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Editorial: Psychotherapy for torture survivors – Suggested pathways for research

Pau Pérez-Sales, MD, PhD, Psych*, Editor in Chief

In its nearly 30 years of existence, the Torture Journal has published different reviews on individual or group psychotherapy for torture survivors[1-6] and a number of studies on the effectiveness of a varied array of intervention models implemented by care centers[7-19] which are in addition to other seminal reviews on the subject.[20-32]

On the whole, the evidence to support one model of intervention over another is usually poor. It can be concluded that, overall, there are low to moderate outcome results for each model or technique and no clear conclusions when different models are compared.[21, 24, 33, 36, 37] This led some authors ten years ago to say that the whole rehabilitation sector was a waste of money until it reached a respectable scientific status through the adoption of "evidence-based" therapeutic models.[34] This in-turn generated a justifiable response of complaint from within the sector on rehabilitation of survivors of torture.[35]

Two similar literature reviews with opposite recommendations: what is a reader to do?

This unclear and somehow confusing situation is exemplified by the first 2016 issue of Torture Journal; two excellent reviews on best psychotherapeutic practices for torture survivors published one besides the other yielded not only different, but opposite recommendations. This undoubtedly deserves an editorial reflection and some proposals.

In the first review, based on their Cochrane meta-analysis, Patel, Williams and Kellezi[1] conclude that there is no evidence to support one therapeutic technique over others in the rehabilitation of victims of torture. In particular, they were critical of the enthusiasm for cognitive-behavioural and exposure techniques, exemplified in Narrative Exposure Therapy (NET), for which, they say, there is more fervour than real evidence when rigorous criteria are applied and the size of the sample, statistical significance and follow-up data are carefully analysed: "*Our conclusions for practice were that there was too little evidence, and it was too heterogeneous and of generally low quality to recommend any particular treatment, that none showed immediate benefit, and that longer term gains were hard to interpret*" (p.13). In the second review, Weiss, Ugeto et al.[6] based on a systematic review with less stringent criteria than those used by the Cochrane rules conclude exactly the opposite: that in reviewing DMS trauma-related disorders one by one, the only treatment that currently can be considered "evidence-based" are different forms of trauma-focused, cognitive-behavioural techniques (like NET) and using any

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1. Any torture rehabilitation center in any part of the world can do first-line research in psychotherapy with torture survivors with very few resources which would be potentially publishable in Torture Journal.

2. There is a long tradition of experimental research on common factors in psychotherapy that has not yet been integrated in the research of best practices for torture survivors. Contemporary research in psychotherapy has shifted from an interest in Evidence Supported Treatments (EST) based on Randomized Control trials of manualized procedures, to Empirically Supported Relationships (ESR) based on naturalistic or semi-naturalistic studies that compare true-life interventions. Both need to be combined.

3. There is no basis to assume that only CB techniques should be investigated and taught in training programs, and offered to individuals with mental health problems. CBT has only been proven to be superior to other treatments in its ability to alleviate "specific" symptoms. This is commendable but limited.

4. There is a need to shift from manual-based one-size-fits-all treatments to defining pathways of care tailoring programs to individual needs. This is also possible even for the smallest center with very basic resources and aligns with well-stablished Do-No-Harm principles.

5. Torture Journal wants to be a platform to promote both randomized clinical studies and evidence-based naturalistic studies, and to help develop models of psychotherapy that respond to the genuine needs of survivors from an understanding and respect for the social and political context in which the torture occurred, the characteristics of each survivor and his/her symbolic world of meanings, the style and the formation of each therapist (helper or healer) and the interaction between all these elements.

technique instead of these with our current knowledge should be avoided, making an appeal to concentrate research efforts on these treatments: "*We recommend that NGOs providing mental health services to survivors of torture and other systematic violence use CBT with exposure components to address PTSD, depression and anxiety. (…)*" (p. 38). So, what is the reader to do? This gives food for thought, so it is worth taking a step backwards and reviewing the evidence.

The first and necessary reflection is to be aware of the pitfalls of reviews and meta-analysis. Wampold et al.[36] have recently offered a compelling critique of three recent meta-analyses maintaining superior effects of cognitive behavioral therapy (CBT) over other psychotherapies, for psychopathology in general and for social phobia. The paper illustrates how easy it is to make basic errors in meta-analyses, and that the results of such meta-analyses can, like any other type of research, be interpreted in different ways; it could be termed a meta-analysis paradox.[1]

Psychotherapy as a symbolic healing procedure: a common factors approach

More than twenty years ago, seminal exhaustive reviews by Wampold[37] and Lambert[38] concluded that when psychotherapies that are intended to be therapeutic (*Bona Fide* Psychotherapies) are compared, the true difference among all such treatments is zero. In other words, all psychotherapies in the long term yield similar results. This has been, since then, confirmed once and again in all reviews based on the comparison of psychotherapy interventions.[39, 40] Research in psychotherapy has shifted from an emphasis on techniques to an emphasis on an integrative, eclectical or common methods approach. The *common factors* explanation for therapeutic equivalence across various orientations observed in the psychotherapy outcome literature is both parsimonious and supported by scientific evidence. Rigorous observational studies clearly show that two senior therapists from opposite theoretical approaches, after years of attending patients, do in practice quite similar things. By contrast, this clearly diverges from what younger therapists of the same theoretical approach are doing when beginning in practice.[40] In other words, experience slowly leads to a convergence of what therapists do.

Rosenzweig[41] already said in 1936 that, "*given a therapist who has an effective personality and who consistently adheres in his treatment to a system of concepts which he has mastered and which is in one significant way or another adapted to the problems of the sick personality, then it is of comparatively little consequence what particular method that therapist uses*" (pp. 414-415). Fiedler, in his series of observational studies, showed between 1950 and 1955 that systematic observation "*clearly differentiates experts from nonexperts regardless of school. These factors are related to the therapist's ability to communicate with and understand the patient, and to his security and his emotional distance to the patient. No factors were found which clearly separate therapists of one school from those of another*" (p. 38).[40]

Jerome Frank, initially an anthropologist, formulated in his book *Persuasion and Healing* the idea, rooted on Levi-Strauss' notions of *symbolic therapies*, that what a western, trained psychotherapist and a traditional healer from a non-western tradition do is basically the same.[42] The difference is the kind of symbolism they use in their healing process. Frank evolved these ideas in successive editions of his well-known book into the *Common Factors Theory*.[42] Different approaches and evidence-based practices in psychotherapy and counselling share common factors that account for much of the effectiveness of a psychological treatment. According to Frank, a healing process needs:

(1) the expectation of help and improvement;
(2) a trusting therapeutic relationship;
(3) a rationale or conceptual scheme, meaningful to the patient, that explains the given symptoms and prescribes a given ritual or procedure for resolving them; and,
(4) the active participation of both patient and therapist in carrying out that ritual or procedure.

In other words, therapy is about creating a myth that explains the problem (myths can be narcissism, self-esteem, hot memories, family scapegoats, an Evil Eye, Latah, depression or post-traumatic stress disorder as explanatory models to be negotiated with the patient within the therapeutic contract) and carrying out a certain procedure (or psychotherapeutic ritual) in a structured manner that will ultimately lead to fulfilling expectancies of help, having access to new experiences and reasonings, and allow the patient to try different options and solutions to solve the myth previously agreed. It is in the experience of many of those who work with torture survivors that traditional healing therapies are not only a better solution, but can be the only possible solution for many of our non-western patients, who are likely to find the explanatory model and the proposal of shared work and ritual more significant. Said in a different way: a cognitive-behavioural therapist, a psychoanalyst and an EMDR therapist are indigenous western healers that use different myths to achieve quite similar results.

Defining trans-theoretical common factors

In 1990, an APA review on effective methods in psychotherapy found 89 trans-theoretical common factors from which 35 were finally selected and classified into five areas of research: patients' characteristics, therapist qualities, change processes, treatment structure, and therapeutic relationship.[43]

Lambert, probably the main author of reference in the field, found out after a series of reviews on experimental studies on psychotherapy outcomes and in successive editions of his well-known book[39] that, when there is an improvement in a given patient, 40% is due to extra-therapeutic factors (life changes out of the therapeutic space), 30% to the climate of the interaction between therapist and patient that depends on common factors, 15% on the expectancies of a positive outcome from both therapist and especially the patient, and importantly only the remaining 15% on the specific technique used. The technique is relevant, but is it so relevant as to make it the sole focus of psychotherapy research as we seem to do today and as the two reviews mentioned above albeit implicitly suggest?

And then came the Manuals

At the end of the 1990s and the beginning of this century, psychotherapy research began to imitate pharmacological research and pretended to solve the dilemma of equivalent results among different psychotherapeutic traditions by manualizing therapies and comparing outcomes through randomized clinical trials (RCT) as if a psychotherapy was equivalent to an antibiotic or to chemotherapy. As amoxyciline is used as an evidence-based treatment for neumonia, the universal evidence-based therapy for each one of the five hundred or so DSM-V disorders must and will be found. Whilst there is a surely an important role for RCT's, this movement did not take into account the very signals from psychopharmacology itself: there is no specific psychiatric medication for any disorder. Antidepressants have a therapeutic impact on such varied problems as depression, social

phobia, panic attack, negative psychotic symptoms and obsessive-compulsive disorder to cite only a few. Once and again, in the pharmacological domain, meta-analysis has shown that there is no single elective medication for a definite DSM-V disorder (such as PTSD) in spite of what the pharmaceutical industry tries to demonstrate.[44, 45]

Imitating pharmacological research in the domain of psychotherapy or counselling by using strict manualized procedures as if they were pills implies four erroneous assumptions are made:

(a) that PTSD exists as a "disease" (like neumonia), when in fact psychiatric classifications and the definition of "disorders" change dramatically every ten years or so;
(b) that all patients labelled as having a certain "disease" (such as PTSD) are similar;
(c) that all therapists that apply a manual do it in the same way irrespective of their personal characteristics; and,
(d) that the interaction between a unique patient and a particular therapist will be equivalent.

None of these assumptions has ever been demonstrated to be true. These are the dangers of thinking manuals as cookbooks[53] and not taking into account common factors in the psychotherapeutic work with survivors.

The position is, then, that research in psychotherapy established a long time ago that there is no intervention which is universally adequate for each DSM problem. There are, however, possible interventions for each time a therapist is confronted with a certain real life problem in a determined context within the realm of a therapeutic dialogue. Instead of putting the emphasis on the efficacy of a certain manual, the alternative option is examining the conditions and processes that make a certain therapeutic interaction successful. The technique chosen is, of course, relevant (15% of success, according to Lambert),[39] but its contribution is minor when compared to the evolving context (psychosocial approach) and the common factors.

A summary of research in 2014 suggested a ranked order of importance. Although the debate clearly continues on what the list should be and the relative importance of each factor, the factors that most contributed to success in therapy were found to be: goal consensus/collaboration, empathy, strong therapeutic alliance, positive regard/affirmation, congruence/genuineness, and therapist personality.[46] But there are many more suggested in literature. These areas clearly need to be the focus of thought and research as well as the treatment technique. Even more if programs are intended for non-western contexts when traditional healing has a long tradition of effective therapies.[i]

These issues are exactly what the reader can reflect on when reading the paper from Iselin Dibaj, Leif Edward Ottesen Kennair, Joar Øveraas Halvorsen and Håkon Inge Stenmark which is published in this issue and an additional contribution to the meta-analysis paradox. The authors designed a pilot study to find out whether a manualized combined treatment of NET plus physiotherapy is a successful treatment for comorbid PTSD and chronic pain in torture survivors. The results were that, in general, it cannot be concluded

[i] This opens the debate on whether traditional healing should be included in RCTs to show its effectiveness and put it under the lens of the "scientifically proven". There are strong epistemological and anthropological arguments against this position, although some non-randomised testing has been done as part of naturalistic or semi-naturalistic studies[64, 66, 67] and more research could probably be done if it does not colude with the healing process and the outcomes are consensual.

that there is a significant positive effect. But if instead of considering it a therapeutic trial we read it as a repeated measures multiple single-case experimental study, we learn that two out of six patients clearly achieved a clinically significant reduction in symptoms of PTSD, one patient achieved clinically significant change in depressive symptoms and two experienced clinically significant reduction in pain intensity. The research question here is, thus, not whether NET plus physiotherapy is the best evidence-based approach for torture survivors with comorbid pain but how can we know which of the patients would benefit from it? If a wider scope is taken, this means considering the combination of patient and therapist characteristics and the interaction between them that will work and moving from the *one-size-fits-all* model to multimodal treatments and interventions that can be tailored to each profile of patients. The authors explain that the manual was not strictly followed with any of the patients because it simply was not possible. The detailed description of each case allows the reader to make some speculative hypothesis to be tested with a bigger sample and more systematic observations of the reasons for success or failure of each case. Such a study suggests that the challenge is being able to define tailored pathways of care and multimodal treatments.

When the Center for Victims of Torture developed a manual for group counselling of torture survivors (see book review in this issue pp 75-76),[47] they adopted an integrative perspective drawing ideas from "*cognitive behavioral theory, narrative exposure therapy, somatic psychology, interpersonal therapy, neuroscience, resilience- strength-based approaches, and CVT's own extensive experience*" (pp. 1-2). Despite being called a 'manual', it is a wonderful starting point particularly because the focus should not be a question of whether it should be preferred over other alternative similar manuals based on Randomized Control Trials, but why this manual is successful in one country and has experienced difficulties in another.[48] Why does it work in a geographical and political context and not in the same place two years later? Why is it appropriate for some patients and not others? Why does it work when used by a specific group of therapists and not with others? The manual is not an answer to a problem in itself. The manual is a therapeutic multimodal group of "myths" to be tested (either by parts or as an overall product) and thus the beginning of a compulsory and much-needed research process towards flexible interventions tailored to each interaction of problem-patient-therapist in a given context.

The ethical question and the do-no-harm principle

If the argument is taken one step further, it becomes even more convincing. If a certain therapeutic, manualized technique (such as NET or EMDR) is proven to be successful compared to another by a poor effect size at a three-month follow-up and not at six and twelve months (as has happened), the conclusion is not that NET or EMDR is preferable to other manuals as the only evidence-based approach.[ii] The conclusion is that NET has worked for some patients,

[ii] The APA Task Force on evidence-based therapies for trauma suggest that brief trauma-focused cognitive therapies have a low to middle size evidence base as a preferable option for the treatment of trauma patients. The detractors of this conclusion have pointed out that the Task Force had a preference for short-term cognitive and behavioral techniques, largely because these studies are more prevalent in the literature as they can be easily manualized and submitted to case-control studies with comparatively little funds. Unfortunately, such qualities of research may be at variance with usual practice and may have skewed the definition of what "empirical validation" means.

has done nothing for others, and has been damaging or iatrogenic for the rest (hopefully not many). A one-size-fits-all solution cannot work, even for the best available treatment. The key point must be how we can know what the preferable option is for each patient, taking into account the do-no-harm principle and what science tells us about psychotherapy; Common Factors are far more relevant that specific techniques, when there are around 200 models of manualized therapies recognised by the American Psychological Association (APA).[49]

Instead of focusing on certain narrative techniques as the only and best evidence-based current option, under a Common Factors perspective, the focus could be: if narrating really is a universal necessary condition for a therapeutic process in torture survivors, then which patients (therapist and interactions) could benefit from it?[iii] Beutler et al.[50] define this line of reasoning and research as a process of systematic treatment selection and prescriptive therapy. This type of approach leads to the therapist and patient defining the problem together, building a culturally and contextually sensitive, meaningful explanation and finding out how to work together on it through a process built on a trusted relationship.

Manuals are only the very beginning of this type of collaborative questioning. They can be useful as myths, but can be part of the problem when overtly relied upon.

Psychotherapy as part of multimodal comprehensive interventions

This conception positions psychotherapy as part of a wider picture, understanding that there are pre-trauma factors (i.e. childhood attachment experiences), factors related to trauma (type, duration, context and meaning of torture) and post-trauma factors (i.e. hostile or discriminating environments and traumatic experiences in host countries), the latter being the best predictors of long-term outcome.[51-52] There are emerging mixed models, like the Common Elements Treatment Approach (CETA) for anxiety and mood disorders. Although it is a manualized, trauma-focused, evidence-based model, it includes some opportunities for flexibility and adaptation, allowing treatment without specifying a disorder classification and including guidance for delivering specific elements to patients with comorbidity.[53] CETA was recently tested in a population of survivors of trauma and torture in two small RCTs, one in southern Iraq and one at the Thailand-Burma border with promising results[iv]. Other flexible models are also emerging.[53]

These models do not in fact take into account what most of the literature calls common factors in psychotherapy (such as, building meaning, empathic bond, therapeu-

[iii] A good and well-known example of this idea is what happened with Critical Incident Stress Debriefing (CISD), proposed as a manualized procedure by Mitchell in 1986. Different Cochrane reviews showed the dangers that the technique entailed and concluded that, overall, there was not a significant statistical effect and it should not be used in a compulsory way in the aftermath of trauma,[47] in what later became an official WHO recommendation.[48] We know today that there are some conditions and contexts that might benefit from one-shot, brief trauma-focused interventions, while CISD proposing it as a universal one-size-fits all solution was an ethically unacceptable presumption.

[iv] It is not a true cultural formulation based on ethnoconcepts of disease and healing, but a cultural adaptation. For instance, 100% of patients in both settings underwent Imaginal Exposure. Cultural adaptation refers to the way the material was presented to counsellors, not to the techniques in itself.

tic alliance), but common techniques in psychotherapy (exposure, relaxation etc)[55] which may be misleading. The idea behind them (tailoring interventions to different profiles of survivors and individualizing treatment), the methodology of development (having different blocks that can be altered in order and contents) and implementation procedures (RCT in low and middle income countries with lay workers) show a groundbreaking and revolutionary path. But let us be clear: as Dereubeis et al. summarize,[65] the state of the art shows that, "*If the question at hand is whether research is far enough along to support the view that only CBTs should be investigated, taught in training programs, and offered to individuals with mental health problems, then the answer is clearly "no."* (…) *CBTs and other disorder-specific therapies may be superior to other treatments in their ability to alleviate "specific" symptoms such as social anxiety, tics, or panic attacks*" (p. 34). That's what we know.

Existential elements not captured by a clinical diagnosis must also be part of the rehabilitation process. The Adaptation and Development after Persecution and Trauma (ADAPT) model that includes five core adaptive systems subdivided into the basic human functions of "safety and security", "bonds, attachment and networks", "justice," "identity-role", and "existential meaning" and its operationalization is the best available example, to my knowledge, on how subtle existential elements can be integrated into a therapeutic model.[56-59]

Integrating basic research into psychotherapy

Torture entails special challenges. To design multimodal and flexible treatments we need to know more about the neurobiology of torture,[60-62] etiopathogenic models of torture (that is, how torture affects the different subsystems of the human mind through analysis using the Scale of Torturing Environments for example),[63] the interrelation between these torturing environments and the psychological structure of the survivor. This will help in going beyond PTSD-based models to more specific treatments that include, for instance, self-conscious emotions like shame or guilt, that clearly help to determine prognosis. While exposition might be helpful for some patients (even perhaps for most patients on average), let us, for instance, accept that a survivor with a strong internalizing psychological structure might benefit from supportive therapy and traditional healing more than crude exposition.

Looking at the future

In order to integrate a common factors approach into psychotherapy research with torture survivors, we need to look towards defining profiles of effect and therapeutic conditions, rather than only looking for universal therapies. As well as asking about the effectiveness of certain techniques, we need to be open to the common factors perspective: What patient profile and under what conditions do patients benefit from re-telling the experience of torture? How should this narration be carried out to be therapeutic? When can this narration have adverse or even iatrogenic effects? We need to do this to advance towards individualized therapies through pathways of care models. All studies are of potential importance from a survival and funding point of view. However, efficiency is not only about how many hundreds of people we target, but if we are really being of help.

To advance in this direction we need to go beyond basic clinical studies based on general purpose clinical questionnaires frequently administered before and after a mixed unstructured treatment consisting often of

manualized techniques. Such research is often only possible due to the resources of larger research centers and conclude that the intervention was partially effective without being able to go beyond that. Whilst this type of research is also surely needed, carefully designed semi-naturalistic studies done in local rehabilitation centers can also draw firm conclusions. For example, profiling what works for who under certain therapeutic conditions. Qualitative naturalistic studies and informed case studies can be used to formulate a hypothesis of specific interactions with respect to the problem/therapist/technique/context. This goes hand-in-hand with the need to develop locally-based community indicators of resilience and healing that go beyond clinical measures and target the social fabric broken by political violence. The Torture Journal and other publications have already published some useful examples of this kind of semi-naturalistic research.[64]

These may in turn open the door to the design of an algorithm of treatment allowing randomised control trials to test the proposed algorithm (i.e. symbolic healing versus community support vs culturally-adapted cognitive behaviour therapy) or different combinations of it. Such studies would allow a new generation of a shared body of outcome studies to be carried out that integrate the Common Factors and Empirically Supported Treatment perspectives.

Perhaps this combination of naturalistic and experimental studies can help to solve the differing recommendations of the meta-analysis paradox set out above.[1, 6]

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An evaluation of combined narrative exposure therapy and physiotherapy for comorbid PTSD and chronic pain in torture survivors

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Key points of interest

- Novel treatment approach coupling narrative exposure therapy with physiotherapy.
- Small detailed study with six torture survivors.
- Torture survivors suffering from high symptom loads can achieve good outcomes when working in parallel with traumas and pain.
- Individual differences between the six different cases; no treatment works for all patients.

Abstract

Introduction: Torture is associated with adverse health consequences, with especially high rates of PTSD, depression and chronic pain. Despite increased awareness of the relationship between pain and posttraumatic symptoms, and the accompanying need for effective treatment strategies, few studies have examined an integrated treatment of comorbid PTSD and pain. **Methods:** In this study, using an A-B case series design with three and six month follow-up, six refugee torture survivors with comorbid PTSD, depression and chronic pain received 20 sessions of Narrative Exposure Therapy (NET) and 10 sessions of physiotherapy. Outcome variables included symptoms of PTSD and depression, pain intensity, physical functioning and quality of life. Symptoms of PTSD and pain were also rated after each treatment session. **Results:** Two patients achieved clinically significant reduction in symptoms of PTSD. Only one patient achieved clinically significant change in depressive symptoms, and two experienced clinically significant reduction in pain intensity. Clinical descriptions of the course of treatment for all patients are provided. **Discussion and Conclusions:** Despite its limitations, the study suggests that some torture survivors who suffer high symptom loads may benefit from a combined treatment of NET and physiotherapy. Appreciating individual differences and how they affect treatment can provide valuable insight and inform clinicians working with torture survivors. Directions for future research

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regarding the improvement of rehabilitation strategies of torture survivors are discussed, and highlighted through descriptions from the six therapy cases.

Keywords: PTSD, chronic pain, torture survivors, narrative exposure therapy, physiotherapy, treatment outcome

Introduction

Torture is associated with adverse mental health consequences, such as high rates of symptoms of PTSD, depression and chronic pain,[1, 2] and low levels of functioning and quality of life.[3] A number of studies have investigated the link between pain and PTSD, including amongst torture survivors specifically.[4] Chronic pain is highly prevalent in torture survivors,[4] often co-occurs with PTSD and is associated with poorer prognosis.[1] Trauma survivors who have suffered trauma-related bodily injury have an eight-fold higher risk for developing PTSD,[5] which could potentially explain the higher incidence of chronic pain and PTSD amongst torture survivors. Defrin et al.[6] conclude that "torture survivors exhibit generalized diminished pain modulation and increased excitability. These alterations in the function of the pain system may underlie the chronic pain decades after the torture" (p549). Furthermore, pain-related fear has been found to be a predictor of chronicity of pain symptoms,[7] and PTSD is a higher risk factor for developing pain than the experience of trauma by itself.[8] PTSD has gained support as a risk factor contributing to more severe pain experience, poorer treatment outcome and greater pain-related disability.[9] A number of theoretical models explain the relationship between chronic pain, PTSD and depression.[4, 10, 11] The theoretical models and empirical studies give rise to several potential treatment implications. First, the effective treatment of PTSD could lead to a reduction of symptoms of chronic pain and depression and thus improve pain rehabilitation outcome in patients with chronic comorbid affective and pain symptoms (for a review, see reference 12). Second, PTSD and chronic pain can be treated simultaneously by targeting shared vulnerabilities[11] or through integrated treatments.[4, 11] Third, successful treatment of PTSD symptoms may lead to increased quality of life and functioning.

Trauma-focused cognitive behavioral therapy (TF-CBT) is currently the best documented treatment for PTSD.[13] Recently, a Cochrane review on effective interventions for torture survivors concluded that narrative exposure therapy (NET) and TF-CBT had moderate effects on posttraumatic symptoms and distress six months after treatment, but the authors stressed the substantial limitations of the current evidence base.[14] Another recent review classified CBT and NET as promising interventions for torture survivors suffering from PTSD, depression or pain.[15]

According to guidelines for physiotherapy for torture survivors, physiotherapy and psychotherapy should be implemented in parallel.[16] To our knowledge, few studies exist which investigate the effects of physiotherapy, or combined physiotherapy and psychotherapy, for torture survivors. However, Carlsson et al.[17] reviewed the effect of multimodal treatment implemented for 71% of a sample of patients at a specialized center for trauma and torture. The treatment included psychotherapy, physiotherapy, medical attention and social assistance with a mean of 35 sessions in total. No treatment effect was found for PTSD, depression or quality of life. At the 23-month follow-up, Carlsson et al.[18] found that approximately 1/3 of the participants reported reliable

symptom improvement as measured by self-report.

Aims of this study

For the present study, physiotherapy was combined with NET in an effort to alleviate emotional distress and pain, as well as to increase quality of life and functioning, in survivors of torture presenting with comorbid pain and PTSD. Specific study aims were:

1. To run a preliminary evaluation of the potential efficacy of a combination treatment for torture survivors, targeting both posttraumatic symptoms and pain.
2. To highlight individual variation in response to the treatment, and discuss potential predictors, based on the reported clinically significant change and an analysis of the six case illustrations.
3. To explore and present topics for future research that may emerge from the descriptions of six therapy cases.

Method

Design

To examine the treatment effect of a combination of NET and physiotherapy for torture survivors with PTSD and pain, an A-B-design[19] with a three and six month follow-up was chosen. A case series design is deemed suitable for preliminary examinations of novel treatment approaches. The patients were divided into three different groups, where the onset time of physiotherapy varied between after the third, sixth and ninth NET session in order to examine whether there was an obvious effect of physiotherapy. Three experienced professionals were involved in the psychological assessment and NET treatment, but the assessor and therapist were independent of each other. All patients had the same physiotherapist, but were assessed by an independent physiotherapist.

Selection of Participants

The recruited patients were referred to the outpatient clinic for refugees connected to The Regional Center on Violence, Traumatic Stress and Suicide Prevention, Mid-Norway.[i] Collaboration between the referring clinician, hospital, general practitioner and Trondheim Municipality Refugee Health Team assured that the patients had been assessed according to the Istanbul Protocol.[20] Patients who met the inclusion criteria were invited to participate, namely, that they were 18 years or older, had experienced torture, reported pain symptoms and fulfilled the diagnostic criteria for PTSD according to DSM-IV. Exclusion criteria were psychosis, high suicide risk or a serious drug/alcohol addiction. Information about the project, including the possibility of withdrawing at any time, was presented in writing in the language of each patient, as well as being orally translated. All patients signed an informed consent. Subsequently, patients were further assessed for PTSD, depression, psychiatric comorbidity, pain symptoms, functioning and health-related quality of life. The study was approved by the Regional Committee for Medical and Health Research Ethics.

Patients

Initially, eight patients were enrolled in the project. As two withdrew before completion, only six patients are included in the data analysis. The clinical descriptions below illustrate different clinical presentations, challenges and outcomes in treatment of torture survivors suffering from PTSD and pain. All six patients had refugee status when

[i] http://rvtsmidt.no/english/

treatment started. The number of traumatic experiences apart from the torture was high, with a mean of 7.83 (SD=2.86). The following case descriptions are based on data from the pre-test assessment. All patients reported substantial sleep disturbances, and all except for patient 5, had economic problems.

Attrition and Drop-out

Two patients were excluded from the project: One, because of psychotic symptoms, which at first did not seem substantial; and, another, because of poor attendance despite a proclaimed intention to continue treatment. Both patients were offered a different type of treatment.

Procedure

After the first assessment and prior to treatment onset, two baseline assessments were performed; after one and three weeks. After the baseline period, the patients engaged in approximately 20 sessions of NET (90 minutes each) and 10 sessions of physiotherapy (60 minutes each). Symptoms of PTSD and pain were assessed at the end of each session by self-report. In addition, the therapists filled out a NET process form after each session, to ensure adherence and document compliance to the NET treatment manual. There were two follow-up assessments, three and six months after treatment. Information about changes in refugee status, marital status, living condition and social activity was also collected. One item from the Brief Pain Inventory (BPI), the Numeric Rating Scale (NRS-11) and the Posttraumatic Diagnostic Scale (PDS) were administered after each treatment session, whereas all other instruments were administered prior to treatment and at the two follow-up assessments. All patients except for patient 3 had an interpreter present during the therapy sessions. Each patient had the same interpreter in all their treatment sessions.

Narrative Exposure Therapy (NET): NET is a trauma-focused therapy that incorporates principles from prolonged exposure and testimonial therapy.[21] It was developed specifically for refugees that have experienced multiple traumatic events, such as persecution, flight and torture. NET is based on dual processing theory and aims to contextualize fragmented, traumatic memories. Usually, NET consists of eight to ten sessions, while in this study we have doubled the number of sessions due to the complexity of severe trauma symptoms and chronic pain. The first session is devoted to make a lifeline where the patient identifies and labels traumatic experiences over the course of their lives. In subsequent sessions, the patient and therapist collaboratively record and read the patient's life narrative and prolonged exposure techniques are applied for traumatic memories.

Physiotherapy: All patients received treatment by the same physiotherapist, who had several years of experience in working with refugees and torture survivors. The treatment was individually tailored according to the different needs of each patient.

Instruments[ii]

Before treatment and at the follow-up assessments, we administered the Clinical-Administered PTSD Scale (CAPS) to diagnose and assess severity levels of PTSD, and the Hamilton Rating Scale for Depression (HRSD) to evaluate the severity level of depression. The Norwegian Pain Association's Minimum Inventory for Pain Patients

[ii] Detailed descriptions of the instruments used can be provided upon request.

Table 1: *Means and Standard Deviations*

	Pre-test		3 months FU		6 months FU	
	M	SD	M	SD	M	SD
CAPS	80.83	18.63	60.33	25.56	54.83	31.24
HRSD	18.67	4.93	14.5	5.58	13.0	5.66
BPI [a]	19.60	6.43	15.60	10.26	14.25	10.87

[a] *= n = 4, CAPS = Clinician-Administered PTSD Scale for DSM-IV, HRSD = Hamilton. Rating Scale for Depression, BPI = Brief Pain Inventory*

(NOSF-MISS) was used to assess factors such as pain intensity (BPI), physical functioning, health-related quality of life, sleep difficulties and financial struggles. In the present study, the MINI International Neuropsychiatric Interview (MINI) was conducted to diagnose depression, to assess eventual comorbid psychiatric diagnoses, and to ensure that the patients did not meet the exclusion criteria. Socio-demographic questions were asked about variables such as age, sex, nationality, refugee status, education level, living conditions, social network and period of time in Norway.

NET Adherence and Compliance: Adherence and compliance with the NET manual were rated through a self-report questionnaire, which the therapists completed after each session. They reported whether the therapeutic tasks in the manual were completed or not, how the patient responded to exposure, and whether time was used on other activities or to discuss current stressors.

Data Analysis

Visual analysis was chosen as it is recommended as the primary method for this type of study design, rather than the performance of statistical analyses.[22] It allows for an informal judgment of whether a clear treatment effect can be seen, and will, according to Parsonson and Baer,[23] reveal any treatment effect solid enough to be of importance for clinicians. In addition, the individual results and the extent of any clinically significant change for all six patients is reported. The raw scores are available on request, making it possible to compute effect sizes as recommended by Brossart et al.[24]

Results

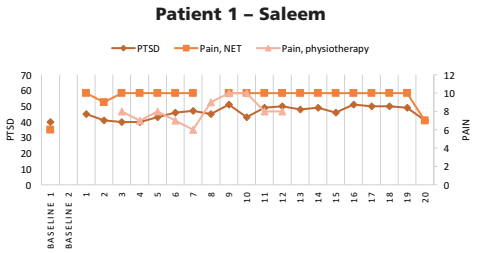
The symptom progression of pain intensity and PTSD symptoms for the individual patients is presented in Figure 1. Means and standard deviations for symptoms of PTSD, depression and pain intensity are presented in Table 1.

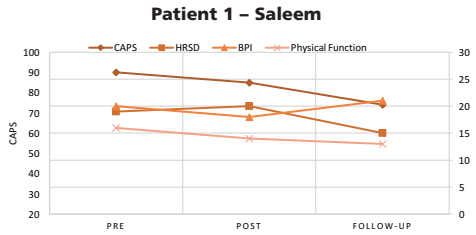
Clinical descriptions

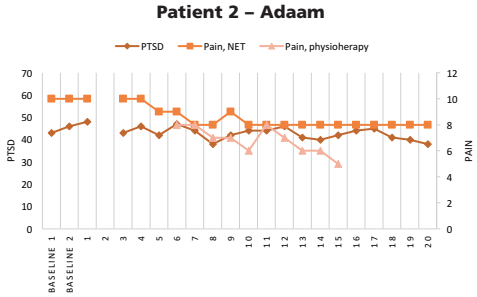
Patient 1: Saleem: *Saleem*[iii] *was in his 30s, was from the Middle East, and had been in Norway for 10 years. He lived with his wife and two children, and attended school. At seventeen, he was arrested and tortured for the first of several times, after he had been politically active for many years. In total, he spent 7.5 months in captivity and was tortured during 5.5 of them. The torture*

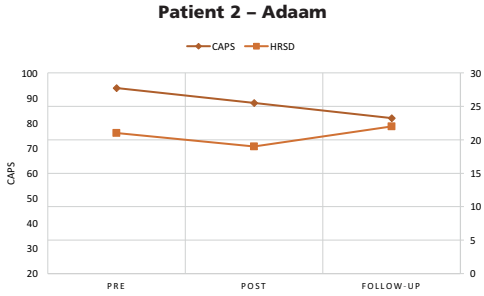
[iii] All patient names are pseudonyms. Pseudonyms were selected from amidst name registers of the patient's respective country of origin. Cross-checking was then performed to ensure that the selected pseudonym also was in use in neighboring countries, to preclude recognition based on nationality.

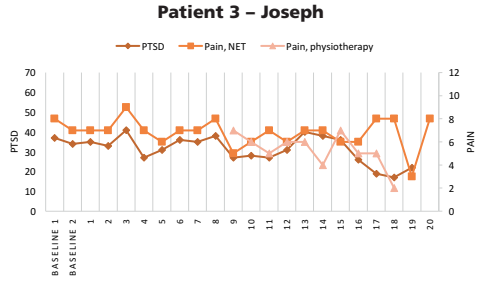
Figure 1: *Symptom progression of pain intensity and PTSD symptoms by patient and session*

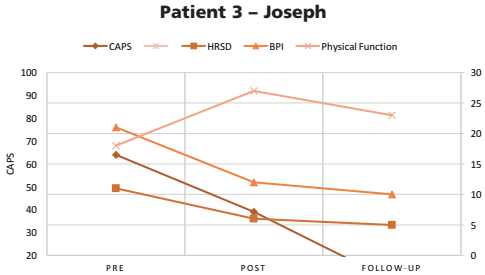












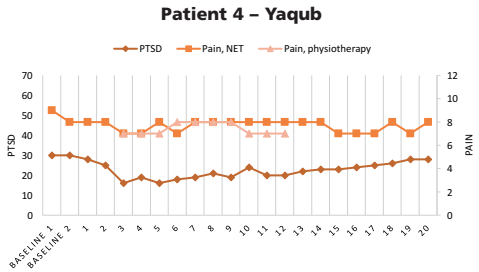
'PTSD'= PDS Scores, 'Pain, NET'= BPI scores, 'Pain physiotherapy'= NSR-11 scores, PDS = PTSD Diagnostic Scale. NSR-11 = Numeric Rating Scale.

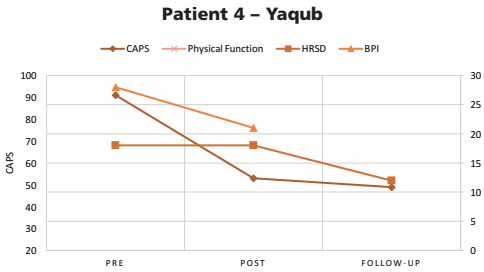
'CAPS' = Clinician-Administered PTSD Scale for DSM-IV, 'HRSD' = Hamilton Rating Scale for Depression, 'BPI' = Brief Pain Inventory, Physical Function is a subscale in the NOSF-MISS.

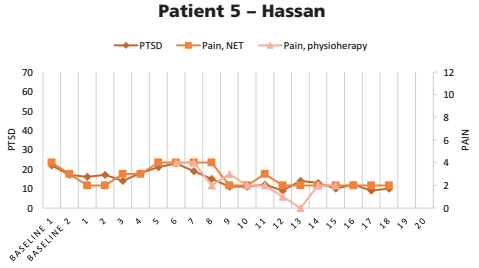
consisted of blindfolding, beatings until he lost consciousness, threats towards self and family members, whipping, isolation, deprivation, water torture, suspension from different limbs, and degrading insults. He fulfilled the criteria for PTSD, a moderate depressive episode, and had chronic pain that started after the torture, located in his head, face, jaw, knees, feet, ankles, elbows, lower back and legs. He suffered damage that required surgery that led to painful repercussions. Also, he was overweight, which added additional strain on his feet, knees and ankles.

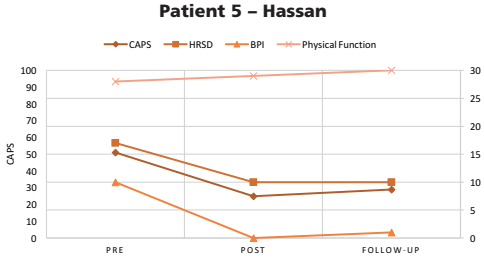
Overall, few treatment sessions fully complied with the NET manual, and the lifeline was not completed until the sixth session. Saleem talked in a detailed manner, and the therapist often found it challenging to moderate his flow of words as well as engaging him in exposure. Filling out

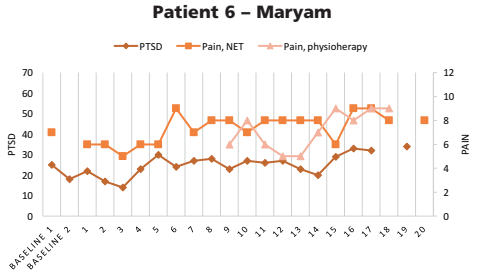
Figure 1: *Symptom progression of pain intensity and PTSD symptoms by patient and session*

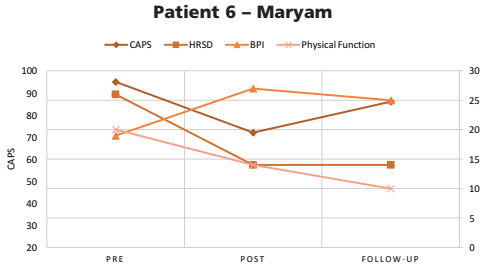












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'CAPS' = Clinician-Administered PTSD Scale for DSM-IV, 'HRSD' = Hamilton Rating Scale for Depression, 'BPI' = Brief Pain Inventory, Physical Function is a subscale in the NOSF-MISS.

baseline recordings sometimes took half of the session, and exposure often closed prematurely, as they ran out of time. Saleem had a number of current stressors he wanted to address in therapy, including the family's living situation, his pain symptoms and physical disabilities. His physical state also made it difficult for him to sit still in the same position for longer periods. He still met criteria for PTSD at the final follow-up.

When starting physiotherapy, Saleem was physically inactive and had some physical disabilities, which impeded him in benefitting from pain-reducing treatments besides hydrotherapy and sitting exercises. He was cooperative and motivated for the treatment. His initial scepticism towards hydrotherapy, as he could not swim, ceased after a few sessions, and he enjoyed reduced pain intensity after five sessions. Still, his

level of functioning did not improve much. Mid-treatment, he had surgery on a foot, which led to a relapse of pain intensity, as the pain increased and became worse than before starting treatment. However, the pain returned to baseline towards the last session. His final remarks were "I feel sorry for my party fellows, as they do not receive the kind of help that I do now".

Patient 2: Adaam: *Adaam was in his 60s from the Caucasus, and had been in Norway for eight years, living with his wife. For many years, he was politically active through critical writings about the government, which led to him being arrested and tortured twice, both episodes lasting a day. The torture consisted of bindings, beatings and water torture – in addition, they tortured a close family member. After the last episode, he fled with his family, living in hiding and constant fear for three years until they came to Norway. Adaam described himself as functioning well after the torture, but he had had reduced functioning for the previous seven years. His pain symptoms began after the torture, were growing increasingly worse and located in his head, chest, stomach, thighs, neck, lower back, shoulder and leg. He also suffered from severe toothache that required painful surgery. Adaam fulfilled the criteria for PTSD, a moderate depressive episode, social phobia and lifetime panic disorder with agoraphobia.*

Overall, most sessions complied with the NET manual, and the therapeutic relationship was described as good. Adaam was a good storyteller with a detail-rich manner of speaking; this sometimes impeded activation of affect as required in exposure therapy. In fact, he often lectured about his torture experiences, even though this made him anxious. How this influenced him was reflected upon throughout the therapy. Although, when the therapist repeatedly pointed out how this style may lead to avoidance and repeated the treatment rationale, Adaam cooperated. In the final stages of treatment, Adaam expressed that he wanted a full disability pension because of his severe pain. He concluded, "This treatment has helped me see how the pieces fit together, but now I don't think there is anything left to do". He still met the criteria for PTSD at the final follow-up.

Adaam was highly motivated to receive the physiotherapy. He emphasized that he saw himself as a survivor of torture, not a victim. He complied with a physical exercise program that he performed both in and between sessions. In addition, he engaged in hydrotherapy. Adaam's level of functioning improved, and his pain was reduced from an extreme to a moderate level of pain. His concluding remarks were "I am proud of surviving, and will manage on my own now, because you taught me what to do when in pain".

Patient 3: Joseph: *Joseph was in his 40s from Central Africa, and came to Norway 10 years ago. He lived with his wife and had regular contact with his child. Joseph had two degrees, a paid job and volunteered in an organization, but was on a sick leave. At a young age, he became politically active with the resistance party, for which he was arrested several times. When in prison, the torture went on for two months. The torture included stabbing, isolation, deprivation, threats and positional torture. He also experienced violence from adults during childhood, a traffic accident and witnessing the torture and murder of others. Joseph described posttraumatic symptoms beginning when he was released from captivity 15 years ago, increasing when he experienced a difficult time living in poverty in exile, with no social network. He fulfilled the criteria for PTSD, a mild depressive episode and had pain in his head, chest, hands, shoulders, elbows, upper and lower back - the latter appeared diffuse.*

In the beginning, Joseph exhibited avoidance during exposure, manifested in sudden changes of topic to daily life stressors. In session 8, he

reported increased symptom load or retraumatization after exposure to childhood memories and encounters with other refugees' stories through his volunteer work. Two sessions focused on these reactions, before returning to exposure. During exposure, he sometimes felt bodily pain and headaches, and the NET therapist and physiotherapist cooperated on this matter between sessions. A few sessions included cooperation with the physiotherapist, and some focused on reflections on meaning, identity, and religion. Joseph stated that this was the first time anyone had talked with him about his traumatic experiences and that it was a relief to have done it. He did not meet criteria for PTSD at the final follow-up.

Joseph was highly committed to the physiotherapy, and was motivated to restore his ability to help others by fighting injustice and poverty. He completed an exercise program in and between sessions, focused on reducing and coping with his pain. The physiotherapist described Joseph as having exercised thoroughly, with reduced pain and improved functioning. At the end of treatment, Joseph announced "I found myself in the project, as well as the way towards becoming independent, and I now know how to ease my own pain".

Patient 4: Yaqub: *Yaqub was in his 30s from the Caucasus, and had been in Norway for 10 years. He lived with his wife and children, had a university degree and a paid job, but was on sick leave. He described a secure childhood until he turned 15, when war hit his village. Due to political activity in his family, he was arrested and tortured twice, both episodes lasting for one day. The torture included electricity, beatings to the head and body, degrading comments, a tight rubber band around his head, water torture, physical abuse with canes, weapon threats, being stripped naked, having rocks thrown at him, cigarette stumping, falanga, suspension from the arms and buried alive in a dark hole. Yaqub described posttraumatic and pain symptoms shortly after the torture, but loss in function for only the previous three years. He fulfilled the criteria for PTSD, a moderate depressive episode and had pain in his head, hands, knees, feet, neck, shoulders, elbows, lower back, and legs.*

In Yaqub's therapy sessions, the exposure complied with the NET manual for most sessions, and the therapeutic relationship was described as good. However, exposure was often closed prematurely or characterized by lack of activated affect in session. The therapist reported time as a hindering factor, since they seldom had time for in-depth exposure after reading through the narrative at the beginning of the sessions. Yaqub also arrived late a few times. During exposure for the torture sequences, Yaqub experienced physical pain but rarely displayed emotional distress. Some sessions concentrated exclusively on positive events (flowers), and a few were focused on current stressors, including the family's living situation, Yaqub's sleep problems, and everyday triggers of posttraumatic symptoms. At the end of the treatment, he communicated that he did not feel that he had improved, however, he did not meet criteria for PTSD at the final follow-up.

When starting the treatment, Yaqub was not motivated for physiotherapy and expressed lack of hope for improvement. Instead of physical therapy, he wanted to focus on talking about the torture, and understanding why the torturers had localized specific body parts targeted with specific methods. Yaqub was anxious about hydrotherapy because of the water torture he had endured, and he did not participate in the first two sessions. In the third session, he complied and enjoyed the exercises in the warm water.

Patient 5: Hassan: *Hassan was in his 30s, from the Middle East and had been in Norway for a year. He lived with his wife and child, and was taking Norwegian classes. When Hassan was a teenager, he started military training and*

became a guerilla soldier for three years. Subsequently, he was imprisoned five times in two different countries. During one of the periods of detention, he was tortured for 12 days, in another for 20. The torture consisted of psychological pressure, breaking of his arm, being stripped naked, electric shocks, deprivation, and living in unsanitary conditions. He described psychological struggles prior to the torture, but that the posttraumatic symptoms began afterwards. Hassan was diagnosed with PTSD, a moderate depressive episode, and had pain and reduced functioning in his, neck, shoulders, chest, lower and upper back – all worsening in wintertime. He also had pain in his head and legs, and suffered additional pain related to medical treatment of somatic disease.

Early in treatment, Hassan expressed ambivalence about receiving treatment, but he decided to give it a try. Simultanously, he was in the middle of a divorce, and 10-20 minutes of most therapy sessions focused on this process or statements and applications related to Hassan's living situation, school and work practice. During exposure, he sometimes experienced headaches and bodily pain, which subsequently the therapist discussed with the physiotherapist between sessions. About half of the sessions complied with the NET manual, but paused halfway as Hassan confided that he had a marijuana abuse problem. Associations between drug use, PTSD and its treatment were addressed, referral to an addiction treatment center was discussed. Hassan decided to try to quit on his own. Subsequently, he complied in all sessions, but found it challenging to endure exposure in the end, as he felt most of his symptoms were gone and instead wanted to focus on his future. Some sessions were focused on how the trauma had influenced his family life, religion, identity, existential issues, and how he experienced meaning after receiving therapy. At the end of treatment, Hassan had successfully ended his marijuana abuse and was working on the relationship with his wife, who was invited for the final therapy session. He did not meet the criteria for PTSD at the final follow-up.

In the physiotherapy, despite his reduced physical function, Hassan was proud of his refusal to let this hinder him from being physically active and performing activities of daily living. He was cooperative and motivated for the treatment and had physical therapy in all sessions. After treatment, his pain intensity level was halved. He expressed that he wanted to return to his home country to show that he is healthy, and described his pain as "small troubles that can't wear down a former guerilla soldier".

Patient 6: Maryam: *Maryam was in her 30s from the Middle East, had been in Norway for a year, was divorced and lived with her child. She had completed high school and was studying. Maryam and her family were politically active, which led to her being arrested with her daughter while in her 20s. They were held captive for 1.5 months and moved between different prisons. In prison, they both fell ill, but were refused food and medical treatment. The torture consisted of beatings with a baton, falanga, deprivation, isolation, refused clothing, being bound, and witnessing the torture of others. She reported struggling with anxiety and depression before, while her posttraumatic symptoms began after the torture. She fulfilled the criteria for PTSD, panic disorder, recurrent depressive disorder (current episode moderate), social phobia and pain in her head, chest, abdomen, hands, knee, foot, neck, hip, shoulder, upper and lower back. She also suffered from fatigue, headaches and rheumatic symptoms, fibromyalgia, a somatic disease and arthritis. Maryam had no social network in the region besides her daughter.*

In the early stages of therapy, Maryam complied with the NET activities and expressed motivation for exposure. During exposure, she often exhibited avoidance, manifesting in excessive details, and she did not always reach

optimal activation of affect. From the fifth session, more time focused on current stressors; Maryam had received news that her mother had fallen seriously ill. This was especially difficult for Maryam, as she was unable to return to visit her and had no social network to turn to. Before the 16th session, she was in a work-related accident, and as a consequence suffered back damage, further decreased physical function and increased pain and distress. She also hit her head in the fall. In sessions, Maryam struggled to conceal her pain, reported constant fatigue, was frequently cold and found walking very painful. Therefore, the therapist used some time to work on sitting posture, relaxation, grounding, and provided blankets. Mid-therapy, Maryam wanted to move to a different part of the country, where she had family. The therapist helped her to arrange this, and considered the availability of social support to be of great importance for Maryam and her psychological health. Maryam expressed that it felt good to have talked about the traumas. She still met criteria for PTSD at the final follow-up.

In the physiotherapy, Maryam was distressed because of high pain intensity in her whole body, both musculoskeletal and rheumatic in nature. Despite this, as well as constant fatigue and headaches, she complied with and was motivated for the physical exercise program in the beginning. However, mid-treatment she suffered a further increase in pain after the aforementioned accident.

Individual results: visual analysis

What emerges from a visual analysis (see Figure 1) of the individual patient data is a trend characterized by decreased PTSD symptoms, but few other changes and still a persistent degree of distress after treatment. In summary, two patients (3 and 5) have reached a relatively low level of symptom severity, two (1 and 4) have had a marked improvement but still suffer considerably, while two (2 and 6) have had unremitting symptoms. For depression, most patients had apparently experienced a decrease, while two (1 and 2) seemingly endure continuous distress. Decreased pain and improved functioning can be seen for two patients (3 and 5), and deterioration for two others (1 and 6). Missing data precludes patients 2 and 4 from the analysis of the NOSF-MISS results.

Adherence Challenges

All therapists reported adherence challenges, mostly due to the patients' needs for help with current stressors or poor compliance. Adherence was evaluated as moderate for four patients (2, 3, 5 and 6) and as low for two (2 and 6).

Evaluation of the combination treatment

A visual analysis of the symptom progression during the course of the treatment for these six patients does not reveal any clear trend, and there are substantial differences between the patients. Despite the modest decrease in PTSD symptoms observed in tracking them session to session, half of the patients no longer met the criteria for a PTSD diagnosis at the three month follow-up, and two experienced clinically significant change, defined as a decrease of >2SD in CAPS total score.[33] Furthermore, this was maintained at the six-month follow-up. Regarding depression, only one patient (patient 3) was no longer diagnosed with depression at follow-up and only one (patient 6) achieved clinically significant change. With respect to pain experience, two patients (3 and 5) had decreased pain intensity, two had no change (1 and 4) and one (6) experienced increased pain. Patient 2 achieved a clinically significant decrease in pain intensity, when considering the symptom progression from baseline to the final sessions (see Table 1). In

addition, no differences regarding startup time of the physiotherapy were observed in this study. The treatment results for pain intensity differed substantially between the patients, with some having dramatic changes and others none. Even though three out of five had clinically significant pain reduction at the first follow-up, only two of them retained these reductions three months later. In summary, as a preliminary evaluation, this novel combination treatment appears to be more effective for PTSD symptoms, and less so for pain and depression. However, this argument is highly speculative, for obvious methodological reasons.

Discussion

Variation in treatment response and potential predictors

It was expected that the combination of NET and physiotherapy would potentially be a promising treatment development for torture survivors with chronic pain and PTSD. However, as this study failed to illustrate an unambiguous treatment effect on PTSD and pain symptoms, it is clearly not generalizable across different clinical cases. With this research design or actual outcomes, it cannot be concluded that the patients improved because of the treatment provided. Still, it is useful to discuss possible explanations for the differential outcome of our patients, since identifying what factors may predict the outcome is of great importance for clinicians. According to Barlow et al., in case studies, "the issue of interpreting mixed results and looking for causes of failure illustrates an important principle in replication series" (p318).[19] Failures do not necessarily indicate that a treatment fails to work, but might point to circumstances and conditions under which the treatment does not have the desired effect.[19] In our study, there are substantial differences in the extent of symptomatic improvement among the patients. In sum, two ("responders": patients 3 and 5) of the patients became much better, with great reductions in both PTSD symptoms and pain intensity. Another two ("part responders": patients 1 and 4) showed improvement with regard to PTSD but still experienced substantial distress, and no change in pain intensity. The last two ("non-responders": patients 2 and 6) did not improve. Why was the treatment more effective for the responders than for the other patients?

Applying Weathers categories,[25] the responders had lower degrees of PTSD severity prior to treatment (severe and moderate), while the other four had extreme PTSD. One possible explanation is that the treatment is more effective for less severe cases. The results might also reflect a ceiling effect, such that the treatment only has an effect up to a certain degree. Furthermore, the results may reflect a therapist effect, as the same therapist had both patients within each category. The moderate to low degree of compliance or adherence could possibly have led to reduced effect of the treatment for some of the patients. In this study, compliance was not related to symptom load, as the non-responders and responders had the same degree of compliance. Avoidance during exposure was reported in all six cases. However, compliance and adherence were evaluated as lower for the part responders compared with the other patients. In addition, the physiotherapist reported compliance challenges with the part responders, including lack of motivation. Another observation was that the therapists reported extratherapeutic stressors and low physical functioning to interfere with compliance. Thus, better identification of obstacles to compliance might lead to improved outcome for some of the patients. As noted by Silove,[26] substantial psychosocial problems

have been associated with poorer treatment outcomes and compliance. Some opponents of trauma-focused therapy for torture survivors argue that it is too narrow and risks ignoring the many and complex issues this group struggles with.[27] In this regard, Patel[28] raises concern that this approach is medicalizing a sociopolitical problem, and the cross-cultural applicability of PTSD has been debated.[29] Thus, we acknowledge that the compliance challenges could be related to cultural or other factors that NET does not adequately address. However, avoidance is one of the core symptoms of PTSD, and a recent paper questions the validity of not offering trauma-focused therapy to refugees based on the assumption that they suffer from complex PTSD due to enduring complex trauma.[30]

The non-responders differed from the others in that both were diagnosed with comorbid social phobia and lifetime panic disorder. Patient 6 additionally suffered from fibromyalgia and recurrent depressive disorder. It is possible that one or both of these disorders negatively influenced treatment outcome, in a similar way to how generalized anxiety disorder affects treatment of other anxiety disorders.[31] Both disorders can possibly lead to social avoidance or isolation, and thus hinder social support, which is indeed a factor associated with poorer mental health in refugees.[32]

According to Silove,[26] current stressors might impede recovery. In fact, patient 6 (non-responder) showed improvement in PTSD early on which subsequently declined and instead was aggravated. The aggravation occurred when she received news of her mother's serious disease in her home country and worried about not being able to visit her. At about the same time she had a work-related accident which led to increased pain and reduced mobility and functioning. In addition, all patients except for patient 5 (responder) reported financial struggles related to their health problems. Three patients had fewer financial struggles at the final follow-up.

Limitations of the Study

First, using an A-B case series design and its accompanied small sample size impedes generalization to other populations. Second, the lack of a control group, only two baseline measurements and no control of eventual parallel pharmacotherapy make it difficult to assess whether the effects found are the consequence of the treatment provided and not owing to common factors, regression to the mean or spontaneous remission. Due to these and a number of other limitations our results should be interpreted with great caution.

Summary and conclusions

In this study, we have evaluated a novel treatment approach coupling narrative exposure therapy with physiotherapy for torture survivors suffering from chronic pain and PTSD. The small sample size and design precluded generalization and inferences about effect, however enabled an exploratory description of six therapies. Despite its limitations, the study is original in its aim to couple physiotherapy with NET, and demonstrates that some torture survivors who suffer high symptom loads can achieve good outcomes when working in parallel with traumas and pain. Furthermore, we have discussed the possible effect of this combination treatment, with an emphasis on individual differences between the six different cases. It highlights some of the complexities regarding assessment and treatment of torture survivors, exemplifies the point that no treatment works for all patients, and provides tentative explanations

as for why that might be. Our hope is that it stimulates research that will enable further refinement of rehabilitation strategies for torture survivors.

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Mercy for money: Torture's link to profit in Sri Lanka, a retrospective review

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Key points of interest:

- This paper supplements earlier studies on prevalence of bribe payments to end torture in Sri Lanka, adding trends throughout the war, after the war, involving multiple armed organizations, and across wide geographic locations.
- Victims may not genuinely be considered to be a security risk but are used for extortion.
- Significant economic and social impact on families is likely.
- Torture unlikely to stop until financial incentives are removed.
- High prevalence suggests that perpetrators act in collusion with their superiors and benefit from impunity.

Abstract

Background: The purpose of this retrospective study is to describe the pattern of bribe taking in exchange for release from torture, during and after the decades-long war in Sri Lanka. **Methods:** We reviewed the charts of 98 refugee claimants from Sri Lanka referred to the Canadian Centre for Victims of Torture for medical assessments prior to their refugee hearings in Toronto between 1989 and 2013. We tallied the number of incidents in which claimants described paying cash or jewelry to end torture, and collected other associated data such as demographics, organizations of the perpetrators, locations, and, if available, amounts paid. We included torture perpetrated by both governmental and nongovernmental militant groups. Collected data was coded and evaluated. **Findings:** We found that 78 of the 95 subjects (82.1%) whose reported ordeals met the United Nations Convention Against Torture/International Criminal Court definitions of torture described paying to end torture at least once. 43 subjects paid to end torture more than once. Multiple groups (governmental and non-governmental) practiced torture and extorted money by doing so. A middleman was described in 32 percent of the incidents. Payment amounts as reported were high compared to average Sri Lankan annual incomes. The practice of torture and related monetary extortion was still reported after the end of the war, inclusive of 2013. **Interpretation:** Torture in Sri Lanka is unlikely to end while profit motives remain unchallenged. As well as health injuries, victims of torture and their families suffer significant economic injuries while their assailants are enriched. The frequent link between torture and impunity means multiple populations the world over are vulnerable to this abuse.

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Introduction

Reports of bribe payments to end torture are commonplace, yet the phenomenon is rarely given detailed attention. Torture's efficacy as a tool to increase security, and the related legal and ethical problems, are frequent subjects for public discussion. Medical accounts generally focus on the physical and psychological impacts torture has on affected individuals, rather than on torture's profound social sequelae.[1] The purpose of this retrospective study is to illuminate one of torture's socio-economic dimensions within a particular context: the link between torture and bribe extortion during the 1983-2009 war in Sri Lanka, and during the war's immediate aftermath (2009-2013). Based on the reports of 98 Sri Lankan refugee claimants assessed in Canada during that time, this study identifies organizations whose members gained financially through torture, the amounts of cash involved, and the frequency with which detainees were released because they paid bribes. The political/security aims of the perpetrators, as reported by the victims as the overt motivation for their torture, distinguish these actions from the criminal form of kidnapping for ransom, which in itself is not considered torture.

By reporting descriptions of recurring patterns involving torture-ending bribes, it can be argued that financial extortion is intertwined with torture in Sri Lanka and that the profit motive is thus a potent driver of the practice of torture.

Background

Civil conflicts, and the locations in which these conflicts devolve into open violence, involve multiple histories, causes and consequences. Outsiders such as ourselves will inevitably omit or misrepresent what are important facts to many. In the following paragraphs, we give what is assuredly a very limited sketch of the context for this paper.

Four hundred years of colonial rule led to identification and administrative representation through essentialized ethnic categories.[2,3] (p3-39, p47-54) After Sri Lanka achieved independence from Britain in 1948, there was increasing friction between the Sinhalese majority and the Tamil minority. Government legislation and successive new constitutions promoted majority aspirations but eroded Tamil and other minority rights and their traditionally held protections.

A war for an independent Tamil state in the north and east of the island was eventually led by the Liberation Tigers of Tamil Eelam (LTTE, or Tamil Tigers). It began after years of political frustration and the development of several militant Tamil groups. Ultimately, open war broke out after the 1983 "Black July" riots in which one to three thousand Tamil citizens were killed in retaliation for the killings of Sinhalese soldiers in the north.

The LTTE developed their own sophisticated army and navy, and also used suicide and other bombings to attack their detractors and civilians to instill fear throughout the country. "Ethnic cleansing" of Sinhalese and Muslim people took place in Tamil "homelands". The LTTE also accepted and conscripted women as members of their fighting ranks, including the elite "Black Tigers" who carried out suicide attacks. This meant that young Tamil women, as well as men, would be suspected of being "terrorists". The LTTE were notorious for conscripting children and forcing them into their fighting ranks.[4] For years the LTTE enforced their de facto governance over large regions under their control.

For its part, the government was brutal in its response. The authorities were already empowered by emergency regulations, originally promulgated in 1971 under the Public Security Ordinances Act to facilitate suppression of the largely Sinhalese, class-based Janatha Vimukthi Peramuna (JVP) uprisings. The Prevention of Terrorism Act (PTA) of 1979, made permanent in 1982, had given the authorities further powers to arbitrarily detain terrorist suspects and move them to undisclosed locations. Millions of civilians were displaced by the war's violence and tens of thousands were killed.[2] (p278) Detention and torture of civilians was common, as were disappearances. This did not change after Sri Lanka ratified the United Nations Convention against Torture in 1994. Also of note is that, in March of 2004, Sri Lanka ratified the United Nations Convention against Corruption.

Multiple Tamil paramilitary groups worked alongside the military in support of the government's aim to destroy the LTTE, and presumably to extend their own power and influence. In a major blow to LTTE hegemony in eastern Sri Lanka, "Colonel" Karuna and his fighters split from the LTTE in 2004 to form their own paramilitary group in support of the government.[5] Government intelligence agencies, "home guards" and the police were all involved in the conflict.

Over the years of the war, there were a number of poorly observed ceasefires. The Indo-Sri Lanka Accord of 1987 brought the Indian Peace Keeping Force (IPKF) to the north and east of the island, until heavy losses inflicted by the Tigers forced their departure in 1990. Another important ceasefire was brokered by Norway and signed in 2002, but peace-talks failed and open conflict resumed in 2006. (6, p243)

The war between the Sri Lankan government and the LTTE was declared officially over in May of 2009. A long military campaign had pushed the LTTE out of their strongholds and cornered them on the east coast, where they were either killed or taken into detention. Velupillai Prabakharan, the supreme leader of the LTTE, was killed in the fighting, along with many other top leaders. Thousands of Tamil civilians had been coerced by both sides to retreat with the LTTE - as many as 40,000 civilians were killed in the final conflict and thousands were detained in "rehabilitation camps".[7] (p32) In spite of the war's end, military suppression and abuses of human rights are ongoing in traditionally Tamil regions of the country. Detentions and torture continue to be reported by Sri Lankans.[8]

Methodology

The reviewed charts were those of all 100 Sri Lankan refugee claimants assessed by two family physicians from 1990 through December 2013. 89 of these medical examinations were originally conducted by Dr. Wendell Block, one of the authors of this article. The medical assessments consisted of relevant history-taking, careful examination of any scars or injuries attributed to torture, a detailed description of the physical findings in the medicolegal report along with a statement as to whether the findings were consistent with the given history. The claimants had been referred to the Canadian Centre for Victims of Torture (CCVT) by their immigration lawyers for medical documentation prior to their refugee hearings, where these medical reports were accepted as evidence by government immigration adjudicators.

The charts reviewed for this study included the claimant's legal narrative and the medical report. Two claimant files were excluded because they did not contain both of these documents (n=98). For each

individual, while reviewing their chart, a separate document was created to note their demographic data (including ethnicity, gender, year of birth, education level, occupation, marital status, year assessed by physician at CCVT) and the details of each reported incident of torture (including year of incident, age of individual during incident, military group involved, characteristics of detention, detention time, mediating group (if applicable), location of incident, judiciary involvement (if applicable), round-up versus individual detention, and related scars). Using a predetermined coding system, the individual data was transferred onto a spreadsheet for grouping of information and comparison. In order to assess inter-rater reliability, each reviewer randomly selected ten of the other's charts and recollected the data. The data recorded the second time was consistent with the initial collection.

In February and March of 2014, the keywords "Sri Lanka civil war", "Sri Lanka human rights", and "Sri Lanka bribery" were used in a search of the University of Toronto Library's articles and databases (which include medical and interdisciplinary databases), looking for writing directly linking human rights abuses with bribe extortion. We also accessed the resources of organizations known to monitor human rights issues in Sri Lanka. Information about Sri Lankan incomes was readily accessed through Sri Lankan government websites.

Relevant reports included Transparency International's "In Pursuit of 'Absolute Integrity'—Identifying Causes for Police Corruption in Sri Lanka", which addressed the issue of ongoing police corruption.[9] "Police Torture Cases: Sri Lanka 1998-2011", an Asian Human Rights Commission publication, summarized the most serious 323 out of 1500 reports of torture during that time.[10] The victims in these cases were not refugee claimants. A common theme was the police use of torture to gain confessions of crimes and/or to extort bribes from randomly arrested individuals, usually from the poorer classes.

The definition of torture used in this article is that of the United Nations Convention Against Torture, as well as Article 7 of the Rome Statute of the International Criminal Court (to include torture perpetrated by non-State combatant groups).[11, 12] These are broad definitions, and to form a clearer picture of the kinds of torture represented by this study's findings, an initial distinction is made between three subtypes: subtype (1) "classical" torture, in which the victim alleges physical and/or sexual abuse while detained at least overnight in a facility controlled by the perpetrator's organization; subtype (2) arbitrary detention, in which the victim alleges detention in poor conditions, without legal access, without knowledge of when they might be released, and with full knowledge that they could be physically/sexually assaulted;[5] and, subtype (3) the victim alleges physical abuse without detention (at least not overnight).

Findings

The 98 subjects described 201 distinct detentions which included physical torture (first subtype). For 121 of these detentions (60.2%), a clearly described payment gained the person's release. Incidents in which a release was arranged without the explicit description of payments of cash or jewelry were not counted. There were 20 clear descriptions of payments paid to end detentions which did not include overt physical abuse (second subtype). Payments were also made five times to end assaults by government authorities or militants outside of detention (third subtype). Thus, there were 146 torture-ending "bribe incidents".

Table 1: *Study Population Characteristics*

Characteristic	Total (n) = 98
Ethnicity	Tamil = 89 (90.8%) Sinhalese = 7 (7.1%) Muslim = 1 (1%) Unspecified = 1 (1%)
Gender	Male = 90 (91.8%) Female = 8 (8.2%)
Year of birth	Before 1930 = 2 (2%) 1930-1939 = 2 (2%) 1940-1949 = 2 (2%) 1950-1959 = 16 (16.3%) 1960-1969 = 20 (20.4%) 1970-1979 = 43 (43.8%) 1980-1989 = 13 (13.3%) 1990 and after = 0
Education	Primary = 6 (6.1%) Secondary = 59 (60.2%) Post-secondary = 18 (18.4%) Unknown = 15 (15.3%)
Occupation	Fishers, farmers, labourers = 44 (44.9%) Commercial business = 23 (23.5%) Professionals = 10 (10.2%) Students = 4 (4.1%) Unemployed = 2 (2%) Unknown = 15 (15.3%)
Marital status	Married = 38 (38.8%) Single = 24 (24.5%) Widowed = 3 (3.1%) Unknown = 33 (33.7%)
Time of medical assessment in Canada*	1989-2001 = 59 (60.2%) 2002-2005** = 11 (11.2%) 2006-2009 = 6 (6.1%) 2010-2013*** = 22 (22.4%)

** In all cases, a significant amount of time had elapsed between the alleged incidents of torture and the time of medical examination*
*** Ceasefire period in Sri Lanka*
****War was officially over*

Three of the 98 individuals made their Canadian refugee claims for reasons unrelated to torture. Of the 95 who had been tortured, 73 (76.8%) described at least one incident in which they paid to end a detention during which physical torture took place. Another five described paying at least once to end a detention not involving physical abuse, or to end an assault outside of detention, in circumstances believed to satisfy the UN torture definition. Thus, of the 95 individuals with a history of torture, 78 (82.1%) described paying to end it at least once. 43 (55.1%) reported paying to end more than one ordeal.

Table 2: *Number of incidents* per claimant*

Number of incidents*	Number of claimants thus affected
0	17
1	35
2	28
3	9
4	4
5	1
6	0
7	1

**Incident = an incident of paying to end torture*

The 146 bribe incidents could be characterized in more detail as follows:

Timing: Two incidents occurred in 1984-1985. 17 incidents took place in the period 1987-1990, when the Indian Peace Keeping Force (IPKF) was in northern Sri Lanka. 105 incidents took place from 1991-2002, seven during the 2002-2007 ceasefire, and three between 2007 and the war's end in mid-2009. 12 incidents occurred after the war.

Table 3: *Military/Militant groups involved in incidents**

Group	Number of incidents	Years incidents occurred
SL Military	60	1984-2013
Police	47	1992-2008
LTTE	14	1990-2003
Paramilitary groups	13	1989-2011
CID	3	2009-2010
IPKF	6	1989
Others	3	-

**Incident = an incident of paying to end torture/ detention*
Paramilitary groups = EPDP, PLOTE, EPRLF and Karuna
LTTE = Liberation Tigers of Tamil Eelam
CID = Criminal Investigation Department
IPKF = Indian Peacekeeping Force

Offenders: See Table 3.

Bribe mediators: In 47 incidents, a specific individual or group was named as a third party who arranged the bribe payment (family members not included). The mediators were described as "brokers" in five cases. Lodge owners in Colombo (Sri Lanka's capital) were described as performing this service in 11 cases. Providers of temporary housing to Tamils fleeing the conflict zones en route to leaving the country, these lodge owners would step in with a payment when the police conducted Tamil round-ups (round-ups which led to detention and torture, generally for a few days). Other mediators included Tamil paramilitary groups (7 cases), "a Muslim man" (6 cases—one of these was "a Muslim woman"), and the agents who had been hired to get the subject out of Sri Lanka (8 cases). Other descriptors were "a lawyer", "the Catholic priest", the "Gram Sevaka" (village leader), "someone with connections", and "a friend of my father's". In one case a bribe was paid directly to a nurse at a hospital to enable an escape. One man, who in 1996 had been apprehended by the army and turned over to the police in Vavuniya, gave this description of his broker: he was "one of the middleman (*sic*) who arranged for and collected bribes on behalf of the army".

Bribe amounts: A numeric amount was recorded in 73 incidents. Jewelry was used in five incidents. The bribe amount was not recorded for 68 incidents. Table 4 shows the lowest, highest and median amounts reported per phase of the war.

Detention times: Time in detention was reported as one month or less in 112 of 141 detentions ended by a bribe (79.4%). The longest detention ended by a bribe was 2.5 years.

Torture method: Although the aims of this study did not include a quantitative catalogue of the methods of torture described by the subjects, the methods should be mentioned. The most common physical torture method included blunt beatings with slaps, punches, kicks, and blows with implements such as batons, sand-filled pipes and rifle butts. Other torture methods included sexual assault, asphyxiation, suspension, burns, and stress positions. Psychological techniques included isolation, humiliation, threats (including death threats), exposure to the torture of others, sleep interruption, and verbal abuse. Detainees were confined in dirty, cramped quarters without beds, toilets, or ready access to water. Food was of poor quality and minimal. There was no access to legal assistance or communication with the

Table 4: *Amounts paid per phase of war, in Sri Lankan Rupees (Rs. 100,000 equals 746 USD (June 4, 2015))*

Phase of War*	Period	Lowest amount reported	Highest amount reported	Median	No. of incidents with amount reported/Total no. of bribe incidents
Eelam War I	1983-1986	20,000	20,000	20,000	1/2
IPKF presence	1987-1989	15,000	25,000	25,000	5/14
Eelam War II	1990-1994	3,000	300,000	29,000	11/16
Eelam War III	1995-2001	5,000	300,000	37,500	39/92
Norway brokered Ceasefire Agreement (CFA)	2002-2003	50,000	500,000	275,000	2/2
LTTE/Karuna split and Tsunami (CFA still in effect)	2004-2005	80,000	120,000	100,000	3/4
Eelam War IV	2006- Jun 2009	100,000	300,000	200,000	2/4
Post War	Jul 2009-2013	25,000	2,500,000	225,000	10/12

**Phases of War as described in The Cage*[6] *(Timeline p240-244)*

outside, and no sense of how long each detention would last.

Location: The incident location was provided in 137 cases. See Figure 1.

Round-ups: In 48 incidents, the reported detention began with a group round-up.

Legal involvement: Access to a lawyer was described in one case.

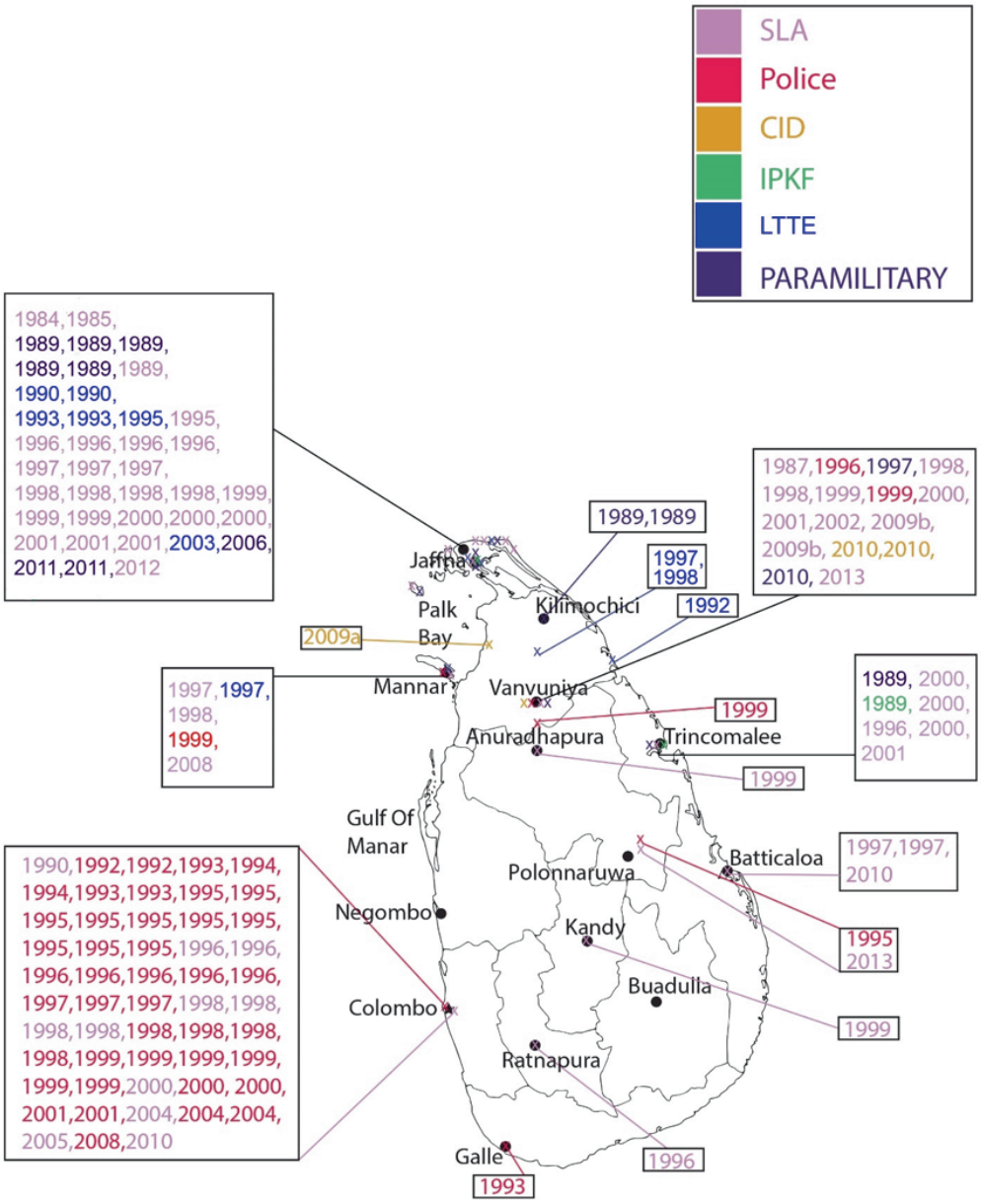
Associated physical scars: Most of the study subjects reported being tortured multiple times. Of the 78 individuals who had paid at least once to end torture, 76 had physical scars consistent with at least one episode of torture. Documentation of scarring and on-going injuries related to torture was the predominant reason for referral to the two assessing doctors in the first place. 43 of the 146 bribe incidents resulted in scars still apparent at the medical assessment.

Age at time of incident: Most incidents (120) occurred when people were age 21 to 50, but 22 were under the age of 21 (three were 15 or younger). The two eldest were 68 and 71.

Women: Five of the eight women (all Tamil) described paying to end torture, one of them twice. Two paid with jewelry.

Sinhalese men: Four of the seven Sinhalese men described paying bribes to end torture:

Figure 1: *Map showing incident locations, year of incidents and perpetrators*



three to policemen, and one to army personnel.

Reasons given for torture: In their legal narratives and medical histories, the study subjects generally related the accusations leveled by their torturers. When LTTE were the torturers, the reasons for torture included refusal to cooperate with them, and suspicion of giving information to the army (or IPKF). In the majority of cases, those tortured by the military, police, or paramilitaries were accused of being LTTE members, of supporting LTTE, or of having information about LTTE. There was an implied assumption that to be Tamil was to be a suspected terrorist. "Round-ups" of Tamils occurred in the conflict zones after LTTE actions, and also in Colombo where Tamils from outside the city were suspect. One person was accused of supporting the JVP. Paramilitaries also used torture to pressure their victims into joining them. Demands for money were generally not overt at the beginning, though one person recorded that the "EPDP demanded 2 lakhs [200,000 Rs.] from me, otherwise they would turn me over to the police . . . I did not have that kind of money. The EPDP took me to the Wellawatte police station and I was kept there." After the war's end, Tamil victims continued to be accused of being members of, supporting, or trying to reorganize LTTE.

No mention of paying bribes to end torture: The 17 individuals who did not mention any bribe payments to end at least one of their episodes of torture were quite similar to the study group as a whole. Nine of these individuals reported making payments to LTTE to avert a threat.

Other extortions: 77 of the 98 people described at least one clear incident of extortion outside the context of torture - generally by LTTE (68 of the 77). These extortions were carried out with threats to assault, kill, or detain the victims; or to conscript their children. 15 people described these extortions by Tamil paramilitary groups, four by the IPKF, four by the police, and eight by the military. The threats were not always demands for cash. People were also forced to give the products of their work, their vehicles and belongings, their labour, and even their blood (for transfusions).

Discussion

Amnesty International's "Locked Away—Sri Lanka's Security Detainees" describes reports of police and military personnel demanding bribes for the release of security detainees.[13] Freedom from Torture's "Tainted Peace: Torture in Sri Lanka since May 2009", based on the medicolegal assessments of 148 people who had been tortured by the Sri Lankan authorities between May 2009 and September 2013, reports that 105 (71%) gained their release by paying bribes.[14] (p9) In 2014, the Bar Human Rights Committee of England and Wales, along with the International Truth and Justice Project of Sri Lanka, published their STOP study entitled "Torture and Sexual Violence in Sri Lanka 2009-2014". This study presents the results of structured interviews with Sri Lankan torture survivors, conducted by nine independent lawyers; in 38 of the 40 cases, the survivor reported that a bribe had been paid to gain their release.[15] The same group's follow-up study of 20 Tamils who had been tortured in 2015 showed that the practice continues: 19 of the 20 reported that ransoms had been paid to gain their release, and the bribe amounts were high (bribes ranged from 350,000 to 1,000,000 Rs.). In "The Rule of Law in Decline - Study on Prevalence, Determi-

nants and Causes of Torture and Other Forms of Cruel, Inhuman or Degrading Treatment or Punishment in Sri Lanka", Kishali Pinto-Jayawardena analyzes the lack of protection from torture afforded to Sri Lankan citizens, in spite of Sri Lanka's international agreements, domestic legislation and institutions which in law should provide them with such protection.[16]

While these studies note frequent bribe payments to end torture, the present study examines the phenomenon in more detail; throughout the war, including ceasefires and the post-war period, and across widespread geographic locations. The practice was not limited to any particular organization, but was practiced by government officials and non-government militants alike. Although most victims were young adults, individuals across all ages and in multiple social groups were targeted - their chief commonality was the accusation that they supported the enemy. The high prevalence of release by payment suggests that the victims were not truly considered to be a high risk to security. Further, the high prevalence also suggests that the practice could only have taken place as a result of the offending authorities/militants acting in collusion with their superiors.

The descriptions of bribe payments within the documents did not describe the processes by which these transactions were initiated or negotiated, aside from the mention of mediators. However, even if payment initiation was on the side of the victim, in a context in which these transactions are common and the discrepancy in power between the parties being so great, responsibility must lie with the torture perpetrators.

Does the "profit motive" act as a primary motive for the apprehension, detention and torture of individuals conveniently labeled as "terrorists" or "enemy supporters"? Economists assume that people tend to pursue opportunities to better their lot in life, while minimizing risk.[17] Thus individuals or groups who are given the opportunity to profit through torture are likely to do so, if on balance the benefits outweigh the potential risks. Comparing the bribe amounts in Table 4 with national household incomes (Table 5) shows that, in Sri Lanka, the financial rewards gained through torture are high. It should be noted that the inflation rate in Colombo for this time period was 696%, or roughly 30% per year (based on the Colombo Consumer Price Index (CPPI) as reported by the Sri Lanka Central Bank).[18] Inflation rates would likely have been higher for regions of the country more directly affected by war. Further instructive comparators include: a police constable's monthly wage in 2004 was Rs. 9,605 to 14,225,[19] while the 2013 Sri Lankan military website advertised monthly gross pay for officer cadets as Rs. 26,617.[20]

Table 5: *Sri Lankan Household Incomes*[19]

Year	Median Monthly Sri Lankan Household Income (Rs)
1990/91	2,547
1995/96	3,793
2002	8,387
2009/2010	23,746
2012/2013	30,814

At the same time as financial rewards gained through torture being high, a review of Sri Lanka's political context reveals that the risks to perpetrators are very low. The Prevention of Terrorism Act and related security measures allow authorities to detain "sus-

pects" without charge, in undisclosed locations, and for extended periods of time. The state of impunity for government agencies, and the paramilitary groups they protect, is well documented. According to the International Jurists Commission, as of 2012, there had been only five court convictions of authorities charged with torture. In one case, the Officer-in-Charge at the Polpithigama Police Station was found guilty of torturing a seven year old. The Kurunegala High Court sentenced the accused to two years in prison (the mandatory minimum sentence is seven years) and ordered the accused to pay the victim Rs. 25,000.[21] (Sri Lanka's 1994 Convention against Torture Act legislates fines should be between Rs. 10,000 and Rs. 50,000 - an amount unchanged during the high inflation time period of this study, and another useful comparator to bribe amounts reported).[22]

Sri Lanka is a signatory to the UN Convention against Corruption, and has an established Commission to Investigate Allegations of Bribery or Corruption.[23] However, the Commission is unable to proactively initiate investigations of its own, and has been the subject of political interference.[24]

As for LTTE, they operated in large regions for many years without accountability and were free to "tax" and extort resources in any way they chose,[4, 25] with the only apparently negative consequence being the loss of "hearts and minds". Some subjects in the current study reported closing their businesses, or reducing their farming/fishing production, because positive output simply brought higher demands from LTTE.

In terms of impact on victims, it is possible that many would not have been apprehended at all without the profit motive. Torturers possibly employ harsher methods to heighten family fears and thereby increase the amounts they can extort. The desperation of the victims' families is apparent in the large sums they were willing to pay to gain the victims' release. The large amounts paid also suggest that the economic impact of paying them would have been severe; a family's ability to pay likely depended on the liquidation of assets, loans arranged under duress, or the resources of extended family networks (including the diaspora). The consequences to those unable to pay the demanded bribes are not apparent to this study.

Furthermore, it is noteworthy that 55.1% of the study subjects paid bribes more than once to end torture. Study subjects paid further large amounts to leave the country (often describing hired agents, the payment of bribes at checkpoints, to police in Colombo, and to passport control), plus the cost of transport leading to Canada. These costs are over and above the 'usual' economic costs of torture, which include interrupted or lost employment/education, temporary or permanent disability, and family/social disruption.[26] (p40-69) Far-reaching consequences would therefore have to be borne by subject's families with respect to their economy, quality of life, and ultimately health, in addition to suffering from the multiple effects of a protracted war.

On a societal level, it is well known that torture and the fear of torture is successful in intimidating and silencing opposition.[26, 27] The threat of torture - to oneself or to loved ones - changes behavior through fear of pain, rape, permanent injury, and disappearance or execution. Given this study's findings, in a context where torture routinely brings the extortion of large sums of cash, it is likely that intimidation through torture also functions by instilling a fear of severe economic injury to a family, business or career.

Limitations

This study's data was collected retrospectively, from documents whose primary purpose was not an inquiry into bribes. This likely resulted in under-reporting of the relevant information.

Subjects may have exaggerated their reports of injustice to strengthen their application for refugee status, as the purpose of the medical assessments was to document physical and/or psychological torture for the claimant's refugee hearing. This could include their reports of the torture they experienced as well as their reports of bribe paying. The fact that the information was collected at an overseas setting eliminated any possibility of substantiating their reports through local secondary sources. Information identifying those refugee claims found "not credible" by the Canadian Immigration Review Board was not available at the time of the review. Although the subjects represent a broad range of educational and occupational backgrounds, the lack of direct information regarding their incomes is a serious limitation.

The findings of this study focus on the behavior of low-ranking officials. The impunity granted to them and to allied paramilitaries must serve the interests of those in power. These links are opaque to this study's methodology, but it would be an error to assume they do not exist.

Lastly, women are under-represented in this study. The female physician whose assessments contributed to this study was no longer available after 2001, and the male physician generally assessed male refugee claimants. It is particularly unfortunate that there are no female subjects to represent the final years of the war and its aftermath.

Conclusions

1) In a context where torture turns a profit, it is very unlikely that torture will be stopped until the financial incentives are removed.

2) Human rights organizations working with torture survivors should routinely collect specific data about bribe extortion (amount paid, to whom, impact). United Nations rapporteurs to the UN Commission for Human Rights should be required to investigate and report the use of torture to extract bribes. The States responsible should be held to account. The United Nations' 2015 Investigation on Sri Lanka, conducted by the Office of the High Commissioner for Human Rights regarding possible war crimes, does report bribe payments as a frequent means to release for "surrendees" held in detention (and often tortured) at the war's end.[28] However, three earlier relevant UN Human Rights Commission reports reviewed are silent on this subject.[5, 8, 29] Neither the Sri Lankan government's 'Report of the Commission of Inquiry on Lessons Learnt and Reconciliation', nor the UN Human Rights Commissioner's formal response, address this abuse.[30]

3) In *Torture and Impunity*, Alfred McCoy argues that torture leads to empowerment of the torturer in terms of social authority.[31] (p114-150) Goodhand et al., based on research done in war-affected Sri Lankan communities, describe shifts of social capital in the context of violence.[32] Our study shows that torture also leads to financial empowerment of the torturer, and to economic weakening of the targeted individual/group. Post-conflict efforts to achieve civil reconciliation must address the particular ways in which "wealth" has forcibly been moved between community groups.

4) The excesses revealed in this study provide another illustration of what happens when individuals/institutions have license to exert unlimited power over other human beings. Impunity and lack of accountability should not be seen as unique to Sri Lanka, and something which 'developed' countries eschew to ensure "ethical torture."; impunity generally accompanies government authorizations to use "coercive techniques", exemplified by the U.S. Administration making enormous efforts to ensure impunity for CIA and military personnel engaged in torture after 9/11.[31]

Ethics committee approval

This study was approved by the Health Sciences Research Ethics Board (REB) at the University of Toronto under the REB's delegated review process.

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Recognition and treatment of law enforcement violence against detainees and prisoners: A Survey among Israeli physicians and medical students

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Key points of interest

- Prisoners and detainees suffer an increased risk of violence and maltreatment but are often overlooked.
- A significant number of physicians and medical students would not report suspected instances of violence and maltreatment and even appear to support the use of torture in certain circumstances.
- Clear practice guidelines must be developed and implemented regarding the role of medical practitioners in treating such cases, with a special emphasis on documentation and reporting.
- The Israeli Ministry of Health needs to provide a clear policy of redress for any reports on violence towards detainees and prisoners.

Abstract

Introduction: Physicians regularly encounter victims of violence. Although some at-risk groups are increasingly recognized as such, the risks faced by prisoners and detainees are often overlooked. The scope of violence against them is unknown and their treatment is often hampered by unique social and institutional impediments. This article reviews the need for improved recognition and protection of such patients and the associated obstacles, while presenting information on the experience, knowledge and attitudes of physicians in Israel regarding the maltreatment of prisoners and detainees. **Methods:** We sent a questionnaire to physicians and medical students in Israel to enquire about their knowledge concerning examination and treatment of persons under police custody who appear to be victims of violence as well as their attitude concerning torture. **Results:** We received answers from

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443 physicians and 114 medical students. Most physicians would correctly examine and document the injuries, but only 59% would report their suspicions of violence to the Ministry of Health. Though 60% of physicians objected in principle to the use of torture, a majority endorsed the use of physical and psychological pressure during interrogation. Moreover, 29% of physicians thought it is permissible for physicians to examine detainees and verify their health so that torture can begin or continue. **Discussion:** Our study shows that there is a need for development and implementation of treatment and reporting protocols as well as educational programs concerning the ethical and legal requirements of physicians towards detainees and prisoners in Israel. Limitations of our study are discussed.

Keywords: Violence, prisoners, torture, attitude.

Introduction

Violence is recognized as a leading worldwide public health problem.[1] In many countries legislation has been passed which mandates that health professionals recognize, treat and report incidents of suspected violence to prevent its recurrence. Studies have focused on high-risk groups, like women, children, and the elderly who might be abused and neglected.[2, 3]

Prisoners and detainees are particularly vulnerable with respect to violence. In a survey conducted in 13 American state prisons, 13-35% of all prisoners reported violence by another prisoner and 8-32% reported violence by a staff member.[4] In a study conducted in 33 prisons in Germany, more than 25% of the prisoners reported being physically victimized within a four-week period.[4] With respect to detainees, a study of medical examinations performed while under police custody found that 25% of detainees reported suffering from violence, 58% of those by a police officer.[5] It should also be noted that victims in custody may be reluctant to report on violence by law enforcement officials. Furthermore, in some cases the treating physician may be employed by the police or the detention center and thus have loyalties which interfere with his/her obligation to the patient.[6]

Emergency medicine departments are a first contact point for victims of violence and can have a large impact on the medical and legal outcomes of such cases. Forensic knowledge and sometimes awareness is still largely lacking among physicians.[7] In a survey of academic emergency physicians in the USA, it was reported that 99.8% of the respondents believed excessive force is used by law enforcement agents and that 97.8% had managed such cases. Most of these instances went unreported, most surveyed departments had no policies and the physicians surveyed had not received training for such cases.[8] In Israeli detention facilities, small clinics exist, but most need to refer injuries requiring more than a physical examination to a hospital emergency room, thus all physicians working in the emergency department may come in contact with such cases.

In Israel, various articles of legislation as well as regulatory directives issued by the Ministry of Health (MOH) have aimed to improve the recognition and treatment of violence within medical settings. In 2003, the MOH issued a directive for the appointment of permanent committees for domestic violence, sexual exploitation and neglect of minors and incapacitated adults,[9] which were charged with the implementation of proper training and treatment within the Israeli health-care system. Persons in police custody, detention or imprisonment are not explicitly included in the directive, although

they are at risk of suffering violence, ranging from maltreatment to torture.[10] That said, the MOH has established a special committee that is charged with examining reports by health personnel of cases of suspected violence by law enforcement agents.[11] However, its current status is unclear, as are its purview and activity.

The true dimensions of violence against detainees and prisoners in Israel are, as yet, unknown. An Israeli media outlet found that 18% of Israeli citizens report they have experienced police violence.[12] Journalists and human rights organizations in Israel report on the continued mistreatment and torture of prisoners by Israeli security forces.[13, 14]

In addition to proper medical treatment of injuries, full treatment must include measures to protect the patient from further harm in the short term, and ensure reporting, with an eye towards redressing past injuries and preventing new cases.

Our survey related to possible obstacles which may hinder full and proper treatment of such cases including documentation and reporting, as well as the attitudes of physicians towards the use of violence and torture by the state.[15,16] Comments of physicians regarding any past experiences in which they suspected that their patient had suffered abuse by law enforcement officials are also presented.

Methods

We distributed an anonymous questionnaire through the Israeli Medical Association (IMA) to their members, and through the Hebrew University Faculty of Medicine to current medical students. In January 2014, these two institutions sent a single invitation to take part in the survey by email, including a short cover letter and a link to the questionnaire on an accessible internet platform. Replies were collected anonymously, identified only by timestamp and demographic data including sex, age and professional status. The questionnaire related to various elements in the treatment of potential victims of violence within psychiatric and detention facilities. Of these, only the questions regarding violence against prisoners and detainees with respect to which there is a legal and professional standard of care are reported here, namely, the need for documentation and reporting with informed consent in cases of suspected violence against detainees and prisoners. In addition, we report on the respondent's past experience in caring for a patient whom he or she suspected had suffered such violence, and questions concerning the respondent's attitude to torture. The attitude questions were adapted and translated from a previously published article.[16] The additional survey questions, not reported in this paper, relate to a number of important issues such as patient privacy, shackling, and protective hospitalization in the case of detainees and prisoners, on which there is less consensus. A second comparable set of questions regarding a patient with psychiatric illness who reports abuse within a mental health facility may be reported in a future paper. Respondents were requested to rate their agreement level to various statements on a scale from 1 to 5, from 'completely agree' to 'completely disagree'. Respondents rating 1 or 2 were tallied as agreeing with the statement, and 4 and 5 as disagreeing. Percentages were calculated as a proportion of all responses given to each question.

The Chi^2 was applied for testing the association between two categorical variables. All tests applied were two-tailed and a p-value of 5% or less considered statistically significant. Prior to administration of the survey, we received approval of the Internal

Table 1: *Documentation and reporting, percentage affirmed by statement*

	Physicians	Students	CHI²
'I would document the patient's complaint of violence in his chart.'	95.0%	93.6%	p=0.73
'I would document the patient's injuries and photograph them.'	80.1%	81.5%	p=0.63
'I would report the incident to the MOH.'	59.7%	68.8%	p=0.07
'I may report the incident only if I received the patients approval.'	19.0%	22.0%	p=0.2

(Questions are translated from the survey). CHI² comparison between answers of physicians and students in our study.

Ethics Review Board of Shaare Zedek Medical Center.

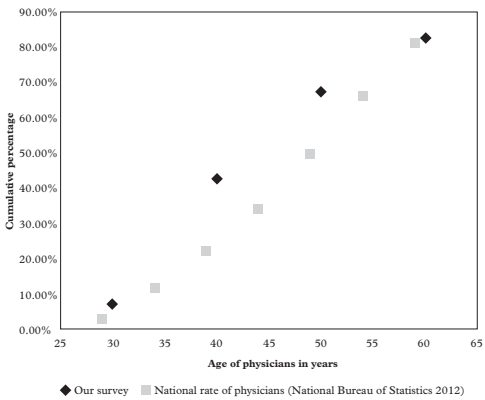
Results

We received answers from 443 physicians (2.2% of IMA members as of 2012) and 114 medical students (who made up 10% of those approached).[17] Low response rates are due partially to a single invitation to participate in the study. Reports of technical difficulties in opening the survey from certain institutional email accounts were also received. Among the physicians who responded, 54.9% were male compared with 59.2% of all physicians working in the field in Israel. The comparison of the age distribution of our sample to that of the national distribution of physicians (Figure 1) shows an increased rate of young physicians, under 40 year of age, among our respondents with a compensatory drop among the 50-60 year old group. As the rate of women physicians is increasing in Israel, this may account for the higher rate of women in our study.[18]

Respondents were asked to consider their actions in the case of a prisoner or detainee presenting in the emergency department accompanied by law enforcement officials, with bruising and signs of violence and complaining that he was beaten during interrogation (Table 1). Almost all respondents answered that they would document the patient's complaint in his chart, and most would also document his injuries in writing and photographs. Only 62% of respondents would report the incident to the MOH and only 20% stated that patient consent was a necessary precondition for such a report. There was no significant difference between student and physician answers to these questions.

Respondents were asked if they had treated a patient that they suspected had suffered violence during his arrest or interrogation. 13.8% of physicians (n=48) affirmed that they had, and most of these (n=36) added free text commentary regarding the case and their treatment in the space supplied. The most common

Figure 1: *Distribution of age of physicians – respondents of our survey compares with physicians in Israel generally*



comment was that they had involved a social worker and in some cases reported to the police and in a few cases to a more senior physician. Two physicians had thought the complaint was false, one of these stating that a psychiatrist determined that it was only a ploy to get better conditions, the other stating that since the patient's bruises seemed to be older than his arrest "he was a liar". One respondent wrote that the patient had said that he had fallen during the arrest and that after reading the questionnaire he thinks that he might have been naïve to believe that.

The comments received also highlighted Israel's mandatory military service, which applies predominantly to Jewish citizens. Many continue military service in the reserve force and physicians often serve as military physicians. Five respondents related incidents from their experience as military physicians, including two who described significant difficulties: one of them wrote that he was discharged from his position in the army after he refused to examine prisoners in interrogation facilities and declare them fit for interrogation and refused to write false information concerning the mechanism of injury. During the in-take process for prisons in Israel, there is a medical examination. One respondent wrote that during the in-take process at a military detention center he was unwilling to admit a patient whom he suspected had suffered from violence by military personnel.

Regarding the respondents' attitude towards torture, 55% of all respondents answered that torture should be permitted in exceptional cases (Table 2). Furthermore, 29% affirmed that a physician can examine and treat a prisoner in order to clear him for interrogation with use of "physical or psychological pressure". To the majority of these questions, there was no significant difference between the replies of physicians and students.

A past experience of treating a detainee or prisoner whom the physician suspected had suffered violence during his arrest or interrogation, was found to have an association with an attitude of objection towards torture (a majority of answers reflecting an objection to torture in the attitude segment) (25% vs. 9%, Chi2 $p<0.01$).

Discussion

Violence is recognized as a public health issue and much research has been done on the recognition and treatment of victims of violence by health care practitioners. Today, medical students and practitioners learn not only how to recognize and treat victims of violence, but most importantly perhaps, they learn that it is their responsibility to recognize the victims and to try and protect them from further harm.[19, 20, 21] There is a need to address additional populations that are at risk of violence and are not properly protected. In the absence of organized systems and protocols for the reporting of such cases, the true scope of violence against prisoners and detainees in Israel is unknown. At the very least, however, the results of the current study shows that physicians in Israel do encounter such cases and lack tools and knowledge of appropriate protocol. While a low response rate inhibits us from assessing the scope of the problem, the worded replies of those physicians who encountered such cases raise a number of distressing issues. None of the respondents stated that they had reported the case to the MOH. Some physicians reported not considering the possibility of violence due to lack of knowledge or since they did not believe their patient. In addition, the responses in some cases related to physicians' experiences working within the military, raising the issue

Table 2: *Attitude towards torture, percentage affirmed by statement (significant differences in bold.)*

			CHI^2		CHI^2
Statement	Physicians	Students	Physicians vs. students, current study	Bean et al[16]	Current study vs. Bean et al
1. 'Rare exceptions for the use of torture can be condoned under extreme circumstances by legitimate state agents.'	53.2%	60.2%	p=0.42	35%	**p<0.01**
2. 'The use of torture to elicit information from arrested persons is immoral and intrinsically wrong.'	60.2%	53.7%	**p<0.01**	63%	p=0.61
3. 'If there is the "slightest belief" that life-saving information can be obtained, it is permissible to use torture.'	42.5%	37.0%	p=0.13	27%	**p<0.01**
4. 'Under extreme conditions, it is permissible for interrogators to yell at prisoners and to use psychological intimidation.'	72.9%	68.2%	p=0.85	50%	**p<0.01**
5. 'It is permissible for physicians to examine and treat individuals to verify their ability to sustain a continuation of interrogation with methods of physical and psychological pressure.'[i]	28.8%	31.1%	p=0.66	22%	**p=0.01**

Answers by Israeli physicians and medical students, compared to answers in previous study (Bean et al.).[16]

of conflicting loyalties in a society where a large proportion of physicians serve as military physicians. In these cases, the physicians reported constraints on their ability to treat the patient and pressure to comply with military procedure.

As no protocol for the treatment of suspected violence against detainees and prisoners exists in Israel, physicians are required to infer from their knowledge of other cases of violence. The vast majority of respondents stated they would document the complaints of the patient and in many cases, document his or her injuries in writing and photograph them. However, with regard to reporting, respondents who attempted to

fulfill this duty often reported the case to the police, which may be the offending party, and to a social worker who may also lack appropriate routes of action. Furthermore, the rate of respondents who stated that they would in fact report the incident to the special committee in the MOH is likely to be overestimated due to the phrasing the question in a leading manner. It is particularly noteworthy that, despite extensive effort, no additional public information regarding this committee could be found by the authors of this study at the time of writing and it is not listed among the committees on the MOH website. The only information generally available regarding the committee is a MOH circular declaring its establishment.[12]

The United Nations Convention against Torture and other Cruel Inhuman and Degrading Treatment or Punishment prohibits torture under any conceivable circumstance[22] and a high rate of respondents agreed that torture is "immoral and intrinsically wrong" (Table 2, statement 2). However, this finding is potentially undercut by responses to other questions; a fairly high number also found that "torture can be condoned under extreme circumstances by legitimate state agents" (statement 1). We speculate that while torture may be considered immoral, physicians may still support its use, considering it a necessary evil (necessity defense); the legitimacy of the perpetrators justifying their actions. Similarly, the importance of obtaining life-saving information also seems to tip the balance in favor of torture for a significant number of respondents, even if not the majority (statement 3). Interestingly, the use of yelling and psychological intimidation is considered acceptable by 72.9% of respondents (statement 4). Whilst the word 'intimidation' rather than 'torture' is used in the question, the general perception is that psychological torture is less serious than the physical. (For an in-depth discussion on the topic of psychological torture see [23]). Particular attention should be given to the issue of the involvement of medical practitioners in torture. Human rights organizations have reported on such cases.[24] In our survey, almost a third of respondents supported examining and treating a detainee in order to clear him for torture. Such involvement is contrary to medical ethics.[25, 26]

This is a preliminary study and, due to a low response rate, we cannot purport to report the true rate of such opinions among Israeli physicians. However, physicians supporting torture, even to the limited extent shown here, reflects the prevailing attitudes within the general public in Israel with regard to the permissibility of violence towards prisoners. The Israeli public polled the third lowest percentage among 25 world countries of people who opposed torture under any circumstances and the highest percentage of people who said that some degree of torture should be permitted in order to combat world terrorism.[27] A recent International Committee of the Red Cross report follows similar trends.[28]

The weakness of this study lies in its low rate of response and the possibility of an accompanying self-selection bias; physicians who encountered cases of maltreatment may have been more likely to have answered the questionnaire for example. This limitation is similar to that of previous studies in Israel which have relied on physician surveys that selected narrow or convenience samples, or lacked information on the size and characteristics of the entire participant population.[29] By supplying information regarding the

[i] Please note that this question was adapted from the original study which read "It is permissible for physicians to treat individuals to verify their health so that torture could begin or continue."

participant population of our survey we hope to have mitigated this bias.

Prisoners and detainees are an at-risk population with regard to interpersonal violence. When treating such patients, who may have been harmed, physicians must be aware of this and have the knowledge and the tools to effectively treat these patients and protect them from further harm. In Israel, there is currently no adequate functioning body to which physicians can report such cases, and no guidelines to adhere to. The permissive attitude in Israel towards the use of torture, both among the general population and among physicians, is cause for further concern and yet another obstacle towards proper treatment. The lack of differences between the replies of physicians and students on this issue mirrors the lack of continued education and practice guidelines regarding such cases. To address these concerns the development and implementation of medical protocol and efforts of medical education are paramount.

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Preventing torture for people deprived of freedom: The Atlantic Hope and Black Swan Prison Model

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Key points of interest

- Simulation exercise trains participants to be aware of and deal with torture from the point of arrest.
- Highlights risk of torture from point of arrest and throughout the penal chain.

Abstract

International law and minimum standards provide certain protection for detainees and prisoners of war (POW) against torture and ill-treatment. Places of detention and parties to conflicts are often monitored to ensure that they adhere to the required standards through, for example, visits to individual detainees and the assessment of facilities. However, monitoring between the point of arrest and eventual remand in prisons is largely inadequate. This paper explains an emerging model to enhance protection of prisoners through readiness training for prospective humanitarian personnel. The Atlantic Hope simulation exercise on monitoring detainees and visits to the mock Black Swan prison represents a teaching model to enhance sustainable protection of detainees and POW during incarceration. The simulation entails comprehensive monitoring, assessment, visits and provision of services to prisoners from the point of arrest, during the transition to places of custody, and imprisonment. These enhance protection of detainees to avoid deaths in custody, disappearance and torture throughout the chain of imprisonment.

Keywords: Simulation, prisoners, detainees, sustainability, protection

Background

Detainees and prisoners of war (POW) are protected under international law.[1] Both international humanitarian law (IHL) and human rights law (HRL) provide explicit protection for people deprived of liberty during an international armed conflict (IAC), non-international armed conflict (NIAC), and peacetime. IHL applies in situations of armed conflict, whereas HRL provides protection in situations of both armed conflict and peacetime.[2] A number of treaties work to ensure that people deprived of freedom are treated humanely in line with the Standard Minimum Rules (SMR) for the Treatment of Prisoners. These rules were first adopted in 1957[3] and were revised in 2015.[4] Now known as the UN Nelson Mandela Rules, they include a revision with respect to the investigation of deaths and torture in custody, complaints and independent inspection as well as enhanced external monitoring of places of custody by a two-fold

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system of regular inspections by both an internal and independent external body.[2] The Rules also specify the powers of inspectors and require written inspection reports as well as the publication of the findings.

In addition to the UN Nelson Mandela Rules, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) adopted in 1984 is a blueprint for prevention. UNCAT includes measures such as reforms, training of personnel, criminalization of torture, and the obligation to prosecute alleged torturers and provisions for victim's redress. The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) established a system of regular visits undertaken by independent international and national bodies to places of custody.

The inspiration for the role of a visiting mechanism for torture prevention and protection of detainees grew originally out of the work of the International Committee of the Red Cross.[5] The ICRC has agreements with states to allow preventative monitoring visits to security detainees during international armed conflict, the rules protecting prisoners of war having first been promulgated in the 1929 Geneva Convention relating to the Treatment of Prisoners of War (and subsequently refined in the Third Geneva Convention of 1949 and the Additional Protocol I of 1977).[6] Whilst the Third and Fourth Geneva Conventions empowered the ICRC with the mandate to visit detainees during international armed conflict, there is no equivalent for non-international conflicts or during peacetime. Other shortcomings of the ICRC visits include being dependent on the government for access to prisons and only being able to issue confidential reports on detention conditions. These limitations necessitate an independent preventive mechanism that does not depend on the goodwill of the government, and that can make reports of detention conditions available for public scrutiny.

In 2007, the Subcommittee on Prevention of Torture (SPT) was established in accordance with the provisions of OPCAT. The SPT undertakes visits to State Parties and plays an advisory role on how to establish a National Preventive Mechanism. Under OPCAT, the SPT has unrestricted access to all places of custody, their installations and facilities, and to all relevant information. Carver notes that the discussion of torture prevention since the adoption of the OPCAT has focused on the visiting mechanism.[5] Carver and Handley acknowledge that prevention measures do work, but some mechanisms are much more effective than others; they maintain, for example, that the results from monitoring in police stations and detention centers are more important than treaties ratified or laws on the statute book.[7]

Additionally, some states have failed to sign or to ratify the relevant treaties making effective independent monitoring unlikely. For example, the United States of America has not signed or ratified OPCAT, asserting in 2002 that the inspection mandate of the protocol would be overly intrusive.[8] It was maintained that complaint mechanisms already existed for detainees under domestic law, despite independent oversight not being provided for. Whilst the United States of America has ratified UNCAT, it was subject to certain declarations, reservations, and understandings.[8] The U.S. administration have maintained that the state may engage in criminal investigation treatment not amounting to torture, if the subject is a foreigner and out of the country when it occurs.[8]

In practice, assessing and monitoring detention conditions are usually limited to places of custody, and in most cases, it remains irregular.[9] Torture, summary execution and

death or disappearance from detention continue despite international protection mechanisms for people deprived of freedom. Additionally, the focus of current practice is on monitoring visits and assessments in places of custody (police cells and prisons), when, in reality, detention starts from the point of arrest. Some transition phases from the point of arrest to eventual remand in custody are often neglected. Detainees have disappeared, been executed, or subjected to inhumane and degrading treatment during transitions to places of custody.[10]

Introduction

In view of these challenges, the Consortium for Humanitarian Service and Education (CHSE) designed a teaching and simulation model to enhance the understanding of the sustainable protection of detainees and prisoners of war among entry-level humanitarian practitioners. The CHSE is a collaborative effort of academic, government, and non-governmental organizations in the United States of America which develops curriculum and organizes annual training events for prospective humanitarian professionals. CHSE provides intensive hands-on opportunities for students and practitioners of international humanitarian response to learn how to conduct safe and efficient relief and protection operations. Since 2005, the CHSE has implemented a mock simulation exercise for undergraduate students with an added focus on visits to prisons and POW exchange. In 2012, the program expanded to include graduate students. This paper is an examination of the sustainable protection model for torture prevention and the protection of people deprived of freedom.

The purpose of this article is to present an emerging torture prevention model for people deprived of liberty through readiness training for prospective humanitarian personnel. The first section of the paper is an overview of the Atlantic Hope exercise and the mock Black Swan Prison (Part I); the second section examines the application of the sustainable protection model (SPM) for detainees (Part II); the third section introduces the different sections of the SPM and the simulation prompts for participants and their rationale (Part III); and the final section presents a limitations and conclusion (Part IV).

Part I: The Atlantic Hope and Black Swan Prison

The Atlantic Hope and Black Swan Prison exercise merges ongoing classroom work with field experience by simulating real-life experiences for students. Initially, it simulated complex humanitarian crises[i] in a fictional country, "Atlantica,", i.e. earthquake and inter-communal conflict.[11] The "Atlantic Hope" simulation was designed to host between 20 to 40 undergraduate students and provided a hands-on opportunity to work as members of a mock NGO (International Humanitarian Action). Over four days, a sequence of interlinked scenarios were carried out, starting with entry into the country vis-à-vis an international airport.

The program continues to flourish due to the experiences and contributions of a core student-alumni cohort who return every year in a train-the-trainer fashion. Five universities or consortium schools have participated in the undergraduate version.[ii] In 2007, the Indian River State College conducted the first Summer Institute on International Relief and Humanitarian Assistance in

[i] The Indian River State College in Florida pioneered the exercise.

[ii] Northwest Missouri State University, Northern Oklahoma College, University of Florida, Washington Adventist University, and the Indian River State College.

Macedonia.[i] The program has also had strong support from the administration of the Indian River State College, Florida (IRSC).

The graduate-level "prototype" program was first run in March of 2013 with the participation of four universities.[ii] The notion for furthering an interdisciplinary training program designed for graduate students in the humanitarian and conflict intervention fields was a follow-up to a meeting between CHSE and Harvard University faculty who direct a similar simulation experience in Parker State Forest loosely based on "Doctors without Borders" operations in post-conflict post-disaster environments. A primary culmination of the collaboration effort in 2011 was the co-edition of *Humanitarian Operations: A Field Guide (2013)* which is a comprehensive field guide for participants.[iii] In order to accomplish this, developments in the program design offer additional scenarios in negotiations, conflict assessment, issues of identity, and reconciliation processes, including those specifically linked to the protection of detainees and Prisoners of War.

Currently, "Atlantic Hope" includes a scenario centered on assessing prison conditions and visiting prisoners held by opposing armed factions in Atlantica. Participants, as members of IHA, are tasked with negotiating prisoner access and conducting assessments in accordance with the principles of International Humanitarian Law and best practices of ICRC. The mock prison managed by the military of the Republic of Atlantica, known as "The Black Swan," is an actual facility with role-player prisoners, guards and wardens who have undergone extensive training and are tasked with actualizing the experience for participants; human rights advocacy NGOs have accused the government of detaining politically-excluded identity groups without due process. Prior to visiting the prison and conducting the assessment, participants undergo readiness training with expert faculty advice based on the ICRC mandate to visit all persons deprived of freedom, assess detention condition, and facilitate contacts with detainee's families.[12]

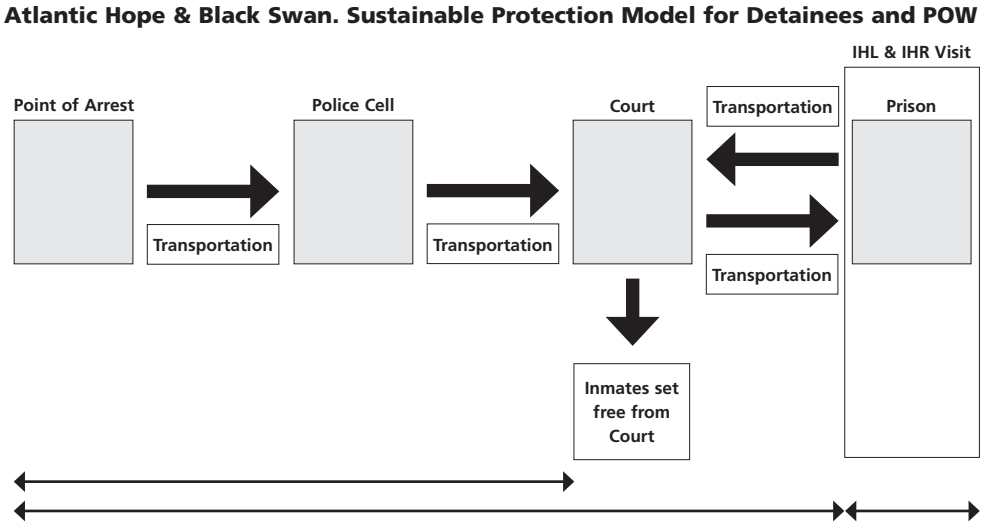
After the completion of the scenario, participants regroup for debriefing, discussion, and must prepare for follow-up visits, continued assessments, and the facilitation of contact channels with the broader aim of developing an understanding of IHL pursuant to prisoners and detainees, related ICRC best practices, and a hands-on comprehension of impacts and challenges associated with the judicial-penal chain. In sum, the Atlantic Hope exercise provides an educational experience concurrent with Lederach's[iv] approach.[13]

Since inception in 2005, a total of 512 students, including both graduate and undergraduate level, have participated in the Atlantic Hope training exercise. At the undergraduate level, about 390 participants at an average of 20 to 40 students per year have

[i] The Indian River State College, Northwest Missouri State University, Institute for Defense and Peace Studies at the University of St. Cyril and Methodius in Skopje, and the Macedonian Ministry of Defense.
[ii] Indian River State College, Kennesaw State University, George Mason University, and the University of North Carolina, Greensboro.
[iii] "Humanitarian Operations: A Field Guide" Spring 2013. A request for an e-copy of the field guide can be directed to the coordinator of the Consortium for Humanitarian Services and Education, info@foragecenter.org.

[iv] "People are helped to forge new experiences, and to use the feelings these situations evoke to challenge prior viewpoints. They are helped to reframe fundamental viewpoints based on new feelings that are triggered by seeing, feeling, hearing, touching, or otherwise seeing the world in new ways. They are freed from the bonds of having to name and rationally explain what they may sense but have not yet fully experienced."

Figure 1: *Atlantic Hope/Black Swan Model for Protection of POW and Detainees*



taken part in the yearly training, whereas 125 participants at an average of 25 to 30 per year participated in the graduate level exercise since 2013. The number of participants has remained relatively constant every year, both at the undergraduate and the graduate level due to limited training resources and to allow for full participation. The need to increase involvement and impact particularly at the graduate exercise led to a review of the program in 2014. Following the successful completion of the second graduate training, participants were surveyed about their opinion on the four-program sectors of Atlantic Hope. Division leaders were also tasked to suggest areas of improvements. Out of a total of 28 participants surveyed, 32% reported that the reconfiguration of the political processes section of the simulation exercise was of highest priority.

Part II: Sustainable protection model (SPM) for detainees and POW

The Atlantic Hope/Black Swan Sustainable Protection Model (AH/BS-SPM) for detainees and POW is a framework to demonstrate a sustainable model for the protection of people deprived of liberty (see Figure 1). The model entails monitoring detainees from the point of arrest until their eventual release by building on the current emphasis of monitoring conditions of places of detention (police cell and prison), as well as often neglected stages in the prison chain (points of arrest, during transportation and judicial trials). AH/BS-SPM protects people deprived of liberty as they move along the chain of incarceration: point of arrest, transportation, police custody, trial, and prison. The model also maximizes the capability of protecting detainees from torture, summary execution, disappearance, and other abuses.

The model is based on the premise that current monitoring mechanisms fail to adequately protect detainees before they arrive at a place of custody, when many human rights abuses in fact occur at this early stage.[14] The specific problems that the model seeks to address are: arbitrary arrest,

protection against disappearance or summary execution during transportation of detainees, delays and unfair judicial trials, elimination of the possibility of jail break and prison riots, and communication between detainees and their families.

The model entails empowering a neutral organization, IHA, with a legal mandate to work alongside criminal justice agents, such as, law enforcement, security agents, judiciary officials and prison authorities. IHA also monitors detainees as soon as they lose their freedom at the point of arrest and continues throughout the various stages of imprisonment. It is anticipated that the vulnerability of people deprived of freedom will be reduced due to constant and regular independent oversight.

Part III: Sustainable protection model (SPM) as a training platform

The purpose of the SPM as a training platform is to cultivate an awareness among graduate students in the field – the future cohort of humanitarian workers and practitioners in peacebuilding - surrounding the current systematic gaps in the judicial-penal chain in order to generate an impetus for critiquing current conventions, cultivating a familiarity with relevant best practice, and facilitating a recognition of broader conflict linkages related to the primary, secondary, and tertiary effects associated with imprisonment on a micro- and meso-level. Primary impacts include the vulnerabilities prisoners face, starting at the point of arrest to the social stigmas that follow upon release. Secondary and tertiary effects include the exploitation of prisoner and former prisoner populations by insurgent groups and even host governments, e.g. prisoner breakouts and recruitment, ill-health and disease associated with detention center conditions, overcrowding, and malnutrition.

The SPM training model offers a proactive template for both treating gaps in and providing education on the judicial-penal chain with potential for replication beyond graduate experiential programs, ranging from training associated with governmental and non-governmental readiness training to organizations affiliated with security sector reform and governance to consulate services. The overall design is enmeshed with the broader Atlantic Hope exercise design and formulated according to Bloom's Taxonomy of learning objectives: knowledge, comprehension, application, and analysis.[15] Thus, participants, prior to and upon arrival for the Atlantic Hope exercise, are introduced to the current conventions through training materials and briefings ("knowledge"), which serve as a 'tool box' for later application; materials include the ICRC *Code of Conduct for Combatants*, 'Country Reports' related to the simulation, and supplemental materials from organizations such as the International Center for Prison Studies. Trainees then receive additional on-site training and guidance from faculty during the planning phases for negotiating prison access and conducting prison visits and assessments ("comprehension"). They are able to experience the challenges of the simulation and scenario prompts through practice ("application"), and can consequently highlight linkages between the detainee experience and broader conflict concerns, and offer informed, reflective critiques of the existing conventions through facilitated de-briefs ("analysis").

This section is structured in the following manner: first, to provide the context for the scenario prompts; second, to replicate the respective role-play simulation based on each node in the SPM and judicial continuum; and, third, to lay out the rationale behind the SPM, specific prompts, and desired outcomes among the trainees. Outside of the

scenario prompts themselves, field experiences, contemporary issues pursuant to the judicial-penal chain, and international and domestic aid agency protocols are utilized to inform the overall design, objectives, desired outcomes, and profiles generated for the various role-players employed.

Point of Arrest

According to the United Nations Body of Principles for the Protection of All Persons Under any Form of Detention or Imprisonment, "Arrest" means the act of apprehending a person for the alleged commission of an offence or by the action of an authority.[16] Arbitrary arrest, detention or exile is of course not permitted under the 1948 Universal Declaration of Human Rights (Article 9).[17] Such rights are also often enshrined in domestic law. To take an American example, the Baltimore Office of Public Defender emphasizes that, "If you are taken into police custody, you have the right to: be informed of the charges against you and the allowable penalties; obtain a lawyer, including the right to have one appointed if you cannot afford one; have a judge decide whether you should be released from jail until your trial; and remain silent."[18] Whilst this theoretically establishes that these rights should begin upon arrest and continue throughout the process, there have been instances which suggest these rights are not upheld, not least the death of Freddie Gray in Baltimore in 2015 from spinal injuries. His death sparked violent protests that lasted for several days in Baltimore.[19]

Arrest must not be overlooked as it is importantly the first point of deprivation of liberty of the individual and, in most cases, individuals are unaware of or unprepared for it. However, the question that remains unanswered is: who monitors the law enforcement agencies, particularly the police, at the point of arrest? The AH/BS-SPM acknowledges this gap and suggests the need to monitor detainees from the point of arrest, if proper protection of detainee is to be achieved.

Point of arrest – scenario prompt: IHA personnel are tasked with conducting a needs assessment of a local village in the Republic of Atlantica impacted by both intra-state conflict and a natural disaster. During the needs assessment, security elements associated with the host government enter the village as part of a broader security sweep and detain a local national in the village for unknown reasons. Some local villagers aggressively protest the arrest or react emotionally, particularly a female villager who claims the detainee is her husband; other villages seem either impartial or partially in favor of the arrest. The detainee is immediately escorted out of the vicinity with no information provided to the IHA team.

Explanation of point of arrest prompt: The point of arrest is the instance in which judicial authorities have actualized their decision to confiscate the "liberty of the person" and "deprive some people of that right for a period of time as a consequence of the actions of which they have been convicted or of which they are accused."[20] For any individual subject to detention, the point of arrest results in the immediate deprivation of all basic human needs – security, welfare, identity, and freedom – and the complimentary satisfaction of having those needs met.[21] Applied within the theoretical construct of Maslow's need hierarchy, arrest constitutes the absolute stripping of welfare and deference values of an individual. Furthermore, detainees potentially suffer decremental deprivation, "angered over the loss of what they once had or thought they could have… by reference to their own past condition."[22] The scenario prompt above is subsequently designed to provide participants with a porthole into not only common

security operations which culminate in the arrest of an individual or individuals, but a snapshot of the socio-psychological impacts of the individual and those who witness the arrest or possess communal or familial ties to the detainee. Subsequently, the SPM prompt is designed in tandem with the village scenario lane as an integrated segment in order to facilitate a more holistic experience. The other village role-players each maintain a unique relationship to or perspective on the detainee and the possible causes for his arrest, thereby adding a more layered experience to the IHA trainees tasked with conducting a needs and conflict assessment.

Figure 2: *Point of arrest*

Picture by the Consortium for Humanitarian Service and Education(CHSE)

Transportation

Safe transportation of detainees is similarly contained in international law and guidelines for handling detainees by law enforcement agencies. For example, the Mandela Rules acknowledge: "The transport of prisoners in conveyances with inadequate ventilation or light, or in any way which would subject them to unnecessary physical hardship, shall be prohibited (Rule 45.2)."[2] However, death or injury during transportation has continued to occur reflecting the fact that there are few or no monitoring mechanisms for detainees during transit. For example, in August 2013, at the peak of the Arab Spring in Egypt, 35 members of the Muslim Brotherhood movement were killed while being transported to custody after arrest. The circumstances behind the death of the detainees remain unclear as there are contradicting reasons and explanations about the cause of the incident.[23] The AH/BS-SPM addresses the problem of protecting detainees by instituting a monitoring and a supervision mechanism for detainees in transit.

Transportation – scenario prompt: IHA personnel are managing a refugee camp when security elements associated with the earlier security sweep arrive on scene. Security elements momentarily stop to evaluate the security conditions of the camp and check the roster for any wanted personalities. During the stop, refugees seem to recognize the detainee from the Point of Arrest scenario and begin to congregate in protest. It remains unclear whether the agitation is against the detainee or his detention, an uncertainty shared by the security forces who immediately surround and secure their vehicle and leave the refugee camp with their original detainee to avoid confrontation.

Explanation of transportation prompt: Phases of transportation from the point of arrest to detention centers, to and from court, and to and from remand or long-term holding cells are often the most vulnerable points in the prison chain due to the inability to monitor mobile personnel; security concerns related to convoy integrity or heightened opportunity for escape, and road hazards. The scenario prompt above offers trainees insight into the inherent security difficulties associated with transporting prisoners, the vulnerability of detainees during transport, and the difficulties associated with third party monitoring. Furthermore, the scenario

is engineered to shed light into the lack of enforcement mechanisms related to the earlier mentioned Mandela Rules.

Figure 3: *Transportation*

Picture by the Consortium for Humanitarian Service and Education(CHSE)

Police custody

The OPCAT, SPT and the Mandela Rules are some of the preventive mechanisms that provide for visiting and inspection of places of custody, including police cells, to prevent torture and other degrading treatment. Additionally, organizations such as the Association for the Prevention of Torture (APT) work to improve detention practices and to strengthen public oversight. Whilst these measures go a long way, it is undeniable that human rights abuses in these settings continue to occur. The AH/BS-SPM reflects the importance of continued monitoring in police custody by providing regular external scrutiny of police custody and temporary detention centers.

Police custody - scenario prompt: IHA personnel are tasked with negotiating access to the police cell in order to conduct an assessment of the police facility. The detainee from the earlier two scenarios is just leaving the director's office after in-processing and appears to have received physical trauma, which the police attributes to outside persons and an incident during transport, subsequently demanding that IHA visit and treat his guards as part of potentially granting access for the assessment. The remand prisoner is adamant that the abuse was received by security officials during transit, but is primarily concerned with his legal situation. He has not yet been provided with a hearing date nor been able to secure legal representation and is concerned that he will be indefinitely held.

Explanation of police custody prompt: The policy custody phase in the chain is often the most precarious due to the uncertainties surrounding the fate and circumstances of remand prisoners. This tends to be the period in which conflicting attitudes begin to ferment due to the high degree of uncertainty, stress and ambiguity associated with perceptions of indefiniteness. If not released on bail, remand prisoners frequently remain in custody until their preliminary hearing and sentencing, which rarely follows a distinct timeline, and are tasked with the additional difficulty of securing legal representation and continuing to attempt to make arrangements for dependents on the outside from their position of confinement. Foreign nationals in remand situations, especially those without diplomatic representation in the host state, face additional challenges in the form of language, cultural, and judicial barriers. This scenario prompt provides trainees with a more comprehensive understanding of the situational differences between remand and sentenced prisoners, especially in assessing their separate needs and concerns and facilitating contacts with relatives. Furthermore, it offers insight into the monitoring gaps, vulnerabilities, and difficulties associated with remand prisoners in securing legal representation and certainty over judicial proceedings.

Detainees in Court

"Fear, ignorance and poverty" can mean that, in addition to physical maltreatment being possible at court, detainees have difficulty in obtaining legal representation even in developed countries.[24] Recognizing the occurrence of this issue accentuates the importance of instituting a sustainable protection mechanism for detainees at court. The AH/BS-SPM attempts to address the challenges of poor detainees by monitoring court proceedings of vulnerable detainees in courts.

In court - scenario prompt: Due to the unlikely nature of NGO personnel actually being present during trial, IHA personnel receive a briefing on the legal process and general trial procedures specific to Atlantica based on Human Rights Watch and Amnesty International reports. Purportedly, the system is partial; detainees from the south report lacking access to legal representation, discrimination from predominantly northern judges and prosecutors, often indefinitely delayed hearings, and the conduct of hearings in the traditional language of the north thus requiring southern defendants to rely on interpreters (who are accused of poorly translating both what the defendant says and what is being discussed in court).

Explanation of detainees in court prompt: Even when defendants are granted what can be seen to be a fair trial or hearing, they still face a broad range of hurdles, including a potential lack of meaningful legal representation, an understanding of the accusations against them and the legal proceedings. Furthermore, an inability to afford any fines imposed may mean they have to remain in custody instead. While international standards, bodies of law, and watchdogs such as Human Rights Watch and Amnesty International monitor discrepancies, enforcement mechanisms and monitoring agents are limited, especially in states facing NIAC, where organizations such as ICRC only have a limited mandate to offer services. Furthermore, those services often apply to pre- and post-hearing situations, not necessarily hearings and legal proceedings themselves. Subsequently, this scenario prompt is designed to introduce participants into a reality-based situation involving defendants subject to a perceived or actual partial legal system. The intent of the scenario is primarily two-fold: first, to cultivate an awareness of the hardships endured by defendants during trial proceedings, which are linked to post-trial grievances and the continuum of their experience in the penal system; and, second, to accentuate the monitoring gaps associated with trial proceedings and to prompt a discussion following the brief on linkages between detainee custody and broader conflict concerns.

Figure 4: *Arrival at court*

Picture by the Consortium for Humanitarian Service and Education(CHSE)

Prisons

As set out in the background section, there are numerous existing mechanisms in place which allow for the protection of detainees and POW in prison. The AH/BS-SPM suggests the additional or alternative of designating a legal mandate of monitoring to an independent

agency such as the simulated agency IHA. *Prisons – scenario prompt: During the actual prison visit negotiated by IHA personnel, the detainee from the previous scenes is now a sentenced prisoner within the long-term holding section of Black Swan. Prior to the visit, a local national in the village claims to be the detainee's wife and says he is an activist and journalist who opposes the regime in power, hence the reason for his arrest and subsequent detention. During the prison visit, the now sentenced detainee acknowledges that he is a journalist, but claims he is a third country national and denies the local national villager as his wife. This prompt is designed as a sub-prompt to the broader prison assessment and visit conducted based on ICRC best practices.*

Explanation of prisons prompt: This scenario prompt relates to the overall simulation associated with a broader assessment of prison conditions related to the stipulations of Geneva Conventions III and IV and the ICRC limited mandate for offering services to visit and assess prisons during NIAC. It is specifically designed to follow the detainee role-player from his initial point of arrest to sentencing and final transport to long-term central holding in the Black Swan. The broader intent of the prison visit as a training module is to cultivate an awareness of general prison populations "who have been deprived of their liberty, many of whom are likely to be mentally disturbed, suffer from addictions, have poor social and educational skills and come from marginalized groups in society."[17]

Discussion and conclusion

The limitations of the Atlantic Hope and Black Swan model include the fact that it does not differentiate between legal mechanisms under IHL and IHRL and with respect to the monitoring mechanisms under UNCAT/OPCAT and the ICRC. For example, it does not explain in detail how the framework could be applied to different categories of detainees. Additionally, no full analysis of participant feedback has been done to date. The *Humanitarian Operations: A Field Guide (2013)* is currently being tested with a view to revision, which is likely to have an impact on the current model. Additionally, it is recognized that, even though the scenario is intended to be in a country where humanitarian workers are posted, it is inevitably influenced by the political and historical backdrop in America where the participating universities are based.

Despite these drawbacks, the Atlantic Hope simulation exercise on monitoring detainees and visits to the Black Swan prison represents an useful teaching model to enhance the sustainable protection of detainees and POW during incarceration. The simulation entails comprehensive monitoring, assessment, visits, and the provision of other services to detainees from the point of arrest, during transition to prison, imprisonment, and eventual release. It is hoped that, as a result of this training, graduates' awareness is heightened and they will use aspects of the sustainable protection model in their future important work in the field.

This study acknowledges that international humanitarian law and human rights law provides protection for detainees and prisoners of war (POW). However, there remain concerns that monitoring, particularly between the point of arrest and eventual remand in prison, can be inadequate[8] or absent.[7] The AH/BS-SPM represents a framework to achieve this objective through readiness training for potential humanitarian personnel. Additionally, the CHSE recommends the testing of SPM with a view to establishing further international legal protection of people deprived of freedom right from the point of arrest.

Acknowledgements

We thank the many faculty, volunteers, and students who participated in the simulations. Special acknowledgment goes to Paul Forage, for his generous encouragement of our critique and adaptation of the "Atlantic Hope" field exercise he created and to our colleague Andrew Baer for his ability to link and animate current policies, problems and training opportunities. This paper is dedicated to them.

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The Mexico Consensus: a resolution of the fifth General Assembly of the International Rehabilitation Council for Torture Victims, 9 December 2016

The General Assembly of the International Rehabilitation Council for Torture Victims (IRCT) adopted a resolution setting out the collective position of its global membership, which consists of 151 centres in 74 countries.

Considering

1. That the membership of the International Rehabilitation Council for Torture Victims, IRCT – comprising of 152 rehabilitation centres for torture victims, in 74 countries worldwide – held its Tenth Scientific Symposium and its Fifth General Assembly in the City of Mexico, United Mexican States, from 4 to 9 December 2016;
2. That during the IRCT 10th International Scientific Symposium, we shared our global knowledge on rehabilitation methods based on evidence derived from the experiences matched to the needs of torture survivors from our work in different contexts around the world. This significant advance in the IRCT's strategy of mapping the global knowledge on rehabilitation provides a strong basis for understanding how appropriate rehabilitation services can best reach as many victims as possible and be a powerful tool for advocacy;
3. That on this day preceding United Nations Human Rights Day, it must be noted that the right to personal, family, community and social integrity exists at the centre of our notions of fundamental rights; and torture and cruel, inhuman and degrading treatment are a plague to our humanity;
4. Our desire to see a world without torture, our experience and understanding of the impact of torture upon individuals, families, communities, and societies: and building upon our efforts to prevent torture, fight impunity and provide redress and holistic rehabilitation to victims;

The General Assembly of the International Rehabilitation Council for Torture Victims, in its Fifth ordinary session,

Declares

5. That it is deeply concerned that torture and other grave human rights violations, including extrajudicial killings and enforced disappearances, continue to be widespread and often systemic in countries worldwide: and that rhetoric instigating or condoning torture and stigmatising victims is growing in all regions of the world;
6. That it is deeply concerned by the growing number of human rights violations and victims of torture due to increasing conflicts, the growth of authoritarianism, persecution and discrimination, among other reasons, which have caused an increase in populations on the move;

Demands

7. That States cease all practices of torture and cruel, inhuman and degrading treatment and fully implement their legal and moral obligations to prevent, prosecute and provide redress that includes reconciliation, for torture, including through the effective investigation and documentation of torture and the provision of holistic rehabilitation to individuals, families, communities and societies;
8. That States protect human rights defenders, rehabilitation providers and others working to support torture victims from all forms of discrimination, harassment, persecution and other forms of suppression for the exercise of their professional duties and activities;
9. That States address the underlying causes of torture and cruel, inhuman and degrading treatment, as well as all other grave violations of human rights;

Resolves

10. That holistic rehabilitation to support victims in concert with other actions to prevent torture, fight impunity and provide redress is an integral component of eradicating torture. We express our concerns about the severe underfunding of rehabilitation services globally, in a context where IRCT members experience an ever-increasing demand for rehabilitation services;
11. As we collectively seek to respond to the current situation of torture and other grave human rights violations, the IRCT membership emphasises that the rehabilitation response must be based on the global knowledge and understanding in our field, as well as human rights principles and a shared understanding of what constitutes effective rehabilitation services;

Further resolves

12. That States must provide all victims of torture and other cruel, inhuman and degrading treatment with access to a choice of rehabilitation services that are inclusive and multidisciplinary in nature and that meet their specific and diverse needs, taking into consideration that torture impacts every aspect of the individual's physical, psychological, material, familial, social, spiritual and legal life;
13. Holistic rehabilitation services must be rendered in full respect of the victim's agency and with their full and meaningful participation in their own rehabilitation process and the consideration of their views in the decisions made by service providers;
14. The wellbeing of torture victims, as well as professional ethical standards and principles, including on informed consent, confidentiality, 'do no harm', and the best interests of victims, must be at the centre of independent and accountable rehabilitation services according to the principles of General Comment 3;

Decides

15. To work together in solidarity and mutual support to further the common mission, combat ongoing oppression and human rights violations in accordance with international human rights standards, and implement the principles and recommendations set forth in this resolution to ensure that torture victims can access independent and accountable holistic rehabilitation services tailored to their specific and diverse needs;
16. To work together to promote a substantial increase in the global resources available to the provision of rehabilitation services to torture victims and, in this

regard, instructs the IRCT Secretariat to facilitate a working group to further advance this agenda;

17. To document systematically the practice of torture as reported by torture victims and conduct assessments, in accordance with the Istanbul Protocol, to demonstrate the impact of torture on individuals, families, communities and society, and the need for rehabilitation. Use this knowledge to counter any attempt to condone or instigate torture and promote policies that contribute to its eradication;
18. To inform relevant government authorities and other stakeholders about the consequences of torture on the individual, family, community and society. In doing so, ensure that victims' rights to confidentiality and privacy is protected;
19. To advocate for the reform or implementation of laws and policies regarding holistic rehabilitation in contexts where the State is not meeting its international obligations to provide the means to achieve as full rehabilitation as possible. Where relevant, encourage States to ratify and implement the UN Convention against Torture and its Optional Protocol;
20. To advocate for State parties to the UN Convention against Torture to provide funding (either directly or indirectly) to national torture rehabilitation services and the United Nations Voluntary Fund for Victims of Torture, in ways that guarantee their independence, autonomy and sustainability and do not compromise their ability to provide rehabilitation on a non-discriminatory basis. Where no such rehabilitation services are available, IRCT members will advocate for the establishment and funding of rehabilitation services;
21. To conduct rigorous and ethical research, with diverse outlooks and perspectives, to benefit the torture victims we serve. This includes documenting torture and its health consequences, identifying and addressing the needs of torture victims, and identifying, developing and evaluating effective treatment modalities that are both individual and holistic in nature;
22. To share good practice solutions in research and documentation, engage in capacity-building exchanges to support the growth and sustainability of skilled professionals, and share specialised knowledge in the field of torture rehabilitation to enhance the global fight to eradicate torture; and
23. To work jointly to enhance accountability towards victims, including in relation to relevant international, regional, national and local stakeholders.

Perspective – The long journey to rehabilitation for torture survivors[i]

Kolbassia Haoussou*

My name is Kolbassia and I am a co-founder and the Co-ordinator of Survivors Speak OUT (SSO), a UK-based network of torture survivors. My work arises out of my life experiences. First, let me tell you my story.

One evening, when I was just seven, I witnessed my father being persecuted. He escaped by jumping our wall and running for his life. As a result, we left our home and I had to live in a refugee camp for several years with my grandmother and my younger brother. Later, when I was in my mid-twenties, I myself was tortured.

Like my father, I was forced to flee my home and had to focus on saving myself. My life had crashed around me. I was depressed, had lost my sense of direction and lost the taste and will to live. I thought I would never turn my life around and wanted to end all the suffering by taking my life.

When I eventually arrived in the UK, I was deeply traumatised. I honestly did not know who I was. I isolated myself and I could not trust anyone. I didn't see myself as having a mental health issue. I couldn't. I was from a culture where there is a lot of stigma and shame attached to mental health problems.

After I had been released from immigration detention, a supportive refugee organisation urged me to seek help to address the symptoms of Post-Traumatic Stress Disorder (PTSD) that I was displaying. I was adamant that I would not be seen by anyone. However, with their support, I eventually became a client at Freedom from Torture[ii] – and was very grateful that I did.

Freedom from Torture helped me see my experience from a different angle. They gave me a key to turn my life around, but this was only the beginning of my long journey to rehabilitation.

As that journey continued, I asked myself: *What is the meaning of rehabilitation for torture survivors like me? And what should we expect of ourselves once formal rehabilitation, for example therapy, ends?*

I wanted to explore the issue more thoroughly, to try to develop an understanding of the concept of rehabilitation from the perspectives of survivors, to gain a greater depth of understanding and insight into what they want from rehabilitation and the

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[i] This article builds on a presentation given at the International Rehabilitation Council for Torture Victims (IRCT) symposium in Mexico City in December 2016. The symposium theme was 'Delivering on the promise of the right to rehabilitation' and was attended by representatives from torture rehabilitation centres across the world.

[ii] Freedom from Torture is a UK human rights charity dedicated to the treatment and support of torture survivors who seek refuge in the UK through offering psychological therapies and also forensic documentation of torture by expert doctors, practical legal and welfare support, and creative groups.

barriers survivors face in their efforts to overcome their trauma. I also wanted to know whether there could be an end to rehabilitation or whether it is a lifelong quest.

To accomplish these objectives, I had to draw on the experiences of other torture survivors. I did not start with a pre-determined thesis, nor assume that the responses would reflect a common narrative. I determined to listen with an open mind, to understand different perspectives and then see what patterns, if any, emerged.

To put the issue on a more formal footing, together with a researcher from Freedom from Torture, I held focus groups at Freedom for Torture centres, safe spaces where torture survivors could speak of their experiences (information on the methodology we used is listed at the end of this article). Over six months in 2016, we spoke with over 100 survivors of torture at our five centres. We also spoke with staff.

Together we explored two main questions:
- What does rehabilitation mean to you?
- Does rehabilitation have an end point?

What do survivors want from rehabilitation?

There were common themes that emerged in almost all our discussions – the need for survivors to move on with their lives while holding on to something of the life they left behind; the desire for independence and the barriers that prevented this; and the need to be empowered and confident to go forward into the future. What emerged was that for rehabilitation to be meaningful, a holistic approach is needed that includes a broad range of considerations.

Moving on or moving back?

There was a consensus that rehabilitation was about getting survivors back to something like a normal life. How this was defined, and whether this is completely possible, was a key component of our discussions.

"Moving on" was seen as essential to rehabilitation but it means different things for different people. For some people it is a part of the personal journey to "*being yourself*" so that you could move on by learning "*how to forgive, how to forget, how to move on with your life without having flashbacks or memories that make you depressed.*"

Others felt rehabilitation means having a life that is similar to the life they had back home. They want to experience again some of the things that made them happy before they were tortured, even if they couldn't have exactly the same life they had had before. Some felt this was about helping them return to the person they were before they were tortured, getting their life back.

One survivor said: "*We need to think of our former life, the life we had back at home, where we were doing very well, we were training, we were having vehicles, we were having festivities, but having arrived here we have lost everything, we don't have anything. So rehabilitation means for me to have the life which I enjoy back home, at least to some extent.*"

Some survivors stressed the importance of acknowledging and accepting what had happened to them as a key part of rehabilitation. One said: "*Maybe I've spoken to one or two persons, but I'm not ready to say those things again… and if those things are inside you, you cannot move on.*"

There was a lot of discussion about how survivors could be helped to start a new life as part of the rehabilitation process. Some said that gaining freedom and their rights was crucial. One survivor explained what this means for him: "*You have the freedom to do your own stuff, you might want to study or work, but you have that freedom and flexibility to choose what you want to do with your life.*"

Other survivors focused on starting a new life as part of the rehabilitation process, they wanted to be able to forget what they had been through and move on.

Independence and restrictions

Gaining independence and making autonomous choices were widely seen as vital steps on the road to rehabilitation. This included the ability "*to stand on your own feet and see a positive future for yourself.*"

Many survivors said that in order to be truly rehabilitated, their life outside Freedom from Torture has to be stable and secure. Many face significant difficulties as a survivor of torture, and as a refugee or as an asylum seeker, in the UK, and this undermines both their own efforts and the work the organisation does to help them return to normality. Some felt that to be rehabilitated, they needed to be able to make choices about what kind of life they wanted to lead.

A common theme was the legal and societal barriers to independence. Survivors said that until these are removed, they are unable to move on, mentally or physically.

The most commonly discussed barrier was the precarious legal situation that torture survivors experience, with many spending years trapped in the UK's asylum system not knowing whether they will be granted asylum or leave to remain, and the consequent stress and anxiety this creates. One survivor described their situation as: "*like a movie when you press pause, you're not moving forward, you're just standing there and waiting for the Home Office.*"

Almost all the survivors brought up the actions of the Home Office and the problems this creates for them in their everyday lives. Many saw these as a barrier to their rehabilitation. One explained: "*I do see benefits by coming here but I'm not in a position to think of the rehabilitation, because I see my life is being destroyed, it is deteriorating, so how can I focus on rehabilitation at this juncture?*"

Several survivors felt the actions of the Home Office continually undermined their rehabilitation work with Freedom from Torture. One said: "*Because of course here [Freedom from Torture] they're trying to boost our morale and restore everything that we lost, but on the other side the Home Office is pushing us down.*"

There was a feeling that the Home Office does not act fairly and draws out the asylum process deliberately in the hope that people will give up and return home. Some survivors described this as a form of mental torture. "*Back home we are tortured physically but what I've noticed is that the system of the Home Office in this country, they are trying to torture us mentally, and I think it is worse than the physical torture that I've been through.*"

Achieving freedom from the restrictions currently placed on them is an important part of rehabilitation for a number of survivors. This includes being allowed to move freely within the country, having access to employment, getting a driving license, and even simply being listened to by the authorities.

This was especially true for those with children who felt unable to provide for their children properly while restricted in this way. "*As far as children are concerned, the money that we are getting is not sufficient enough to meet their needs. What did they do to have such a lifestyle, whilst others are enjoying a different lifestyle?*"

Other issues described by survivors as barriers to rehabilitation included finding work, when they finally have legal status to remain in the UK and permission to work, and the difficulties of learning a new language. One survivor explained: "*In my*

country I don't speak English, you need to learn English because everything here is in English, you need to learn more. Here I need to start a new life, a new language, new people. It's not easy to start a new life. Not the life I had before."

Survivors also face more nebulous barriers. These include not understanding the (often unwritten) rules of society and difficulties assimilating into the new culture. One survivor said: "*The big problem is we can't make ourselves understood and they can't understand us, where we're coming from and why we are asking for certain things, it's cultural issues.*"

In addition, society lacked knowledge of the needs of survivors of torture. "*They just don't know; they just don't understand why you're suffering with something you experienced twenty years ago.*"

Some survivors said that the profound effects of torture makes rehabilitation even more difficult, especially when it comes to difficult tasks involving retaining new or complex information or learning a new language. "*[Because of] the torture I received, the attention of my mind is stopping learning the language because no matter what I do I just can't retain.*" Another said: *"As you can see I'm physically disabled. This is not coming from nowhere, this is not a natural disability, this is from torture. But I try to put all this behind me because of the help of the therapy.*"

A number of survivors also spoke of the negative impact of discrimination. "*It is very hard to reach a point [of rehabilitation] when you get people dealing with you in this disrespectful way. It has a knock-on effect on your morale, on your confidence, on your ability to be positive and work and deal with the struggles in your situation.*" One survivor felt so threatened in the area where he lived that he was unable to attend therapy sessions, or even leave the house.

Empowerment and confidence

Feeling confident and empowered was seen as a key aspect of the rehabilitation process. Participants talked about being empowered to take back control of their life and meaningfully navigate their own circumstances.

Several survivors spoke of the positive effect of feeling productive, and the possibility of restarting the career they had before they were tortured. Many people suggested that access to courses, training and careers advisors could help them to grow in confidence and become active members of society. One person said that it is important to "*bring out the best in other people… because a lot of us, we've got different talents.*" Survivors said they sought opportunities to rebuild their confidence, either through training or through becoming active in the communities where they live.

Others talked of the importance of being busy, socialising and not spending all of their time isolated in their house. This was a particular concern for those housed by the Home Office in more remote, sometimes hostile, areas. Activities which aided people's confidence and alleviated their isolation included going to the gym, swimming and volunteering. One survivor suggested: "*when you keep your mind occupied by doing something, get busy, you know it helps keep your mind out of things.*"

Being able to speak out about what happened to them, and advocating for other survivors with decision makers or to public audiences is a key part of rehabilitation for some survivors. They said that using their voice empowers them and helps restore their confidence. This is especially important for people who previously felt unable to use their voice to speak out in public.

However, there are barriers that many find hard to overcome. Several survivors expressed the view that torture, and their

experiences in the UK asylum system, had drained their confidence. "*You know when you are in one stage of life for a very long time it brings your confidence down, right down, so you need something that will motivate you that will help you to get back that confidence.*"

Can there ever be an end to rehabilitation?

All the survivors agreed that rehabilitation is a very long process, with no short cuts. One said: "*All the nightmares and the memories and the struggle I've had over the last twenty years is not going to go away with three or six or twelve months of therapy here; it's an ongoing thing.*"

Several survivors described the deep impact torture had had on their lives: "*What we experience under torture, it changes you from inside [which means] it is an ongoing situation that needs monitoring and looking after.*" Many spoke about how long, difficult and uncertain rehabilitation could be. They spoke about being uncertain of how fully they were recovering, as their mood and feelings changed from day to day.

While all the survivors stressed that rehabilitation could not happen without secure legal status, they also said that, in itself, legal status did not end their stress and anxiety. They would find themselves moving on to a new stage of their life with new difficulties, and the effects of their trauma would not simply disappear. "*You still have nightmares because the papers [immigration documents confirming legal status] don't stop your nightmares. You still weep and walk; it is not that papers give you the full joy.*"

In fact, gaining legal status and permission to remain in the UK could bring new problems, at least in the short term. These include losing the (minimal) income and housing available to people seeking asylum, looking for work and finding new housing, all within a short time frame. One survivor said: "*The added problems, even after your status is granted, just pour in.*"

The ongoing uncertainties of life and the barriers survivors face made many feel that, if there is going to be an end point to their rehabilitation, it could not be achieved without feeling secure about their accommodation, their income, and their legal status.

Some survivors felt that, for them, rehabilitation would never be achieved and that the effects of torture will remain with them for their rest of their lives. They said this is partly because, even if they are improving, they feel that stresses in life can always bring back their past trauma. "*The added problem, it [life stress] reignites the problem I have, the nightmares and the depression.*"

A number of survivors also stressed that sometimes other people assume that a person is fully rehabilitated when they do not feel that they are. "*People think, oh you have moved on, but within you still know you are just going round in a circle.*'

Some survivors felt they would always need therapy to cope with the continuing stress. "*I think it's not something that should end, it's an ongoing thing that should go on and on.*" Some said that it is always possible they would have a setback. "*It is not a physical illness where you take a medication and you're sorted, it is an ongoing situation that needs monitoring and looking after.*"

Others felt that they would always be working to engage with life, so rehabilitation would be an ongoing process throughout their life. One client compared it to having a hand cut off. "*You won't grow a new hand but you'll learn how to adapt and that takes a lifetime.*"

But not everyone believed that rehabilitation would be lifelong. Some survivors said that once they reach a point where they are feeling better, working and living a normal

life, their rehabilitation would end. The trauma would remain, but it would not affect them in the way it had in the past – they would learn how to deal with it.

The importance of therapy

All the survivors we spoke with had been offered therapy at Freedom from Torture. I found that for many torture survivors, rehabilitation as we know it in western countries, was unknown and unfamiliar; talking to a therapist individually or in a group was unchartered territory. Like me, many people had preconceived, negative views of mental health, which was associated with stigma and shame.

Although the concept of therapy was foreign to most, they all came to value it highly. All said that physical and psychological therapy, both in one-to-one and in group settings, was a very important part of their rehabilitation.

First, it meant they had someone to listen to them. One survivor said: "*We are here alone and the only hope we have is at least someone to listen to us*." Another said: "*Freedom from Torture was the only organisation that actually took time to sit down with us and look at the whole picture*."

Second, therapy has enabled them to start to address their trauma in ways that are constructive and has helped them deal with the terrors they face, such as intrusive memories, flashbacks and nightmares.

Survivors spoke of the difficulty of dealing with the effects of the torture they had experienced while also dealing with new problems: '*I deal with two problems, whereas most people deal with one… I have to go back and get rid of the traumas in the past as well as the problem today.*"

They said that therapy has given them more resources to cope with day-to-day life and the many ongoing difficulties they face. "*The services you [Freedom from Torture] provide are of great help to me, and the treatment I have received from you. Without it, it would be a lot harder.*"

One-to-one therapy was not the only method of rehabilitation that was valued. Many survivors spoke highly of the range of other activities that are provided by Freedom from Torture, which brought them together with other survivors and helped overcome isolation. This includes activities such as football, gardening and cooking, and the service users group (which enables current and former service users help shape Freedom from Torture's services).

These activities were seen as particularly helpful as they allow clients to keep occupied and engage with people who are going through similar experiences: "*It is good to go in a group to see that you're not the only person struggling. There are other people like you.*"

Attending meetings with other torture survivors was also seen to be an important part of rehabilitation. These help survivors deal both with their current problems and their past trauma: "*When we come together to discuss, it is helpful, because when I am alone it is not easy to deal with those things.*"

However, for some survivors the meetings are bittersweet as talking together with others reminds them of what they have gone through, and the life they had before they were tortured. The shared memories of home, the knowledge of shared customs, culture and lifestyle, can bring comfort and reassurance, together with sadness and homesickness. One survivor expressed his feelings in this way: "*When we talk about these things, I am reminded of what life I had back home, so in a way I would like to avoid coming for this meeting. But on the other hand there's a hope when I come here that we will do some sort of help so that we can have a life, which we are longing for.*"

Some survivors also spoke about their involvement in making a contribution to the wider work of Freedom from Torture through service expert panels and how this contributes to their rehabilitation. One said: "*We feel like we were part of it, and when we go home we feel better, so it is like part of therapy.*" For these current service-users and for former service-users who are now members of the Survivors Speak OUT network, having their concerns listened to and acted upon, and then, if they chose to, becoming an advocate in their own right, is a part of their rehabilitation process.

Others suggested that they wanted to help Freedom from Torture grow so it could reach other survivors who would benefit from its services: "*It makes me also feel better about myself, that I am doing something back for the society.*"

Other survivors also expressed support for the work Freedom from Torture does to influence policy and decision makers, to try to improve the asylum system so it works more humanely and effectively.

Some survivors said that legal and welfare advice services contribute significantly to their rehabilitation, by helping them to address many of the practical and legal difficulties that arise during the asylum application process and beyond. Survivors said that it makes a big difference to them if they feel supported and not alone in their dealings with the Home Office. Survivors suggested that without such attention, these problems would continue to act as barriers to rehabilitation. One said: '*I can say that there's no way that we can call it rehabilitation, or we can do the rehabilitation process if for example the Home Office is there just to let us down.*"

Common themes – Lessons learnt

Despite the varied experiences and responses revealed in the discussions, a few common themes emerged. The first is that torture is extremely damaging to physical and mental health and torture survivors want and need humane, consistent and tailored rehabilitation support before and during the asylum process and after they have gained refugee protection. For some survivors this is a lifelong process. Others learn better how to cope with their trauma, although many fear that the damage from their past torture can always return in unforeseen and unexpected ways.

A second theme is that the dysfunctions and delays in the asylum system play a huge role in exacerbating the trauma of torture. Individuals who are trapped in the asylum system for months and years, often going through multiple tribunal hearings, their experiences being routinely disbelieved by caseworkers, find their lives on hold, unable to move forward.

Added to that are the privations of living on meagre benefits, being accommodated in inadequate housing, often with strangers in a hostile area, and the indignities of being unable to work or study. All these factors hinder effects at rehabilitation.

A third theme is that therapy can be effective in helping torture survivors on the road to rehabilitation. Although rehabilitation through psychotherapy is an unfamiliar concept to many, survivors feel that it helps them to make sense of their own experiences. Just being listened to and being seen as a whole person is seen as being of value in itself. Group therapy that enables survivors to be active, to meet and connect with each other plays a very positive role in rehabilitation.

My journey to rehabilitation

I have been reflecting on some of my own experiences which happened over ten years ago, but still my rehabilitation journey

continues. Throughout that journey, I have often wondered when rehabilitation begins and when it ends – or indeed whether there is an end. You might be surprised to hear that I strongly believe that my journey to rehabilitation started, not during therapy, but when I was taken from my home that evening and tortured.

Looking back to various moments of my own experience of rehabilitation, I felt different things at different times. Sometimes I wished I could have become the old person I used to be before torture. And sometimes I would have liked to be a different version of my old self - more prudent and far-seeing but still rebellious against torture. At other times, I would have liked just to disappear somewhere, build a quiet life and forget everything.

But, again, my anger at the treatment I received in my home country and then later in the UK through the asylum process wouldn't allow me to forget and be quiet. That was the anger that drove me to become a co-founder of Survivors Speak OUT, a network of torture survivors who speak out against torture and its impact on our lives.

I see rehabilitation as a soul-searching journey of pain, joy, acceptance of the past and perhaps the present, but also rediscovering. Above all, it is also about finding resilience and strength to accept yourself in all that you have been through and all that you now are or will be. It is a continuous journey.

Through the survivors I spoke to about the meaning of rehabilitation, I learnt that this is about holistic support using conventional approaches to rehabilitation through therapy but that it is also about feeling empowered, finding independence in the host country, securing protection without a risk of return to torture, and ultimately regaining the confidence that many of us lost.

One thing that torture attempts to achieve is to take away the ownership of your power and your voice. Torture reduces you to silence; you feel numb. That is why it was crucial for me and for us survivors to speak up so that we will never be silenced, and so that, as a group of survivors, we can advocate for other victims and survivors. For us, that is also an important part of rehabilitation.

Acknowledgements

I wish to thank all the survivors of torture who participated and gave so generously of their time and experiences.

Afternote

The research referred to in this article was designed in collaboration with the research department at Freedom from Torture. A qualitative design was adopted, in order to explore the range and diversity of views and experiences of survivors of torture on the topic of rehabilitation. It was decided that focus groups would be the most appropriate method, as the group setting would enable participants to share their experiences and would allow for a rich discussion based on a range of views and perspectives. Focus groups would also be less time intensive than individual semi-structured interviews and would enable a larger number of people to participate.

Participants were recruited from existing service-user groups in each of Freedom from Torture's five centres in London, Birmingham, Manchester, Glasgow and Newcastle. Service-users who are active in these groups are comfortable sharing their views and discussing sensitive issues in a group setting and the majority therefore consented to participate in the research. Although participants were recruited using an 'opportunistic' approach, there was a reasonably good overall level of diversity in the groups in

terms of: nationality of origin, gender (although the majority were male), age and length of time that participants had been in receipt of Freedom from Torture's rehabilitation services. Participants also included those who are currently awaiting the determination of their asylum claim, and those who had been granted refugee status.

The research was conducted over a period of six months. Focus groups lasting between 90-120 minutes were co-facilitated by Freedom from Torture's researcher, Jo Pettitt, and the survivors advocate and Survivors Speak OUT network co-ordinator, Kolbassia Haoussou. Over 100 participants were involved in the research overall. In the London centre, which has the largest number of service-users, three parallel focus groups were held, with one focus group in each of the other centres. An additional focus group was held with Freedom from Torture staff in the London centre.

To enable meaningful participation, time was spent understanding the purpose of the research and terminology. Interpreters also attended, where needed. Focus groups were audio recorded with the permission of participants, and each was transcribed verbatim.

The findings were analysed systematically using thematic analysis, which is an appropriate method for identifying, analysing and reporting patterns or themes arising from research data. This approach allows for data led findings to emerge, rather than imposing a theory onto the data. This was considered appropriate given the exploratory nature of this research.

Restoring Hope and Dignity CVT Manual

Published by CVT (ISBN: 978-0975978948)[i]

Marianne C Kastrup, MD, PhD

The Restoring Hope and Dignity CVT Manual was developed by the Center for Victims of Torture in Minnesota and is meant for group counselling. It was made possible due to financial support from different US Agencies and the US Department of State's Bureau of Population.

The manual focuses on group counselling interventions and is based upon 15 years of experience from around the world, including Guinea, Sierra Leone, Liberia, the Democratic Republic of Congo, Kenya, Ethiopia, Jordan, and training and capacity building in Uganda, Bosnia, Cambodia, Sri Lanka, Cameroon, South Africa, Moldova and Lebanon. The model described has evolved gradually over this time based upon the experience and feedback from the involved counsellors and trainers and importantly from the very large group of clients.

As can be seen from the list of countries where the model has been used, it is intended primarily for humanitarian or low-resource settings where war and human rights violations have left the population in extreme distress and with a concomitant low level of functioning. The intention is that the interventions described should be delivered by trained counsellors in local settings. It needs to be emphasied that the model may be implemented even if counsellors have limited previous training in mental health issues, but it is important that they receive ongoing supervision and training. Counsellors with previous experience and with an academic background within a given local context may of course also provide the intervention.

To overcome the consequences of atrocity, a 10 session counselling model has been developed. Elements are taken from different theories such as cognitive behavioural theory, narrative exposure therapy, somatic psychology, interpersonal therapy and from different evidence-based trauma interventions. The model pays particular tribute to Judith Herman's tri-phase stages of trauma recovery. In an initial phase of safety and stabilization, focus is directed towards providing a safe physical environment for counselling. The clients are taught grounding techniques, and receive psycho-education related to trauma and its effects, but are also helped to understand the connection of thoughts and feelings. The aim is to support the clients in achieving greater emotional security.

In the second phase, the focus is on remembrance and mourning. The idea is that clients should come to terms with the traumata they have experienced and the impact on their life through processing traumatic memories. A mourning process will take place over previous loss and clients are supported in working with difficult feelings that have arisen as a consequence of the traumatic experiences. Finally, in the third reconnection phase, clients will begin to look towards the future, set goals, and hopefully be able to reconnect with themselves and their community, as well as finding new meaning and purpose in life.

The manual also provides a comprehen-

[i] www.cvt.org 2016

sive, easy–to–grasp overview of the practical dimensions of the intervention, starting with the assessment of whether the client may benefit from group-counselling at all, and whether any adjustments are needed. It is in this initial phase that the first steps of the therapeutic relationship are taken, in an atmosphere of respect and empathy.

The following step comprises the treatment planning. According to the client's needs, the plan may involve several dimensions including individual or family treatment, medical and psychiatric care, physiotherapy, or social work. The overall idea is to have a holistic perspective and ensure that no problem is neglected. Counselling in a group may be very beneficial for some clients as they get the feeling that they are not alone, and that many others may experience similar problems. The model emphasizes that group counselling needs live supervision, with an emphasis on self-care and that the manual should be used combined with supervision.

Ethical and safety aspects - emotional as well as physical - are important parts of the model. Any processing of traumatic experiences needs an environment of emotional safety where clients are informed about confidentiality and professional boundaries. But the physical part should not be neglected, and it recognizes the importance of a warm, friendly environment where it is possible to feel at ease.

The model describes a structure where each session follows a fixed pattern. All sessions start with an opening - a kind of check-in to both evaluate how clients are doing as well as a kind of recap from the last session. In doing so, it is intended that clients stay focused on what were important issues at the previous session, what has happened since then, and what should be the theme for the next session. From there, the session then moves to the working part, where clients are taught new coping skills and time may be spent on remembrance and mourning. Finally, the session ends with a closing exercise helping the clients to integrate the lesson learned and prepare to move on – all carried out in 90 minutes.

To implement this requires that the counsellor is well-prepared and stays focused, and the manual provides ample information that is valuable for the counsellor to achieve this.

The manual outlines the 10 sessions: Introduction and Creating a Safe Space (1); Using our Strengths and Resources to Help Us Cope (2); Connecting our Minds and Bodies (3); River of Life: Honoring Our Life Story (4); Working Through a Traumatic Memory (5&6); Addressing Multiple Losses and Reclaiming Goodness (7); Living with the Loss of a Loved One (8); Reconnecting to Self, Community and the Future (9) and Integrating and Saying Goodbye (10). Rich practical advice for each session, which is both easy to use and very illustrative, is also included, as are useful annexes, namely, (a) assessment training material, which is a detailed explanation of the CVT's assessment process; and, (b) handouts for closing practice.

The manual's strength lies in it being based on extensive experience in a number of settings involving clients from different cultural backgrounds and types of adversity. Furthermore, it is easy to read, also for non-academic staff; it is generously illustrated and uses a language that is full of respect and understanding for the variety of settings in which counsellors have to work. I recommend that it should be widely used and that there should be a continuous interaction between users of the manual and those responsible for its publication in order to monitor any limitations and shortcomings to ensure its ongoing improvement.

Psychological Torture: Definition, evaluation and measurement, By Pau Pérez-Sales

Published by Routledge (ISBN: 978-1138671553)

Jim Jaranson, MD, MA, MPH

Psychiatrist Pau Pérez-Sales has compiled a masterful and thorough analysis of an ambiguous but extremely important topic using a multidisciplinary approach. The book's objectives are to define torture, to build a theoretical framework for understanding and re-defining torture, to propose operational criteria for research, to propose working criteria for deciding whether a case constitutes torture and, finally, to propose adjustments in the Istanbul Protocol for documentation of torture. The author has accomplished all of these objectives successfully in a book that is well-written and easy to read, even though he draws from the esoteric concepts and language of legal, political, and scientific fields.

The definition of psychological torture has little consensus in the field. Considerable differences arise from the needs of researchers to have objective scientific criteria, for mental health clinicians to help survivors in treatment, for lawyers and judges to assess forensic cases, and for governments and human rights advocates to prevent torture. Psychological torture, as defined by Pérez-Sales, is "the use of techniques of cognitive, emotional or sensory attacks that target the conscious mind and cause psychological suffering, damage and/or identity breakdown in most subjects ..."

This book begins with an historical review of definitions which provide a basis for contemporary review of the definition. The related and overlapping concept of CIDT (Cruel, Inhuman, and Degrading Treatment) or punishment in international law is compared with torture. This detailed history smoothly paves the way to the contemporary review of the definition and recommendations for the future.

The next two sections include case presentations of survivors and of perpetrators with a detailed analysis of the relevance for a discussion of psychological torture. This is particularly noteworthy, a valuable and innovative approach to this topic.

Subsequently, Pérez-Sales discusses how psychological torture has gained recognition in international law, how humiliation serves to differentiate legal and mental health perspectives, and how the perpetrator justifies his motivation, intention, and purpose.

Adding scientific approaches to the discussion, the author concludes that, rather than cataloguing torture methods, emphasis should focus on the objectives of torture. Using newer biological techniques such as neuroimaging have shown correlates of torture but perhaps the future will provide greater specificity. Discussions about trauma, which itself has no satisfactory definition, have provided insights from clinical psychiatry for psychological torture theory.

Next follows a lengthy section of techniques of psychological torture beginning with a discussion of the French, British, and American schools of psychological torture and their historical convergence. This section continues with the influence of

the environmental manipulation and coercive interrogation, the targeting of the body to reach the mind, interrogation for both law enforcement and military intelligence gathering, psychological manipulation of identity, i.e., brainwashing, and the use of technological research vis a vis psychological torture.

Finally, Pérez-Sales integrates and summarizes the conceptual "map" of torture based upon his work as described earlier in the book, proposes new ways to define and measure torture environments, suggests ways to improve the Istanbul Protocol, and proposes an agenda for research in the future.

This book should be available to everyone with an interest in politically-motivated torture and its treatment. It has multiple potential uses as a textbook, a reference work, or just as an interesting book for those who need or want to know about psychological torture. The many charts, tables, research instruments, references, and appendices can be useful for reference or in training.

This book has few limitations or shortcomings. The ones I can find are minor. For example, "tones" on page 8 is ambiguous and could refer either to audible or visual tones. The general attorney of the United States (page 273) should be attorney general. Table 10.2 (page 167) should include the mental health work of early North American torture treatment centers: PTV in Los Angeles, 1980; CCTV in Toronto, 1982, CVT in Minneapolis, 1985.

Personally, I find the book extremely interesting and have learned new information and approaches to the topic, even though I've had more than thirty years of clinical, research, training, and administrative experience as a psychiatrist in the field of torture rehabilitation. The book has summarized the history of methods worldwide, the evolution of definitions, and conceptualized the concept of psychological torture in ways that I found creative and most useful. Pérez-Sales has accessed material that has only been published in Spanish and would be missed by those limited to the English language literature, documents and testimonies.

Of particular use for reference are the eight appendixes: 1) classification systems for torture methods, 2) the CIA and Army interrogation manuals, 3) classification of interrogation techniques, 4) the Torturing Environment Scale (TES), 4) a toolbox of assessment instruments, 5) the Standard Evaluation Form for Credibility Assessment (SEC), 7) the Intentionality Assessment Checklist (IAC), and 8) a guide to documenting torture.

I strongly recommend the book as necessary for anyone working in or with an interest in politically-motivated torture and its rehabilitation--for mental health practitioners, researchers or forensic experts, policy-makers and as a necessary reference work for many others. Pérez-Sales has brought together in an eloquent text what is known and needs to be known "from all possible angles…testimonies, studies, opinions, reports, laws, and facts" (page 258). Much of the content can be found piecemeal elsewhere but, as Alexander Pope stated in 1711, the book contains "What oft was thought but ne'er so well express'd." I appreciate the incredible effort that Pérez-Sales expended in researching and writing this book as a single author--but I am most appreciative that he did.

This book will complement the volume edited by another psychiatrist and researcher, Metin Başoğlu: Torture and its Definition in International Law: An Interdisciplinary Approach, scheduled for publication by Oxford University Press in August, 2017.

Reproductive Freedom, Torture and International Human Rights: Challenging the Masculinization of Torture, By Ronli Sifris

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The title of the book could not be clearer about its key message. In the words of the author, it aims to "contribute to a feminist conceptualization of international human rights by examining restrictions on reproductive freedom through the lens of the right to be free from torture and CIDT [Cruel, Inhumane or Degrading Treatment]" (p8). Sifris' book draws attention to the grave reality surrounding women's reproductive freedom in numerous countries and, in particular, the severe restrictions on abortions and the practice of involuntary sterilizations. The author affirms how inhumane and dangerous it is for international law to overlook women's choices in relation to their own bodies, and the consequences this may have, with many women suffering or dying because of lack of protection. The important question, which is not only raised but discussed in depth, is: how the prohibition against torture can actively be applied in this context?

The author presents a very comprehensive overview of the prohibition against torture, both in international human rights laws and in regional human rights legislation. Rich examples of jurisprudence and the changes in jurisprudence with regard to reproductive rights are provided, with reproductive rights being defined as those related to pregnancy and childbirth. Despite the importance of a whole range of existing legal provisions regarding torture, priority is given to the UN Convention against Torture, in particular the definition of torture in Article 1, and the jurisprudence of the UN Committee against Torture, including a useful historical overview. This is done in a convincing way as the author "deconstructs" the definition in the convention through a step-by-step analysis of its four main elements and how these can relate to violations on reproductive freedom. The discussion is both conceptually sound and provides substance, including appropriate reference to jurisprudence, recommendations presented to States as part of periodic reporting and the Committee's General Comments. Despite the jurisprudence based on decisions in individual complaint cases being fairly limited, there are a number of very clear concluding observations by the Committee against Torture ('COB'), on restrictions on abortion (for instance in the COBs to Peru in 2006, to Nicaragua in 2009, to Paraguay in 2011 and to Ireland also in 2011), and on involuntary sterilizations (COBs to Czech Republic in 2004 and 2012, to Peru in 2006

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[i] UN CAT (2008). General comment No. 2 on article 2 of the Convention against Torture. AVailable from: http://www2.ohchr.org/english/bodies/cat/GC2.htm

etc.). The references that are made to General Comment No. 2[i] on the obligation of states to prevent torture and ill-treatment, and the inclusion of the term 'reproductive decision' relating to women (paragraph 22), firmly position this form of violence as being under the Convention. The author clearly acknowledges the importance of the concrete steps taken by many of international bodies and the Committee against Torture in strengthening the reproductive rights of women by pointing out state responsibility under the Convention.

The book's review of both the definition and its elements (that is, severe pain and suffering, intentionality, purpose: discrimination and public official) is remarkably thorough as well as challenging and eye-opening. Serious limitations to women's decisions over their bodies can mean severe pain and suffering and the principle of intentionality is understood in this context. In particular, an understanding of the discriminative element as an example of purpose is clearly explored and supported by cases and principles. The public official element of the definition is fulfilled by the fact that decisions taken over women's reproductive rights are more often than not related to legal provisions in a country, or even when non-state actors are involved, lack of due diligence and failure to protect on the part of the state. How this relates to the definition of torture also allows for the analysis of examples and situations that may fall under the concept of torture and thereby an accompanying state obligation to prevent. A number of strong examples of the injustice women have been exposed to are provided, such as denial of abortion on very young girls who have become pregnant after rape, including by their own fathers, denial of ending pregnancy even when life is at stake, and sterilization forced upon women for reasons of racial discrimination or political oppression.

An interesting discussion regarding the condition of "powerlessness" often associated with torture is also included which builds on the work of Burgers and Danelius, as well as M. Nowak, all of whom have highlighted the importance of the key difference between being in a situation where there is some power to escape and where there is not. This element of powerlessness is discussed and analysed by the author in the same way as the formal elements of the definition of torture. It is a very interesting discussion and arguments relating to domestic violence and the definition of torture and CIDT are brought in. However, it was surprising that there was no further discussion about the problematic aspects of the powerlessness concept, especially since it has been challenged from a feminist point of view. Copelon, for example, is concerned that a focus on powerlessness risks diminishing the plight of battered women vis-a-vis men in detention, implying that the former have a greater ability to leave an environment where there are tortured. It also risks bringing back the blame on the woman for her abuse.[ii] The discussion is nevertheless valuable and contains substantial and relevant arguments as well as cases.

As a former member of the Committee against Torture, who has taken an active part in the discussions surrounding these issues during the period in which the analysis covers, I found the review and analysis of primarily the four elements of the definition to be an extraordinarily valuable and

[ii] Copelon R, Gender Violence as Torture: The Contribution of CAT General Comment No. 2, 11 N.Y. City L. Rev. 229 (2008).
Available from: http://academicworks.cuny.edu/clr/vol11/iss2/7

stimulating contribution to the field in general, and in particular to the field of reproductive rights and international law. That said, this publication should not stand alone, but be a springboard for further thinking and discussion on the issue. The mapping exercise carried out in the book importantly includes highlighting the gaps, silences, and vagueness that continue to surround violence and abuse in connection with reproductive rights and, in particular, restrictions on abortion and involuntary sterilization procedures. This also brings attention to rape as a form of violence against women and as a form of human rights violation. It also furthers the discussion about when and under what conditions international human rights law considers rape to be torture. The discussion on this topic has developed over the last few years and the contribution also from the Committee against Torture on this issue is significant.[iii] The book represents a very important summary of the process that has taken place with regard to women's rights, serious human rights abuses and in particular sexual, gender-based violence over the last 20 years. In so doing, it contributes to the call for how women's lived experiences of torture should be defined as just that: torture.

The book's reach - or its potential impact – goes further than an analysis of the specific points raised – it is a feminist analysis of international law, highlighting the fact that torture has been, and usually still is, described and discussed in a gendered way, that is, as a mainly male-related problem, and specifically, as something that happens to men in detention. The author argues that international law reflects this exclusionary and masculinized understanding of torture and, as such, serious violations may fall under the radar and threats to women's lives and well-being may fall short of the scrutiny otherwise given to acts of torture or CIDT. In light of this, the book represents a very important contribution to the field and it opens up a larger debate about prevention, protection and accountability with regard to women, reproductive rights and torture. Moreover, it is a book which gives insight and perspective to all those involved in working with human rights and prevention of all genders and all ages.

'Reproductive Freedom, Torture and International Human Rights: Challenging the Masculinization of Torture' is not only worth reading, but worth studying in depth. It succeeds in its aim to analyze "the meaning of torture and CIDT under international human rights law with a view to conceptualizing these terms so as to include issues of disproportionate concern to women, particularly restrictions of reproductive freedom" (p4). Anyone trying to understand, study, or work with international law should read this book in order to conceptualize the gendered nature of it and in order not to discount half the world's population. Furthermore, this book challenges the international legal system, which was developed primarily by men and does not properly address women's lived experiences. It is a timely and a very important book.

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[iii] Gaer FD. Rape as a form of torture: the experience of the Committee against Torture. Cuny Law Review 2012;15:293-308. Available from: http://www.cunylawreview.org/wp-content/uploads/2013/08/Gaer_Rape-as-a-Form-of-Torture.pdf

Effective and humane ways to manage the drug problem in the Philippines, a human rights and public health perspective

Jerbert M. Briola*

Dear editor,

We, at the Medical Action Group (MAG), a health and human rights organization, are uniquely placed to see a particularly disturbing aspect of Duterte's drug war: it disproportionately targets the poor and vulnerable. A five-year-old girl was killed in late September 2016 after suspected gunmen aiming to kill her grandfather opened fire. A picture went viral of a wife weeping while cradling her husband, a pedicab driver and alleged drug peddler, who was shot and killed by men on motorcycles on the street of Pasay City. Filipinos immediately associated this image with Michaelango's famous Pietà sculpture. A cardboard sign next to his body carried the chilling message "*Pusher ako, wag tularan*" (I'm a pusher, don't do what I did). We see both the drug war's human toll and, from their story, we learn the crushing poverty of the majority of its victims.

President Rodrigo Duterte has attracted international condemnation with his violent crackdown on drugs in the Philippines. Even at its own admission, the Philippine National Police (PNP) said a total of 2,169 drug suspects have been killed in anti-drugs operations from July 1 2016 to January 1, 2017. These killings, which have been dressed up in the trappings of a 'war on drugs' bear all the hallmarks of punitive policies by the authorities in dealing with the drugs problem in the Philippines. This approach is contrary to the Philippines' obligations under various human rights treaties it has signed to respect the right to life and uphold due process. This was recently reiterated by UN Special Rapporteur on summary executions, Agnes Callamard: "Claims to fight illicit drug trade do not absolve the Government from its international legal obligations and do not shield State actors or others from responsibility for illegal killings."[1]

Approaches premised on a punitive law enforcement paradigm have failed, emphatically so. They have resulted in more violence, larger prison populations, and the erosion of governance. The health harms associated with drug use have got worse, not better. The drug problem in the country cannot be viewed and treated simply as a law enforcement problem. Putting health and community safety first requires a fundamental reorientation of policy priorities and resources, from failed punitive enforcement to proven health and social intervention. We

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strongly advocate for an approach to drug policy that puts public health, community safety, human rights, and development at the center. We recognize the adverse effects of illegal drug use especially on youth. We are also fully aware that illegal drug use and trade have destroyed the lives and future of individuals as well as families and communities. However, while we support the government's intention to make the public safe from the harm of illegal drugs, it should not put the country in greater harm by allowing the proliferation of violence. We would particularly ask the Philippine government to take advantage of the 2016 UN General Assembly Special Session on Drugs (UNGASS),[i] as an opportunity to finally start fighting drug problem in public health perspective and under control.

In addition to the rise in extrajudicial killings, thousands of people have surrendered themselves to the authorities out of fear of being targeted in the drug crackdown. As of January 16, 2017, a total of 1,155,819 drug personalities have turned themselves in, eight to ten percent of whom will need to be committed to a drug facility, according to a government report.[ii] Nevertheless, an increase in arrests during Duterte's presidency has caused already overcrowded jails to further overflow with prisoners. Images from Quezon City Jail in Manila show tightly packed rows of inmates lining the floors of the facility, which was built to house 800 people but now holds 3,800. Prisoners reportedly take turns sleeping on the ground.[iii]

The Global Commission on Drug Policy have stressed that a new and improved global drug control regime is needed that better protects the health and safety of individuals and communities around the world.[2] Harsh measures grounded in repressive ideologies must be replaced by more humane and effective policies shaped by scientific evidence, public health principles and human rights standards.

The Global Commission on Drug Policy have also called for an end to the criminalization and incarceration of users together with targeted prevention, harm reduction and treatment strategies for dependent users. In order to reduce drug-related harms and undermine the power and profits of organized crime, the Commission recommends that governments regulate drug markets and adapt their enforcement strategies to target the most violent and disruptive criminal groups rather than punish low-level players. The Global Commission's proposals are complementary and comprehensive.

Illegal drug use happens in almost all communities and is associated with substantial health and social problems. The obstacles to reform are both daunting and diverse; the drug problem is primarily a public health issue with poverty at its root. Using the criminal justice system to force people arrested for drug possession into 'treatment' often does more harm than good; far better to ensure the availability of diverse supportive services in communities.

Rehabilitation is essential to combatting the effects of drugs. With the massive number of people who have surrendered, we cannot ignore the need for health interventions. Barriers in the provision of health services currently exist, such as the lack of treatment and rehabilitation centers nationwide due to funding problems and the fact that many services are unaffordable to the majority in need. Concerted efforts and

[i] http://www.unodc.org
[ii] http://www.dilg.gov.ph/news/New-PHP700M-drug-rehabilitation-center-to-rise-in-Malaybalay/NC-2017-1055
[iii] http://time.com/4438112/philippines-overcrowded-prison-manila-rodrigo-duterte/

evidence-based policy actions therefore need to be made. Government-run treatment facilities in the country are located only in the National Capital Region (NCR), Caraga Region and Regions I, IV-A, V, VI, VII, X and XI. There are 42 drug rehabilitation centers nationwide which are only able to cater for 5,000 patients. Of the 42, 14 are state-run while the rest are privately operated and are therefore not available to the vast majority of people in need. Community and families can definitely be helped through the establishment of community-based programs, drug after care or local support interventions for out-patients.

People's health and safety need to be at the center and the government needs to ensure access to essential medicines and pain control. This is the only way to reduce drug-related death, disease and suffering and the violence, crime, corruption and illicit markets associated with ineffective prohibitionist policies. Treatment and rehabilitation, ensuring access to essential health goods and services, education and decent employment are all necessary to eliminate this drug menace.

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2. The Global Commission on Drug Policy. Available from: http://www.globalcommissionondrugs.org
3. Statement of the Medical Action Group. Available from: http://www.magph.org/news/216-address-illegal-drug-use-through-health-interventions

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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

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