The need for reparation for torture survivors from a health perspective
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Despite the prohibition of torture contained in the Universal Declaration of Human Rights, the world is far from seeing an end to this practice – a practice that can be stopped only by breaching impunity. Torture is directed against individuals and against their communities. Challenging torture therefore entails not only reparation of the individual but also challenging the perpetrators and bringing them to justice. Health professionals have a role in both of these tasks, an obligation spelt out in international declarations for doctors, psychologists, nurses, and physiotherapists, largely endorsed by their national and/or international professional bodies.

Forms of torture

There are several purposes, which torture can serve, but the broad objective includes the maintenance of social control, the defence of ruling values and the suppression and prosecution of political opponents and criminals. Where torture has become institutionalised or where law enforcement personnel can act with complete impunity, the threshold at which torture is seen as an appropriate tool can decrease.

The methods of torture have been described in several publications and are usually somewhat arbitrarily divided into physical and psychological methods. In most cases, however, the victim is exposed to a combination of forms of torture – physical as well as psychological. The psychological methods often include induced exhaustion and debility through food, water and sleep deprivation, isolation, monopolisation of perception through e.g. movement restriction and high pitch sounds. In many cases, the victims and their families are threatened with death, experience mock executions, or they witness or are forced to participate in the torture and maltreatment of other prisoners or of family members.

Physical torture is in most instances directed towards the musculoskeletal system, aiming at producing soft tissue lesions and pain and usually at leaving no visible or non-specific findings after the acute stage. Random beatings, systematic beating of specific body parts (head, palms, soles, and lumbar region), strapping/binding, and suspension by the extremities, forced positions for extended periods of time, and electrical torture is frequent. Other physical torture methods include asphyxiation, near drowning, stabbing, cutting, burning, and sexual assaults including hetero- and homosexual rape.

National and regional variations in torture practices are reported including geographical differences in the use of specific torture methods. Such knowledge is of value in documenting alleged torture adding to the validity of the statement.

Long-term health related consequences of torture

It is empirically well documented that survivors of torture referred to treatment have a broad range of mental, physical, and social problems.

Psychologically, torture survivors often develop symptoms of major depression, generalised anxiety and traumatic stress. Other frequent mental reactions are cognitive disturbances with
impaired memory, loss of concentration, irritability, sleep disturbances, nightmares and a negative sense of self, characterised by shame, feelings of guilt, and loss of self-esteem.

Pain and pain-related disability is the dominant physical symptom in the chronic phase. Studies indicate a high prevalence of persistent pain in survivors of torture, with overall estimates as high as 83%. Chronic pain has a serious impact on the functioning of individuals and is a barrier to overall rehabilitation. It is strongly associated with incapacity for normal employment, poor social participation and progressive functional loss in persons disabled with pain. Poor coping may lead to chronic anxiety, depression and problems interacting with health care, which are often associated with chronic pain conditions. Torture survivors are probably highly vulnerable to the secondary psychological disadvantages of chronic pain due to their prolonged history of violent trauma and stress.

Clinically, the picture is one of regional or widespread muscle pain, joint pain, pain related to the spine and pelvic girdle, and neurological complaints, mainly irradiating pain in the extremities and sensory disturbances. Visceral symptoms (cardiovascular, respiratory, intestinal and urological and genital complaints) and headache also prevail. Only a few systematic studies have addressed the association between specific long-term physical sequela and the use of identified torture methods. Associations between exposure to falanga (beating of the soles) and pain in the lower legs and feet, with impairment of walking; between severe beating of the head and headaches; between suspension in the upper extremities and pain in the shoulder girdle and reduced shoulder function; and between sexual assaults and low back pain/pelvic pain and urological and genital symptoms have been described.

The impact of torture on ‘social health’ is described in terms of impairment of interpersonal interactions and of social participation leading to social isolation and stigmatisation, poverty, family and marital problems, all factors of which may have a negative influence on symptoms and outcome of health care, thereby impeding trauma recovery. Flight in to exile; displacement and settlement in a new country are additional events that aggravate the social and economic consequences of torture.

Knowledge about the health-related consequences of torture arises from studies of torture survivors, mainly in specialised documentation and/or treatment centres. In primary or secondary care, however, many go unrecognised: estimates of up to 41% in the UK and USA. Disclosure of torture is difficult for many reasons, including fear and distrust of anyone in a position of authority, anticipation of adverse judgment, and avoidance of thinking or speaking about it. Identification of torture survivors in the clinical setting therefore often relies on the clinician. The situation, where both the health professional and the torture survivor are silent about the trauma, usually results in lack of understanding and failure to make sense of the patient’s presentation. This leaves the torture survivor isolated and uncertain of the appropriateness of treatment based on partial understanding. Disclosure of the torture history is often felt as a relief for the torture survivor, and as a sign that s/he is likely to be believed and treated with concern.

Assessment and rehabilitation of torture survivors
Clinical assessment of torture survivors can be used to document findings consistent with allegation of torture or to plan treatment and rehabilitation.
In documenting torture, the focus will be on the description of symptoms and signs, which provide evidence to support the account of torture. Medical documentation of alleged exposure to torture is based on the reporting of the degree of consistency between: 1) the torture history, 2) symptoms as described by the victim and 3) possible findings at medical examination. Expert documentation of torture is well established in medical work against torture and international guidelines on assessment of torture survivors for medico-legal purposes are described in the “Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment” (the Istanbul Protocol), drafted in 1999.

When assessment is for the purpose of treatment or rehabilitation, the aim is to identify targets for intervention within the various domains of health that may produce maximum improvement. There is now a broad agreement that the concept of positive health is more than mere absence of disease or disability and implies completeness and full functioning of mind and body as well as social adjustment. Consequently there are complementary approaches applied by professionals in understanding and addressing the impact of torture on the overall concept of health.

Recognising the multifaceted problems of torture survivors referred for treatment and acknowledging the relation between rehabilitation and prevention have led to a significant broadening of the efforts, skills and methodologies needed for what is now increasingly labelled reparation of torture survivors. So far a multidisciplinary treatment study involving individualised physiotherapy and psychotherapy showed a significant effect on musculoskeletal complaints in torture victims. However, there is a need for further clinical studies in that field.

After all it is obvious that the concept of reparation includes medical and psychosocial rehabilitation of the individual, including rehabilitation as societal and political actor. It also includes public recognition of the criminal atrocity committed – and ideally punishment of the perpetrators. It is a commonly held view among health professionals working with survivors of torture that impunity for perpetrators contributes to social and psychological problems and impedes healing processes.

The right to reparation is part of international legal standards as described in the United Nations Declaration of Human Rights where article 14 of the convention states that “each State party shall ensure redress and adequate compensation, including rehabilitation”.

**The Parker Institute**

The Parker Institute is Frederiksberg Hospital’s rheumatological research unit inaugurated in 1999 as a result of financial grants from the OAK Foundation, the Health Insurance Foundation and the Copenhagen Hospital Corporation (H:S). The aim of the Parker Institute is to conduct clinical research on musculoskeletal disorders in order to create an improved platform for their diagnosis, treatment and prevention.

The Parker Institutes mandate does not call for it to provide direct clinical care to torture survivors. However, the institute have long-standing expertise in the assessment of torture survivors and have throughout the years been engaged in research related to: 1) the musculoskeletal consequences of torture and 2) development of validated assessment methods, including diagnostic imaging for documentation purposes. A research area of particular interest has been magnetic
resonance imaging (MRI) and ultrasound examination applied in the documentation of falanga torture.

Based on this expertise the Parker Institute has been consulted on documentation of selected cases of alleged torture, e.g. the cases of five British citizens alleging exposure to torture and ill treatment during detention and imprisonment in Saudi Arabia. In all of the cases there was a high degree of consistency between the allegations of psychological and physical abuse and the history of acute and chronic symptoms and disabilities described by these five men. The alleged torture methods were all well known and their after-effects well described consequences. Likewise there was a high degree of consistency between allegations of abuse and the findings at medical examination, which included ultrasound imaging supportive of the allegations of exposure to falanga torture.

The medical examinations thus demonstrated, that all five cases only could be labelled as torture as defined in UN Convention against torture article 1. In spite of this evidence the men have unsuccessfully attempted to sue Saudi Arabian officials responsible for their false accusations and human rights abuses after their homecoming. Further, all of the men have only been offered limited assistance in their country of origin; none has been offered specialised rehabilitation and care or financial compensation.

The Parker Institute supports any initiative aiming at ensuring survivors of torture their right to adequate medical and psychosocial rehabilitation and effective prosecution of perpetrators responsible for torture. Tolerating impunity is legalizing torture and the struggle against impunity should be considered a major priority in the fight for restoring human rights.

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Literature


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