includes psychosocial and community interventions.

Therapists bring to the task whatever school of psychotherapy they have learned (Jaranson, 1995). However, there is evidence in the general psychiatry literature that a person well trained in a therapy framework gets better results than general counseling with no framework. There are many transference and counter-transference issues to be dealt with in the very emotive area of torture, and even if traditional forms of psychodynamic therapy are not used, some knowledge of psychodynamic principles and practice is useful, both for therapists and especially for those supervising therapy staff (Kristal-Andersson, 1997). Psychotherapies can be brief, prolonged or intermittent, based on the perceived need, the goal of therapy, the therapist's habit, and the time available. If cathartic methods with subsequent reconstruction and reintegration are chosen, more than 20 sessions are usually required (Herman, 1992). Other members of the family may also require counselling or psychotherapy (including play therapy) for direct and indirect trauma, or for issues due

to the changed behaviour of the survivor, but there are no papers mentioning the number of sessions required.

Most psychotherapy approaches are not based on a consistent theory. Treatment outcome evaluation is crucial in determining the efficacy of an approach, as discussed in greater depth elsewhere in this review. "Multidisciplinary" rehabilitation approaches contain many interventions on different levels and no analytical outcome evaluation has been carried out to identify the effective (and redundant) components of these rehabilitation programs. Certain common elements can be found amongst the various modalities of treatment, but controlled studies are needed to identify the therapeutic ingredients in various treatment approaches. Although retelling the trauma story for reframing and reworking has been a central tenet in treatment, recovering memories of the torture must be done in a safe setting, with the appropriate timing, and with acknowledgment of cultural variations in the expression and interpretation of these memories. If done within a therapeutic setting, this can lead to anxiety reduction and cognitive change. Especially if catharsis and abreaction are involved in recovering a torture survivor's memories, many clinicians fear the task can be risky, but this risk has not been validated by controlled studies. Testimony, albeit important, is only the first step in the process of treatment, but long-term therapy, which begins with telling the story, can eventually lead to anxiety reduction and cognitive change. In some therapies the torture story is transformed into a testimony, to transform the survivor's story of shame and humiliation into a public story about dignity and courage, returning meaning to life. This method seems to have worked best with Chilean survivors of torture within that political context (Cienfuegos

and Monelli, 1983), and less well with survivors of indirect violence, such as disappearances. It is argued in the literature that both insight psychotherapies and the testimony method are in fact using a form of imaginal exposure to the trauma (Basoglu, 1998). It is possible that exposure is the key element in improving positive symptoms of PTSD. However, if there is no follow-up intervention, most clinicians believe that testimony alone will likely cause rather than address problems for many survivors.

Jefferson (2000), at RCT in Copenhagen, discusses the narrative psychotherapeutic approach, involving the role of memory and narrative in constructing new identities for torture survivors. Memory and the processes of remembering are central to this therapy, suggesting the benefits of this restorative approach within the context of a positive mutual therapeutic relationship. The term “re-story-ing” is used to emphasize the re-formation of the remembered stories.

In the Truth and Reconciliation Council in South Africa, where great care has been taken to protect and support those victims giving testimony, there is a fine balance between the difficulties inherent in media exposure, publicly validating the survivors’ experiences, and following through with their care once Pandora’s box has been opened.

Basoglu et al. (1994b) have shown that severity of torture predicts PTSD but not depression, whereas lack of social support relates to depression but not to PTSD. This implies that social support measures may help with depression but may not have an effect on PTSD. The symptoms and other effects of torture and severe trauma are modulated by bio-psycho-social factors related to the individual. There is evidence of a chronic fluctuating course in PTSD, which can last a lifetime if untreated. There are fluctuations in the revelation of, and reaction

to, the trauma experiences, as the survivor’s level of psychological security fluctuates with life events and life stages. Besides symptom reduction, goals for therapy include functionality to achieve personal goals.

PTSD is a chronic condition and psychotherapy is a crucial component of treatment. A meta-analysis of controlled clinical trials of behavioral, cognitive, and psychodynamic treatment of combat veterans, crime victims, and severely bereaved showed that psychotherapy reduces PTSD symptoms, with the effects persisting after termination of treatment (Sherman, 1998). Rabois et al. (2002) have reviewed the biological findings in PTSD in an attempt to link effective psychological treatment for specific biological parameters dysregulated in PTSD. For example, since immediate physiological arousal to trauma may predict development of PTSD, those affected may respond to exposure therapy, while non-reactors may be better suited for cognitive or interpersonal treatment. For those with an elevation of catecholamines, exposure therapy, relaxation training, and stress management groups may help decrease hypervigilance and hyperarousal. For those with smaller hippocampal volume, affecting information processing and attention, strategies from cognitive rehabilitation therapy integrating verbal and visual memory in context may help.

Rabois et al. (2002) also review empirically validated psychological treatments for PTSD (exposure therapy, anxiety management training, combined treatment approaches) and innovative treatment approaches (acceptance and commitment therapy (ACT), interpersonal psychotherapy (IPT), and early intervention). These authors propose the concept of subtypes of PTSD, which may respond differentially to treatment.

Rabois et al. make the following com-

ments about psychotherapies for PTSD. However, there has been little documentation about use with torture survivors:

- **Exposure therapy:** In vivo or imaginal exposure has been used effectively with combat veterans and rape victims, but not all patients respond positively.
- **Anxiety management training (AMT):** This approach has been shown to reduce PTSD symptoms and improve psychosocial adjustment.
- **Combined treatment approaches:** Combining components of exposure therapy, cognitive therapy, and AMT has the potential of addressing multiple problems.
- **Cognitive processing therapy (CPT):** Combining exposure therapy, AMT, and cognitive restructuring, has provided superior treatment for rape victims.
- **EMDR:** Combines components of exposure and cognitive therapies with repeated sets of lateral eye movements.
- **Acceptance and commitment therapy (ACT):** ACT is a behavior therapy approach helpful in treating the core PTSD symptoms of avoidance and re-experiencing.
- **Interpersonal psychotherapy (IPT):** Initially developed to treat depression and conceptualized within psychoanalysis, this approach may improve the difficulties PTSD patients often have with their interpersonal relationships. It is more helpful for individuals who experience shame and guilt than re-experiencing and fear.

Cognitive and Behavioral Therapy (CBT)

Although many of the psychological treatments described above by Rabois et al. are cognitive or behavioral, some additional details of CBT will be described below.

Implosive therapy involves an imaginal

reconstruction of traumatic events in an emotionally supportive therapy context (Basoglu, 1998). The survivor is asked to imagine the traumatic situation and retain the trauma-related imagery in mind until anxiety diminishes. The therapist helps sustain the state of mental arousal by stimulating the imagery related to the form of torture used, the physical and psychological pain experienced, and other aspects such as sounds, sights, smells, and tactile sensations. The therapist also focuses on the conditioned stimuli relating to the individual's cognitive and emotional responses to torture, such as fear, guilt, self-blame, humiliation, shame, and loss of control. Graded in vivo exposure to situations avoided by a survivor can be useful, with a high level of therapist involvement initially, followed by homework and self-directed activity.

Some case studies suggest that EMDR, which Rabois et al. described above, may be effective with torture survivors, but controlled treatment studies are needed to confirm this. However, severely traumatized individuals require longer-term treatment than the relatively short-term approach of EMDR. Pitman et al. (1996), for example, found that EMDR was as efficacious as flooding but could find no evidence that eye movements themselves play any role in traumatic information processing.

These therapies may have beneficial effects on the PTSD positive symptoms of intrusive memories, nightmares, re-experiencing of the trauma, sleep disturbance, irritability, and startle responses, but less effect on the negative symptoms of emotional numbing and estrangement. A stress management approach that includes relaxation training, cognitive restructuring, and problem-solving skills may be needed to improve the residual symptoms (Basoglu, 1998).

Based on cognitive behavior theories,

cognitive intervention involves encouraging survivors to think that their behavior under torture was a normal human response necessary for survival; that torture is designed to induce total loss of control and helplessness, which might explain why they behaved the way they did. Behavior regarded as mistakes is identified, and self-assessment associating blame with one's character is replaced by self-statements that attribute mistakes to one's behavior. Other statements useful in shifting blame back to the torturers are used. The survivor also needs to re-establish old values and assumptions about human beings and the world, or to adopt new values and assumptions that enable the development of trust and meaning in life (Basoglu, 1998). Some of these developments can occur indirectly through physical therapy and the supportive environment.

Although the vast majority of the recent literature involves variants of cognitive behavioral therapy, these techniques may not effectively address the multiple traumas often experienced by torture survivors. A comprehensive approach that includes community and social interventions may be necessary.

Group therapy

Although group therapy is discussed and practiced, relatively little is written about group therapy in the recent literature. Psychosocial education groups can involve the whole family, or groups of families, in teaching about the effects of torture, the meaning of symptoms, ways of helping each other, when professional assistance is required, and how to access it. Therapies are explained and basic problem-solving skills may also be included. Support groups usually include individuals but may also include families and are a useful integrative tool. For survivors whose cultures are reticent to discuss the

trauma and personal problems, indirect groups provide opportunities to develop trust and build networks of social support, with the occasional direct exchange of experiences and the opportunity for cognitive therapy (Gurr and Quiroga, 2001). More classically-defined treatment group therapy often incorporates education and support.

Nicholson and Kay (1999) describe a culturally-appropriate group therapy approach for Cambodian women, co-led by a Cambodian and an American social worker. Discussion and activities address skills, health, or self-expression. Sehwal and Rasras (2002) of Palestine conducted a cognitive behavior group primarily of survivors of torture in Israeli prisons or otherwise traumatized by Israelis. A psychotherapist and co-therapist conducted the group.

The authors comment that their patients were more likely to accept education or counseling than to focus on the trauma, but many members disclosed their traumatic histories. Of the twelve group members, eight reported benefit and four were partially improved.

Brief and short-term therapy

Rose and Bisson (1998) reviewed the literature on brief, early psychological interventions following trauma and found six randomized controlled trials, none of them including groups. The results were mixed, and the authors urge additional study.

Reeler (1998) describes a brief form of psychotherapy piloted for 15 adult torture survivors in Zimbabwe, 12 of whom completed treatment, suggesting that all patients improved after a single counselling session and follow-up interviews quarterly for a year. Munczek (1998) describes her short-term treatment of a Honduran torture survivor, 12 sessions during 11 weeks, lasting from 45 to 150 minutes. This detailed ac-

count discusses the challenges of time-limited treatment with a challenging survivor.

E. Psychiatric rehabilitation: Pharmacotherapy
Psychotropic agents from virtually all of the major categories have been used to treat survivors of extreme trauma who suffer from psychiatric disorders or chronic pain. Psychotropic medication may facilitate psychotherapy, may be necessary to reduce distress from symptoms, and in some cases is the only treatment available. It is possible that some medications given acutely may prevent the evolution of a normal posttraumatic reaction into PTSD. Medication can be used in any treatment setting, despite cultural and ethnic differences in the populations, assuming the choice of medication is appropriate and the medication is available. The clinician must be aware of possible concurrent use of traditional medications, over the counter medications, or abusable substances which may alter the effect of prescribed medications. Alternatives (Hiegel, 1994) or supplements to medication, such as acupuncture, hypnosis, relaxation, massage, or medicinal teas have also been used, but scientific support for the efficacy of these treatments remains minimal.

Despite the demonstrated effectiveness of Western medications, the literature has shown that relapse is common upon discontinuation of medication for treatment of anxiety disorders such as PTSD in torture survivors. However, since long term follow up studies have not been conducted, conclusions about medications having a lasting effect cannot be drawn. On the other hand, in one of the largest studies of 255 English language reports, random clinical trials involved only eleven studies (Solomon et al., 1992) but indicated that medications showed a modest but clinically meaningful effect. Nonetheless, strong interactive effects be-

tween psychotherapy and pharmacotherapy in PTSD may exist, and psychological and social variables complicate the picture.

The conceptual basis for pharmacotherapy and the literature supporting treatment of torture survivors with psychotherapeutic agents is reviewed by authors including Smith et al. (1998) and Jaranson et al. (2001). In a comprehensive review, Lin et al. (1993; 1995) have discussed the psychobiological basis for ethnicity and its implications for pharmacotherapy. Jaranson (1991), in a concise review of pharmacotherapy for refugees, stressed the importance of starting medication for highly symptomatic patients even if the initial evaluation and assessment is still in process. The findings, both from research and from clinical experience, indicate that prescribing smaller doses of psychotropic medications than recommended for Caucasians can effectively treat survivors who belong to non-Caucasian groups (Jaranson, 1991; Lin et al., 1993, 1995). Both pharmacokinetic (metabolic, affecting the required doses and the side effect profile) and pharmacodynamic (brain receptor, or differential clinical response) influences have been demonstrated (Lin, 1993). Both nature (genetics) and nurture (environmental, cultural) are superimposed on the wide individual differences within any given population group.

Aside from biological response differences, cultural factors also affect medication compliance (Jaranson, 1991). This has considerable relevance for traumatized refugees and torture victims, who come from diverse ethnocultural backgrounds. A number of cultural factors influence the effectiveness of psychopharmacologic therapy for torture survivors. For example, medication compliance in Southeast Asian refugees has been poor, based upon antidepressant blood levels, even if the patients have specifically

stated they were taking the medication as prescribed (Kroll et al., 1989). Kinzie (1987) has demonstrated that this poor compliance can be improved with patient education including how it works, how long it will need to be taken, what can be expected, and what side effects are possible. Many cultural attitudes towards medication affect compliance. For example, torture survivors may take medication only until symptoms begin to remit, rather than continuing for the full course of treatment, and may not benefit from the maximum therapeutic effect. On the other hand, psychotropic medications that show benefits may be shared with family members or friends who suffer from similar symptoms (Jaranson, 1991).

Most drugs tested in PTSD were developed as antidepressants and later shown effective against panic and other anxiety disorders. This seems to make sense with high co-morbidity rates of PTSD and the symptomatic overlap between PTSD, major depression, panic disorder, and generalized anxiety disorder (Stout et al., 1995). On the other hand, PTSD is more complex than affective or other anxiety disorders and its underlying pathophysiology appears to be qualitatively different. For example, abnormalities in the HPA system are markedly different than those present in major depressive disorder despite similarities in clinical phenomenology.

The results from randomized controlled trials show a moderate, but clinically meaningful effect at post treatment. Most of the earlier randomized trials were published between 1987-1991, focusing on tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs). Results were too inconsistent and modest to stimulate further research until selective serotonin re-uptake inhibitors (SSRIs) became available.

TCAs, SSRIs, and clonidine have all

been found useful for the intrusive and hyperarousal symptoms of PTSD (e.g., Kinzie and Leung, 1989). TCAs are the most studied psychopharmacologic agents, but have been replaced by SSRIs as first-line drugs in PTSD treatment because TCAs are relatively less potent, have more side effects, and fail to reduce the avoidant or numbing symptoms of PTSD.

MAOIs, such as phenelzine, produced excellent reduction of PTSD symptoms during an eight week randomized clinical trial, in two open trials, and in several case reports. Southwick et al. (1994) reviewed all published findings (randomized trials, open trials, and case reports) concerning MAOI (phenelzine) treatment for PTSD. Most published reports show that MAOIs effectively reduce PTSD symptoms. However, many clinicians appear reluctant to prescribe these agents because of concerns about the risk of administering these drugs to patients who may ingest alcohol or certain illicit drugs or who may not adhere to the dietary restrictions.

SSRIs have revolutionized pharmacotherapy and are beginning to emerge as the first choice of clinicians treating PTSD patients. The SSRIs generally have fewer side effects and are less lethal if the suicidal patient takes an overdose. SSRIs reduce the numbing symptoms of PTSD. In the first published randomized clinical trial of an SSRI in PTSD, fluoxetine (Prozac) produced a marked reduction in overall PTSD symptoms, especially with respect to numbing and arousal symptoms (van der Kolk et al., 1994). Connor et al. (1999) studied 53 civilians with PTSD treated for twelve weeks with fluoxetine or placebo and found fluoxetine more effective on measures of PTSD severity, disability, stress vulnerability, and high end-state function. Martenyi et al. (2002) completed a double-blind, random-

ized, placebo-controlled study of fluoxetine responders who continued in a 24-week relapse prevention phase and found the treated group (N=69) significantly less likely to relapse. Brady et al. (2000) found that sertraline (Zoloft) was significantly better than placebo on three of the four outcome measures and on the PTSD symptom clusters of avoidance/numbing and hyperarousal, but not re-experiencing. Davidson et al. (2001a) completed a large multicenter study of sertraline in PTSD and found improvement on all outcome measures compared with placebo. Marshall et al. (2001) found that paroxetine (Paxil), in a large (N=551) multicenter placebo-controlled study, was effective in treating all PTSD symptom clusters.

Trazadone and nefazadone (Serzone), serotonergic antidepressants with both SSRI and 5-HT₂ blockade properties, also exert alpha-adrenergic blockade and strong sedative effects. Trazadone has capacity to reverse the insomnia caused by SSRI agents such as fluoxetine and sertraline. An open trial (Hertzberg et al., 1996) indicated that trazadone may be an effective drug in its own right. Nefazadone is closely related to trazadone with respect to mechanism of action but appears to have greater potency. Multi-site trials with nefazadone are currently in progress. Clark et al. (1998) retrospectively reviewed charts of VA patients meeting the criteria for PTSD, compliant with treatment, and with no substance abuse during the previous three months. Of the 27 male combat veterans who met the criteria, six dropped out of treatment, 10 of the remaining 21 responded to treatment with Nefazadone even though 19 of the 21 had failed prior treatment with either TCAs or SSRIs.

It is well established that adrenergic dysregulation is associated with chronic PTSD (Yehuda and McFarlane, 1997; Friedman et

al., 1995) and positive findings with both propranolol and clonidine drugs were reported as early as 1984 (Kolb et al., 1984). Kinzie et al. (1994) found that clonidine may decrease nightmares and improve sleep, while Kinzie and Leung (1989) found benefits to positive symptoms, particularly when clonidine was combined with a TCA.

Benzodiazepines have been prescribed widely for PTSD patients in some clinical settings, but the use of benzodiazepines in PTSD has questionable efficacy and poses problems of addiction. In a randomized clinical trial (Post et al., 1995) and two open label studies, alprazolam and clonazepam showed modest reductions in anxiety but no improvement over placebo in reducing core PTSD symptoms.

Friedman and Southwick (1995) proposed that, following exposure to traumatic events, limbic nuclei become kindled or sensitized, then show excessive responsiveness to less intense trauma-related stimuli. The anticonvulsant/antikindling agent carbamazepine (Tegretol) produced reductions in re-experiencing and arousal symptoms, while valproate (Depakote) has produced reductions in avoidant/numbing and arousal symptoms, but not in the re-experiencing symptom cluster (Glover, 1993).

With the hypothesis that emotional numbing in PTSD might result from excessive endogenous opioid activity, Friedman (1991) conducted an open trial of the narcotic antagonist, nalmefene, with Vietnam veterans who had PTSD. Some exhibited reduced numbing, while the others showed no improvement or worsening of anxiety, panic, and hyperarousal.

Prior to the empirical and conceptual advances of the past two decades, PTSD patients were often considered to have psychotic disorders, based upon symptoms of intense agitation, hypervigilance resembling

paranoid delusions, impulsivity, and dissociation. Most of these symptoms respond to anti-adrenergic or antidepressant drugs, so antipsychotic medications should only be prescribed for the rare PTSD patient exhibiting severe paranoid behavior, overwhelming anger, aggressivity, psychotic symptoms, fragmented ego boundaries, self-destructive behavior, and frequent flashback experiences marked by auditory or visual hallucinations of traumatic episodes (Friedman and Yehuda, 1995). However, posttraumatic stress disorder with co-morbid psychotic features (PTSD-PS) may be emerging as a separate entity according to unpublished research in the Netherlands (Braakman, 2004). PTSD-PS, which may be a separate, cross-culturally valid nosological entity, can be differentiated from schizophrenia and from the dissociative symptoms of PTSD.

Smith et al. (1998), in their review of medication to treat torture survivors, have also found that lithium showed evidence of improvement in positive PTSD symptoms while buspirone (Buspar) showed improvement in depressed mood, anxiety, flashbacks, and insomnia.

F. Psychosocial rehabilitation and community-based interventions

Although the concept of community has been used for more than one hundred years, the elusive concept is waiting for an acceptable definition. Hillery found more than 90 definitions when he wrote his paper in 1955 (Hillery, 1955).

Brink provides a good operational definition of community as “aggregates of people who share common activities and/or beliefs and who are bound together principally by relations of affect, loyalty, common values, and/or personal concern (i.e., interest in the personalities and life events of one another)” (Brint, 2001).

Considering the basic context of the interaction, Brint identifies two basic subgroups: 1) those communities bound together by “geographical” reasons because they live close together or 2) those that are bound because of “choice”, independent of the geographical proximity. At the same time these two groups can be subdivided as “activity-based” and “belief-based”. Using this definition it is possible to differentiate several distinct subgroups.

Some of these refugees are escaping from regions or countries where genocide, local and international war, military dictatorship, or gross violations of human rights have occurred.

The violence previously described is not only a suffering of individuals, but also a form of social trauma that targets individuals, their interpersonal relations, and the socio-cultural order in a community. Rehabilitation of torture victims should be understood as rehabilitation in their medium as well as healing into a society. This is a valid concept whether the victim of violence is living in the country of conflict or living in exile in a refugee community.

Several studies in the US and others host countries have shown a high proportion of survivors of organized violence and torture living in those communities. Some of them are more functional than others but most of them have psychological suffering.

Most of the programs for rehabilitation of torture survivors have focused on the treatment of individuals who approach the program looking for help. A few are only community-oriented programs or a mix of approaches.

Community interventions for victims of organized violence and torture in host countries are relatively new. Many programs in countries of origin and in countries of refugee resettlement want to work with com-

munities. This work will be in addition to innovative approaches to treatment based on a needs assessment of the refugee communities and traumatized survivors.

Some anthropologists, social psychologists, and physicians interested or working in human rights and torture have presented convincing arguments that rehabilitation of torture victims must have not only an individual and family approach, but a psychosocial component linked to the community. The community approach extends the benefits of healing to a complete community (Pederson, 2003; Ekblad and Jaranson, 2004).

Ekblad and Jaranson (2004) explain that cultural differences may result in delayed psychosocial rehabilitation, non-compliance with psychiatric treatments, and premature termination of treatment which can result in more severe illness.

Community-based interventions should have the following:

Goals

Individual: Foster psychological and social health through personal, group and environmental change.

Community healing and empowerment: Restore a sense of security, create a sense of belonging, and of a self-generating community.

Community development: Permit increased employment and economic activity of individuals and the group to improve standard of living and welfare of the community.

Most community programs actually “take a development approach which empowers refugees and enables them to rebuild a self-generating community” (Bakewell, 2003).

Approach

Planning and implementation of a community program should be based on active par-

ticipation by members of the community. The interventions should be based on an analysis of the community needs and structures.

Stages

A program should have four stages:

1. Identification of the communities
2. Psychosocial, cultural assessment of the refugee communities (needs assessment)
3. Development of strategies, methods, and material for community-based interventions
4. Implementation of psychosocial community-based interventions

1. Identification of the communities

Identifying a community in a post-conflict society or in a refugee community in a host country with a large number of traumatized people is the most difficult task.

2. Psychosocial, cultural assessment of the refugee communities (needs assessment)

There are many reasons for conducting needs assessments, even when a program is already in place. Some of them have been identified (Soriano, 1995; Weiss, 1972).

- Assessing the needs of specific, underserved subpopulations
- Identifying torture victims within the refugee population
- Allocating resources and decision making to determine the best use of limited resources
- Justifying funding

Several methods have been used to identify the unmet needs of the community. The most frequently used include:

- Use of secondary data: Some agencies,

governments, or NGOs have already collected aspects of the information useful for the needs assessment.

- Key informants: Interviews with members of a group who have information about the target community, such as community leaders.
- Interviews: Collection of information from face to face or telephone interviews with members of the community.
- Small groups or focus groups: Meeting with a small group of participants and a moderator to talk about the needs of the community.
- Survey methods: There are several techniques to collect information from the total or a sample of the target community.

The decision to use one of these methods will depend on the information needed, resources available, time, and the level of cooperation from the target population. One method does not exclude the use of another. The ideal is to use all available sources of information to evaluate the needs of the community. The investigator must have a clear idea of the key areas to be researched and develop the proper questions for each area to be included in the research instrument.

3. Development of strategies, methods, and material for community-based interventions

- Treatment groups
- Socio-educational group
- Social action groups
- Administrative groups training members of the community as group leaders
- Self-help groups to support members of the community

4. Implementation of psychosocial community-based interventions

The literature on the use of psychosocial ap-

proaches in post-conflict societies is limited and descriptive. In populations traumatized by local or international conflicts, there is no information discussing torture survivors as a separate group.

Several protective factors for refugees and displaced populations have been identified, including:

- Extended family
- Employment
- Cultural and religious practices
- Support from human rights organizations
- Integration in host or local community
- Safe legal status in host country
- Self-help groups
- Empowerment

Most of the psychosocial techniques are oriented to enhance the protective factors but the approaches practiced are different among programs, regions, and countries (Blackwell, 1993; Perkins and Zimmerman, 1995; Montgomery, 2000; Mollica et al., 2002; Ekblad and Jaranson, 2004; Quiroga, in press).

Examples of psychosocial, community-based intervention

Central America: Beristain worked in several Central American countries during the civil war of the 1980s. He trained leaders of the community and community health promoters to organize support groups through a process of group discussion. The objectives of the political repression and the situation of stress and fear in the community were discussed. The group discussed later the individual and community consequences of the political repression. Finally, they planned how to organize themselves (self-help groups) to promote the individual and collective healing and social reconstruction of their community. Beristain has published

this methodology (Beristain and Riera, 1992).

Guatemala: Guatemala has a long history of violent social conflicts, ethnic discrimination, unequal distribution of income (with a poverty rate of 90% among the indigenous population), military dictatorships and civil war. The Catholic Church in Guatemala has the highest capacity, legitimacy and acceptability among the rural population. The Human Rights Office of the Archbishop of Guatemala (ODHAG) and the Rehabilitation and Research Centre for Torture Victims (RCT), with funding from the Danish International Development Assistance (DANIDA), have organized a community-based program for survivors of organized violence, including torture, massacres, disappearances, displacements, and violent repression. The program focuses on healing, empowerment, and community development in a post-conflict society. The entry strategy in the community is health-related interventions to increase the overall functioning capacity and community healing. The basic community intervention strategy is the “community reflection group” that is a large group of 60-70 persons from a community. The aim of the group is to analyze national, local and intra community conflicts affecting individuals as well as the community, followed by search of possible solutions. Another intervention is the formation of “self-help groups” to assist groups of 10-15 persons with common problems, facilitated by a volunteer community promoter. The “individual attention” is another strategy reserved to support members of the community who can not participate in groups because of severe traumatic experiences. The groups develop knowledge, build a social support system, and develop skills useful in the healing process. The healing process em-

powers the members and the total community to advance to the next stage of community development and self-sufficiency (Anckerman et al., in press).

Former Yugoslavia: Several NGOs grouped in the “Medical Network for Social Reconstruction in the Former Yugoslavia” implemented psychosocial techniques to heal individuals and society as a contribution to the social reconstruction in a post-conflict setting. Gutlove and Thompson describe the most useful approaches used in Former Yugoslavia in three categories: community integration, volunteer action, and training and training of trainers (Gutlove and Thompson, 2005). Community Integration is a process to integrate vulnerable or marginalized individuals or groups into a community, strengthening the social fabric of that community. The resources needed are in the local community. The integration is achieved through local level psychosocial projects. Some of these projects have focused on women and children, two vulnerable groups among refugees and displaced populations. The approaches include:

- Finding a safe place, such as a room where survivors can meet and interact in an open non-judgmental dialogue. The location is also used to practice creative means of expression such as visual art, music, literature, and theater.
- Identifying people’s strengths and help to develop those artistic, athletic, academic or other talents. Helping to identify medical and dental care for those who are uninsured. Helping to legalize their status if they are asylum seekers. Helping to collaborate with other institutions to develop or improve languages skills and employment (Miorner-Wagner, 2003).
- Encouraging volunteer action. During

conflict and tragedies ordinary citizens can demonstrate solidarity. Volunteers collaborate with health professionals to reassure survivors that their cause has not been forgotten. Volunteers can provide psychosocial assistance, education and practical aid (Mikus, 2003).

- Training and training trainers. In post-conflict societies there are not enough professionals to respond to the needs of survivors of trauma. The traditional medical/clinical approach of individual therapy in this situation was not sufficient. A psychosocial approach was the most appropriate to heal post-conflict societal trauma. The criteria for training of care providers were never met and, when the trained persons put their knowledge into practice, new training needs appeared (Ajdukovic, 2003).

Colombia: For the last fifty years, Colombia has experienced a cycle of violence that has escalated to a complex mix of belligerent forces with vastly different orientations: the government, military forces, para-military forces trained by the army, two leftist revolutionary groups, and the narcotic trafficking forces. The conflict has been characterized by constant attacks on the civilian population by all armed participants, creating fear and distrust in the civilian population. Political killing, torture, and forced displacement of a significant segment of the population are the most immediate consequences. The forced displacement has significantly deteriorated the quality of life of individuals and families. The structure and roles in the family have broken apart and the community social support has disappeared. The social, medical, and mental health needs of these populations are overwhelming. AVRE is a Colombian NGO founded with the objective to facilitate the full recovery of individual

and communities who have been victims of sociopolitical violence. AVRE has been able to take advantage of their institutional and other Latin American experiences and decided that the most important and productive task in Colombia is to give psychosocial support to the displaced populations and the populations at risk of displacement by political violence (Salazar, 2003; de Arco, 2003). AVRE uses a crisis intervention approach for individuals or groups and also contributes to the satisfaction of basic needs such as food, shelter, and the reconstruction of family and social networks. AVRE has designed and is implementing a training model called “Training Process for Grassroots Therapists and Multipliers in Psychosocial Actions” oriented to training grassroots organizations and individuals working with victims of sociopolitical violence. They are trained in the understanding of the causes of violence and human rights violations, promotion and support of peace building and self-help (Cardinal, 2003; Puerta, 2004; Salazar, 2003).

Guidelines and core curriculum for training
Since psychosocial intervention is a developing field, the International Society for Traumatic Stress Studies organized a task force to develop consensus-based guidelines for training in mental health and psychosocial interventions for trauma-exposed populations (Weine, 2003). The task force developed some guidelines for this training:

1. Training must address cultural dimensions.
2. Training initiatives must identify ways to appropriately enter complex environments in conditions that may be insecure.
3. Training must help recipients face both short- and long-term challenges.
4. Curriculum must be designed to best fit the realities of the local situations.

The task force identified a core curriculum for this training:

- Training includes competence in listening and other communications skills.
- Training covers assessment of psychosocial and mental health problems.
- Training includes teaching established interventions to diminish stress. A wide range of specific social, psychosocial, and biological interventions exist in the literature.
- Full understanding of the local context determines the appropriateness and feasibility of specific interventions.
- Training provides strategies for resolving stress induced symptoms and reducing problems situations at the individual, family, and community level.
- Training includes the treatment of medically unexplained somatic complaints.
- Training includes learning to collaborate with existing local human resources and change agents.
- Training ensures the establishment of an ongoing supervision structure.

G. Vicarious traumatization

The sensitivity healers need to help torture survivors can be very stressful. Previous concepts include burnout and countertransference. Burnout occurs when goals are too high and do not change when feedback is given. Symptoms of burnout include depression, cynicism, boredom, loss of compassion, and discouragement (Freudenberger and Robbins, 1979). McCann and Pearlman (1990) coined the term “vicarious traumatization” (VT), or the psychological effects on therapists or others who work with traumatized persons. These reactions can occur short-term after working with a particular client or longer-term as an alteration in the “therapist’s cognitive schemas, or beliefs, ex-

pectations, and assumptions about self and others” (p. 132). Therapists may experience PTSD symptoms and must be able to work through these experiences within a supportive environment. Otherwise, the helper may become numb or distant emotionally and unable to help the survivor of torture.

Lansen (1993) constructed a questionnaire sent to 99 addresses from an IRCT list of treatment centers and others. Twenty-five completed questionnaires represented 310 workers, 161 non-professional volunteers, and more than 4,600 traumatized patients. Less than 3% of therapists left their centers because the work was too difficult emotionally, but 17% suffered emotional burnout and fatigue. Strict PTSD symptoms were found in 11% of therapists and depression in about 8%. Lansen recommended, among other suggestions, working in a team with supervision. Jenkins and Baird (2002) also discuss secondary traumatic stress (STS) or compassion fatigue. They describe the TSI Belief Scale (TSI-BSL) to measure VT and the Compassion Fatigue Self-Test (CFST) to measure STS. Concurrent validity between these two scales was shown for 99 sexual assault and domestic violence counselors. Those with interpersonal trauma history scored higher on the CFST but not the TSI-BSL, consistent with the former’s emphasis on symptoms of trauma.

Therapists, especially those who have themselves been traumatized, need skilled supervision to help them deal with their own issues, as they arise in trying to help others (Becker et al., 1990; Kristal-Andersson, 1997). Holtz et al. (2002) surveyed 70 expatriate and Kosovar Albanian staff who were collecting human rights data in Kosovo. Anxiety (17%), depression (9%), and PTSD (7%) were found, indicating that the sample of human rights workers was at risk. Franckovic et al. (1998) found that, among 65

volunteers providing support to refugees from Croatia and Bosnia, techniques of motivation, education, and alteration of work factors provided little help to ameliorate “burn-out” in a setting subjected to the continuous threat of war.

10. Special populations

Women, children, and the elderly are at special risk for torture. The following sections will discuss these three special groups.

A. Elderly

Literature on the elderly torture victim is limited and most relevant information concerns the general category of refugees rather than the specific plight of torture survivors. Averaging 8.5%, up to 30% in some UN-HCR locations, refugees older than 60 years may have compromised ability to meet their basic needs because of physical disability, mental impairment, loss of social support, or malnutrition (Burton, 2002). Medications for chronic diseases may be unavailable or access to health services difficult for those with limited mobility. Losses after displacement may be more profound and readjustment may be challenging with the availability of fewer future opportunities to rebuild their lives.

Carlin (1990) identifies as number of problem areas for the elderly refugee or immigrant, including 1) separation from or loss of family members as well as disapproval by younger family members who are better able to acculturate; 2) isolation from friends and problems making new friends; 3) compromised independence due to language difficulties and illness; 4) loss of job status and productivity with few future opportunities left for them.

Interventions should take advantage of the respected position that the elderly have in many societies and cultures, such as in

conflict resolution and as heads of extended families. Training for new vocations and skills should not be restricted to the younger members of society because the elderly have much to offer (Burton, 2002).

B. Children and adolescents

Neurobiology

Although clinicians working with survivors who were tortured as children or adolescents have generally believed in the serious interruption of the normal developmental process for these survivors, Heim et al. (2003) have reviewed the recent neurobiological evidence to support this clinical impression. Evidence from both clinical and preclinical studies indicates that psychological trauma permanently shapes the brain circuitry regulating stress and emotion. These biological alterations lead to increased behavioral and physiological responsiveness to environmental stressors, increasing the chances of adulthood psychopathology, especially PTSD. Variability by trauma severity and by elapsed time between trauma and assessment affect the rates of PTSD in children. PTSD may persist into adulthood and be aggravated by other traumatic events. Early trauma not only increases the risk of experiencing later trauma (and PTSD) but also the risk of developing PTSD after adulthood trauma. Early trauma is also associated with many other disorders which are frequently co-morbid with PTSD.

Sequelae

Although the prevalence is not known, considerable evidence has established that many children and adolescents have been physically or mentally tortured, or suffered secondary torture by witnessing beatings, torture or the killing of relatives, and other severe events. Younger children, in particular, are vulnerable to imposed separation

from family, abduction, and the death or disappearance of parents or other caregivers (Ekblad, 2002). Children may be orphaned in countries with no family to care for them, or they may escape as refugees, become separated from family, or be resettled without any relatives. Each violent traumatic event has secondary stressors influencing family, housing, school, and other life conditions (Montgomery, 2000). Adaptation after torture is affected both by the initial experience and by secondary stressors, while adaptation after additional trauma later in life depends upon adaptation to the initial torture and the new secondary stressors (Montgomery, 2000). Pynoos et al. (2001) has stated that, with the vast amount of politically-motivated violence, there is a serious risk for many adolescents to become part of a "lost generation" unless adequate intervention occurs in post-disaster communities.

Young children of survivors of torture have been reported to show chronic fear, depressed mood, somatic complaints, and regression in social habits or school performance. Preschool children may show attachment disturbance and separation anxiety. School-age children may exhibit either withdrawal and inhibition on the one hand, and disruptive behavior or attentional disturbances on the other. Adolescents may show symptoms more characteristic of psychiatric disorders in adults, but also acting-out behavior or reduced impulse control (Ekblad, 2002). Pynoos et al (2001) reported PTSD symptoms of persistent hypervigilance, insomnia and nightmares, and exaggerated startle responses, which were consistent across languages and cultures.

Psychological problems may arise in the children of torture survivors as a result of indirect exposure to parental torture, parental absence, or subsequent behavioral problems of parents. Having mothers who suffered

PTSD after political violence, as well as maternal avoidance and anxious responses to traumatic reminders, correlated with symptoms of posttraumatic distress in their children (Ekblad, 2002). Providing refugee children with responsibilities during their family's flight seems to protect against psychological distress (Ekblad, 2002). Other common problems in survivors' children include anxiety, withdrawal, depression, irritability, aggressiveness, generalized fear, excessive clinging and dependence, and psychosomatic problems and deterioration in school performance. Especially in adolescents, behavioral problems such as introversion, withdrawal, isolation, excessive stubbornness, and authoritarian attitudes may cause further maladjustment in the family.

Sexual torture in children has been acknowledged but the prevalence is unknown because the problem has been concealed or unnoticed until relatively recently (Blaauw, 2002). The consequences are serious for the physical, psychological, and social health of those affected. Little research has been completed, but an assumption can be made that many of the documented effects of torture in adults may occur, in addition to the specific effects of sexual torture in adults.

Montgomery (1998) studied Middle Eastern refugee families in Denmark to identify prevalence of torture survivors among asylum-seeking parents, of violent experiences among the children, and of the psychological problems of the children. In addition, risk and ameliorating factors for anxiety among the children were identified. Of the 311 children from 149 families, 44% of the fathers and 13% of the mothers had been tortured, and 51% of children had a family member who survived torture. Living in refugee camps (92%), under conditions of war (89%), and the escape with parents (89%) were the most common violent events

experienced. Two-thirds of the children were clinically anxious. Living in prolonged violence preceding immigration was a greater risk factor for anxiety than events and changes after immigration. Keeping refugee families intact during the asylum process in Denmark reduced children's anxiety, while use of parental corporal punishment during resettlement increased the children's anxiety. Montgomery and Foldspang (2001) also studied sleep disturbance among these 311 children and found that a family history of violence and a stressful family situation in exile strongly predicted sleep disturbance, while immigrating to Denmark with both parents decreased sleep disturbance.

A 2004 research study (unpublished), conducted by the Gaza Community Mental Health Program (GCMHP), concluded that the majority of children living in the Gaza Strip are exposed to various degrees of traumatic experiences. The results indicated that, in areas of direct exposure, 54% of children were suffering from PTSD symptoms, while 32% of children living in remote areas were suffering from PTSD symptoms. The remaining children were not spared suffering from PTSD symptoms in one way or another. The study also found that only 1.7% of children in areas of direct exposure and only 2.5% of children in remote areas did not display symptoms of PTSD.

Halcon et al. (2004), studying 338 Somali and Oromo refugee youth aged 18-25 in the United States, found that PTSD symptoms correlated with increased traumatic events, and that physical, psychological, and social problems were strongly associated with trauma history, but varied by gender/ethnicity. Common strategies to combat sadness were praying (55%), sleeping (40%), reading (32%), and talking with friends (28%).

Berthold (1999) found in her sample of

76 Khmer high school students and their parents that half of the students survived direct violence and two thirds had witnessed violence. About a quarter of the students had PTSD symptoms, and the number of violent events predicted both PTSD and level of function. In a community sample of adolescent Cambodian refugees in Oregon during the 1980s, 50% had PTSD and depressive disorder (Kinzie et al., 1986) and, over time, PTSD persisted and remained episodic while depression diminished (Kinzie et al., 1989).

Several recent studies of former Yugoslavians have been reported. Goldstein et al. (1997) studied 364 internally displaced children living in central Bosnian collectives during the war and found exposure to large numbers of war-related experiences, not dependent upon demographic differences other than region of residence. Nearly 94% met DSM-IV criteria for PTSD and significant levels of sadness, anxiety, and other symptoms were also found. Children with the greatest number of symptoms witnessed trauma (death, injury, torture) to a nuclear family member, and were older and from an urban area. Totozani et al. (2001) studied 150 randomly selected Kosovar refugee children living in Albania. The most traumatic events were the murder of family members, risk for the child's life (69%), and destruction of the family home. Half of the children had repeatedly experienced the traumatic event and only 21% had not experienced these events. Large numbers of children had symptoms of fear when faced with the traumatic event (70%), decreased concentration at school (71%), frequent bad dreams (39%), avoidance (38%), irritability (39%), and were easily startled (39%). Despite these symptoms, 49% had not lost hope for the future. In Denmark, 1,224 Kosovar refugee children (89% of those admitted)

were screened for emotional problems within a week after arrival (Abdalla and Elklit, 2001). Forty per cent had witnessed violence and 9% had been victims. Emotional (20%) and psychosomatic (24%) problems were found. Poverty, torture, and length of flight explained 16% of the variance of all symptoms.

Therapy

In recent years relatively little has been published about therapy for tortured children. The Victorian Foundation for Survivors of Torture (1996) has developed a manual for professionals who work with young refugees exposed to trauma. Individual, group, and family approaches are discussed. Recovery goals include restoration of safety and control, re-establishing attachment to others, restoring meaning and dignity, and finding values. Education about trauma and solving social problems are included, as well as therapy strategies. Van der Veer (2003) discusses transcultural therapy with adolescents, including methodology. Elklit (2001) systematically reviews the relatively few studies in the field of psycho-education for refugee children. Based upon the screening results described above (Abdalla and Elklit, 2001), the Danish Red Cross developed a psycho-educational project for 490 Kosovar refugee children. Intrusive memories and hypervigilance decreased, while self-satisfaction increased significantly. Pantic (1998) discusses integrative gestalt group for Bosnian children and their families, helping them to overcome their problems, avoid long-term sequelae, and reach acceptance of their experiences in a search for meaning and identity.

Psychopharmacology is rarely discussed for children. Several of the SSRIs have been approved for use in the United States to treat PTSD (see section on Psychiatric Re-

habilitation: Pharmacotherapy). Cognitive-behavioral treatment, SSRIs and clonidine have been recommended although evidence for the latter two is weak (Cohen et al. 2000). That the US Food and Drug Administration recently (Autumn, 2004) issued a "black box" warning for children and adolescents based upon data indicating an increased risk of suicide when taking SSRIs does not strengthen the case for using these medications.

C. Sexually tortured women

Background

Women are at greater risk for organized violence compared with men. Unlike men who are often politically active, most women are relatively innocent victims, poorly prepared for the risk of torture (Bot and Kooyman, 1999). Women are also at increased risk for gender-based violence (Baron et al., 2003), in particular rape, and most of this section will discuss the implications of this method of torture.

Domestic violence (Copelon, 1994), trafficking of women (and children), and female genital mutilation (Walley, 1997), although considered by some as torture and now more frequently presented as justification for granting asylum or refugee status, have not generally been accepted as methods of politically motivated torture and will not be discussed in this desk study. Rape of men is discussed in the next section.

Certainly within the international legal community, but also within much of the torture rehabilitation community, rape was not considered torture until relatively recently (Arcel, 2002). It was only during the ethnic cleansing in Bosnia and Rwanda during the 1990s that war criminals were first indicted for war-rape and sexual slavery. Gottschall (2004) reviewed four possible theories to explain wartime rape: feminist, cultural pathol-

ogy, strategic, and biosocial, concluding that the biosocial theory provides the best explanatory context.

Psychological (Agger, 1989), medical (Swiss et al., 1993), legal (Kelly, 1997), and philosophical (Schott, 2002) perspectives of rape as torture have been published.

Agger cites the definition of sexual torture as “the use of any form of sexual activity with the purpose of manifesting aggression and of causing physical and psychological damage” (Lira and Weinstein, 1986, p. 1). As with all torture methods, the goal is generally to destroy individual identity but specifically to disturb sexual functioning. Based on her clinical experience with refugees to Denmark, Agger (1989) proposes a psychodynamic theory of sexual torture involving moral conflict, complexity, and ambiguity. Swiss et al. (1993) provides an overview of the medical community’s role in 1) documenting rape incidence and prevalence, 2) verifying the public health implications using medical data, 3) validating testimony of individuals who were raped, and 4) treating individuals traumatized by rape. The goals are to hold perpetrators accountable, to restore lawful order, to reduce future violations, and to facilitate development of recovery strategies by increasing the medical knowledge about rape.

Recognition of political rape of women as violating human rights protections and as a basis for asylum applications is relatively new. Women have historically had problems gaining asylum because a) the legal standard does not include gender as a protected category, 2) adjudicators have not acknowledged that rape is “political”, and 3) a safe environment for a woman to present her case did not exist. In 1995, the UNHCR guidelines stressed that sexual violence is a method of torture and individual countries have also produced guidelines that address,

among other things, the legal standards for evaluating claims and procedural recommendations for interviewing women (Kelly, 1997).

Schott (2002) discusses war rape as an instrument of ethnic cleansing or genocide, aiming to systematically annihilate a people and their culture. Schott provides a philosophical analysis of war rape as breaking down moral codes and transforming values. She disagrees with claims that war rape can be avoided if soldiers understand the right for all persons to be secure and free from torture. Instead, she asserts that a soldier must acknowledge wrongdoing of the physical transgression, move away from a cognitive recognition of morality, and “incorporate the bodily element of judgment” (p. 52).

Sequelae

Jaranson et al. (2004) found that, in a community sample of 1,134 East Africans in Minnesota, women were tortured as often as men.

As Arcel (2002) states, “Sexual torture harms women’s bodies and minds, controls and stigmatizes them socially, impairs their sexual identities, and in the worst cases turns them into living dead” (p. 5). Physical consequences are common, including pain in the lower lumbar back pain and genitalia. Menstrual disturbances, sexual dysfunction, and many musculo-skeletal symptoms are found. Women who have been raped or otherwise sexually assaulted suffer from mental sequelae including the posttraumatic stress and depressive symptoms described in earlier sections. However, the frequency of PTSD following sexual assault is higher than for other crimes, in the range of 90%, with the strongest predictors for PTSD threats to the woman’s life, actual physical injury, completion of the rape, and depression preceding the torture (Wolfe and Kimerling, 1997).

Survivors have increased rates of major depression, suicidal ideation and attempts, anxiety disorders, substance abuse, as well as decreased frequency of sexual relations. Fear both of social situations and of being alone are common. Humiliation and shame persist, often for the rest of a woman's life. A natural and healthy feeling of invulnerability may be destroyed. As Arcel asserts, "prolonged and repeated sexual torture is the most traumatizing human experience of all" (p. 13).

Assessment

Interviewing women who have been tortured requires a great deal of sensitivity and empathy on the part of the clinician who must also retain objectivity. Unless the clinician uses extreme care, the evaluation may replicate the torture interrogation and elicit feelings of powerlessness and intrusion. The woman's anxiety may increase and her willingness to disclose crucial information may decrease. A safe environment must be created. Specifically the clinician should explain the interview process and allow the woman to request breaks, to interrupt, or to leave the interview if her level of stress becomes unmanageable (Laws and Patsalides, 1997). In the medical interview, clinicians should ask directly about sexual assault since this information is unlikely to be volunteered. Frequently the presented symptoms are somatic, anxious, or depressive. In the psychological evaluation, the clinician must assess potential defense and coping strategies, including shame or survivor guilt. PTSD screening questions need to be asked. Inconsistencies in the woman's report should be considered in light of possible posttraumatic amnesia or culturally-based time differences in perceiving time (Laws and Patsalides, 1997). Helpful interview techniques include avoiding excessive detail, offering normaliz-

ing statements that her experiences are not uncommon, and providing verbal support.

Rehabilitation

The shame with which patriarchal or traditional societies view the sexually traumatized woman extends to her family and even to her community. Chester (1992) recommends the use of support groups for women who are not accustomed to divulging personal information, such as many Southeast Asians. According to Kastrup and Arcel (2004), the therapist must differentiate between the original trauma and gender discrimination as well as the social relationships exerted on the woman while she attempts to overcome her trauma. Consequently, the goal for the therapist is to empower the woman. Axelsen and Sveaass (1994) identify a number of therapeutic principles in working with women exposed to sexual violence, including working with self-esteem, giving new meaning to the trauma, seeing the trauma in a life span perspective, working with body perception and guilt, clarifying the meaning in the woman's reactions to the trauma, and strengthening self-control. Roth and Newman (1991) present a conceptual system to characterize recovery from sexual trauma. The survivor must understand both the emotional impact of her trauma in order to eliminate the preoccupation with negative feelings and the meaning of her trauma in order to achieve an adaptive resolution. Consequently, both cognitive and emotional understanding and resolution are included in this system. The system identifies affect and schema categories describing the sexual trauma experience. Affect categories include helplessness, rage, fear, loss, shame, guilt, and diffuse affect. The four fundamental schemata include perceptions of the world as benign, the world as meaningful, people as trustworthy, and herself as worthy.

D. Sexually tortured men

Sexual torture in men is a subject usually ignored in the torture literature. Sexual torture in men as a political instrument in war or during political repression is frequently cited but has not been systematically studied, in spite of the apparent fact that it occurs more frequently than has usually been reported (Agger and Jensen, 1996; Hardy, 2002; Bravo-Mehmedbasic et al., 2003).

The abuse and torture of prisoners in Abu Ghraib has shown that American interrogators used sexual torture techniques as a method of humiliating and manipulating the emotions and weaknesses of prisoners. The prisoners were stripped of their clothes and remained naked for days. They were photographed while naked and were threatened by stating that their photographs would be published which, ironically, did happen. Military personnel using surgical gloves explored every body cavity (vagina and rectal area) of prisoners using security reasons as an excuse (Cittim, 2004).

A Briton released from prison alleged that prisoners were obliged to simulate oral sex, practice forced masturbation, and participated in a human pyramid of naked prisoners. Naked prostitutes were paraded before the inmates to taunt them (Dodd, 2004). The Taguba report included in its list of abuses "sodomizing a detainee with a chemical light and perhaps a broom stick" and positioning a naked detainee on a box with a sand bag on his head and attaching wires on his fingers, toe, and penis as they simulated electric torture (Taguba, 2004).

Beatings and application of electric torture in the genital area in men is frequently practiced during torture around the world. The introduction of foreign bodies, such as a stick, broomstick, or a pole in the rectal area is frequently used in sexual torture. A victim

may suffer from an anal stricture and dilatation of the colon as consequence of sodomy with a wooden stick. The incidence or prevalence of torture/rape in men is unknown, but the consequences are the same as in prison rape.

Prison rape

Most of the research on sexual torture in men has been done on prison rape. Rape in prison is defined as sexual aggression towards a prisoner against his will by another inmate, and it should be considered torture when an official allows the rape to occur.

Prison rape represents one of the most frequent and egregious human rights violations in the jails around the world today. The victims of prison rape are generally men who are young, physically weak, gay, non-violent, and generally first time offenders.

A study in four Midwestern states in the US found that approximately one in five male inmates reported having experienced sexual incidents while they were incarcerated. One in ten males reported they had been raped (Struckman-Johnson C and Struckman-Johnson D, 2000).

A similar study, of women in three Midwestern prisons in the US, reported sexual abuse that varied among facilities from 27% to 9%. Most of the incidents involved genital touching. About one fifth of the incidents were classifiable as rape. Half of the perpetrators were female inmates (Struckman-Johnson C and Struckman-Johnson D, 2002).

Youth in detention are also extremely vulnerable to abuse. Juveniles incarcerated with adults are five times more likely to report being victims of sexual assault than youth in juvenile facilities. The suicide rate of juveniles in adult jails is 7.7 times higher than that in juvenile detention centers (Stop Prison Rape, 2004 a).

The studies of victims of prison rape have shown that the prisoners experience feelings of powerlessness, loss of control, and vulnerability in relation to the aggressor. The victim feels that his gender identity has been destroyed and experiences confusion in his sexual orientation. Most of them also present symptoms of severe PTSD, major depressive disorder or suicidality.

Prisoners and ex-prisoners are a source of infectious diseases such as HIV/AIDS, syphilis, gonorrhoea, chlamydia, or Hepatitis A and B. As an example, prisoners in US jails have an HIV/AIDS rate five to ten times higher than the general population. AIDS accounts for one third of all deaths in California prisons. More than 90% of the prisoners are eventually released into the community without the knowledge, skills, or access to resources to treat their condition and stop the cycle of transmission (Stop Prison Rape, 2004 b).

“Survivors” (www.survivorsuk.co.uk) is an organization founded in London to promote awareness of the prevalence of sexual abuse and rape of boys and men. “Survivors” offers support and help to male victims in England. “Stop Prisoner Rape (SPR)” (www.spr.com) was founded in Los Angeles, California with the same objectives. SPR was successful in changing government policy when the American Congress approved, and President Bush signed as law, the “Prison Rape Elimination Act” in September, 2003. The law calls for the gathering of national statistics about the problem, the development of guidelines for states about how to address prison rape, the creation of a review panel to hold annual hearings, and the provision of grants to states to combat the problem. The law is not entirely adequate, but is considered to be the beginning of real reform.

11. Future research recommendations

This study and many other publications have identified areas in the field of torture rehabilitation where research is needed. Some examples by category are:

Psychobiological mechanisms, memory

Future research needs to focus on psychobiological mechanisms of traumatization.

Issues of memory recall await additional research in both clinical and laboratory settings. Future research should include controlled clinical trials to test the efficacy of treatments which focus on sense of control.

Evaluation of the effects of recalling the trauma itself in the absence of treatment is particularly important when many individuals are being called to make public statements of the past atrocities inflicted on them. Such statements may, in fact, exacerbate the symptoms. It is possible that by breaking down avoidance and numbing, symptoms may actually get worse.

Assessment/diagnosis

Studies are needed to develop standardized and validated assessment instruments for refugee and non-refugee torture survivors. There are not enough studies that have included recognized diagnostic instruments and large enough samples to provide statistical proof of the frequency of psychological symptoms, although a meta-analysis of published papers might do so.

Multiple measures (quantitative as well as qualitative) are needed to assess trauma, diagnostic categories, and variation in the properties of the measures.

Long-term studies of symptoms in torture survivors, including the persistence of PTSD symptoms, concentration and learning problems, ability to work, and health problems are needed. Many studies have shown increased vulnerability to stress with

reactivation of the symptoms. If such vulnerability is found universally, it would have a profound effect on treatment philosophy and disability evaluations.

Any consequences specifically associated with torture, compared with other traumatic events which refugees commonly experience, still need to be identified or the effects quantified (Silove et al., 2002; Steel et al., 1999).

Much of the US experience with veterans has concentrated on substance abuse problems. This seems to be a different experience for many refugees and this should be studied – although for some refugees, such as Afghans and Central Americans, this may be an increasing problem, which would certainly complicate treatment efforts.

Head injury

The neuro-psychological effects of head injury in survivors have not been adequately researched. To clarify the relationship to torture would be a major undertaking, but this should be done for the treatment and prognosis implications.

Further studies using modern methods of neuropsychiatric and neuropsychologic investigation are required to clarify the role of head trauma in the development of post-torture symptoms.

Coping and resilience

Studies on how the majority of people in different cultures, who never receive treatment, cope with their trauma are needed. Future research should have a stronger focus on resilience factors, including studies of resilience factors and an elucidation of why not all exposed to severe trauma develop long-lasting conditions. A better understanding of resilience factors could be helpful in developing more effective treatment programs for torture survivors related to long-term psychological functioning.

Many patients of all traumas cope by using active suppression, i.e., avoidance behavior, by refusing to talk about the trauma or be reminded of the event. Since this technique is so frequently used, its utility should be studied, and the benefits and problems for refugees of various cultures determined (Kinzie and Jaranson, 2001).

Controlled studies of non-refugee survivors of torture (Basoglu et al., 1994b, Basoglu 1997; Basoglu and Paker, 1995) have identified subjective severity of torture, post-torture psychosocial stressors, family history of psychiatric illness, post-captivity social support, “psychological preparedness for trauma”, and education as predictors of long-term psychological status. These findings need replication in other groups of torture survivors in different cultures and in refugee torture survivors.

Future research needs to explore the possible differential mental health effects of torture and refugee trauma and examine how various traumatic stressors associated with these events interact in producing the symptoms commonly observed in tortured refugees. Of particular interest is whether the psychological impact of these stressors is additive or interactive. These issues could be best examined by controlled studies using a 2x2 design that would allow comparisons between tortured refugees, non-tortured refugees, non-refugee torture survivors, and non-refugee controls with no torture experience.

Better understanding of how various stressors such as torture, uprooting, refugee trauma, and loss of social support relate to PTSD symptoms, anxiety, depression, and other psychological problems in survivors of torture is needed. Controlled comparison studies involving refugee and non-refugee torture survivors could address this issue.

Studies on the coping strategies of the

second generation of torture survivors, and on integrative problems to elucidate how the impact of trauma is transmitted to the next generation are needed.

Culture

Studies of the cultural influences on the response to trauma are needed.

Transcultural studies of the effects of trauma and gender on mental health promotion, health, illness, and health care gaps are needed.

The respective advantages and disadvantages of the different "Westernized" approaches would be useful to select treatments.

Valid comparison of mental illness around the world using multicenter, cross-national, cross regional studies with computerized management of data and establishing a common database across countries has been proposed by the Global Torture Victims Information System (GTIS), initiated by the IRCT, and would help to allocate resources.

Pharmacology helps certain symptoms, particularly intrusive symptoms of sleep disturbance in PTSD, and research is needed to see if this is universally true among refugees in various cultures. The effects to measure include not only PTSD symptoms, but demoralization, distress, functioning (work, education, family life, participation in psychological treatment), effect on psychotherapy, gaining control over violent impulses, reducing hyperarousal, reducing/eliminating use of other drugs/alcohol, and providing some emotional distance from the trauma to facilitate work in psychotherapy (Blank, 1995).

The effects on public expectation are important in treatment in various cultures. There is a need of many to address the atrocities. The legal and social needs are at variance with some other personal needs of patients who may be afraid or made vulner-

able by such expression. Guidelines should be developed.

The value of insight therapy has been questioned. Many groups have emphasized psychodynamic insight, understanding, and reintegration for people of various cultures, where others have found this unacceptable. The differential effects of psychotherapy should be studied with particular emphasis on long-term follow-up studies, the value of groups and the value of indigenous treatments. Most of the latter have never been subjected to systematic evaluation.

Gender

Among the issues needing study are gender differences in PTSD, gender and neurobiology (e.g., some literature states that women are more sensitive to painful stimuli), gender and cultural differences in response to medications (Jaranson et al., 2001), the advantages and disadvantages of providing specific mental health services for traumatized women, the outcome of gender-specific services, coping styles in different cultures, and factors that inhibit women from seeking treatment.

Treatment

Studies on intervention strategies for the prevention of the onset, the reduction of the severity, or the prevention of the recurrence of mental health sequelae in torture survivors are needed.

Some case studies (Basoglu and Aker, 1996) suggest that interventions aimed at reducing avoidance behavior lead to a significant improvement in social disability. The importance of this symptom should therefore be born in mind in future studies of social and economic consequences of torture.

Pharmacological agents and psychological treatments with demonstrated efficacy in treating PTSD in survivors of other

types of trauma must be subjected to controlled trials to test their efficacy in both refugee and non-refugee torture survivors. Of particular interest would be the study of drug-psychotherapy interactions in reducing traumatic stress reactions.

Specific pharmacologic agents, including adrenergic alpha-2 agonists such as clonidine and guanfacine, SSRIs and other serotonergic agents, and anticonvulsants with anti-kindling/sensitization properties require further study.

Developing and testing drugs that have been developed specifically for PTSD rather than using recycled pharmacological agents developed to treat affective or other anxiety disorders (Jaranson et al., 2001) is essential. From this perspective, promising future directions might be to test drugs that antagonize the actions of corticotropin releasing factor (CRF), the substance that appears to play such a central role in the stress response (Krystal et al., 1995). Another promising direction for future research might be to design drugs that can reverse the dissociative and amnestic symptoms associated with PTSD (Krystal et al., 1995).

Vicarious traumatization

Studies of the efficacy of different methods to avoid burnout among mental health providers would be helpful.

Outcome

Efficacy

The efficacy of current rehabilitation models need to be evaluated and their therapeutic ingredients clarified. Outcome evaluation in rehabilitation work with torture survivors should receive greater emphasis. Controlled treatment trials with adequate follow-up are urgently needed to identify the most efficacious treatments and the mechanisms by which they exert their therapeutic effect.

Studies of the criteria for successful outcomes in treatment and the duration of achieving these outcomes is needed to accomplish the above.

Cost effectiveness

Cost effectiveness of various treatment approaches must be studied given the increasingly scarce resources available for the care of torture survivors. There are no estimates of the cost of medical services utilized by torture survivors, whether in their country of origin or in a host country, and this should be investigated.

Impunity and compensation

Systematic research is needed to understand how impunity for perpetrators and compensation/redress for the acts committed affect the psychological functioning of survivors of political violence and torture. Such research would be useful in clarifying the psychological effects of truth and reconciliation processes, such as in South Africa, on survivors as well as on the community. It could also provide valuable insights into the ways in which such processes should be conducted to avoid further traumatization and maximize the psychological well-being of survivors and their community. This could be useful, not only for South Africa, but also for other countries where similar attempts are being considered.

Research design

Research design must give greater priority to psychological and social variables. Chronic symptoms may be slow to change, where one might expect that subjective distress would be the first to change, then functioning, then symptoms.

Studies, especially among groups with chronic PTSD, should be carried out over a longer time period. Currently, 6-12 weeks is

a typical time frame, while 6-12 months may be more appropriate.

Prevalence studies

For Western countries, which face a serious refugee problem, research priorities need to include epidemiological studies to investigate the prevalence of past torture experience among refugee populations and the prevalence and nature of medical and psychosocial problems among torture survivors.

The prevalence of torture and torture sequelae in different groups, regions, and countries needs to be identified.

Models of organization

Studies of the effectiveness of the different models of the organization of torture rehabilitation services are needed.

Many countries suffering under repressive governments or war have significant numbers of survivors of torture who are in need of help for a relatively short period of time. Are the current approaches useful in this situation?

12. Conclusion

This update of the desk study published in 2001 has identified some progress and confirmed the persistent and significant lack of knowledge, in critical areas, in the field of rehabilitation of torture survivors.

The torture rehabilitation movement has been in existence more than twenty years and it has now been universally accepted that a multidisciplinary approach is the best treatment for torture survivors. However, nobody has scientifically proven the efficacy of the total or any of the components of this approach to treatment. For the near future this is the most important challenge for research in torture rehabilitation.

There is not a good methodology to calculate the magnitude of the problem of tor-

ture worldwide, but the numbers of torture survivors should be several million. The majority of them cope with the help of family or community. Some of them, because of the severity of their symptoms, are not able to reintegrate into society and they need assistance. Assuming the efficacy of treatment, another important challenge is to design new, creative approaches to identify and help survivors in their communities.

The most important utopia of the health professional working with the rehabilitation of torture survivors is the abolition of torture worldwide, to live in a world free of torture and where there is no need for torture rehabilitation programs. Unfortunately, torture is practiced systematically in the majority of countries. Fortunately, this desk study has identified some progress in the legal arena with the ratification of the Optional Protocol of CAT and the ratification of the International Criminal Court, indicating acceptance of the universal jurisdiction of torture.

13. Appendices

I. International law

II. Interrogation techniques and methods of torture

III. Impunity as failure of justice

IV. Reparation

V. Prevention

VI. Research

APPENDIX I**International law**

The abuse and torture of prisoners of war in the prison of Abu Ghraib in Iraq, has fueled an international discussion on the aspects of torture and international law around the world.

Since the Universal Declaration of Human Rights, torture has been universally proscribed by international laws related to human rights. Torture, in addition, is considered one of the most severe violations and is classified as a “crime against humanity” and as a “war crime”.

A. Treaties

The Universal Declaration of Human Rights of December 10, 1948

The Universal Declaration of Human Rights was adopted for the General Assembly of the United Nations on December 10, 1948. The initial paragraph recognizes that all members of the human family are equal and have similar rights that are the foundation of freedom, justice, and peace around the world.

Article 1 recognizes that “all human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in spirit of brotherhood”.

Article 5 specifically relates to torture and states that “no one shall be subjected to torture or to cruel, inhuman, or degrading treatment or punishment”.

The Geneva Convention of August 12, 1949 (the Humanitarian Law)

The four Geneva conventions have in common article number three. This article is a convention in itself and states that persons not taking active part in the hostilities, including members of the armed forces who have laid down their arms and those who are *hors de combat*, will in all circumstances be

treated humanely without any adverse consequences. “To this end, the following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above mentioned persons:

- a) violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture
- b) taking them of hostages
- c) outrages upon personal dignity, in particular humiliating and degrading treatment
- d) the passing of sentences and the carrying out of executions without a previous judgment pronounced by a regularly constituted court, affording all judicial guarantees which are recognized as indispensable by civilized peoples” (International Committee of the Red Cross, 1987).

The Covenant on Political and Civil Rights, approved in December 1966

The condemnation of the use of torture is also clearly denounced in the Article 7 of the Covenant on Political and Civil Rights, approved by the General Assembly of the UN. Article 7 states that “No one shall be subjected to torture or cruel, inhuman or degrading punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation”.

The Convention against Torture (CAT), in force since 26 June, 1987

The most important international legal instrument against the practice of torture is the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or punishment. The General Assembly of the UN approved the Convention by consensus on December 10, 1984 and it went into force on June 26, 1987. As of April 23, 2004, 74 States are signatories and 136 are

parties of the Convention (United Nations, 2004).

The Convention defined torture in article number one as previously described. The Convention also obligates the signatory countries to have domestic legislation condemning torture. Also, in Article 2.2 it states that “No exceptional circumstances whatsoever, whether a state war, internal political instability or any public emergency, may be invoked as a justification for torture”.

Article 10 of the CAT requires of States to educate their “law enforcement personnel, civil or military, medical personnel, public officials and others persons who may be involved in the custody, interrogation, or treatment of any individual subjected to any form of arrest, detention, or imprisonment about the prohibition against torture”.

“Each State party shall keep under systematic review interrogation rules, instructions, methods, and practices, as well as arrangements for the custody and treatments of persons subjected to any form of arrest, detention or imprisonment in any territory under its jurisdiction, with a view to preventing any cases of torture” (Article 11).

Article 12 obligates States to investigate allegations of torture. The CAT also says in Article 15 that “Any statement which is established to have been made as a result of torture shall not be invoked as evidence in any proceeding, except against the person accused of torture”.

The victims of torture are entitled to redress, fair and adequate compensation, and full rehabilitation (Article 14). This article is especially relevant for the torture rehabilitation movement and it should be used as an argument for funding.

The Convention in Article 17 established the Committee against Torture, also called the Committee, consisting of ten experts of high moral standing and recognized compe-

tence in the field of human rights. The most important function of the Committee is to monitor the implementation of the Convention. The Committee should receive a report from each State party, every four years, on the implementation of the Convention. If the Committee also receives “reliable information which appears to it to contain well-founded indications that torture is being systematically practiced in the territory of a State party, the Committee shall invite that State party to cooperate in the examination of the information” (Sorensen, 1998).

The Optional Protocol,
adopted on 18 December 2002

Article 1 of the Optional Protocol states that “The objective of this Protocol is to establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman and degrading treatment or punishment”.

The Protocol establishes a committee of ten members called the “Sub-Committee on Prevention” to carry out the work laid down in the Protocol. In order to enable the Sub-Committee on Prevention to fulfill its mandate, the State parties to the Optional Protocol should grant unrestricted access to all places of detention and their installations and facilities, and to allow private interviews with prisoners. The Sub-Committee should also have unrestricted access to all information related to the number of prisoners and their places of detentions.

The International Criminal Court (ICC),
in force since July 1, 2002

The Rome Statute of the International Criminal Court was adopted on July 17, 1998, at the diplomatic conference of plenipotentiaries, organized by the United

Nations (159 countries participated in the conference, and 120 States approved the statute). The statute entered into force on July 1, 2002, after 60 States had ratified it. As of May 3, 2004, 94 countries are State parties to the Rome Statute of the International Criminal Court.

Part II of the Statute relates to the jurisdiction of the Court, which is restricted only to the gravest crimes affecting the entire international community, which are enumerated in Article 5 as:

- The crime of genocide
- Crimes against humanity
- War crimes
- The crimes of aggression

Article 7 names and defines 11 crimes against humanity, which include torture. Torture is defined as “intentional infliction of severe pain or suffering, whether physical or mental, upon a person in the custody or under control of the accused; except that torture shall not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions”.

Article 8 names and defines war crimes as violations of the Geneva Convention of August 12, 1949. “Torture or inhuman treatment” is also included in this article as a war crime.

The Court only has jurisdiction to crimes committed after July 1, 2002. State parties, the Security Council, or the *ex officio* prosecutor may submit cases to the Court. The prosecutor acts on the basis of information received from victims, NGOs, or other sources it considers appropriate. The Court exercises jurisdiction only if the State concerned is unable or unwilling to prosecute the perpetrator. Statutory limitations do not apply to crimes falling within the jurisdiction of the Court. The death

penalty is excluded as an enforceable penalty, and life imprisonment is the highest penalty that may be sentenced.

The Court is comprised of 18 judges, one prosecutor and one court registrar. An assembly of State parties elects the judges and the prosecutor. The Court has established a fund to compensate victims or communities affected by these crimes.

B. United Nations organizations related to torture

There are four main United Nations organizations dealing with torture. The organizations are the UN Voluntary Fund for Victims of Torture and its Board of Trustees, the Committee against Torture, the Special Rapporteur on Torture, and the High Commissioner for Human Rights.

The UN Voluntary Fund for Victims of Torture and its Board of Trustees

The Fund was established by the General Assembly resolution 36/151 on January 28, 1982, to help in the rehabilitation of torture victims around the world. The Fund is administered, in accordance with the Financial Regulations of the United Nations, by the Secretary General, assisted by a board of trustees composed of five members with wide experience in the field that serve in a personal capacity for three years.

The Fund depends completely on voluntary donations from governments, non-governmental organizations, and individuals. The Fund receives project proposals for funding from torture rehabilitation programs. The Board holds an annual two-week session to approve the grants.

The projects subsidized by the Fund aim at providing medical, psychological, social, and/or legal assistance to victims of torture and to members of their families. Certain projects also give assistance for training sem-

inars to health professionals on the treatment of torture victims (Nagan, 2001).

Committee against torture

The Committee against Torture is the body that monitors the implementation of the Convention against torture by the State parties.

All States are obligated to submit a report to the Committee, initially one year after becoming a party to the Convention and then every four years. The Committee reviews each report and makes recommendations. The committee meets in Geneva twice a year.

The Committee, under certain circumstances, may consider individual complaints or communications.

The Special Rapporteur on Torture

The United Nations Commission on Human Rights, in resolution 1985/33, decided to nominate a rapporteur on torture. The mandate includes:

- a) transmitting urgent appeals to States and individuals reported to be at risk of torture as well past allegations of torture
- b) undertaking fact-finding visits to countries
- c) submitting annual reports on the mandates and methods of work to the Commission and the General Assembly

The High Commissioner for Human Rights

The High Commissioner for Human Rights is the principal UN official with responsibilities for human rights and is accountable to the Secretary General. The Office of the High Commissioner (OHCHR) is based in Geneva.

There are different international treaties, institutions, and agencies promoting and protecting civil, cultural, and economical

rights. The High Commissioner has the role of leading the advancement of the human rights movement and to bring a voice to the victims.

The Commissioner is involved in dialogues with a wide variety of organizations, such as governments, academic institutions, the private sector, NGOs, and victims' organizations. The Commissioner also investigates violations, promotes research, gives expert advice, and disseminates information on human rights.

The United Nations International Day in Support of Victims of Torture

The Economical and Social Council of the United Nations was established by resolution 52/14 on December 12, 1997, and proclaimed June 26 as the UN International Day in Support of Victims of Torture. Since 1998, the four UN organizations identified above issue a joint statement in support of victims of torture each year and express their concern about the continuing reports of torture taking place in many parts of the world. This day has been used as an instrument of advocacy with the aim of creating awareness of the problem of torture, of the fight for the total eradication of torture, and of the effective functioning of CAT. The International Rehabilitation Council for Torture Victims (IRCT) has been instrumental in promoting, organizing, and disseminating information around the world on June 26. Since 2000, IRCT has promoted celebrations around the world on June 26 via the publication "Together against Torture" (International Rehabilitation Council for Torture Victims, 2003a).

C. International standards

There are several international instruments that aim to establish minimum international standards to prevent torture or cruel, inhu-

man, and degrading treatment or punishment of prisoners.

These legal instruments should be a part of the training for any person who has contact with detainees or prisoners, such as law enforcement personal and health professionals.

- Standard minimum rules for the treatment of prisoners
- Basic principles for the treatment of prisoners
- Body of principles for the protection of all persons under any form of detention or imprisonment
- Principles on the effective investigation and documentation of torture and other cruel, inhuman, or degrading treatment or punishment
- Principles of medical ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman, or degrading treatment or punishment
- Code of conduct of law enforcement officials
- Basic principles on the use of force and firearms by law enforcement officials
- United Nations rules for the protection of juveniles deprived of liberty
- United Nations standard minimum rules on the administration of juvenile justice

APPENDIX II

Interrogation techniques and methods of torture

A. Background

Until recently, information on interrogation techniques and torture methods has been provided only by the testimony of torture victims to human rights organizations and torture rehabilitation programs. Occasionally, some secret military field manuals of in-

terrogation have been released (Cohn, 1997; Haugaard, 1997). These manuals only explain the methods of psychological manipulation of the detainee and generally describe methods that are legal, in accordance with the interpretation of international law that each country has. The methods of physical torture are not written in any manual, but taught and demonstrated directly in the torture chamber by a senior torturer.

After the worldwide scandal of the maltreatment and torture of war prisoners in the Abu Ghraib prison in Iraq, the US was obligated to release several secret documents to justify that the interrogation techniques used were legal under the American interpretation of the Geneva Convention.

These documents have given new clues to the methods that the American military, and probably other countries, are actually using in the war against terrorism. The definition of each method used has very careful wording that makes the methods appear very innocent and benign.

These manuals and other documents confirm what we already know from Latin America. The interrogation techniques and torture methods used were “derived from conditioning, behavior modification, sensory deprivation, psychoanalytic elements as well as various drugs used in combinations with those techniques. The system has perfected its techniques to the point of being able to specify tailor made forms of torture and psychological manipulation for each person” (Vazquez, 1977).

A Department of Defense document reports that “These manuals state that the interrogation techniques are designed to manipulate the detainee’s emotions and weakness to gain his willing cooperation. The purpose of all interviews and interrogations is to get the most information from a detainee with the least intrusive method”.

(Department of Defense working group, 2003).

*B. Counter resistance techniques
in the war on terrorism*

All of the following techniques have been recommended and/or approved by US officials and have been used as noted by a declaration from ex-detainees (Department of Defense Joint task force 170, 2002; Department of Defense working group, 2003).

1. *Direct*: asking straightforward questions
2. *Hooding during transportation and interrogation*
3. *Incentive or removal of incentive*: providing a reward or removing a privilege
4. *Emotional love*: playing on the love that a detainee has for an individual or a group
5. *Emotional hate*: playing on the hatred that a detainee has for an individual or a group
6. *Fear up harsh*: significantly increasing the fear level in a detainee
7. *Fear up mild*: moderately increasing the fear level in a detainee
8. *Reduced fear*: reducing the fear level in a detainee
9. *Pride and ego up*: boosting the ego of a detainee
10. *Pride and ego down*: attacking or insulting the ego of a detainee
11. *Futility*: invoking the feeling of futility of a detainee
12. *We know all*: convincing the detainee that the interrogator knows the answers to questions he asks the detainee
13. *Establish your identity*: convincing the detainee that the interrogator has mistaken the detainee for someone else
14. *Repetition approach*: continuously repeating the same questions to the detainee within interrogation periods of normal duration
15. *File and dossier*: convincing the detainee that the interrogator has a damning and inaccurate file, which must be fixed
16. *Mutt and Jeff (good and bad cop)*: a system consisting of a friendly and a harsh interrogator. The harsh interrogator might employ the Pride and Ego Down technique
17. *Rapid fire*: questioning in rapid succession without allowing the detainee to answer
18. *Silence*: staring at the detainee to encourage discomfort
19. *Change of scenery up*: removing the detainee from the standard interrogation setting (generally to a location more pleasant, but not worse)
20. *Change of scenery down*: removing the detainee from the standard interrogation setting and placing him in a setting that may be less comfortable; would not constitute a substantial change in environmental quality
21. *Dietary manipulation*: changing the diet of a detainee; no intended deprivation of food or water; no adverse medical or cultural effect and without intent to deprive subject of food or water
22. *Sleep adjustment*: adjusting the sleeping time of the detainee, e.g., reversing sleeping cycle from night to day (this technique is not sleep deprivation)
23. *False flag*: convincing the detainee that individuals from a country other than the United States are interrogating him
24. *Removal of detainee clothing*
25. *Removal of comfort items*: including religious items
26. *Forced grooming*: including shaving of facial hair (beards) and head hair
27. *Prolonged interrogations*: for up to 20 hours
28. *Environmental manipulation*: altering the environment to create moderate discomfort

fort (e.g., adjusting temperature or introducing an unpleasant smell). Conditions would not be such that they would injure the detainee. Interrogator would accompany detainees at all times.

29. *Exposure to cold*: cold environment or cold water with adequate medical monitoring
30. *Isolation for up to 30 days*: Isolating the detainee from other detainees while still complying with basic standards of treatment. Caution: the use of isolation as an interrogation technique requires detailed implementation instructions including specific guidelines regarding the length of the isolation, medical and psychological review, and approval for extension of the length of isolation by the appropriate level in the chain of command.
31. *Threat of imminent death to him and his/her family*: The use of scenarios designed to convince the detainee that death or severely painful consequences are imminent for him and/or his family. Authorized but note that “caution should be applied with this technique because the torture statute specifically mentions making deaths threats as an example of inflicting mental pain and suffering”
32. *Suffocation*: the use of a wet towel and dripping water to induce the misperception of suffocation
33. *Mild physical contact*: use of mild, non-injurious, physical contact such as grabbing, poking in the chest with the finger and light pushing.
34. *Using detainee phobias*: e.g., using dogs to induce stress
35. *Use of stress position*: e.g., prolonged standing, for a maximum of four hour.
36. *Slaps*: face slaps or stomach slaps: limited to two slaps per application and two applications per interrogation

C. Safeguards

The document recommends that the application of these techniques be subjected to the following general safeguards:

- Limited to use only at strategic interrogation facilities
- When there is good basis to believe that the detainee possesses critical intelligence
- The detainee is medically and operationally evaluated as suitable (considering all techniques to be used in combinations)
- Interrogators are specifically trained for the techniques
- There is a specific interrogation plan
- There is appropriate supervision

These techniques recommended or approved have been designed to be used by military intelligence officers. These are only guidelines because the intelligence officers have a discretionary authorization to change them at the moment of interrogation. These methods are short of what is really happening in most of the interrogation/torture units. Some detainees have died in custody and during interrogation sessions, as a demonstration that these regulations are not followed in reality and that the interrogation methods are lethal.

The secret services, in most countries, have a different set of rules, unknown until now, and working in secret detention centers around the world with ghost detainees whose names and final destination are unknown (Graham and White, 2004).

D. Methods of torture

Several publications describe the most frequent methods of physical torture reported by torture victims (Cathcart et al., 1979; Goldfield et al., 1988; Rasmussen and Lunde, 1980; Allodi et al., 1985. Ras-

Method	Percentage
Beating	100.0
Threats	77.1
Electric torture	46.7
Blindfolding	32.9
Mock execution	27.9
Water asphyxiation	16.9
Isolation	15.7
Starvation	15.7
Sleep deprivation	15.4
Hanging	14.1
Sexual torture	13.8
Burning	13.7
Falanga	9.7
Rope bondage	9.4
Telephone	7.2
Forced standing	5.9
Throwing urine or feces on victims	5.0
Medicine administration	3.8
Lifting by hair	2.5
Needles under nails	2.5
Water deprivation	1.6
Forced extraction of teeth	1.6
Deprivation of medical care	1.6

Table 3. *Methods of torture in a sample of 319 survivors of torture*

mussen, 1990). Goldfield summarized six papers and found the results shown in Table 3.

Some countries, such as Chile, El Salvador, Congo, and Bhutan, have published a list of the torture methods most prevalent in their countries (Orellana, 1989; Comision de Derechos Humanos de El Salvador (CD-HES), 1986; Mpinga, 1998; Adhikar, 1999). Most of the countries practiced very similar methods of psychological manipulations and physical torture. The similarity can be explained through the globalization of contact among military, police and security forces, and centralized training.

APPENDIX III

Impunity as failure of justice

A. Background

The Convention against Torture obligates state parties to make torture a criminal offense in domestic laws.

Torture is a criminal act in itself, in addition to being a crime against humanity and a war crime. 75% of the states in the world practice torture systematically, in spite of being signatories of the torture convention. States and perpetrators are allies in keeping the problem silent and the torturer out of jail.

A commonly held view among mental health professionals working with survivors of gross human rights abuses is that impunity for perpetrators contributes to social and psychological problems and impedes healing processes in survivors (Lagos, 1994; Roht-Arriaza, 1995; Nicoletti, 1991; Gordon, 1991; Carmichael and McKay, 1996; Flores, 1991; Neumann and Monasterio, 1991).

Impunity for torturers is said to lead to erosion of moral codes, mindless violent behavior in the community, feelings of fear, helplessness, and insecurity in society, and "social alienation" manifested by feelings of failure and scepticism, frustration, and addictive and violent behavior (Lagos, 1994). It has also been suggested that impunity impedes bereavement process, induces self-blame and guilt, enhances re-experiencing of trauma, and generates feelings of helplessness, isolation, or resentment towards the social environment, survivor guilt, and other traumatic stress reactions such as nightmares, insomnia, depression, and somatization (Lagos, 1994).

Keeping silent about the existence of torture and silencing the voices of torture survivors gives impunity to the perpetrators and are two of the most significant violations of the right to reparation for a victim. Impunity interrupts the normal process of healing for the survivor of repression and the families of disappeared victims. It also interrupts the process of social reparation. Impunity prolongs the psychopathological consequences

of repression, both in the individual and in the society. Impunity is an illegitimate legal process and produces loss of credibility in the legal system. Bringing a torturer to justice is the most important step in the worldwide fight for total eradication of torture. Impunity is a failure of justice. Several authors, mostly from Latin America, have described the negative impact of impunity, although there is no research specifically measuring the negative impact of impunity or the beneficial effects of justice (Becker et al., 1988; Becker et al., 1990; Sveaass, 1994; Brinkman, 1999; Kordon et al., 1995; Kordon et al., 1998; Brinkman, 2002; Calhau, 2002).

The target of the repression generally has been oriented towards a select subgroup of the population. The rest of the society may deny the existence of victims of the repression, either because they supported the military or because they are indifferent since the repression did not affect them. This majority, who did not understand the needs of the victims, has been able to approve popular plebiscites in favor of impunity, such as in Uruguay (Gurr and Quiroga, 2001).

B. Barriers to the criminal investigations of torture

Amnesty International, which has wide experience investigating torture cases and advocating for the eradication of torture, has investigated the mechanism of impunity. These are the most frequent barriers to the criminal prosecutions of torturers (Amnesty International, 2001).

Narrow definition of torture

Domestic laws define torture more narrowly than CAT and do not criminalize maltreatment and inhuman punishment. This loophole permits them to practice torture and maltreatment legally.

National amnesty laws

Military governments or civilian dictatorships, before they leave power, approve amnesty laws intended to protect them from further prosecution. Occasionally, the dictatorship negotiates the transition to democracy, replacing justice with impunity as a way of obtaining reconciliation, thereby avoiding confrontation with the military power in the name of social peace.

Statutes of limitation

The CAT does not specifically forbid a statute of limitation for torture as a criminal offense, although the International Criminal Court treaty has, since 2002, forbidden statutes of limitation. Many countries apply a statute of limitation to avoid prosecutions and investigations of torture cases.

Obstruction to justice

Authorities use harassment and intimidation victims, and witnesses to persuade them to not file a complaint or to withdraw it if it has already been presented. Other countries place a prohibition on prosecuting a member of the armed forces or a civil servant. They keep the victims in detention until the bruises or medical evidence resolves. The authorities refuse an independent forensic examination. State organisms that practice torture destroy evidence vital to the successful prosecution and conviction of torturers and frequently use false medical evidence or death certificates.

Confessions extracted under torture

are used as evidence

Some States, in spite of prohibitions for using confessions obtained under torture, nonetheless use these confessions to prosecute victims, such as in Mexico.

Lack of impartial investigation (“cover ups”) The institution that practices torture investigates itself, such as with the Procaduria General de la Republica in Mexico or with the Pentagon in the US investigating torture in Abu Ghraib, Iraq.

Failure to prosecute

Official prosecutors frequently refuse to prosecute a member of the police in spite of overwhelming evidence that torture occurred. The perpetrators escape conviction when legal systems permit the use of arguments, such as “they were following orders” or torture was justified as a “defense of necessity”.

Basil has also elaborated a listing of barriers to the prosecution of perpetrators and he emphasizes the need to study this problem (Basil, 2002).

C. Universal jurisdiction of torture

Before the establishment of the international criminal court, several NGOs in different parts of the world had fought for the universal jurisdiction of torture as a crime against humanity or as a war crime (Arcel, 2000).

The Center for Constitutional Rights in New York brought the first suit in the US District Court of the Eastern District of New York in 1978 against a Paraguayan torturer living in the US. The family of Joelito Filartiga, a Paraguayan youth who was kidnapped, tortured and killed by police in Paraguay, was living in the US. The family sued the torturer using an old statute, the Alien Tort Claims Act (ATCA) enacted in 1789. The Second Circuit Court, in an appeal, decided that “construing this rarely-invoked provision, we hold that deliberate torture perpetrated under color of official authority violates universally accepted norms of international law of human rights, regardless of the nationality of the parties”. The Fi-

lartiga v. Pena-Irala is a landmark case in the fight against impunity (van Shaack, 2001; Claude, 1985).

REDRESS has the objectives “to obtain reparation of torture and, when appropriate, their families, anywhere in the world. To make accountable all those who perpetrate, aid, and abet acts of torture”. Keith Carmichael, a survivor of torture himself, founded Redress, in London in 1992. Redress strategies are “to provide legal advice and assist torture survivors gain both access to courts and redress for their suffering” and also “to promote the development and implementation of national and international standards which provide effective and enforceable civil and criminal remedies for torture”. Furthermore, Redress tries “to increase awareness of the widespread use of torture and measures to provide redress” (Carmichael, 1996; Cullinan, 2001).

The Center for Justice and Accountability (CJA) in San Francisco, California “works to deter torture and other severe human rights abuses around the world by helping survivors hold their persecutors accountable”. CJA represents survivors in civil suits against persecutors who live or visit the United States (Center for Justice and Accountability, 2003).

Amnesty International has 14 principles on the effective exercise of universal jurisdiction (Amnesty International, 2002).

1. Crimes of universal jurisdiction
2. No impunity for people acting in official capacity
3. No impunity for past crimes
4. No statutes of limitations
5. Superior orders, duress, and necessity should not be permissible
6. National laws and decisions designated to shield persons from prosecutions cannot bind courts in other countries.

7. No political interference
8. Grave crimes under international law must be investigated and prosecuted without waiting for complaints from victims
9. Internationally recognized guarantees for fair trials
10. Public trials in the presence of international monitors
11. The interest of victims, witnesses, and their families must be taken into account.
12. No death penalty or other cruel, inhuman, or degrading punishment
13. International cooperation in investigations and prosecution
14. Effective training of judges, prosecutors, investigators, and defence lawyers

Other authors have begun to study the process of social breakdown as a way to understand the process of reparation in social reconstruction. They present an ecological model for responding to the effects of social breakdown. They advocate for the social reconstruction needs of justice, democracy, prosperity, and reconciliation. Fletcher and Weinstein (2002) suggest that social reparation needs several critical interventions, such as:

1. State level interventions
2. Criminals (national or international)
3. Commission of historical records (truth commissions)
4. Individual and/or family psycho-social support
5. Externally driven community interventions
6. Community-based responses

For them, reparation and social reconstruction is a complex problem which has the problem of justice and impunity as only one

of its components (Fletcher and Weinstein, 2002; Halpern and Weinstein, 2004).

APPENDIX IV

Reparation

A. Background

The right to reparation is part of international legal standards and is described in Article 8 of the United Nations Declaration of Human Rights. Article 14 of the Convention against Torture states that each State party shall ensure redress and adequate compensation, including rehabilitation.

Reparation is a developing area that has been in the front line of interest for the United Nations, some States, and human rights and non-governmental organizations (NGOs) in the last ten years (Arcel et al., 2000).

During this period a new vocabulary has been unfolding. Several documents from the United Nations, human rights organizations, and NGOs have been using concepts such as “reparation”, “restitution”, “rehabilitation”, “redress”, “reconciliation”, “reintegration”, and “compensation”. The definition of most of these concepts has, however, not been universally accepted.

Reparation does not have a commonly accepted definition. In the area of human rights violations, reparation is a complex process of restoration for damage from a prior situation that includes not only the individual, but also the family and his or her relations with society.

The United Nations Commission on Human Rights has been interested in developing guidelines on the right to reparation for victims of violations of human rights and humanitarian laws. Professor Theo van Boven prepared three versions of basic principles on the right to reparation for victims in 1993, 1996, and in 1997 (Boven Guidelines). Professor Louis Joinet prepared two

versions in June and October of 1997 (Joint Guidelines). The Special Rapporteur, Mr. Cherif Bassiouni, did an analytical comparison of both guidelines and submitted comments and recommendation to the UN Commission on Human Rights (van Boven, 1996; van Boven, 1997; Bassiouni, 1999).

These two guidelines agree in the most significant concepts. Under international law every state has the duty to respect and to ensure respect for human rights and humanitarian laws.

Reparation of victims of violation of human rights is a complex issue and needs a holistic approach and not just monetary compensation. Reparation may be claimed individually or collectively or by family or dependents. Van Boven defined four forms of reparation that have been basically accepted:

- Restitution
- Compensation
- Rehabilitation
- Satisfaction and guarantees of non-repetition

The Human Rights Commission requested that Mr. Bassiouni, as an independent expert, submit a revised version of the basic principles and guidelines prepared by Mr. Theo van Boven that take into account the views and comments of States and intergovernmental and non-governmental organizations. He did so at the 56th session of the Commission. There were no significant changes in the Bassiouni code in relation to reparation (Bassiouni, 2000).

Restitution: “should, whenever possible, restore the victims to the original situation before the violations of international human rights or humanitarian law occurred. Restitution includes: restoration of liberty, legal rights, social status, family life, and citizen-

ship; return to one’s place of residence; and restoration of employment and return of property”.

Compensation: “should be provided for any economically assessable damage resulting from violations of international human rights and humanitarian law, such as:

- a) Physical or mental harm, including pain, suffering, and emotional distress;
- b) Lost opportunities, including education;
- c) Material damages and loss of earning, including loss of earning potential;
- d) Harm to reputation or dignity;
- e) Cost required for legal or expert assistance, medicine and medical services, and psychological and social services”.

Rehabilitation: “should include medical and psychological care as well as legal and social services”.

Satisfaction and guarantees of non-repetition are basically prevention and “should include, where applicable, any or all of the following:

- a) Cessation of continuing violations;
- b) Verification of facts and full and public disclosure of the truth to the extent that such disclosure does not cause further unnecessary harm or threaten the security of the victim, witnesses, or other;
- c) The search for the bodies of those killed or disappeared and assistance in the identification and reburial of the bodies in accordance with the cultural practices of the families and communities;
- d) An official declaration or a judicial decision restoring the dignity, reputation, and legal and social rights of the victim and persons closely connected with the victim;
- e) Apology, including public acknowledgment of the facts and acceptance of responsibility;

- f) Judicial or administrative sanctions against persons responsible for the violations;
- g) Commemorations and tributes to the victims;
- h) Inclusions of an accurate account of the violations that occurred in international human rights and humanitarian law training and educational material at all levels;
- i) Preventing the recurrence of violations by such means as:
 - I) Ensuring effective civilian control of military and security forces;
 - II) Restricting the jurisdiction of military tribunals only to specifically military offenses committed by members of the armed forces;
 - III) Strengthening the independence of the judiciary;
 - IV) Protecting persons in the legal, media, and other related professions and human rights defenders;
 - V) Conducting and strengthening, on a priority and continued basis, human rights training to all sectors of society, in particular to military and security forces and to law enforcement officials;
 - VI) Promoting the observance of codes of conduct and ethical norms, in particular international standards, by public servants, including law enforcement, correctional, media, medical, psychological, social service, and military personnel, as well as staff of economic enterprises;
 - VII) Creating a mechanism for monitoring conflict resolutions and preventive intervention”.

Few countries in the world have established a system of reparation for torture survivors

or other victims of organized violence. Chile is probably one of the few countries that has established a reparation project, which is incomplete but is more comprehensive than that of most countries. The Chilean Truth and Reconciliation Commission had a very restricted aim of investigating only cases of violations of human rights that resulted in death. The commission recommended a reparation program that was implemented by the Congress in law 19.123 of reparation and reconciliation, law 19.234 of political exoneration, and law 19.258 of returnees. The law defined the concept of victims and established partial restitution; compensation that included a pension; free education; and medical and psychological care for families of the disappeared, detained, politically killed, and torture survivors. At the Mental Health Unit level of the Ministry of Health, rehabilitation was resolved by creating a special program (PRAIS) for the medical and psychological care of victims of political repression in Chile. This program was created by an internal resolution of the Ministry and not by law (Guajardo, 2002).

Argentina also paid several million dollars to Jose Siderman, a survivor of torture, in a settlement before the High District Court in Los Angeles, California.

The Inter-American Court has reached decisions for compensation for the families of several cases involving the disappeared in Honduras, Argentina, and Guatemala. Germany approved monetary compensation for victims of torture and detention by the communist regime. Hungary has compensated victims of unlawful detention (Bronkhorst, 1995).

B. Torture survivors' perception of reparation
Different forms of reparation have been outlined and agreed on by experts in the field. Many authors theorize about the need for

reparation but there are no investigations of the needs of survivors or the need for and effects of reparation. Cullinan did an extensive review of research on theoretical and empirical studies looking at the level of expectations and difficulties of reparation from the torture survivors' perspectives. She concluded that "further extensive research must be carried out in this important area". She further states that "if we are to help torture survivors rebuild their lives we must encourage them to express their opinion, thereby ensuring that reparation, in appropriate form, contributes to their recovery" (Cullinan, 2001; Carmichael, 1996).

One of the most difficult decisions is to determine the amount of economic compensation. As an example, the US Congress recommended guidelines for reparation of 9/11 victims. The guidelines stated that compensation provide reparation for material damage, the loss of earnings or potential earnings, physical harm, mental harm, suffering, and emotional distress. One of the questions raised is how to calculate this amount. There is no universal prescription for calculating an amount and the method and amount decided upon could be a source of more problems and re-traumatization for the survivors. The difficulty in calculating an amount may also cause anguish for an administrator of the funds. These problems were experienced when funds became available for the victims of 9/11 in the US (Feinberg, 2004).

Argentina paid, by law, monetary compensation to the families of the disappeared during the period of political repression against groups opposed to the military dictatorship from the 1970s and 1980s. The compensation to the ex-detained was based on a monetary value for each day of unlawful detention.

Some survivors reject any economic compensation until the truth is revealed, the

bodies of disappeared are found, and the perpetrators of these crimes against humanity are brought to justice. These survivors believe that any compensation in the name of impunity or reconciliation is completely unacceptable. This is the position of a segment of the "Madres de la Plaza de Mayo" in Argentina, as well as several organized groups of torture survivors.

APPENDIX V

Prevention

A. At the national and local levels

We know that 74 States are signatories and 136 are parties to the Convention against Torture (CAT). Since 75% of countries practice torture systematically, a significant number of States are practicing torture in spite of being signatories.

Ideally, if all countries of the world decided to follow CAT, torture could be eradicated in a short time. The CAT has all the provisions to prevent the occurrence of torture. We know exactly how to prevent torture.

The European Committee for the Prevention of Torture (CPT) has been concerned with prevention and combating impunity. In its Annual General Report 2004, CPT emphasizes that the existence of suitable legal framework is not in itself sufficient to guarantee that appropriate action will be taken in cases of torture. The relevant authorities must be sensitized to investigate and prosecute the perpetrators. Since some type of torture and maltreatment do not leave obvious marks such as psychological techniques, asphyxiation, and uncomfortable positions, all allegations of torture should be investigated whether or not the person concerned bears visible scars. There are principles of an effective investigation, capable of leading to the identification and punishment of those responsible. Disciplinary culpability

of the officials should be systematically examined and adequate sanctions applied (European Committee for the Prevention of Torture, 2004).

*B. Twelve point program
for the prevention of torture*

Amnesty International developed this 12-point program in 1983 as a way to measure the willingness of governments to end torture. After ten years these twelve points of the program are still relevant (Amnesty International, 1994):

1. Condemn torture: Governments should make clear that torture will never be tolerated
2. Ensure access to prisoners: Torture often takes place while a prisoner is incommunicado
3. No secret detention: The prisoners are held only in officially recognized places
4. Provided safeguards during detention and interrogations: Prisoners should be informed of their rights. A lawyer should be present during interrogation
5. Prohibit torture in domestic law
6. Investigate all complaints of torture
7. Prosecute: Those responsible for torture must be brought to justice
8. No statement extracted under torture should be used as evidence
9. Provide effective training of all officials involved in the custody, interrogation, or medical care of prisoners
10. Provide reparation: Victims of torture are entitled to prompt reparation
11. Ratify international treaties
12. Exercise international responsibility

The most important recent advances in the fight for prevention of torture are the foundation of CINAT, the ratification of the Optional Protocol of the Convention against

Torture adopted on December 18, 2002 and the adoption of the International Criminal Court on July 17, 1998 in Rome (Arcel, 1999; United Nations, 2002).

CINAT (Coalition of International Non-Governmental Organizations against Torture), brings together six well-known organizations that work in different but complementary ways for the eradication of torture. CINAT works to make the worldwide movement against torture more effective.

These six organizations are based on activist membership structure, “umbrella” advisory and support bodies, and networks of specialist professionals’ agencies:

- Amnesty International (AI)
- Association for the Prevention of Torture (APT)
- International Federation of ACAT (FI. ACAT) (Action by Christian for the Abolition of Torture)
- International Rehabilitation Council for Torture Victims (IRCT)
- World Organization Against Torture (OMCT)
- Seeking Reparation for Torture Survivors (REDRESS)

CINAT aims to increase awareness of the widespread use of torture and its consequences and to combine capacities and resources to undertake specific activities to eradicate torture. CINAT members share information on all aspects of torture, including relevant international and national laws, alleged perpetrators, victims’ issues, and common strategies.

One of the most important activities carried out in the framework of CINAT was writing the draft of the Optional Protocol for the CAT.

The objective of the Optional Protocol is to establish a system of regular visits by in-

dependent bodies to places of detention undertaken in order to prevent torture. The Optional Protocol will help to fulfill some of Amnesty International's 12 points for the prevention of torture.

Members of the "Sub-Committee on Prevention" will visit any place where persons are or may be detained and will make recommendations to State parties concerning the protection of persons deprived of their liberty from torture and other cruel, inhuman, or degrading treatment or punishment. The State party shall grant to the Sub-Committee access to all information concerning the numbers of persons deprived of their liberty and places of detention, access to places of detention and their installations, and the opportunity to have private interviews with the persons deprived of their liberty. The Sub-Committee shall publish its report together with any comments of the State party.

Each State party, at least one year after the entry into force of the Protocol, shall maintain, designate, or establish one or several independent national preventive mechanisms for the prevention of torture at domestic level. The State party shall guarantee the functional independence of the national preventive mechanisms.

Eradication of torture:

Some components of a plan of action

The principal development objective in prevention is the complete eradication of the practice of torture in all its forms. Some immediate steps at both local and international levels are needed to fulfill this major aim (Rasmussen and Rasmussen, 1997; Mada-riaga, 1997; Sharma et al., 1998; Staiff, 2000):

- Encourage universal and speedy ratification of the United Nation Conventions

Against Torture, the Optional Protocol, and the International Criminal Court.

- Encourage not only the ratification of the CAT but also the full recognition of the competence of the Committee against Torture (Article 22).
- Ensure that the States Parties implement mechanisms to comply with CAT and its Optional Protocol and permit detainees to challenge the legality of detention and to complain about their treatment.
- Ensure immediate access to detention facilities worldwide for independent human rights monitors such as the United Nations, International Committee of the Red Cross, and /or NGOs (Staiff, 2000).
- Review the field manuals of interrogation of detainees to ensure that they comply with international standards prohibiting torture and ill-treatment.
- Encourage to all State parties of CAT to cooperate fully with the United Nations Special Rapporteur on Torture.
- Implement these international conventions in domestic legislation to ensure that torture is considered a crime and that the definition of torture incorporates the basic elements of CAT.
- Ensure that torture survivors have access to justice and reparation.
- Ensure independent, impartial and prompt investigation of alleged cases of torture.
- Ensure that civilian and military personnel are adequately trained in international and domestic humanitarian and human rights laws.

APPENDIX VI

Research

A. Background

Despite the prevalence of torture and its mental health consequences, there has been relatively little scientific interest in the study

of torture, its psychological effects, and their treatment. Study of torture survivors may have important implications for human rights, theory, assessment, classification, treatment of traumatic stress responses, and legal issues concerning torture survivors. The effects of torture on the individual have interacting social, political, cultural, economic, medical, psychological, and biological dimensions. Studies on specific high-risk groups among victims of organized violence, such as women, rape victims, children, orphans, family members, ex-soldiers, and others require rigorous research methodology, often costly research budgets, adequate sample sizes, academic expertise, and interdisciplinary collaboration. Most torture rehabilitation programs do not have the skilled research personpower or the budget. Most donor organizations give funds only for the direct care of survivors, and they are not willing to finance necessary infrastructures or scientific research.

Most studies conducted in refugee clinics and in other treatment settings rarely include control groups, generally have small samples, and are not designed to address the prevalence of torture survival in communities. Most of the information published on torture survival is descriptive. Few clinical outcome studies exist (Basoglu, 1998; Gurr and Quiroga, 2001). These studies have limitations including the lack of control groups, definitions of diagnostic criteria, and validation of assessment instruments. Estimates of the prevalence of torture have been unreliable because epidemiologic studies are extremely difficult, often impossible to conduct, and rarely attempted. The sensitivity of the topic of torture makes it difficult to study, and refugees are challenging groups for research under any circumstances. Clinicians have been reluctant to include sur-

vivors in controlled trials, feeling a need to protect them from re-traumatization (Basoglu et al., 2001).

Some recent publications can help to elucidate and guide research in the field. Hollifield et al. (2002) reviewed the literature measuring trauma and health status in refugees, analyzing 183 publications, concluding that most articles about refugee trauma or health are descriptive or include quantitative data from instruments with limitations of validity and reliability for refugees. Willis and Gonzalez (1998) reviewed the use of survey questionnaires to assess the health effects of torture. Spring et al. (2003) described an approach to gathering a sample representative of refugee communities which are difficult to access.

B. Outcome research

History

For more than twenty years, programs for the rehabilitation of torture victims around the world have been treating survivors of torture. The needs of survivors are multiple and in response, the programs have usually adopted a multidisciplinary approach. The components of these interventions vary significantly between centers as well as between regions of the world.

In spite of this long history studies of the efficacy of different treatment approaches and of the indicators to measure successful outcomes have not been completed. Few outcome studies exist, and those have limitations including the lack of control groups, definitions of diagnostic criteria, validation of assessment instruments, sample size, and other factors (Gurr and Quiroga, 2001).

A review of 25 treatment outcome studies in torture survivors and traumatized refugees follows:

Torture Survivors

Testimony method: Perhaps the earliest attempt to study outcome of torture survivors was by Cienfuegos and Monelli (1983), who studied 39 tortured Chilean ex-prisoners and others from Chile who suffered trauma but not torture. The best results were found in those who were tortured (12 of 15 improved).

Treatment at CVT: Jaranson et al. (unpublished) reviewed the charts of 220 clients at the Center for Victims of Torture (CVT) in Minneapolis, Minnesota. Using independent clinician evaluators, overall 64% showed improved function, 35% were unchanged, and 3% declined. Of those who completed treatment, 86% showed improvement, while only 39% of those who left treatment prematurely showed improvement within the five-year study period (1991-95).

Treatment at RCT: Elsass (1998) interviewed 20 torture survivors from the Middle East and their therapists from the Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen, Denmark. Although this study was much more complicated than reported here, quantitative outcome three months after the end of treatment found that 17 of 20 survivors evaluated treatment results as extremely positive.

Brief psychotherapy: Reeler (1998) found in a pilot study at Amani Foundation in Zimbabwe that 12 adults torture survivors who completed brief psychotherapy showed improvement.

Psychotherapy at BZFO: Birck (2001) used standardized instruments and interviews to assess symptom change after two years of psychotherapy with 30 former patients at the Treatment Centre for Torture Victims

(BZFO) in Berlin, Germany. Although intrusive PTSD symptoms had decreased, former patients were still highly symptomatic. Birck attributes this high symptom level to the phasic course of PTSD, which can be exacerbated by post-treatment stressful events.

Treatment at 4 centers: Amris and Arenas (2003). The first phase of the Impact Assessment Study conducted by the International Rehabilitation Council for Torture Victims (IRCT) was an exploratory study to find the perception of torture and rehabilitation in different cultural settings by health professionals and by clients. The results of the first phase showed that all programs used a multidisciplinary approach in the assessment and treatment of the clients, but the clinical practice and priorities varied, reflecting the professional profile and composition of staff across centers. The programs used a broad spectrum of theories, methods, and treatment approaches. The clients had very concrete expectations of treatment such as pain relief, improved physical function, improved relations with their families and interpersonal relationships within the community, and the capacity to return to work and provide for the family. Across centers the clients expressed satisfaction with the support, treatment, and rehabilitation they were provided.

Treatment at RCT: Carlsson (2005) studied changes in symptoms of PTSD, depression, anxiety and quality of life over time and identified factors associated with mental health and health-related quality of life (QOL) of survivors treated at RCT in Copenhagen. A concurrent cohort study interviewed 86 refugees attending a pre-treatment assessment at RCT in 2001-02, and 68 of them at 9 month follow-up. The historical cohort study in 2002-03 included 151 of the 232 refugees attending a pre-treatment assess-

ment at RCT in 1991-94. In both studies, mental health sequelae and poor QOL persisted even many years after exposure to torture. High emotional distress was associated with low QOL. No changes were found between the initial and the 9 month follow-up for the concurrent cohort, although the historical cohort (10 year follow-up) showed a slight decrease in psychiatric symptoms. Factors associated with emotional distress and low QOL were number of torture methods, lack of current occupation, and minimal social contacts. A number of explanations are posited for these findings.

Traumatized Refugees,
including torture survivors

Stress intervention module: Snodgrass et al. (1993) compared 8 undergraduate Vietnamese students with moderate to severe PTSD symptoms given a stress intervention module (SIT) with a control group of 6. Post-intervention PTSD symptoms were significantly reduced in the treatment group while controls showed no change.

Outpatient PTSD treatment: Drozdek (1997) studied a sample of 120 male concentration camp survivors from Bosnia-Herzegovina in Dutch asylum centers given early OP treatment for PTSD for 6 months. Three treatment groups (group therapy, medications, combination group therapy and medications) and 2 control groups (refused treatment, did not meet PTSD diagnosis). Fifty randomly chosen subjects from the initial 120 were re-tested at the end of treatment and at 3 years. No differences were found among the treatment groups. The author concludes that treatment was effective in the short-term, somewhat long-term.

Testimony psychotherapy: Weine et al. (1998) studied 20 Bosnian refugees in Chicago be-

fore and after receiving testimony psychotherapy, and at 2 and 6 months. The authors found significant decreases in PTSD diagnosis and symptom severity, depressive symptoms, and increased Global Assessment of Function (GAF) scores at post-treatment, with additional effect on follow-ups. This is the first known study to use standardized instruments to evaluate the efficacy of a psychological treatment for a group of refugees with PTSD.

Integrative gestalt treatment: Pantic (1998) discusses integrative gestalt group therapy for Bosnian children and their families, helping them to overcome their problems, avoid long-term sequelae, and reach acceptance of their experiences in a search for meaning and identity.

Psychotherapy versus medication: Westermeyer et al. (1988) studied a community sample of matched pairs of Hmong refugees who had major depression, 15 treated and 15 without treatment. The patient group had higher symptom levels prior to treatment and at follow-up reported fewer depressive symptoms than controls.

Home visit interventions: Fox et al. (1998). Home visits by school nurses and bilingual teachers to Southeast Asian refugee women in the US were conducted with follow-up at 10, 20, and 33 weeks. For comparison, women who did not receive the home visits were twice evaluated for mental health status ten weeks apart. Home visits reduced depression for subjects compared with controls.

Psychiatric treatment: Mollica et al. (1990) evaluated changes in symptoms and perceived distress of 21 Cambodian, 13 Hmong/Laotian, and 18 Vietnamese patients in Boston before and after a 6-month treat-

ment period. Most patients improved significantly, with Cambodians having the greatest and Hmong/Laoians the least reductions in depressive symptoms. Although psychological symptoms improved, many somatic symptoms worsened.

Psychiatric treatment: Kivling-Boden and Sundbom (2001) assessed 27 traumatized refugees from the former Yugoslavia seen in psychiatric treatment initially and on follow-up three years later. On follow-up, social welfare dependence was high and unemployment at 32% was sixfold the mainstream Swedish labor force. Positive factors were housing and a reasonable knowledge of the Swedish language.

Selective serotonergic re-uptake inhibitor (SSRI) treatment: Smajkic et al. (2001) studied 32 Bosnian refugees at a mental health clinic receiving open trials of Sertraline (N=15), Paroxetine (N=12), or Venlafaxine (N=5). Sertraline and Paroxetine showed significant improvement at 6 weeks in PTSD symptom severity, depression, and Global Assessment of Function (GAF), while Venlafaxine did not improve depression and had high side effect rates. All 32 still had PTSD diagnoses at 6 weeks.

Psychosocial treatment: Dybdahl (2001) studied 42 mother-child dyads internally displaced in Bosnia-Herzegovina randomly assigned to psychosocial support with basic medical care compared with 45 dyads receiving only medical care. The treatment group showed positive effect on mothers' mental health, children's weight gain, and measures of children's psychosocial functioning and mental health.

Psycho-educational treatment: Abdalla and Elklit (2001) of the Danish Red Cross

developed a psycho-educational project for 490 Kosovar refugee children. Intrusive memories and hypervigilance decreased, while self-satisfaction increased significantly.

Cognitive-behavioral therapy (CBT) versus exposure therapy (ET) in treatment of PTSD: Paunovic & Ost (2001). This study is the first known randomized psychological treatment outcome study with a refugee sample. 6/20 were torture survivors. Both treatments showed large improvements on measures of PTSD, anxiety, depression, quality of life and cognitive schemas before and after treatment, and at 6 month follow-up. No difference between CBT and exposure therapy was found.

Cognitive-behavioral therapy (CBT) groups: Sehwal and Rasras (2002) of Palestine conducted a cognitive behavior group primarily of survivors of torture in Israeli prisons or otherwise traumatized by Israelis. A psychotherapist and co-therapist conducted the group. The authors comment that their patients were more likely to accept education or counselling than to focus on the trauma, but many members disclosed their traumatic histories. Of the twelve group members, eight reported benefit and four were partially improved.

Belief systems model: Brune et al. (2002) reviewed 141 charts of consecutively treated refugees in Hamburg, Germany, finding that a firm belief system was an important predictor for better therapy outcome. Psychotherapy ranged from 3 months to 6 years with a mean of 2 years.

Thought field treatment: Folkes (2002) evaluated 31 refugee and immigrant clients' pre-treatment, then after 30 days. A significant

decrease in all symptom subgroupings of PTSD was found.

Community intervention: Goodkind (2002) studied the effect of building upon Hmong refugee strengths, experiences, and interests, finding that this was effective in increasing quality of life and English proficiency while decreasing distress levels.

Psychiatric treatment: Boehnlein et al. (2004) assessed treatment outcome by chart review in 23 Cambodian refugee patients with PTSD, all of whom had been treated continuously for at least ten years at the Intercultural Psychiatric Program in Portland, Oregon. Using symptom, disability, and quality of life instruments, thirteen were improved, but the remaining ten were still impaired.

Health realization model: Halcon et al. (in progress) found that groups of Somali and Oromo (Ethiopian) women responded positively to the health realization model of intervention. The health realization model is a community-oriented, psycho-educational intervention that shows promising results in a variety of settings and populations including high risk and traumatized individuals and groups. Based on a resiliency framework, this intervention assists people to put intrusive thoughts into a manageable perspective and improve their daily functioning through learning a process of thought recognition.

The mission of torture rehabilitation programs has generally been to treat every survivor who requests care. For ethical reasons programs are unwilling to allocate a random control group, in spite of the fact that no one has proven the efficacy of the interventions. The problem they now face is how to design acceptable, experimental studies in the absence of a control group.

Recently, some foundations and government agencies which fund these programs have requested an evaluation of the success of different treatment approaches. The objective of measuring consumer outcomes in torture rehabilitation programs is to study the efficacy of the intervention compared to the goals of the program. The information garnered should be used to improve the quality of services and care. Additional gains from measuring consumer outcomes include professional development and empowerment for the survivors of torture.

To improve the quality of care we need to investigate treatment efficacy (clinical impact) and treatment effectiveness (economic impact). Treatment efficacy can be measured at the individual and at the group level. Treatment effectiveness is measured as cost benefit and cost effectiveness of the program to guide the allocation of resources. This type of evaluation uses a different methodology that is beyond the scope of this paper.

Programs for the rehabilitation of torture victims vary enormously in the specific types of therapeutic interventions utilized, size of the target populations, duration of the rehabilitation process, clarity and specifications of goals, economic resources, professional and staff manpower, data collection capabilities, and communications skills of the staff (Amris and Arenas, 2003).

Consumer outcomes measure the "effect on a patient's health status attributable to an intervention done by health professionals or health services". In other words, they measure the anticipated benefits after the implementation of the program (Andrews, 1994).

Donald et al. (2002) have three basic criteria for the development of outcomes: Outcomes should 1) be congruent with the evidence, 2) be relevant for the level of action and stated clearly and concisely, and 3) have face validity to stakeholders.

Measuring outcomes should be an integral part of the care. Practically, the assessment must be integrated into the daily routine care of clients in the program, not as a separate evaluation research component. In addition, the measure of outcomes should be a part of a process that includes an analysis and reporting of the outcome data, as well as incorporating the information in order to improve the quality of the care through education and training of the providers. This methodology routinely used in health care is called "Continuous Quality Development" and has been adopted as a national policy for the Regional Office for Europe of the World Health Organization (World Health Organization, 1993).

Areas of outcome measurements

The best approach to evaluating the efficacy of the program is a multidimensional, multidisciplinary measure of individual outcome.

Another important area of evaluation and research is the perception that the participants in a program have of the outcome of their interventions. Professionals (service providers) often have a different assessment than the survivors (consumers) in relation to parameters such as quality of life, symptoms, and social skills (Stedman et al., 1997; Amris et al., 2003).

The areas most frequently measured include:

- a) Symptom measurement: medical and psychological
- b) Level of functioning or disability
- c) Quality of life measures
- d) Consumer satisfaction
- e) Consumer empowerment
- f) Family burden

Outcome measurement instruments

In evaluation research, outcome measures

may include the application of some known scales and instruments before and after intervention. There are many instruments that can be used in each of these areas on interest.

Several authors have defined some of the criteria for selecting a measurement or indicator for consumer outcome (Donald et al., 2002; Ciarlo et al., 1986; Green and Graceli, 1987; Andrews et al., 1994). The measure must be: applicable, acceptable, practical, valid, and sensitive to change.

Outcome indicators

Donald has identified ten criteria to guide in the development of outcome indicators. The first three are similar to the first three criteria for outcomes (Donald et al., 2002).

Indicators should be:

- congruent with the evidence
- relevant for the level of action
- stated clearly and concisely and have face validity to stockholders
- sensitive to changes over time
- measurable
- affordable
- unique and comprehensive

Validity is defined by the degree that the instrument measures what it is supposed to measure. The instrument also has to be reliable, or free of measurement errors.

The Consumer Outcome Project Advisory Group of the Commonwealth Department of Mental Health and Family Services of Australia was created to review existing measures of consumer outcome. The group concluded that disability and quality of life were the most important outcomes to be measured, followed by consumer satisfaction and symptoms. The group recommended the further testing of six instruments as potentially useful for routine outcome measurements (Andrews et al., 1994):

Consumer measures:

BASIS 32	Symptoms Identification Scales
MHI	Mental Health Inventory
SF 36	Short Form Survey

Provider measurements:

HoNOS	Health of the Nations Outcomes Study
LSP	Life Skills Profile
RFS	Role Function Scales

This is an example of how the Commonwealth Department approached this problem. The choice of measurement instruments should be based on the specific objectives, outcomes, type of intervention implemented, and information needed, all of which will be unique to each program.

Many instruments that are both valid and reliable can be used in different circumstances. There are also several publications that have analyzed the validity and reliability of each instrument and can be used for reference in the selection of an instrument (Bowling, 1996; Bowling, 1997; Donald, 2002). Obviously, any outcome measure needs to be accepted by the professional staff and clients of the program.

After a measure has been selected and implemented for a defined period of time, it should be evaluated to decide if it fulfills the goals of the research evaluation. Some programs implement outcome measurements but do not systematically analyze the data.

The following are examples of instruments which have been selected for use in research:

Symptoms

Symptom checklists

Hopkins SCL-25	(anxiety and depression)
SCL-90	
SCL-110	

Health Symptom Checklist (HSC)
Symptoms Identification Scales (BASIS
32)

PTSD structured

- 1) Clinician-Administered PTSD Scale (CAPS) is the most common. Used by mental health professionals to evaluate development of PTSD and complex PTSD symptoms even after repeated events.
- 2) Watson PTSD Interview

PTSD rating scales

- 1) Harvard Trauma Questionnaire (HTQ) includes exposure to events, brain trauma, general posttraumatic symptoms, and associated symptoms (complex PTSD) and has cut-off score for DSM criteria
- 2) Impact of Events Scale (IES)
- 3) Mississippi Combat Scale
- 4) Posttraumatic Stress Checklist-Civilian Version (PCL-C) is a self-report Likert scale with 17 items and has shown high internal consistency and reliability as well as a strong correlation with PTSD diagnosis using the CAPS
- 5) Many Others

Note potential problems: Cut-off scores vary by ethnic and patient group; Scoring for DSM-IV criteria (x symptoms from symptom group y must be present – this might result in a negative or distorted finding, e.g., if avoidance is predominant, intrusion criteria might only be fulfilled later when the survivor is confronted with triggers; cultural and linguistic factors make a difference).

Anxiety rating scales

- 1) Hopkins Symptom Checklist, Anxiety Scale (HSC-25) is short, well-validated, and translated into many languages.

- 2) Spielberger's State-trait Anxiety Inventory
- 3) Hospital Anxiety and Depression Scale (HADS)
- 4) Anxiety disorder module of the Structured Clinical Interview for DSM-IV (SCID)

Anxiety screening scales for use in primary care settings

- 1) Index of Psychological Distress of Santé Québec (IDPESQ)
- 2) Prime-MD

Depression rating scales

- 1) Hopkins Symptom Checklist, Depression Scale (HSCL-25) is short, well-validated, translated into many languages, and is the best documented in torture survivors
- 2) Zung Self-Rating Depression Scale
- 3) Hamilton Depression Scale (HDS)
- 4) Beck Depression Inventory (BDI)
- 5) Hospital Anxiety and Depression Scale (HADS)

For the above scales, a distortion of results by items based on somatic symptoms is possible and could reflect physical injury sequelae (e.g., BDI), but less prominent in the HADS. Overlap is high with brain trauma and PTS symptoms.

- 6) Mood disorder module of the SCID

Depression screening scales

- 1) Index of Psychological Distress of Santé Québec (IDPESQ) is useful screening
- 2) Prime-MD did not adequately distinguish affective disorders when compared with the gold standard of clinician diagnosis.
- 3) Vietnamese Depression Scale (VDS)

Cognitive testing

Mini Mental Status Exam (MMSE) is a very Western ethnocentric 30-point scale. At-

tempts have been made to develop a shorter scale that is relatively culture-free.

Quality of life

- 1) World Health Organization Quality of Life (WHOQOL-Bref, 26-Item Measure)
- 2) Quality of Life Inventory (QOLI-B)

Occupation/work (level of function)

- 1) Short Form (SF-36, SF-12)
- 2) Functional Impairment Scale – Medical (FIS-M), to assess the extent to which major medical conditions interfere with functioning
- 3) Functional Impairment Scale – Psychiatric (FIS-P), to assess the extent to which PTSD symptoms interfere with functioning
- 4) Life Skills Profile (LSP)
- 5) Role Function Scales (RFS)
- 6) Global Assessment of Function (GAF)
- 7) Sheehan Disability Scale
- 8) International Classification of Functioning, Disability and Health (ICF), complementary with the ICD diagnostic system

Coping/resilience

Minnesota International Coping Scale (MICS)

Social support

Duke-UNC Social Support

Satisfaction

- 1) Client Satisfaction Questionnaire (CSQ-8)
- 2) Treatment Experiences and Expectancies (2-Item Measure)
- 3) Client Access to Services Questionnaire (CAS-Q)

Family function

- 1) Sheehan

- 2) “Families in Transition” questionnaire – Refugee Population Study (RPS)

Diagnosis

Structured and Semi-Structured Clinical Interviews offer a reproducible standard with good test-retest reliability. The following have been validated in many languages and are seen as “gold standards” for diagnosis, including PTSD diagnosis.

- 1) Structured Clinical Interview for DSM-IV (SCID) is for use by experienced raters
- 2) Composite International Diagnostic Interview (CIDI) uses ICD-10 and DSM-IV classification systems and is administered by non-professional raters
- 3) Schedules for Clinical Assessment in Neuropsychiatry (SCAN) is based on the Present State Exam (PSE), uses ICD-10 and DSM-IV classification systems to be administered only by trained clinicians

However, there are still problems with diagnostic assessment tools, as has been shown in minor changes leading to major variations in prevalence shown by epidemiological surveys (Regier et al., 1998). This has important implications for assessing services needs.

Trauma history

- 1) Harvard Trauma Questionnaire (HTQ)
- 2) Trauma Symptom Inventory (TSI)

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Based on these guidelines, the following is specific to TORTURE:

The paper should be typed on one side only with double spacing on A4 (297 × 210 mm) paper or the nearest equivalent. Pages must be in numbered sequence. A short abstract or summary should be included (see below).

A statement giving the author's name, title and present position, as well as an address where he or she may be contacted by readers, should be provided on a separate sheet.

We prefer articles, reviews and other material to be sent as a formatted text file, for example MS Word or WordPerfect, and that they be sent either by email or on a disc.

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Aims

TORTURE is an international journal intended to provide a multidisciplinary forum for the exchange of original research and systematic reviews among professionals concerned with the biomedical, psychological and social interface of torture. The journal is dedicated to studying the effects of torture. There is a growing awareness of the need for exploring optimal remedies to restore physical, psychological and social harm as well as various interactions against torture. The journal seeks to enhance the understanding and cooperation in this field through the varied approaches represented. There will be focus not only on medicine and psychology, but also on epidemiology, social sciences and related disciplines. The editors wish to encourage dialogue among experts whose diverse cultures and experiences provide innovative and challenging knowledge to existing practice and theories.

Priority will be given to articles that give new knowledge and information with comparative and interesting perspectives.

Scope

TORTURE is divided into sections of which the first part fulfils international standards as a scientific journal and is dedicated to 2-4 in-depth original analyses with focus on torture, using a biomedical, health and human rights

framework. Articles categorised as clinical trials, research methodology papers, data based population examinations, critical or explaining case descriptions may be preferred.

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The editors of TORTURE identify reviewers based on bibliometric data, i.e. the selection is based on registered publication activity within the torture field in general and in the area addressed specifically by the manuscript.

The journal also contains contributions from other sources, mostly by health professionals or correspondents on development in the field of human rights.

When submitting a paper, the author should make a statement to the editor about all submissions and previous reports that might be regarded as redundant or duplicate publication of the same or very similar work.

What to do before submission

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- Patients' consent and permission to publish
- Copies of correspondence from other journals and reviewers, if previously submitted.

In this issue:

Politically-motivated torture and its survivors: a desk study review of the literature

Jose Quiroga and James M. Jaranson

The IRCT is an independent, international health professional organisation that promotes and supports the rehabilitation of torture victims and the prevention of torture through nearly 200 rehabilitation centres and programmes around the world.

The objective of the organisation is to promote the provision of specialised treatment and rehabilitation services for victims of torture and to contribute to the prevention of torture globally. To further these goals, the IRCT seeks on an international basis:

- to develop and maintain an advocacy programme that accumulates, processes and disseminates information about torture as well as the consequences and the rehabilitation of torture
- to establish international funding for rehabilitation services and programmes for the prevention of torture
- to promote the education and training of relevant professionals in the medical as well as social, legal and ethical aspects of torture
- to encourage the establishment and maintenance of rehabilitation services
- to establish and expand institutional relations in the international effort to abolish the practice of torture, and
- to support all other activities that may contribute to the prevention of torture