



Approaches to torture rehabilitation

A desk study covering effects, cost-effectiveness,
participation, and sustainability

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Roger Gurr & José Quiroga
*Approaches to torture rehabilitation: a desk study
covering effects, cost-effectiveness, participation, and sustainability*

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Editors' preface

It is a great pleasure to be able to publish Roger Gurr and José Quiroga's desk study, since its discreet title *Approaches to torture rehabilitation* covers nothing less than a comprehensive study that includes a detailed review of the ongoing global work against torture and its preconditions, a thorough analysis with a professional evaluation and outline of what these initiatives have started, and a series of recommendations based on the authors' detailed and objective preparatory work and knowledge from deep involvement in the subject.

The purpose of TORTURE's supplements is to provide space for large analyses, monographs, and research articles. The supplements will therefore often be of interest only to specific target groups, not necessarily to all readers of TORTURE. But this particular supplement should be of interest to the majority of readers because of its easily understandable presentation, the wealth of information of general interest to all involved in torture, and the thorough and wide-ranging analysis based on objective criteria. *Approaches to torture rehabilitation* can thus be used as an introductory tool based on some key words with reference to the field of torture, including a diagnostic concept that is able to distinguish between facts and hypotheses. The authors have collected a solid knowledge of the available literature, and, as outsiders, they have been able to outline some advantages and disadvantages that may be difficult to identify for those of us who are so deeply involved with torture that we may not be able

to see the essentials with the clarity with which they are presented here.

Torture rehabilitation work is a new discipline, and every day brings new knowledge and progress within this field. The present study is based on material collected in 1997-98, and is therefore already now in need of certain corrections, e.g. with respect to the extent of the IRCT's service programmes and country coverage, to mention one example. A quotation in section 17.1 reads "repressive governments practise torture in spite of international law and world opinion because there is no international criminal court to prosecute those who promote or execute crimes against humanity". This is another example of how development, fortunately, is fast since heads of state of torture regimes cannot travel freely today, and since the International Criminal Tribunal for the Former Yugoslavia in The Hague is already functional.

We hereby welcome the readers to *Approaches to torture rehabilitation* – use it, wear it out.

The Editors

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DANIDA (Danish International Development Assistance) has commissioned this desk study and kindly given permission to publish it as a TORTURE Supplement.

Approaches to torture rehabilitation

*A desk study covering effects, cost-effectiveness,
participation, and sustainability*

Roger Gurr & José Quiroga

This study, which was prepared on behalf of the Danish International Development Assistance (DANIDA), forms part of a pre-appraisal of five projects submitted by the Rehabilitation and Research Centre for Torture Victims (RCT).

Based on current knowledge, the objective of the study is to identify and discuss possible ways and means of dealing with rehabilitation of victims of torture.

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1. INTRODUCTION

Having done as thorough a review of the literature (refereed journals, other journals, books, unpublished papers and personal communications in both English and Spanish) as was possible in the time available, with over 400 scanned and over 250 selected for review, we are disappointed by how few questions in service provision are answered. In some areas of interest there is virtually nothing available.

It would be nice to be able to come up with clear and scientifically valid recommendations on the design and functioning of torture rehabilitation services and the interventions they offer in different environments. However, the complexity of contributing factors and the lack of controlled studies means that decisions have to be made based on simpler evaluation methods and professional judgement. While there is growing interest in the subject and an increasing number of programmes around the world, it will be many years before even a small proportion of the possible questions are answered.

What is clear, based on qualitative evidence and judgement, is that if services are to meet the needs of their consumers and become sustainable in the longer term, then there are principles that need to be followed. These principles can be summarized as:

1. Interventions should be based on the best current knowledge, taking cultural differences into account.
2. Interventions must be diverse to meet the range of needs, of both type and severity.
3. Participation is essential in determining the best use of resources.
4. Participation is essential in developing sustainability.
5. Good governance of services is essential for good performance.
6. Education and training at all levels will improve performance.

Participation means the involvement of the target community in the creation and management of services.

The world has now put into place several covenants and treaties to inter-link human rights, health services, and country development, which are international law. It is time for the UN and donor governments to apply those laws in a systematic fashion to assist the survivors of torture through primary prevention to stop torture and the provision of services (secondary and tertiary prevention).

2. DEFINITION OF TORTURE

Torture needs to be defined in order to determine violations of human rights standards by the authorities, and to establish eligibility for treatment in a torture programme. The simplest, broad definition of torture was adopted by Amnesty International (AI) in the "Report on Torture" in 1973:

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

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

"Torture is defined as the deliberate, systematic or wanton infliction

of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason." (Amnesty International, 1994).

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

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

"For the purpose of this Convention, the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purpose as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed, or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by, or at the instigation of, or with the consent or acquiescence of, a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions." (United Nations, 1984).

This legal definition applied only to nations and restricted the definition to government sanctioned torture. It does not include cases of torture such as mutilation, whipping or caning, practised in some countries as a lawful punishment, nor does it include torture practised by gangs or hate groups.

The Convention reintroduced the concept of grades, when it defined torture as *severe pain or suffering*, the other level being cruel, inhuman or degrading treatment (also called maltreatment). For an experienced clinician, there is no problem distinguishing a true torture survivor from a malingering case in the clinical setting. The problem is more difficult in an epidemiological study or in an advocacy report, if you want to separate torture from maltreatment. If we accept the possibility of a difference, it is almost impossible to define this difference from a subjective or an objective point of view. "However, given that cruel and inhuman treatment is itself also contrary to international law, attempting to set clear borders between the two is probably a futile and potentially misleading task." (Welsh and Rayner, 1997).

The WHO working group in 1986 introduced the concept of Organized Violence and it was defined as:

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

This broader definition includes other victims of violence, in addition to survivors of torture. The definition includes government repression and also terrorist group violence. Some

torture rehabilitation services only provide care to torture survivors, while others also provide care to survivors of organized violence.

2.1. Torture characteristics

Torture has very unique characteristics:

- Torture is a perverted form of human interaction that involves at least two persons, the torturer and the victim. The interaction is characterized by extreme degradation, humiliation, and dehumanization.
- The torturer inflicts severe pain or psychological suffering on the victim.
- The torturer/victim relationship is asymmetric (Doerr-Zegers et al., 1992), meaning that the torturer has physical control over the victim, who is defenceless (handcuffed, blindfolded, physically and mentally debilitated). This situation creates a relationship of extreme dependency and helplessness that permits the psychological manipulation of the victim.
- This relationship is characterized for its anonymity (Doerr-Zegers et al., 1992). The torturer and the victim do not know each other. The name of the torturer is a fictitious one. Because the victim's or torturer's head is covered, they cannot identify the other or establish eye contact. This is a planned depersonalized relationship that could explain in part the violence of the interaction.
- The victim is entrapped in a double bind situation (Lira et al., 1990). He has been deprived of all rights as a human being and he is forced to choose between two equally impossible options. He has to cooperate with the torturer, by giving him confidential information and the names of comrades, or he has to suffer more pain and possible death.

2.2. Torture objectives

Torture has a rational purpose. Authoritarian governments of all colours have used torture as a political tool to suppress dissidents. These political structures, which do not have the support of the population, have to resort to violence in order to maintain power. As AI states in its report on torture, "[...] torture is part of a government security strategy." Torture is planned and implemented by state officers. It is one form of political ritual. It belongs to the ceremonies by which power is manifested (Foucault, 1979). It is a ritual to produce the truth, the truth in the absence of the accused; that is to say, to produce a confession from an individual subjected to torture about his/her comrades (or companions).

Torturers are trained in a variety of sophisticated and brutal techniques of physical and psychological abuse. Because torture is a technique, it is not an extreme expression of rage. It is a technique that must produce a certain degree of pain, which may be measured exactly. It is not applied to the body indiscriminately, it is calculated according to detailed rules. The number of lashes of the whip, the position of the body hanging from the wrist with the tip of the toes touching the floor, the number and parts of the body where electrical shocks are applied, etc. The purpose is to carry pain almost to the infinite. "Torture is the art of maintaining life in pain, by subdividing it into a thousand deaths, by achieving before life ceases the most exquisite agonies [...]" (Foucault, 1979).

Torturers are trained to exert the maximum pain without killing the individual. They will reach the edge (or limit) between life and death, knowing scientifically the limits of human resistance to pain. Torturers are advised and assisted by professionals to better handle each individual case.

Torture has been used:

- At an individual level as punishment, with the intention to destroy the victim as a human being, through a systematic method of infliction of severe pain and psychological suffering. To destroy his/her dignity by humiliating him/her through the most macabre forms of harm.
- To destroy the victim's identity by forcing him/her to give confidential information and names, to become a traitor to his/her ideology and comrades.
- To obtain a false confession to condemn the victim of an unlawful criminal act. The confession is the result of breaking the prisoner's will and an expression of submission.
- In some extreme cases to transform the victim into a collaborator, which is the maximum expression of identification of the victim with the aggressor.
- At a social level, torture has been used as a method to intimidate dissident groups, with the objective of preventing the population from expressing opposition towards government policies. To create fear with a subliminal message: political action could risk torture and possible death.

3. PREVALENCE OF TORTURE

The first global survey of torture was done by Amnesty International and published in 1973 (Amnesty International, 1973). The survey showed that out of 168 countries, 72 countries (42.8%) practised torture systematically. The second global survey published in 1984 showed that 109 countries (64.8%) were practising maltreatment and/or torture (Amnesty International, 1984). The most recent data is the 1997 Annual Report of AI, which reported torture and maltreatment in 115 out of 215 countries, or 53.5% (Amnesty International, 1997 (a)). This apparent increase probably is not a real one but a reflection of better information through non-government organizations (NGOs) monitoring violations of human rights.

3.1. Prevalence of torture among detained and political dissidents (in countries of origin)

The most accurate method to measure the magnitude of the problem is to use a *rate* that measures an event in relation to a unit of a population. The incidence rate of torture measures the new cases of torture in relation to the population at risk (detained people) over a period of time. The prevalence of torture measures the total cases of torture in the total population at a point in time.

These rates have not been calculated because the total number of tortured people is unknown or under-reported and the population at risk (detained) is also unknown. As an alternative, the rate has been measured as torture survivors in refugee populations.

3.2. Prevalence of torture in refugees

The prevalence of torture in refugees varies from 5-70%, depending on the composition of the sample in relation to age, sex, nationality, and point in time. Torture in selected samples of refugees, such as those consulting a general medicine outpatient clinic in New York was 5% in 1997. The prevalence of torture was 70% in males, and 31% in females in a selected outpatient psychiatric clinic in Oslo between 1991 to 1995 (Lavik et al., 1996).

The prevalence in samples of unselected refugees showed

intermediate values. It was 20% in a random sample of 3,000 from the 10,000 asylum seekers who arrived in Denmark in 1986 (Jepsen, 1988). A Swedish group of the Red Cross found a torture prevalence of 23% in refugees requesting asylum in Sweden (Horvath-Lindberg, 1988). A prevalence of 30% was found in a small sample of 74 Middle Eastern asylum seeking refugees in Denmark in 1992 (Montgomery and Foldspang, 1994).

The studies on prevalence of torture in refugees are very scarce. Many papers give prevalence numbers citing secondary sources.

3.3. Medical and psychological services worldwide for survivors of organized violence

The service programmes working with victims of political or other forms of organized violence have expanded enormously in the last 10 years. The precise number is unknown, because some programmes are new, small, and without international connections. Amnesty International identified 100 programmes in 25 countries in 1995 (Amnesty International, 1995). The International Rehabilitation Council for Torture Victims (IRCT) listed 94 programmes in 49 countries as belonging to its network (IRCT, 1997 (a)). The United Nations Voluntary Fund for Victims of Torture received 117 requests for funding from 64 countries in 1997 (United Nations, 1997). The IRCT estimated that there were as many as 166 torture programmes in 81 countries in 1997 (IRCT, 1997 (b)).

4. METHODS OF TORTURE

From a didactic point of view, torture methods have been divided into physical and psychological.

The physical methods of torture reported by survivors challenge any possible classification, because of the increasing number and variety of methods. The Human Rights Commission of El Salvador published a list of 40 different methods (Comisión de Derechos Humanos de El Salvador, 1986). The Chilean Human Rights Commission listed 85 different types (Orellana, 1989). Occasionally, torture is brutally indiscriminate and leaves visible traces and mutilations with a high mortality rate. Most of the time torture is very selectively tailored to the characteristics of the victims. The most frequent methods of physical torture are beating, electric torture, stretching, submersion, suffocation, burns, suspensions, planton, cuts, and sexual assault.

Psychological methods include several categories:

- Induced exhaustion and debility through food, water, and sleep deprivation.
- Isolation: the victims are blindfolded in solitary confinement. They are completely isolated from their family and social network.
- Monopolization of perception: during detention, movements are restricted and the environment may have a high pitch sound, strident music, or a crying sound. The victims are in darkness or facing bright lights.
- Threats: the victims are threatened with death. These threats are extended to their family and occasionally they experience sham executions.
- Witness torture: among the most traumatic experiences is to witness the torture of another prisoner or of family members. A Salvadorian torture survivor has related, after several sessions of testimony about the terrible torture that he suffered, "What happened to me is nothing

compared to being forced to witness the torturing to death of other comrades".

The majority of publications on torture, and the Annual Report of The Rehabilitation and Research Centre for Torture Victims (RCT), describe the different methods of torture and its frequency in the population under their care. The most detailed information is found in Cathcart et al., 1979; Goldfeld et al., 1988; Rasmussen and Lunde, 1980; Allodi et al., 1985. Rasmussen in 1990 published the most detailed paper of the medical aspects of torture in a sample of 200 victims. This paper also included the methods used.

Goldfield summarized six papers and found the following frequency in 319 survivors:

Methods of torture in a sample of 319 survivors of torture:

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

The fact that the most frequent methods of torture around the world are beating, threats, electric torture, mock execution, and water asphyxiation, suggests a centralization of training. As in any subject, generalizations about the frequencies of the various methods cannot be made. There are clear differences between regions and countries. For example psychiatric abuse was almost unique to Russia (Bloch and Reddaway, 1985), and falanga was more frequent in Greece. Shaking is practised mostly in Israel (Physicians for Human Rights, 1995), whipping is more frequent in the Middle East and Africa, and almost unknown in Latin America. Hanging from the feet or ankles from a rod is more universal than the 'Parrots perch', a type of hanging that is more frequent in Brazil and Ethiopia. Because of this, the frequency table of method will be different depending on the country or composition of the survivor population of each centre. The survivor population in countries of resettlement varies over time in relation to the changes in repressive governments around the world and the pattern of migration of the country. The rehabilitation programme of one of the authors received torture victims from many different parts of the world.

However, most of them were survivors from South America in the first five years, later from Central America for 10 years. Now most of them are from Africa and the Middle East. The frequency table of methods of torture has changed accordingly.

Data on the gender distribution of government sanctioned torture is scanty. The prevalence of detention, torture, and political killing is less in women than in men, but women are at higher risk of sexual torture and subsequent sexual difficulties than men (Lunde and Ortmann, 1990; Allodi and Stiasny, 1990). Initially sexual torture appeared in the listing of methods of torture practised as direct genital injury (Rasmussen, 1980) or as a rape or insertion of foreign bodies in the vagina or rectum (Cathcart et al., 1979; Goldfeld, 1988; Rasmussen, 1990; Fornazzari and Freire, 1990). Most investigators later defined sexual torture more widely as:

1. Violence against sexual organs such as electric torture in genital areas; the introduction of foreign bodies into the vagina or rectum.
2. Physical sexual assault; such as rape by torturer or other victims, forced masturbation, fellatio, and oral coitus.
3. Mental sexual assault, such as forced nakedness, sexual humiliation, sexual threats, and forced witness of sexual torture.
4. A combination of these (Lira and Weinstein, 1986; Mollica and Son, 1989; Lunde and Ortmann, 1990; Allodi and Stiasny, 1990; Agger and Jensen, 1993; Meana and Morentin, 1995).

The prevalence of sexual torture using this wide definition is very high. Lunde and Ortmann, in a study of 283 torture survivors in Denmark, found a prevalence of 61% in the total sample (80% in women and 56% in men). Agger and Jensen found similar data in a Salvadorian database (cited by Lunde). Meana and Morentin, in a sample of 64 detainees of the Basque Country (Spain), found sexual torture in 73% (women 94%, men 66%).

5. THE REFUGEE EXPERIENCE

Each year thousands of people who have been tortured by their governments emigrate to host countries, usually as refugees. They come from all parts of the world, including South and Central America, Africa, regions of East and South Asia, and the Middle East. They have several characteristics in common:

- They have migrated to the host country looking for a safe haven because they have a reasonable fear of being persecuted, arrested, tortured or even killed if they return to their countries of origin.
- A significant number of survivors of torture have a history of repetitive trauma in their countries of origin as a result of political and racial discrimination associated with poverty, chronic unemployment, low levels of education, and illness due to a lack of access to medical care.
- The emigration process is an additional trauma for the majority of those who enter the host country unlawfully. They have travelled alone or in small groups. The trip probably took several days or months through areas of the continent that might have included jungle, desert, or combat zones in countries in civil war, often travelling without any means of support. They may have crossed dangerous seas in small boats with little food or water

and the danger of pirates. Many of them are assaulted, beaten, robbed, raped, and some have died during the trip. Some of them are detained by the immigration police and are kept in custody in detention camps for several days, months or years.

- The majority of asylum seekers are treated as illegal aliens in many countries. Because of this condition they can not have stable work and the majority are unemployed or work temporarily in low-paid jobs. If they were technicians or professionals in their home countries, they usually work in positions below this level of expertise in the host country.
- They live in poor neighbourhoods, occasionally in areas with high levels of criminality and racial tension, in which they may become victims of crime. They may have to frequently change dwellings and some of them are homeless.
- Often they have emigrated alone, because of the need of a rapid departure, leaving the nuclear and extended family in the country of origin.
- They have migrated to a country with a culture and language unknown to them.
- Their adopted country, in some cases, may have supported and trained the repressive apparatus that has tortured them.

The additive accumulation of the effects of all these stressors in their lives constitutes the traumatic experiences at the moment of the initial interview and evaluation. These factors explain why resettlement survival issues can be of more immediate concern than the torture story or psychological symptoms.

6. PHYSICAL AND PSYCHOLOGICAL SEQUELAE OF TORTURE

6.1. Physical sequelae of torture and medical needs of torture survivors

In the torture situation the torturer wants to control the mind of the victims with the infliction of severe physical and psychological suffering. Torture is mostly tailor-made, especially psychological torture. Physically, the torturer wants to avoid visible body marks.

Physical torture can be brutal and indiscriminate with severe physical damage and a high lethality rate (Vazques et al., 1997). Dr Rivas reviewed the autopsy protocol of two torture victims who died in an ER of a hospital in Chile. They died because beating caused acute bleeding and rupture of abdominal viscera (Rivas, 1990). Malik in India gave medical care to 34 victims of torture who presented in acute renal failure secondary to rhabdomyolysis, due to severe beating involving muscles. These victims would have died without an emergency dialysis. In spite of the treatment, 5 of the 34 died, with a lethality of 15% for this group (Malik et al., 1993; Malik et al., 1995). Two other victims with a similar medical problem were diagnosed in Israel (Bloom et al., 1995). In Peru, a female survivor of severe torture (LLB) had irreversible damage to the cervical spinal cord with quadriparexia. She has a permanent disability, which requires permanent assistance and specialized medical care. She is dependent on others for her activities of daily living (Asociacion para la prevencion de la tortura, 1997). The film "Your Neighbour's Son" shows a Greek survivor of torture with a right hemiplegia as a result of brain trauma. A Chilean female suffered severe second and third degree burns on her

face and body. She was treated initially in a burns unit and she later underwent multiple plastic surgery.

These are a few examples of severe physical damage and disabilities that require costly inpatient and specialized medical care that no torture rehabilitation programme can afford.

Torture rehabilitation programmes give care to a selected sample of survivors of the total universe of torture survivors. The most severely damaged die during torture, survivors with severe disability go directly to the hospital and later most of them remain in their home country, and of the rest, only a small fraction request medical or psychological care. The survivors present a variety of symptoms of different body systems that have been reviewed in several publications (Cathcart et al., 1979; Rasmussen, 1980; Petersen et al., 1985; Allodi et al., 1985; Goldfeld et al., 1988; Rasmussen, 1990; Cunningham and Cunningham, 1997). Most of these papers have a listing of symptoms and signs, but no diagnosis. Some of these symptoms are the result of somatization rather than physical trauma.

Physical torture produces a well-defined group of acute symptoms and visible signs, mostly secondary to the physical traumatism. Some types of torture are related to specific symptoms and objective signs. The amount of chronic or late sequelae is related to the type and intensity of the method applied.

In survivors of torture, most of the symptoms and signs resolve spontaneously or under the influence of therapy. However in a number of victims a residual effect of short or long duration persists, mainly chronic pain, skin scars, neurological and orthopaedic deficits, and clinical or radiological evidence of bone fractures. Very few of the late skin scars are characteristic except burns, cigarette burns, corrosive fluids, and tight rope scars.

In this case, the time between exposure to torture and medical examination is crucial. If the victim is examined close to the time of torture, it is possible to observe physical signs. After a few weeks there is not enough physical evidence to establish a causal relationship.

Victims of trauma and survivors of torture are at increased risk of infectious diseases, cancer, cerebrovascular accidents, and heart problems (Goldman and Goldston, 1985).

6.2. Psychological sequelae of torture and severe trauma

The response to systematic persecution, torture, other severe traumas of conflict and exile is determined by many factors, from the person's genetic vulnerabilities or resilience, to personal psychology and the social environment. Torture is intended to damage the person's self-esteem and personality, to destroy trust in fellow humans, and to terrorize the population. Usually the person has suffered from many traumatic episodes and the trauma can be ongoing in exile. The meaning of torture and trauma is very important in determining the effect on an individual, and this meaning is shaped by religious, cultural, and political beliefs (Holtz, 1998). However, there are similarities in the psychological symptoms that emerge, with the main constellation of symptoms corresponding to those collected into the syndrome labelled as Post-Traumatic Stress Disorder in the DSM-IV classification of mental disorders (Cunningham and Cunningham, 1997). There is continuing controversy over this disorder, due to many boundary problems (McGorry, 1995). There has been a continuing narrowing of the diagnosis for medico-legal purposes (to limit compensation claims), so that many people may have clear symptoms, but not quite enough for the diagnosis to be applied, with the concept of "partial PTSD" now

emerging. There are differences in the diagnosis of PTSD between the two main diagnostic systems used in psychiatry, the DSM-IV and ICD-10 (Andrews et al., 1997). When symptoms were mapped to both diagnostic criteria using the computerized Composite International Diagnostic Interview (CIDI), results from a major epidemiological survey, the groups of people selected were not identical. There is also the concern that for survivors of torture, the symptoms are a "normal" response to societal pathology and that labelling of the survivor implies personal pathology and the stigma of mental illness. There is no doubt that simply to label survivors as having PTSD is a quite inadequate description of the magnitude and complexity of the effects of torture, and we need to be careful that it does not over-medicalize the problems (Reeler, 1994; Becker, 1995; Lira 1998). Psychiatric diagnostic systems are cognizant of the need to be more holistic in assessment, with both DSM-IV and ICD-10 including multi-axial assessments. Apart from the psychiatric diagnoses, attention is also paid to any physical co-morbidity, to psycho-social stressors and life events, as well as to the level of social and adaptive functioning. However, the scales provided are somewhat subjective and probably do not have sufficient inter-rater reliability for comparisons.

However, it is necessary to identify syndromes for research and treatment purposes, and a disorder may be defined as the need for assistance rather than emphasizing pathology or vulnerability, which may nevertheless be present. There are connections with the general traumatic stress and head injury literature that assist our understanding of the effects of torture, (e.g. McFarlane, 1995). The prevalence of PTSD was considered to be low in the general population, at 1.3% (Davidson et al., 1991), but more recent studies have shown a much higher prevalence using DSM-III-R criteria (Resnick et al., 1993; Breslau et al., 1991); and the National Comorbidity Survey in the USA (Kessler et al., 1995) estimated a lifetime prevalence of PTSD of 7.8%, and survival analysis showed that more than one third of people with an index episode of PTSD failed to recover even after many years (including the treated sample). The traumas most commonly associated with PTSD were combat exposure and witnessing among men, but the prevalence was higher among women as a result of rape and sexual molestation. In veterans of the Vietnam war, the prevalence is 30-38% (Reeler, 1994). The prevalence of PTSD in a sample of Turkish torture survivors was 85% (Paker et al., 1992).

The neuro-psychological effects of head injury in survivors have not been adequately researched, but most torture has involved beatings to the head, and Mollica (1989) has commented that most of the 1,000 patients seen have suffered neuro-psychological sequelae, but he does not supply the evidence. Textbooks of organic psychiatry indicate that even seemingly mild closed head injuries can lead to long-term problems, such as post-concussive syndrome (the symptoms have many similarities with PTSD and psychosomatic symptoms) and an increased incidence of mood disorders, obsessive compulsive disorder, and psychosis (Lishman, 1998). To do the necessary research to clarify the relationship to torture would be a major undertaking, but it should be done, as there are implications for treatment and prognosis.

Contrary to the physical effects of torture, the psychological symptoms are persistent. If untreated, the victims may still experience anxiety, panic, irritability, rage, insomnia, nightmares, memory difficulties, lack of initiative, apathy, social withdrawal, helplessness, affective lameness, and flashbacks of the traumatic event even several months or years after the torture (Turner and Gorst-Unsworth, 1993; Som-

nier et al., 1992; Genefke and Vesti, 1998). There may also be the development of the symptoms of major depression, other mood disorders, obsessive compulsive disorder, phobic disorders (Basoglu et al., 1994 (b)) and psychosis, greater than would be expected in control populations. However, there are not enough studies that have included recognized diagnostic instruments and large enough samples to provide statistical proof, though our impression is that a meta-analysis of published papers would do so. There is a significant level of sexual dysfunctioning, whether or not the person was sexually tortured. There may also be changes in identity (Somnier and Genefke, 1986; Barudy, 1989). There are many studies showing that there is a high level of comorbidity (e.g. Cunningham and Cunningham, 1997; Somnier et al., 1992). However, these diagnoses are not sufficient to explain all the reactions reported.

Many very emotionally charged processes, chiefly concerned with loss, are intimately involved with the experience of torture. The survivors of torture may have lost body parts (e.g. limb or eye), a normal bodily function or bodily health. They are likely to have lost work, status, family, and credibility. Even if they succeed in resisting torture, their colleagues are likely to be suspicious of them. They know that there is a similar threat to their families and friends. If they leave the region to seek asylum, the losses are compounded. Torture, therefore, must be seen not only as a very important life event, but also as the cause of many others (Turner and Gorst-Unsworth, 1993). There is also the loss of normal life development (due to lost time in imprisonment, recovery or waiting for resettlement), including education, marriage, accumulation of wealth and status, leading to excessive work schedules to catch up (Skinner, 1997). There is often a high level of depression, which seems to relate to poor social support, particularly in refugees. For example, the Cambodian widows, who have experienced at least two of the three traumata of rape, loss of spouse or loss of children, have very high levels of depressive symptoms (Mollica et al., 1987 (a)). They perceive themselves as socially isolated and living in a hostile social world, including their own cultural group, with no one to rely on.

It is important to note that the symptoms presented can change over time. There are often dissociative reactions that suppress symptoms until immediate survival or resettlement needs are met and the person is in a safe enough environment to cope with reliving the horror and other emotions of the trauma memories (Kinzie, 1989). A similar process has been noted with some survivors of childhood sexual assault, who only retrieve and deal with the memories once they have developed a stronger ego and a stable support system.

Children have at times been directly physically or mentally tortured, including witnessing beatings, torture or the massacre of relatives and friends (including disemboweling in Cambodia). They show similar PTSD symptoms to adults (Cohn et al., 1980; Sack et al., 1986; Udwin, 1993; Richman, 1993). Often parents and teachers are not aware of how distressed the children are. The children's moral developments, what they value, and how they view others, are inevitably influenced by their experiences of violence, and this affects their future social integration. Distrust of others, doubts about the possibility of having a good future or finding a good spouse are not uncommon (Richman, 1993).

There are also effects to the immediate family of torture survivors, with the frequent destruction of the closeness and intimacy of the marriage relationship and the sexual relationship, with increased irritability and domestic violence. Young children of survivors of torture have been reported

to show social withdrawal, chronic fear, depressed mood, clinging and overdependence, sleep disorders, somatic complaints, and an arrest or regression in social habits or school performance (Allodi, 1980). The children can show coping strategies that fall into four types: isolation and withdrawal; mental flight; eagerness to acclimatize; strength of will and fighting (Montgomery et al., 1992).

Where "disappearances" have occurred, there can be tragic effects on the surviving relatives, who do not know if their loved one is dead, tortured, or alive in a secret camp. How can these relatives work through their feelings of grief if they do not know the reality? (Turner and Gorst-Unsworth, 1993). Children may be orphaned in countries with no family or services to care for them, or they may escape as refugees (or become separated from family) and be resettled without any relatives, as has been found for some Cambodian and Vietnamese adolescents in Australia.

6.3. Social effects

In countries subjected to repression and torture on a very large scale, whole communities may be affected. Torture and killing of individuals may have a striking effect on the social and political life of a country or region, such as El Salvador (Martin-Baro, 1990), Chile (Fruhling, 1992), Guatemala or Cambodia.

A climate of terror is the political effect that the authorities want to establish in the general population. Fear is the mechanism to internalize the terror and to privatize political violence. The families of victims of organized violence have to mourn their loss in private (Padilla and Comas-Diaz, 1987; Becker, 1990 (a)). As a consequence, the political action of the opposition is frozen. The price of being a political activist is very high, with harassment, arbitrary detention, torture, and possibly death.

Societies may remain highly polarized and suspicious, with much remaining anger, which requires a process of reconciliation for national healing. Social reparation needs several sequential steps: truth, compensation, justice, and pardon. Social reconciliation requires that society acknowledges what has happened. Truth is the mechanism, because it is the end of the social denial and silence. Truth commissions have been created in several countries to investigate the atrocities of past regimes, such as in Argentina, Chile, Uruguay, Brazil, South Africa, etc. Social reparation also needs compensation to the victims of the organized violence, and this subject will be expanded later in this report. Justice is the logical next step after the truth is known. Pardon comes after justice, if society accepts it (Padilla and Comas-Diaz, 1987; Becker, 1990 (b); Bronkhorst, 1995).

Even after the civil conflict is over, there are usually traumas due to a failure to follow these logical steps, pardon has been granted to the perpetrators, without justice (impunity), through amnesty laws (e.g. Chile, South Africa) and because of inadequate compensation to those injured (e.g. South Africa, Zimbabwe, etc.).

6.4. Psychobiological mechanism for PTSD

Recent research reviewed by Charney et al. (1993) and Southwick et al. (1994) is leading to a psychobiological mechanism for PTSD. Severe physical or psychological trauma, fear, and danger activate multiple neurobiological mechanisms that release neurochemical modulators such as noradrenergic, dopamine, opiate, and corticotropin-releasing factors. Experimental data suggest that PTSD symptoms such as flashbacks, avoidance of stimuli associated with the trauma, and symptoms of increased arousal are related to

this mechanism. They are pathologic sequelae of what is a normal mechanism for self-preservation; it is critically important to remember that these traumatic events occur during an aroused state of alarm that signals danger. Under normal circumstances, failure to remember such situations makes one vulnerable to similar dangers in the future.

The strength of the traumatic memory relates to the degree to which particular neuromodulatory systems are activated. Some of the acute neurobiological responses to trauma may facilitate the encoding of traumatic memories. The memories of traumatic experiences remain indelible for many decades and are easily reawakened by all sorts of stimuli and stressors (Charney, 1993).

The amygdala is the region of the brain where all these traumatic experiences are encoded. The amygdala is connected to and integrates the information of the five senses, the cortical sensory systems, and the emotional reactions of the thalamus and hypothalamus (Southwick, 1994; Charney, 1993).

If this hypothesis proves to be true, it could have significant implications for the treatment of PTSD patients and survivors of torture. This long-standing alteration of the neurobiological response could explain the extended duration of the symptoms of PTSD, and why current treatments are only partially effective. A 20-year follow-up of torture victims shows a chronic pattern, with recurrent reactivation of symptoms (Kinzie, 1989). Beal (1995) reported a 50-year follow-up of a large sample of Canadian veterans and prisoners of war (POWs) who completed a questionnaire diagnosing PTSD and other psychological and health problems in 1946 and in 1992. She found that while there were high levels of PTSD for both groups, the POWs showed more symptoms than non-POWs. While 46.5% of POWs had PTSD in 1946, 42.4% still had PTSD in 1992. These results suggest that torture treatment programmes should include prolonged follow-up, and an open door for care during periods of reactivation of symptoms.

7. IMPLICATIONS FOR ASSESSMENT

The above listing of effects has implications for assessment and treatment, but we also need to first consider the transference issues between the survivor and the therapist. The survivor may not reveal all the symptoms or tell the whole story, due to dissociation or for fear of frightening the therapist (for good reason, as therapists have been known to actually run away (Mollica and Son, 1989)). Mainstream professional staff often do not wish to know, or do not know how to ask, the difficult questions. Therapists, especially those who have themselves been traumatized, need skilled supervision to help them deal with their own issues, as they arise in trying to help others (Becker et al., 1990; Kristal-Anderson, 1997). The sensitive personalities of people motivated to help torture survivors can find the imagining of torture pain and suffering very stressful.

The history-taking needs to be done sensitively, allowing the survivor to control the pace of revelation and giving priority to the needs identified by the survivor. A trusting relationship must be developed if progress is to be made, so this is the highest priority, beyond diagnosis or the torture story. Cultural understanding is essential in choosing the methodology of the assessment. A standard Western psychiatric interview can be toxic (Mollica and Son, 1989).

However, many services have found that using structured interviews and diagnostic instruments as part of the assess-

ment process can have several advantages, systematically recording symptoms in a way that elicits more than would otherwise be volunteered by survivors. Some can be self-administered or administered by even briefly trained non-professionals, to give reasonably accurate diagnoses, and to provide information for research purposes. Many of these are now in versions that have been translated and validated for increasing numbers of cultural groups and new measures are being developed specifically for assessing refugees and torture survivors. These tools are also useful for repeat assessments for comparison purposes.

The general psychiatric diagnostic interview being developed internationally is the Composite International Diagnostic Interview (CIDI) (World Health Organization, 1990; Robin et al., 1988). This interview includes questions to elicit basic symptoms that, if positive, leads to more detailed questions to determine if diagnostic criteria are met. To better detect PTSD in epidemiological surveys, various modifications have been used that expand the number of questions and frame them in ways that will overcome reluctance to admit the occurrence of embarrassing and stigmatizing traumas (Kessler et al., 1995), and these modifications are being built into specific structured interviews for refugees (see below).

Some examples of instruments developed for refugees and torture survivors are the Harvard Trauma Questionnaire (Mollica et al., 1992) and the Hopkins Symptom Checklist (Mollica et al., 1987 (b)). Silove et al. (1998) have responded to the need for a purpose-designed measure, which is user-friendly for clinicians and which has the qualities necessary to assess change over time, by developing the R-CAT (Refugee Comprehensive Assessment Tool, Draft 1.7 August 1998). This tool incorporates measures that have already been tested for validity and reliability (SF-12, Kessler's 10 Psychological Distress Scale, Harvard Trauma Questionnaire) and covers resettlement needs, physical and psychological health. The tool is set out in a way that allows for easy computerization of the results. It can be used as a self-administered assessment or as a structured interview, and it assists in the development of intervention goals, which can be used for outcome measurement.

However, there are still problems with diagnostic assessment tools, as has been shown in minor changes leading to major variations in prevalence in epidemiological surveys (Regier et al., 1998), which have important implications for assessing needs for services. There was not the time in this study to get into the very technical issues of assessing and comparing the instruments available (see section on outcomes).

Sensitivity is also required in the physical medical examination, as some survivors can find medical procedures reminiscent of the torture experience and become highly anxious and frightened.

An assessment of the individual's larger life experiences, personal values, current life situation, family situation, and external social support are of equal importance to the medical assessments. There are problems if either the medical or the social assessments and actions dominate, as the diversity of the needs of survivors means that some will have medical treatment priorities, some psychological treatment priorities and others practical assistance priorities. Triaging on intake can help to sort out the assessment and immediate assistance priorities in a flexible service which is responsive to consumer needs.

8. IMPLICATIONS FOR TREATMENT

The symptoms and other effects of torture and severe trauma are modulated by bio-psycho-social factors related to the individual. There is evidence of a chronic fluctuating course in PTSD, which can last a lifetime if untreated (Basoglu, 1993). There are fluctuations in the revelation of, and reaction to, the trauma experiences, as the survivor's level of psychological security fluctuates with life events and life stages. Psychological treatment is very important for the more severely affected survivors, and there is evidence that social support may not be of much use if the survivor is not psychologically healthy enough to access and use it (Basoglu, 1993). The family is intimately involved and may need as much assistance for indirect trauma and for dealing with the survivor.

Thus there are good arguments for a bio-psycho-social approach to care, for a comprehensive treatment and rehabilitative approach that provides long-term flexible involvement to cope with relapses (Shalev et al., 1996). The closest similarity in mainstream psychiatry is the community care of persons with schizophrenia, a highly traumatizing fluctuating disorder with a wide range of severity, the more severe having many similar chronic "negative" symptoms, social alienation, and diverse rehabilitation needs. Systems thinking and hierarchies of care have been required in designing interventions, and this approach is also needed for torture survivors. However, only a minority needs, or will take up, offers of the full range of interventions, as will be detailed later.

The main outcome goal for therapy is increased functionality to achieve personal goals, rather than symptom reduction (Shalev et al., 1996), though that may also be a goal, particularly for high levels of positive symptoms of PTSD, major depression or other disorders that respond to medication.

9. MODELS OF PSYCHOLOGICAL TREATMENT AND REHABILITATION

Survivors of organized violence have a combination of medical, psychological, social, and legal problems. These facts were recognized very early in the history of treatment programmes. The initial rehabilitation programmes in the 1970s in South America (Chile and Argentina) and in Europe (Germany, Denmark, Netherlands, and Belgium) adopted a multidisciplinary approach.

Many psychological treatment approaches have been used with torture survivors such as psychodynamic talk therapy, insight therapy, cognitive therapy, behaviour therapy, and the testimony method. The effectiveness of available treatment programmes remains unproven for the target group. This is for the same reasons that have made proof difficult with most psychological disorder syndromes with multi-factorial aetiology. Research is very difficult and requires a high level of design skills to perform well, it is time-consuming, and large sample sizes are needed, which are usually not available at any one service. There are few funds available for research, as there are insufficiently perceived direct economic benefits. There are strong pressures to provide services and spend all the resources on immediate care, when services have long waiting-lists (Parong et al., 1992). Thus services have utilized knowledge and skills developed in mainstream mental health services and assumed that they would be equally effective in the care of survivors.

9.1. Psychodynamic therapy, counselling

Therapists bring to the task whatever school of psychotherapy they have learnt, and there is little evidence in the literature to say that one is better than the other. However, there is evidence in the general psychiatry literature that a person well trained in a therapy framework gets better results than general counselling with no framework. There are many transference and counter-transference issues to be dealt with in the very emotive area of torture, and even if traditional forms of psychodynamic therapy are not used, some knowledge of psychodynamic principles and practice is useful, both for therapists and especially for those supervising therapy staff (Kristal-Andersson, 1997). Psychotherapies can be brief, prolonged or intermittent, based on the perceived need, the goal of therapy, the therapist's habit, and the time available. Mollica (1989) reports seeing survivors for 15-20 minutes per week for 4-5 years. Somnier and Genefke (1986) reported a three-phase therapy through in-depth interviews with a median number of 22 and a range of 10-52 sessions. A later report stated that therapy at the RCT ranges from 20 to 80+ hourly sessions, two or three times a week (McIvor and Turner, 1995). If cathartic methods with subsequent reconstruction and reintegration are chosen, more than 20 sessions are usually required (Herman, 1992). Other members of the family may also require counselling or psychotherapy (including play therapy) for direct and indirect trauma, or for issues due to the changed behaviour of the survivor, but there are no papers mentioning the number of sessions required.

9.2. Testimony method

In some therapies the torture story is transformed into a testimony, to transform the survivor's story of shame and humiliation into a public story about dignity and courage, returning meaning to life. A series of three to six sessions is held to record all the details of the detention, torture, and previous history. When transcribed, the text is reviewed with the therapist, the final document being revised and edited jointly and it can be 15-120 pages in length (Cienfuegos and Monelli, 1983). The process requires 12-20 weekly sessions (Herman, 1992). This method seems to have worked best with Chilean survivors of torture within that political context, and less well with survivors of indirect violence, such as disappearances. It is argued in the literature that both insight psychotherapies and the testimony method are in fact using a form of imaginal exposure to the trauma (McIvor and Turner, 1995; Basoglu, 1992, 1998). It is possible that exposure is the key element in improving positive symptoms of PTSD.

9.3. Behaviour therapy

Behaviour therapy is usually an individual therapy and also requires a well-trained therapist, though the training period can be much shorter than for psychodynamic therapies.

Implosive therapy consists of 10-20 sessions of 1.5-2 hours, initially two or three times per week involving an imaginal reconstruction of traumatic events in an emotionally supportive therapy context (Basoglu, 1998). The survivor is asked to imagine the traumatic situation and retain the trauma-related imagery in mind until anxiety diminishes. The therapist helps sustain the state of mental arousal by stimulating the imagery related to the form of torture used, the physical and psychological pain experienced, and other aspects such as sounds, sights, smells, and tactile sensations. The therapist also focuses on the conditioned stimuli relating to the individual's cognitive and emotional responses to tor-

ture, such as fear, guilt, self-blame, humiliation, shame, and loss of control. The latter are particularly important because torture is often deliberately designed to produce such emotions. This method involves homework between sessions to maintain exposure to the memories until anxiety has dropped to a satisfactory level.

Eye Movement Desensitization and Reprocessing (EMDR), a variant, has been shown to work well in some, but not all, in a small controlled trial (Coello, 1994). Graded in vivo exposure to situations avoided by a survivor can be useful, with a high level of therapist involvement initially, followed by homework and self-directed activity.

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

9.4. Cognitive therapy

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

Cognitive therapy usually has a variable number of one-hour sessions, depending on the number of issues to be dealt with, and on progress.

9.5. Group therapy

Fischman and Ross (1990) reported on a model for a time-limited group treatment that focussed on symptoms of torture-related Post-Traumatic Stress Disorder, allowing group members to attain gradual psychological reorganization. The groups of Central and South American refugees met weekly for six months, and both therapists were on call to group members for crises 24 hours per day (only eight calls received). The positive evaluation was based on the subjective impressions of the therapists and group members. Cognitive restructuring, relaxation training and training in problem-solving skills can be a group activity. Using a Stress Inoculation Training (Meichenbaum, 1985, 1993) approach in a small controlled study, good results were obtained over seven 2.5 hour sessions with Latin American women in Australia (Aroche, 1994).

9.6. Psychosocial education

This therapy involves the whole family, or groups of families, in teaching about the effects of torture, the meaning of symptoms, the ways of helping each other, when specialist assistance is required and how to access it. Therapies are explained and basic problem-solving skills may also be included.

9.7. Therapy groups for children and adolescents

Some services have found value in organizing therapy groups for children and adolescents within or across cultures. We only have details from the STARTTS service in Sydney, Australia, which currently has eight groups, but these change, depending on changing needs. These groups may be held as camps in the countryside, over several days to develop trust, and with therapy activities interspersed with enjoyable physical activities. Selected parents assist with these youth camps, which deal with resettlement issues as well as trauma experiences. Other groups are closed, direct therapy groups for around 10 three-hour weekly sessions, usually for specific language or ethnic groups. Some groups utilize indirect techniques, such as the "Middle Eastern Video Project" for 12-25 year-old youths having problems at school; the "Wilderness Program", a closed group for 10 males aged 14-18 that runs for 2 hours weekly, with day-long excursions fortnightly, to build confidence, self-esteem and leadership, and indirectly dealing with trauma issues; or the "Study Group" for primary and secondary students experiencing school or resettlement problems, which utilizes volunteer teachers.

9.8. Indirect therapy and support groups

STARTTS also currently runs 13 groups for adults, some across cultures and others for specific language groups and/or single sex. Some of these are open or closed direct therapy groups (including the "Families in Cultural Transition" psycho-educational format, "Stress and Anger Management", etc.) and others are indirect therapy or ongoing support groups. For cultures that are reticent about discussing the trauma and personal problems, the indirect groups provide opportunities to develop trust and build networks of social support, with the occasional direct exchange of experiences and the opportunity for cognitive therapy. These indirect therapy groups use the teaching of English (incorporating selected relevant topics); creative arts and crafts; women's pool exercise group to relieve pain, stress, and tension; and other techniques as needs arise. There is an open Spanish-speaking women's group that is ongoing and involves educational, social, craft, and fundraising activities. Some groups have been started and then hived off as self-help groups, such as a men's horticultural cooperative.

9.9. Cultural issues in psychotherapies

Apart from dealing with positive symptoms of PTSD, which seem to be similar across cultures and which seem to respond to controlled exposure across cultures, the main issue is to restore meaning to the survivor's life and to restore social connections and status.

There are major differences between cultures in their concepts about the process of torture and its meaning, which obviously affect the type of therapy required. In English, the word torture comes from Latin roots and means to cause pain or suffering to get a confession. In Cambodian, the words for torture are a combination of the Sanscrit/Pala word for savagery/cruelty and the Buddhist concept of karma. Cambodian survivors generally feel they are somehow responsible for their suffering because of their karma, and will endure amazing suffering because they believe it to be part of their destiny (Mollica, 1988). So, unlike Chilean survivors, they do not politicize their torture and its subsequent effect on their lives.

Some cultures are very reluctant to express emotions or to cry (e.g. Afghan males) or to reveal sexual torture or rape, so the torture story has to be pieced together over a long period

once trust has been established (Mollica, 1988). In refugee groups, the most meaningful snippets of information have at times been expressed during informal contact, such as while being driven to appointments. This means that pushing survivors to tell their torture story may be counter-productive and indirect supportive methods may be more useful.

Some societies have no history of psychological therapies and expect cures based on medications or religious ceremonies. There can be an expectation that the therapist will divine what is wrong with them and decide on treatment without their active involvement, so there can be an expectation in some refugees that therapists will be directive. In cultures that value social connections rather than individualism, group activities and therapies can be more useful. Symbolic actions to assist with grieving for lost family members where proper burial and mourning ceremonies were impossible have also been found useful in some refugee communities.

These and many other issues indicate the need for different approaches for each culture in designing interventions. Thus in both developed and developing countries, services could legitimately take on very different appearances.

Western psychology is more egocentric in orientation, where the forces of the individual psyche are the most important factors explaining psychological experiences. Individuals are considered as a bio-psychical unit. Most of the rest of the world has a socio-centric ideology that places individual experiences in a network of social relationships, which are the sources of self-esteem, self-realization and self-control. Western therapies are individualistic and seldom emphasize the social and cultural context (Elsass, 1997).

Illnesses, tension, and conflicts are resolved in these societies through existing in-built cultural processes. Interventions that do not recognize these factors could be detrimental (Chakraborty, 1991). A good example is the experience of the Medical Foundation of London in Uganda. They were invited by the government to begin a centre for survivors of war trauma and torture in the Ugandan capital. The number of survivors was overwhelming, independent of a wide or narrow definition of survivor eligibility for the programme. In spite of the fact that the prevalence of trauma and symptoms was high in the population, there was no great increase in psychiatric breakdowns: social cohesion and solidarity acted as protective forces. The most serious problem they found was the danger of undermining local, individual, and community responses by establishing a specialist centre. It was decided that, instead of a centre modelled after those in Europe, it was necessary to support local efforts and establish special programmes for those survivors who did not receive the social support they needed, such as refugees, children exposed to violence, women survivors of rape, and ex-soldiers (Bracken et al., 1992).

Psychologists who work with torture survivors in the countries where torture is happening daily consider that PTSD is a diagnostic category that is too limited, and does not capture the magnitude of torture as a trauma. Torture is a man-made, politically motivated, physical and psychological trauma oriented to destroy the political identity of the victims and to intimidate a sector of the society. The term "post-traumatic" means that the torture was a single isolated trauma. However, most survivors have a history of previous cumulative traumas that continue after this episode, even in those who migrated to other countries with different cultures, and languages, without family and local social support (Reeler 1994; Becker 1995).

PTSD is a subcategory of anxiety disorders, which are classified as mental disorders in the DSM manual. Most psycho-

logists do not consider torture survivors as true psychiatric patients in that they are experiencing a normal reaction to an abnormal stressor. Labelling torture symptoms as a mental disorder is seen as a medicalization of a socio-political problem (Becker 1995; Lira 1998).

10. MEDICATION

Medication has a definite place in the range of therapies found effective in helping survivors. With the high levels of comorbidity, there are clear indications for medication in major depression, obsessive compulsive disorder, psychosis, and some anxiety states. It is also well known that tricyclic antidepressants can assist with chronic pain, which is a common feature of survivors of torture. In PTSD, the situation is not as clear, but theories are being developed based on animal studies simulating PTSD (Smith et al., 1998) and there may be possibilities for new medications in the future. The responses to some current medications in PTSD support the theories and are worth using in selected cases, though the symptoms may reappear if the medication is ceased (Basoglu, 1993). Smith et al. (1998), in their review, came to the following conclusions:

Tricyclic antidepressants – modest improvements in positive symptoms of PTSD, especially intrusive recollections, distressing dreams, sleep disturbance, and startled reactions, have been found in several studies.

Monoamine oxidase inhibitors – there is evidence that they also improve positive symptoms of PTSD, but also provide some improvement in symptoms of emotional numbing and distancing from loved ones.

Selective serotonin reuptake inhibitors – there are as yet no formal trials in the literature, but case studies show benefits.

Anticonvulsants – carbamazepine – there is some evidence of benefits in impulsivity, violent behaviour, and angry outbursts: *valproate* – improvements in hyperarousal, hyperactivity, avoidance and withdrawal, but further studies are required.

Lithium carbonate – some evidence of improvement in positive symptoms.

Benzodiazepines – mixed result in small studies, possible benefits but dangers of addiction.

Buspirone – benefits in depressed mood, anxiety, flashbacks and insomnia in two very small studies.

Clonidine and propranolol – benefits in positive symptoms, and particularly clonidine in combination with a tricyclic antidepressant (symptom relief in 63%, Kinzie and Leung, 1989).

Neuroleptics – low doses in those with ego fragmentation, poor impulse control, flashbacks associated with auditory hallucinations and impaired reality testing can give benefits, but research is very limited.

The use of these medications needs to be modified by ethnic differences in metabolism, nutritional status, age, smoking, and concomitant medications. Some authors have commented that medication does not interfere with psychotherapy for PTSD, and that would also be true for torture survivors.

11. PHYSICAL THERAPIES

The majority of survivors of torture have physical complaints related to the musculo-skeletal system such as joint, back, and muscle pain. Others could have a neural component of pain, as direct or indirect pressure on a nerve root and nerves can produce oedema and inflammation. Physiotherapists can help patients with chronic pain, influencing pain tolerance and the perception of pain (Skjaerbaek, 1995), correcting locomotor dysfunctions, and regaining body awareness, which often has been lost during imprisonment and torture (Prip and Tived (a), 1995). Physiotherapy for torture survivors is no different from the physiotherapy for other patients. Physiotherapists and other somatic therapists, with some precautions, using sensitive physical techniques can relieve the legacies of severe pain, improve physical fitness, gain better posture and body balance (Prip and Tived (b), 1995), and relieve stress. The physical medium is especially effective for people who are unable to speak of their experience. Physiotherapy can form a vital link in rebuilding the personality of the survivor because trust can be fostered in the context of physical contact (Hough, 1992). The use of somatic therapies began at the RCT, and other services around the world have found them useful, whether in a centre or as part of a network of therapists, with agreement that there are dual benefits in terms of physical and psychological health. A non-verbal, manual stress-tension reduction therapy was given to four women survivors of torture with sexual abuse from the Philippines, who had difficulties in sexual and social relationships and non-specific complaints such as headache, dizziness, irritability, aggressiveness towards their children, etc. (Larsen and Pagaduan-Lopez, 1987). There were four individual sessions followed by a group training session, with significant improvement, if not complete relief, in most of their prior complaints, including at the 12-weeks follow-up.

12. MODELS OF REHABILITATION SERVICES

The descriptions of rehabilitation services have traditionally been divided into two groups. Rehabilitation services in countries where torture is, or was, practised (home country services) and rehabilitation services in countries of resettlement (host country services) (Chester, 1990; Willigen, 1992; Cunningham and Silove, 1993; Jaranson, 1995 and 1998).

12.1. Rehabilitation services in countries where torture is, or was, practised

Developing rehabilitation services in countries where torture is practised has been difficult and has often required the umbrella of a powerful organization, such as a religious or other local organization that can provide the physical infrastructure and support. The staff of these programmes can be at risk because they are providing care to members of the opposition to the repressive government. They look for international connections, now much easier due to global communications, as a way to get exposure and protection for their work and staff. Some of the better known rehabilitation programmes have been in Chile, Uruguay, Argentina, the Philippines, El Salvador, Guatemala, and South Africa.

Cross-cultural psychological issues are not only a problem in countries of resettlement, as the majority thinks, but also in countries of origin. Most of countries in the Third World are not homogenous culturally. They are divided along ethnic

and economic lines. Each of those groups have different economic and educational levels, different patterns of consumption and values and these constitute subcultures within the country. Examples are the Maya Indians in Guatemala, the Incas, Ayamaras, Collas, Indians of Peru, several Indian groups in Ecuador and Mexico that speak different languages other than Spanish. These groups are the poorest on the social scale, they have different cultures and a 400-year history of repression by the dominant classes of European origin.

The needs of the victims of organized violence are multiple, and if there has been internal migration, there may also be resettlement issues. These institutions offer a multidisciplinary approach with medical and psychological services, social support, and legal help. The survivors undergo a medical, psychological, and social evaluation whenever possible. Care is provided by physicians, psychiatrists, psychologists, social workers (or their equivalent) and lawyers. Most started with volunteers or people working for minimal reimbursement. An important part of their task is to work in a closely integrated manner with the family of the survivors, detainees and disappeared people, as well as the target community under repression.

The survivors are the citizens of the country, or occasionally from other countries (e.g. Guatemalans in Mexico). Some institutions are close to certain political or ethnic groups and the survivors seen are mostly from that group. One of the biggest problems has been access to care. Many of the survivors are in rural areas and areas of active military operations, whereas most of the programmes are localized in the capital of the country or other urban areas (Lopez, 1990).

Advocacy is an important part of their work. Because torture is a political method of repression designed to obtain social control of the population, they fight against the repressive government in favour of democratic changes and respect for human rights as a part of primary prevention. The advocacy work is usually as open as the political space permits. Frequently the staff is the target of repression, and there are several examples of arbitrary detention, torture, and killing in different countries.

Financial support is minimal and is generally obtained from local churches, international religious organizations such as the World Council of Churches, European foundations, the European Union, and the UN Voluntary Fund for Victims of Torture. The governments do not support these services during the period of repression. During periods of change from repression to transition or democracy, the international funds may begin to dry up and the organizations may need to change. Some have dissolved or reduced the scope of their work. Others have changed their main objective to resettlement of exiles. Others have been able to obtain funds from the new democratic government, or, as in the case of the PRAIS programme in Chile, to integrate their work into the health care system of the country (Lira, 1998).

12.2. Rehabilitation services in countries of refuge or resettlement

The services in countries of resettlement have usually adopted a multidisciplinary approach to fulfil the multiple needs of the survivor population (Bojholm and Vesti, 1992). The professional staffing may include physicians, psychiatrists, psychologists, social workers, occupational therapists, nurses, and physiotherapists. Some services employ bicultural workers and interpreters with differing levels of training. Some programmes are more oriented to mental health assistance only.

The survivors requesting help may belong to different regions and countries of the world, for example the STARTTS organization in Sydney, Australia, has had 654 referrals from 60 countries of origin and 34 language groups in a recent 18-month period, a very heterogeneous population. The pattern of clients differs between host countries and over time, because the migrants have a preference for certain countries and because the areas of conflict in the world change over time. Most of the programmes accept torture survivors independently of their legal status in the country, others, such as the RCT, accept only legal residents. Some programmes accept only torture survivors and others accept all victims of organized violence. Sometimes there are separate organizations to assist asylum seekers.

If the torture survivors are illegal, the most important psycho-social intervention is to obtain political asylum. This requires legal assistance, a medical and a psychological evaluation, and the preparation of medical and psychological affidavits for the immigration hearing or immigration court, depending on the legislation of the country. If the proportion of illegal torture survivors is high, as happens in the USA, the programme can be overwhelmed with the flood of demands to act as expert witness, squeezing the resources for psychotherapy. The need for practical resettlement assistance (income, work, recognition of qualifications, housing, learning the language, education, etc.) can also squeeze the resources for psychotherapy.

These programmes are funded by a range of sources. Most are non-government organizations dependent on local donations, international government aid funds, private foundations, the UN Voluntary Fund for Victims of Torture, and the European Union. The government provides most of the finance for the programmes in Australia, Denmark, Norway, the Netherlands, and Sweden. The scarcity of funding and the difficulty in obtaining a regular, continuous flow of money absorbs a significant amount of professional staff time just in writing grant applications or in fundraising activities.

13. MODELS OF SERVICE STRUCTURE

13.1. Integrated centre based

Rehabilitation centres appeared initially in Europe in the early 1970's when a significant number of torture survivors arrived, especially from Chile, Argentina, Uruguay, etc., and there were no mental health services available to them. The centres were created to fulfil their needs, but all the potential problems of small organizations have also occurred (Westermeyer and Lam, 1989). The idea of a specialist centre was based on the idea that an environment should be created where the survivors could feel relaxed and safe. "There is both a therapeutic and a symbolic significance in the existence of a specific centre created solely for the purpose of treating torture victims." (Chester, 1990). A centre was also seen as a way of developing expertise through specialization and because it was clear that mainstream services usually did not recognize the effects of torture or know how to treat survivors. Not all centres have been established as isolated islands of care, some being seen as the core for training and support of a network of services and community development activities, actively linked to mainstream health services and stakeholders.

Advantages of the integrated centre

- Most of the big centres have been able to raise money for the treatment of the survivors as well as for growth

through better infrastructure, including public relations expertise.

- The centres are able to act as clearing houses for information regarding torture, and have been better able to increase awareness of the problem locally, nationally, and internationally.
- Most of the centres have been able to offer mental health services, basic medical care, and partial social assessment and assistance in a period when these services were unavailable or not appropriate.
- Centres are better able to employ and support bicultural workers.
- Centres can generate the volume of clients needed for sub-grouping to deal efficiently with the wide range of needs of diverse populations.
- Centres allow for ease of communication between professionals, for training and supervision of staff and students.
- Centres make research easier to accomplish.
- Centres can better support coordinated community development activities and structured feedback from consumer communities.
- Centres can be a better base for the development of expertise and coordination of training for mainstream health workers, welfare agencies, government immigration officials, etc.
- Centres can also be the base for a network of volunteers and provide immediate advice, support, and supervision for mainstream health and welfare staff seeing survivors.
- Centres allow division of labour and the recruitment of specialist expertise and support staff.

Disadvantages of the integrated centre

- Centres may be institutions created independent from the mainstream health services and then lack the resources to provide, or the ability to access, full medical care for survivors who need inpatient, expensive or specialized medical care.
- Some centres have been created for political reasons, unrelated to the local needs, such as centres opened in areas of low density of torture survivors.
- Centres may duplicate services already available in the community (e.g. legal services, language classes, etc.).
- The financial overheads of a stand-alone centre may be proportionally higher than the other structural approaches for torture services.
- Centres may become isolated intellectually and managerially from mainstream developments in general mental health and specific torture services, or dominated by one or two people and biased in particular ways that do not optimally meet survivor needs.
- Centres can end up serving the interests of staff rather than consumers.

13.2. Networks

If the resources available for treatment of torture victims are scarce or non-existent, the only alternative is to use volunteers and to utilize their physical resources (offices, telephones, etc.) to provide services. Networking is an approach that could also use paid staff attached to public or private facilities and distributed geographically, but without a central support function it would be hard to provide training, support, and continuity. Networks often depend on the ability to overtly or covertly divert the resources of a public or private health facility. Networking with volunteers can operate in low volume situations, but it would be very difficult in high volume situations, as volunteers would burn out. The

charitable nature of the operation may affect perceptions of entitlement to care. The inherent limited availability of the therapist may affect disclosure due to anxiety about support between appointments.

Advantages of the network approach

- Operate with a very low budget or with none at all.
- All or the majority of the professionals are volunteers or low paid.
- Can be located in pre-existing institutions and use their infrastructure and services.
- There is no need to spend a lot of time on fundraising and proposal writing activities.
- Professions highly committed to human rights, as they are not motivated by money.

Disadvantages of the network approach

- Volunteers donate only a few hours a week or a month and so may not provide continuity, develop expertise, or participate in quality activities.
- You need a big pool of volunteers to have enough appointment hours to cover the demand for services.
- The frequency, regularity, and continuity of sessions required for effective psychological therapies may be difficult to arrange.
- The growth of the organization is limited by the capacity of the group to recruit, train, and retain volunteers.
- Networking and community development are more difficult, or impossible, with only volunteer personnel.
- The range of services available depends on the range of volunteers.
- The turnover of volunteers could be high and the training programme a permanent effort.
- Volunteer work is not an alternative in countries without a tradition of volunteer work.
- Volunteers may have personality and practice problems that are not controllable in a loose network.
- The wealthy volunteers can dominate the attendances at conferences, etc.
- Policies are harder to develop and implement consistently.
- Evaluation and research are almost impossible.

13.3. Mainstreamed contracts

This is an extension of a centre structure, as repeated training of mainstream health staff across the state did not lead to the taking up of cases, just to more referrals to the centre (STARTTS, Sydney). It was decided that no more training would be provided unless there was a service agreement in place that required the staff receiving training to take up a minimum number of cases under supervision. The process has also forced the chief executive officers and clinical managers of health services to be better educated about the needs of refugees and torture survivors and to help them feel that they are getting some benefits from the centre. The process has also helped to ensure that health-funded support, such as health interpreters and interview space for visiting centre staff, are available.

13.4. Community development

Community development is an activity to empower the particular community to address the internal and external needs of the individual, groups, and agencies that co-exist within it (Aristotle, 1990). An organized community can bring real and concrete improvements in peoples lives, give people a sense of their own power, and alter the relations of power if necessary, by creating a constituency and becoming involved

in local politics. The STARTTS programme in Australia created a specialist staff position for community development "[...] to promote dialogue with each community about the provision of the services and its implications for their community". "The success of community development programmes depends on effective networking with ethnic organizations" (Cunningham and Silove, 1993). Some communities that have arrived in Australia as refugees have had to develop local networks and structures from scratch, which has been difficult for people from fragmented societies, such as Afghanistan. Centres in countries with an active annual intake of refugees and limited resources must always be adjusting their work to accommodate new ethnic groups, and one way to do this is to reduce the relative level of work in mature communities. Community development work can be just as relevant for countries where torture is, or has been, practised, depending on the circumstances. The programme is shaped by the needs, culture, and affiliations of the affected group. The difference is the type of organization. In countries under repressive governments or in transition, the torture rehabilitation institutions need to network with local religious, professional or educational institutions (universities), as well as political parties that have given them not only technical support, but some protection from the government, depending of the situation of the country. Torture rehabilitation institutions also need to network with organizations of ex-political prisoners, survivors of torture, families of detained and of the "disappeared" (such as the "Mothers of Plaza de Mayo" in Argentina) if these networks are active. If such networks do not exist locally, the torture rehabilitation institutions need to help them to organize.

Most of the survivors are strong and politically motivated, with the wish to overcome their symptoms in order to function in society, and they are able to identify their needs and priorities and to offer input in the development and implementation of the programmes. The programmes should respect the survivors' priorities, while trying to keep limited funding for activities that others will not or cannot provide.

Important aspects of a policy of community development for torture survivors:

- The services offered should be culturally sensitive and relevant, and community development allows for structured collective feedback that opens for frankness without offence and for communication to communities about centre problems and difficulties for their understanding and political support.
- As community support organizations develop, referrals can be made back to them and duplication avoided, with reinvestment of centre resources in new cases from that community or emerging communities.
- The therapeutic process should be aimed at avoiding dependency and at empowering the survivor and the family as consumers and citizens in their new home.
- Community development can include the setting up of self-help groups based on "job clubs", vegetable-growing cooperatives, arts and crafts groups, etc.
- Community development is also about helping health, welfare, and government agencies to change their policies to accommodate sensitively the needs of survivors.
- To share the load of need, other organizations or programmes can be created through coordinated networking with supportive groups. For example, a separate asylum seekers group to provide expert reports or the Early Intervention and Case Management Service in Australia to assess all new refugee arrivals, to triage them, and to link

them to appropriate physical and mental health, welfare, and resettlement resource agencies, with case management to see that they get the services required. The creation of such services frees up staff for core torture survivor work.

13.5. Self-help groups

The majority of torture survivors have limited, or no, access to mental health care. They get support from the family, extended family, and friends. Several efforts have been made to train members of the community to help victims of torture and repression, for example in Hong Kong and the Philippines (Loughry, 1990) and in Guatemala and El Salvador (Beristain and Riera, 1992). In these two programmes some members of the community are trained to conduct small group discussions in their community, oriented to recognizing signs of torture and trauma, sharing traumatic experiences, and supporting survivors in helpful activities. The most important messages to help torture survivors are that they are not alone, that their reactions to torture are not their fault, that their ongoing symptoms are a normal response to severe trauma, and that they can find new meaning in their lives.

Advantages of self-help groups

- Done by members of the community.
- Communicate without the problem of language or cultural barriers.
- They can screen and refer members of the community who need professional individual or group therapy.

Disadvantages of self-help groups

- These members of the community have limited capacity for diagnosis and psychotherapy.
- They need supervision.

14. COST-EFFECTIVENESS

We could find no papers or private reports on cost-effectiveness. Even if we had the time to collect the cost information from all the services now operating, it would be impossible to compare effectiveness without massive research activities. One of the authors took part in the organization of the largest study of the costs and outcomes of mental health services in the world, sampling a quarter of Australia's psychiatric activity over three months in 1997. The study was only able to explain a small proportion of the variance in cost and the best outcome instruments available were of little help. The field of torture treatment has so many variables that it would not be worth the effort to try to design the tools to make internationally valid comparisons. In such a situation, a better approach is to ration whatever fixed amount is available to the best effect, based on clinicians' and consumers' combined judgements.

The number of survivors of organized violence in the world adds up to millions, independent of the method used to calculate them. The majority of survivors of organized violence live in the Third World where locally funded treatment resources are minimal or non-existent. The full rehabilitation of all these survivors with any of the current approaches is a utopian ideal. We can think about trying to provide first aid to all those who seek help through "barefoot doctor" approaches. These could provide psycho-educational support (cognitive therapy, relaxation therapy, and problem-solving), but to provide exposure therapy to many, as suggested by

Basoglu (1998), would still be very difficult. Thus we could spread resources very thinly, providing only information to most, but not be very effective in providing the therapies with the most scientific support for symptom reduction (behaviour therapy, cognitive therapy, and medication).

As spelt out above in the section on psychotherapies, there are differences in the length of treatments from the RCT insight therapy, taking from 20 to 80 sessions, to the behaviour therapy, taking 10-20 sessions. However, it is acknowledged by Basoglu that cognitive therapy would have to be added to the behaviour therapy, which took seven sessions in the case study he published (Basoglu, 1998), so the total is probably closer to 20 sessions minimum when you add assessment time.

One important factor is that not all survivors seek treatment. Higher levels of resilience in some survivors means that they do not develop severe symptoms or need specific therapy. Torture has less effect on people with forewarning of torture, a clear understanding of the conflict and their willing place in it, and cultural beliefs such as the Buddhist belief in karma (Holtz, 1998). Others may not come forward for treatment even if it is available, for cultural, personal or other reasons (Skinner, 1997). In Iranian survivors in Germany, only those with higher PTSD symptoms of intrusive thoughts and increased arousal, and with a poorer knowledge of German, indicating a less successful adaptation to the new environment, sought treatment (Priebe and Esmaili, 1997). The general PTSD literature also indicates that only a minority of war veterans with PTSD accepts therapy. Some survivors may not be ready psychologically to deal with exploration or exposure therapies until they are more settled with other therapies, such as medication and a strong development of trust, which can take time (Shalev et al., 1996). Others will survive for a while without help and then deteriorate quickly due to new stress or comorbidity and even become emergency cases due to suicide risk or psychosis.

Many survivors find that the educational and cognitive therapy is the most important for them, and this can be given at lower cost.

Most services operate on a fixed income rather than fee for service or capitation basis, so a service has to try to stretch its resources to cover as many needs as possible, and this means making compromise decisions. In the absence of clear research results to determine the shape of interventions, we have to use the second best method, which is to gather the knowledge, opinions, and perspectives of as many stakeholders as possible, and this needs to be built into the design of the service organization and practices. This is really the best protection for funding bodies, and it builds in the development goals of participation and a practical use of small-scale democracy.

Rationing of service provision occurs in public mental health services, and it is usually based on the following hierarchy, which may only approximate best practice:

Everyone, self-presenting or referred, needs an assessment, but we do not search for them (services are generally publicized, so people know where to go if they want a service).

Those who require the specialized care of the mental health service are given the lowest level of assistance consistent with safety, basic effectiveness, and political necessity.

The others are referred elsewhere or sent home with the one therapeutic assessment interview.

Those taken into care are monitored and only given higher levels of care if they are not responding. Quality is still important in an ongoing search for more cost-effective methods to achieve goals and policies mutually agreed with our consumers and carers, who are involved in consultative processes. Part of the process is an internal managed care approach that tries to ensure that resource-use matches need, that staff are supervised in a positive way, and that cases are closed in a timely fashion.

14.1. Cost of not providing care

The cost to society of not providing therapy for torture survivors is not insignificant. Some survivors are unable to work because of their untreated physical and/or mental injuries. Others cannot work at their previous level of functioning. There may be high costs to the general medical services, if, as happened in one case in Sydney, a person having panic attacks due to torture calls an ambulance weekly to go to hospital. He imagined he was having a heart attack, resulting in repeated tests and wasted medical time, while the mainstream medical staff did not know what to do with him and did not recognize the cause of his anxiety. The cost of lost productivity and utilization of services was probably around USD 700 per week. We have mentioned the high levels of somatization that can lead survivors to visit doctors frequently and can lead to the prescription of ineffective medications, again usually without recognition of the cause, and how quickly some of these conditions can resolve with appropriate treatment. There is evidence of higher levels of physical illness in the survivors of trauma resulting in the PTSD syndrome, and treatment may reduce this increased morbidity. Then there is the more subtle cost of the loss of energy, creativity, and leadership due to apathy caused by torture. It is not currently possible to estimate the economic and social cost of the damage, or the savings to be made from interventions for survivors.

14.2. Outcome measures

It has been stated in some service agreements for funding that services should have outcome measures along the lines of "100 fully rehabilitated" or "100 fully functional" or "100 people seen". These are simplistic and almost meaningless. How do you measure "fully rehabilitated" or "fully functional"? How do you know that any of the 100 people seen have improved? There is confusion between utilization and individual benefit.

This is a difficult area in mental health as well as torture services, and without going into great detail, after many years of international work, there is still no effective way to objectively measure functional improvement in any really meaningful way.

The development of international tools to document the effect of treatment and to compare different treatment models is not a simple task. There are many factors to be controlled in any quality research, and without good methodology the results are useless. Developing any measurement instrument takes years in one culture, let alone across cultures, with time needed to devise the instrument and then test for applicability, acceptability, practicality, validity, reliability, and sensitivity to change. There are structured questionnaires for measurement of positive symptoms of PTSD and psychiatric disorders such as major depression, obsessive compulsive disorder, psychosis, etc., but the most important issue to consumers and their families is social functioning, which is not easily measured.

The best minds in psychiatry have been trying to develop

outcome and quality measures and have had great difficulty finding the ideal measures. This was also found in two pieces of research commissioned by the Australian Government to look for measures that could be used for measurement of outcomes and for decision-making on the use of resources. One was a literature review and critical analysis of the measures, their reliability and validity (Andrews et al., 1994). The other was a study to field test the instruments identified as technically the best in the first study and involved consumers, carers, and service providers across the three settings of general practice, private psychiatry, and public psychiatry (Stedman et al., 1997). This study found that the measures differed across the settings, that change in measures could not be attributed to any single factor, including the intervention, and that both consumers and providers suggested that people may respond in a biased manner should resource or service delivery implication be attendant upon the results. The selection of the *measure* is not the only issue, the *processes* of outcome assessment need a lot of attention. Training is a major issue. There are resource implications in implementing measurement systems for the routine assessment of outcomes. There is some confusion between the issues of consumer outcomes and the quality of service provision in questionnaires. There was poor convergence between consumers' and service providers' assessments.

Goff Shepherd, Professor of Rehabilitation Research in London and recently appointed the joint Chief Executive Officer of a new UK government body to assess service provision standards and outcomes in mental health, recently stated that outcome measures and standards are not going to be enough to provide the information sought. We will need to pay more attention to process issues and consumers views. He believes that a lot more research is necessary for mainstream mental health, which deals with the same types of needs as those of torture survivors.

Many services have concluded that the achievement of goals agreed between client (usually including some involvement from the client's family) and therapist is the best measure, and built into this is a time for review and consideration of service completion. Outcome measuring really boils down to the global assessments by the service system (management, supervisor, individual therapist) and the consumer system (client, family, and cultural group). All these sources of outcome feedback are important and need to be built into the service design for proper checks and balances to exist. It is when these things are in place that utilization and quality indicator data become more useful as management tools in a specific context.

There is a desire by all funding bodies for indicators of individual improvement, service quality, and utilization efficiency. As imperfect as they are, the indicators that can be used are symptom reduction, improvements in functionality, achievement of negotiated goals and consumer satisfaction, and measures of activity.

Symptom reduction is probably the simplest to measure, using the instruments previously discussed under diagnosis, though better scoring of severity would be of help in detecting change over time. However, consumers often rate improvements in symptoms as less important to them than other outcomes, such as getting paid work.

Improvement in functionality is possible to measure, but with greater difficulty by questionnaire and across cultures. As the consumer needs to be an active participant in deciding what would be an improvement in function for him or her, the idea of the achievement of goals negotiated between the consumer and therapist has arisen. These goals can be

recorded in the care plan and given estimated times for achievement, with periodic reviews on progress by them and monitored by the therapist's supervisor, who can put the number of goals achieved into statistical reports. Some auditing may be required to prevent gaming. Individual therapist effectiveness can be reviewed in this process.

Consumer satisfaction can be measured by questionnaires, but the results can be biased. It has been noted that consumers of mental health services tend to say what their therapists want to hear, unless they are quite sure the results are not identifiable. Consumer satisfaction measurement should involve the wider system of family and community. Feedback meetings can be held and results recorded, and the process of holding feedback meetings can be as useful as the overt outcome, as it creates a psychological framework of therapists being there to meet community needs rather than their own interests. Silove et al. (1997) examined the levels of satisfaction with mainstream mental health services and specialized mental health services for refugees among 86 Vietnamese psychiatric patients and 56 of their relatives. They concluded that specialized mental health services for refugees may be more acceptable to refugee populations than their mainstream counterparts, perhaps because better communication with patients and their families is possible in the specialized services. Patients and families who are in a position to evaluate services fully are more likely to be critical of treatments offered.

Other process indicators can be the achievement of standards (such as those used for accreditation of mental health services in various countries) and the formal planning and carrying out of quality improvement activities (e.g. reviewing policies and procedures with consumer involvement, reviewing processes for efficacy and efficiency, the development of critical clinical pathways for care, etc.). Formal case review meetings, peer review activities (e.g. file audits, medication practices, etc.), risk management reviews for high-risk consumers (self harm, violence to others), and ensuring personal supervision for all clinical staff can really add to quality. A good database recording occasions of service, including such factors as where, when, with whom, time, travel time, service type, etc., can be useful in measuring trends, group and individual therapist activity, and the allocation of resources to individual consumers or groups of consumers.

The area of outcome indicators requires a lot more work, and it would be worthwhile to pull together a group of experienced managers and academics to recommend a set of standards and outcome indicators that could be used internationally, with flexible amendment for a particular country situation. Included in this would be consideration of the data that should be routinely collected for both evaluation and utilization review. Advice should be requested on available software that is already tested to be bug-free and which can be easily supported in the range of settings. If there is nothing suitable available, then a consortium could be coordinated to commission software development.

15. RECOMMENDATIONS ON SERVICE DESIGN

The way that a torture service is set up and its connections with society are as important as the actual services provided. Unless there is good governance with participation involving the stakeholders and with clear feedback mechanisms for all its individual and organizational consumers, a service is always in danger of poor performance. With rationed re-

sources, no effective objective output measures, and controversy about the application of treatment methods in particular cultures, compromises will always have to occur. Participation is essential if these compromises are to be a reasonable balance between provider and consumer interests.

If a new service is to be established and external funding requested, then there is a need to ensure that the initial planning committee is as fully representative of the stakeholders as possible. It is wise that this committee be set up on the basis that it is temporary until a board is appointed according to a constitution, drawn up to allow for the proper long-term governance of the organization. Prevention is better than cure in good governance as well as torture. There should always be a strong board to control the excesses of any paid staff. But the board should also be set up in a way to avoid political infighting, diversion from the task or conflicting directions to staff. Boards are there to approve the budget and policies, to suggest opportunities for development and warn of environmental problems, to hire and fire the director and other senior staff, and to monitor quality, productivity and financial prudence. The director needs a clear line of authority.

As an example, STARTTS was set up with nominated board members from various organizations (AI, Red Cross, Ethnic Affairs Commission, Refugee Council, Ethnic Communities Council, Area Health Service), plus four community representatives selected by a publicly advertised recruitment process with selection criteria to avoid partisan ethnic representation and two senior clinicians (including a professor of psychiatry). As the service is state government-funded, these allies were chosen to act as check on the government by having a board that has power through its connections. Even though the Minister for Health formally approves those positions not nominated by organizations, he could not control the board if he attempted to implement bad policies or tried to cut funding. The board also has the connections to bring useful external information into the organization and for the coordination of efforts in influencing decision-making in government and elsewhere.

When planning the structure of STARTTS, much thought was given to whether it should be a non-government organization or attached to mainstream public health services. In the end it was decided that it was better to be part of the mainstream, to ensure that the government was committed and to give leverage in forcing mainstream services to become partners and to provide decentralized services. In other states of Australia the services are non-government organizations. There have been no problems with survivors using a government-connected service because of the nature of the board and the more benign view towards the state governments (no secret intelligence service involvement in repression around the world). The offices used are in a purpose-built building on a campus with a collection of community-based health services or in commercial, leased office space. Satellite services are in mainstream health facilities.

In countries with past or current repression, the issues of trust, confidentiality of information, and safety need to be weighed against the advantages over time of influencing the mainstream services to be trained and to provide decentralized services, and in ensuring sustainability of funding, which really should eventually come from the national budget. Thus, even though it is not attainable at first, there could be a long-term strategy to progressively achieve local funding by annual environmental reviews with adjustments to connections, partnerships, and alliances, because if it is not actively kept in mind, inertia will tend to maintain the status quo.

Whatever the political situation or culture, the same principles can still be applied, though the composition of the connections made will vary to suit the local ecology.

Having got the planning committee in place, it is then useful to go through the process, recommended by many management schools, of developing the "mission, values, goals, and strategies". It is worthwhile having a check-list of issues to be addressed and decisions made, which could include the following. It is useful to identify a hierarchy of problems in order to develop an overall strategy.

15.1. Needs and strategy analysis

- Assessment of the organized violence situation (problem analysis) that includes the magnitude of the problem (prevalence), description of the major characteristics of the possible target groups, if available, including age, sex, geographical distribution, and proportion of minority groups in this target group.
- Assessment of the types of interventions that are culturally acceptable.
- Assessment of the professional resources available to implement interventions, including people who could be trained.
- Assessment of how torture survivors could be reached, including connections with specialist organizations related to victims of organized violence.
- Assessment of barriers that need to be overcome in achieving the goals.
- Assessment of short-term and long-term funding sources and possible funding levels.
- Assessment of likely demand and realistic throughput and outcome targets.

15.2. Style issues

- Should the service operate on a network, a centre or a hybrid structure, or should it be integrated into a mainstream health or rehabilitation service?
- Should the organization be a separate non-government organization, part of a larger existing institution that can provide infrastructure and protection, or associated with mainstream health services, etc.?
- Should the target group be limited to torture survivors and their families, or wider in scope?
- How should resources be divided between direct interventions and other possible areas of activity, such as training, public relations, prevention, etc.?
- Should techniques such as annual business plans be used?

15.3. Partnerships

- What organizations should the services be linked to in partnership for providing interventions? For example, university, mental health service, community health service, hospital, similar NGOs, welfare agency, etc.
- What professional training organizations should the service be linked with, and what students should be encouraged to participate as part of their course or as volunteers?
- What universities or research organizations should the service link with for evaluation and research activities?

15.4. Business issues

- Should support services (e.g. purchasing, accountancy, personnel, payroll, etc.) be provided in-house or purchased from another organization with the skills and systems to make it cheaper and more effective?

- Should staff be employed as permanent staff or on time-limited contracts to enable flexibility when demands change?
- Are there any ways that reasonable charges can be made for services provided, such as training?
- Are there any ways that clinical services can be paid for under local health insurance systems?

15.5. Staff selection and management

- What are the desired characteristics and criteria for the recruitment of the senior staff? International experience suggests that while clinical experience is advantageous, no particular discipline is required, the most important characteristics relate to breadth of vision and leadership and administrative skills. The positions need to be set up to make positive use of personal motivations, with appropriate checks and balances.
- How will an open and fair recruitment process be organized to ensure that the best people for the positions are found and selected?
- How will performance measures be developed and periodic appraisals be done?
- How will staff remuneration and conditions of service be developed and periodically reviewed?
- Will staff be encouraged to become organized, and will a staff representative be added to the board?

15.6. Services offered

Whether there are large or small numbers of survivors, a logical service design is likely to do the following, based on a hierarchy of care and other activities, dependent on resources available:

- Organize widespread distribution of basic information about the recognition of and needs for interventions of survivors to relevant clinicians, community agencies, and distribution systems (including an ongoing media campaign, if possible).
- Train people, whether clinicians or community educators (including volunteers), to run psychosocial education groups and give them simple assessment tools to identify survivors that need a higher level assessment.
- Train clinicians to provide a comprehensive assessment.
- Train clinicians in the specific interventions chosen (e.g. psychodynamic therapy, behaviour therapy, cognitive therapy, physical therapy, group therapies, support groups, self-help groups).
- In parallel, undertake community development activities to assist the above.
- Implement prevention activities.
- Become involved in evaluation and research.

16. THE CONTRIBUTION OF SURVIVOR SERVICES TO COUNTRY DEVELOPMENT

Torture treatment contributes to the development of countries where torture has occurred or is still occurring, because a local programme gives messages that torture is occurring, or has occurred, that it is wrong, and that all people are valued and worthy of the investment in treatment. This can help people in the struggle for equal participation and democracy to know that, like the soldier in battle, they will receive help for their injuries and so diminish the repressive effects of torture on society. As mentioned above, there are high economic and development costs of not treating the survivors of organized violence.

There can be cross-fertilization between survivor services and the mainstream mental health services. This can be through teaching the mental health services about a more holistic approach to care in the community (including a community development approach) (McGorry, 1995), the recognition of the results of severe trauma and techniques to manage it, which can be applied to any source of trauma. The mental health services can keep survivor services up-to-date on advances in the medical assessment and medical treatment of the frequent comorbid disorders that can occur. In some societies the mental health services are almost non-existent or primitive, and the survivor service can be an advocate for improvements in mainstream mental health services.

The Jakarta Declaration on Health Promotion into the 21st Century (WHO, 1997) states that:

"Pre-requisites for health are peace, shelter, education, social security, social relations, food, income, empowerment of women, a stable eco-system, sustainable resource use, social justice, respect for human rights and equity."

Survivor services are clearly contributing to many of these factors in their societies.

If donor governments used the "Rights Way to Development" (The Human Rights Council of Australia, 1995; Alston, 1995; Frankovits and Earle, 1998) approach discussed under prevention below, then they would be able to use the funding of survivor services to influence the achievement of these pre-requisites to health.

17. PREVENTION OF TORTURE

The programmes that care for survivors of organized violence cannot ignore the political, social, or cultural context in which the torture took place. The majority of countries in the world are practising torture systematically. Torture produces medical and psychological sequelae that affect the individual, the family, and the society. Because the rehabilitation programmes reach only a small minority of these survivors, and because prevention is always better than cure, strenuous effort should be directed to primary prevention oriented towards the eradication of torture. In 1983 Amnesty International called on all governments to implement the following 12-Point Programme for Prevention of Torture (Amnesty International, 1983):

1. Official condemnation of torture.
2. Limits on incommunicado detention.
3. No secret detention.
4. Safeguards during interrogation and custody.
5. Independent investigations of reports of torture.
6. No use of statements extracted under torture.
7. Prohibition of torture in law.
8. Prosecution of alleged torturers.
9. Training procedures for officials involved in custody, interrogation, or treatment of prisoners.
10. Compensation and rehabilitation.
11. International response.
12. Ratification of international instruments.

The United Nations (United Nations, 1984), desiring to make more effective the struggle against torture throughout the world, approved the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in 1984.

The convention is a multilateral, universal, human rights treaty, open to the ratification of all members of the UN. The articles 2 to 16 list the obligations of a state party to the convention. The Convention begins many articles with the statement:

"Each State Party shall [...]"

Article 2.: Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture [...]. No exceptional circumstances [...] may be invoked as a justification of torture. [...].

Article 3.: No State Party shall expel, return (*refouler*) or extradite a person [...] in danger of being subjected to torture. [...].

Article 4.: Each State Party shall ensure that all acts of torture are offences under its criminal law. [...].

Article 10.: Each State Party shall ensure that education and information regarding the prohibition against torture are fully included in the training of law enforcement personnel, civil or military, medical personnel [...] involved in the custody [...] of any individual [...]. [...]

Article 11.: Each State Party shall keep under systematic review interrogation rules, [...] for the custody and treatment of persons subjected to any form of arrest [...]. [...]

Article 13.: Each State Party shall ensure that any individual who alleges he has been subjected to torture [...] has [...] his case promptly and impartially examined [...]. [...].

Article 14.: Each State Party shall ensure [...] that the victim of an act of torture obtains redress [...] including the means for as full rehabilitation as possible. [...]

Article 15.: Each State Party shall ensure that any statement which is established to have been made as a result of torture shall not be invoked as evidence in any proceedings [...].

The Convention established a committee of ten experts called the "Committee against Torture" (CAT) that shall review the implementation of the Convention. The States Parties shall submit a report every four years on the measures they have taken to implement this Convention. CAT shall investigate, with the cooperation of the State, any allegation of torture systematically practised in the territory of a State Party to the Convention. The State Party may at any time declare if it recognizes the competence of the CAT.

The United Nations had 180 Member States at June 30, 1996. Only 90 countries (50%) had ratified the Convention and only 36 (20%) of them recognized the competence of CAT (United Nations, 1996). At 16 June 1997, the number of Member States which had ratified the convention had increased to 102 (56.6%) (UN, 1997), still a very low number.

17.1. Assessment of the problem

The international human rights standards contained in the Charter of the United Nations, the Covenant on Civil and Political Rights, the Covenant on Economic, Social and Cultural Rights, the Convention against Torture, and in domestic legislation should be enough to promote harmonious relations between individuals, communities, and nations, and to avoid torture. The implementation of these measures by a

Member State of the UN should be a clear indication that the government is committed to the eradication of torture.

The World Conference on Human Rights expressed grave concern about continuing human rights violations in all parts of the world, in disregard of standards contained in international human rights instruments and international humanitarian law, and about the lack of sufficient and effective remedies for the victims. The problem is not the absence of legislation, but the lack of political will by governments to implement the law, and also the promotion of impunity for the torturers. Repressive governments practise torture in spite of international law and world opinion, because there is still no international criminal court to prosecute those who promote or execute crimes against humanity.

In democratic countries torture is practised as police brutality, during criminal investigations of criminal suspects, and as punishment of prisoners, because of ineffective control of law enforcement officers and impunity for those who carry out torture (Welsh and Rayner, 1997). During war, torture is practised as an instrument of intimidation, terror, and control of the enemy population, as for example rape was used during the Balkan War.

17.2. Prevention activities by services

The prevention activities of the organizations providing care for survivors are not well known. Few publications are related specifically to strategies and actions. The IRCT sent a survey on the subject of prevention to 50 network centres, and only 26 centres replied. When asked if prevention had been a matter of specific concern, 23 centres answered affirmatively. In 12 centres the concern was theoretical, in 17 it was formally incorporated into their work, and in 8 it was reduced to isolated activities. Most of the prevention work is in the area of education and public awareness (Madariaga, 1997).

The promotion and protection of human rights is a matter of priority for the international community. There is a need for closer cooperation between national governments, international organizations, and non-government organizations in this work.

Amnesty International, the UN Convention against Torture, and several other organizations and authors have given concrete examples of prevention that summarize their experience and philosophy (Amnesty International, 1983; United Nations, 1984; Harding, 1989; Sorensen and Vesti, 1990; Mollica, 1992; Basoglu, 1993; Asociacion para la Prevencion de la Tortura, 1995; Madariaga, 1996; Akukwe, 1997; Frankovits and Earle, 1998; IRCT, 1998). From a development point of view, some of the actions have had a broader impact than others. The activities oriented to primary prevention (eradication of torture) are more significant.

17.3. Primary prevention at the international level

Governments that support the cessation and prevention of torture need to demonstrate to other governments and their constituencies how important it is to them. There can be no more concrete way to express that commitment than to give precious resources for the treatment of torture survivors and related activities. However, this should not be done in isolation, but as part of a negotiated aid package that uses the funding in a developmental way in discussion with the government concerned (The Human Rights Council of Australia, 1995; Alston, 1995; Frankovits and Earle, 1998). There should be explicit dialogue with the government of the recipient country or state about torture issues, as set out in the relevant conventions, making explicit the human rights aims of the programmes and projects. The process enables the recip-

ient government to formulate its own objectives in human rights terms.

The International Covenants and the Vienna Declaration call on governments to work for the realization of all rights through a process of cooperation. Cooperation based on the rights framework will mean a move away from a punitive conditionality approach to one of mutual interest. We are taking up the idea that there should be a system of negotiations between governments that will lead to contracts based on the human rights instruments and the realization of rights. The human rights framework provides a defence for governments against the arbitrary imposition of conditions, be they economic or political. Donor governments, as well as recipient governments, are bound by law.

This is not about placing negative obligations on governments. On the contrary, the UN Charter places an obligation on governments to provide international cooperation and assistance to support the realization of rights, and that means taking action here and now. The process can also be used to encourage the participation that is clearly called for in the Declaration on the Right to Development that was reaffirmed in the Vienna Declaration.

Issues that could be addressed in the dialogue include:

- Reconciliation.
- Justice issues, including acknowledgement, redress, and impunity.
- Education of police, prison staff, armed forces, and other agencies, with government supported access for a systematic programme.
- Ratification of the Convention against Torture, recognition of the CAT, and encouragement to provide periodic reports on progress.
- The adoption of an Optional Protocol to the Convention against Torture, which is intended to establish a preventive system of regular visits to places of detention promoted by the Association for the Prevention of Torture (Asociacion para la Prevencion de la Tortura, 1995).
- Ratification of the treaty for the new International Criminal Court, which will bring individuals to justice for genocide, crimes against humanity, war crimes, and aggression.

As AI has found, governments are more likely to change their policies if there are coordinated approaches from all levels. The governments providing aid to a particular country could liaise with each other to adopt a similar human rights framework, even if they are not going to fund the same type of service. In fact, the funding needs for complementary services could be shared between donor governments with reduced duplication.

If the IRCT is included in the circuit, it could alert AI, other sympathetic international networks, and the country specific sympathetic organizations and networks to take action at the same time with international bodies, national governments, and the specific country government. Ideally, the IRCT would first discuss strategies with relevant bodies, such as AI (to avoid unnecessary duplication and to take advantage of other sources of information and ideas) to develop a strategy and to devise practical actions that the different levels can effectively implement.

It is recognized that at times such a dialogue may inhibit the development of services or cause danger to service staff, so it obviously needs to be done sensitively and usually without public fanfare. However, relevant constituencies will get the message, and donor governments their rewards. The

Danish Government and Danida could take a lead in this approach.

Independently from the above, the growing number of organizations working in advocacy and treatment of torture survivors should be consolidated into one or more inter-connected networks to work for the primary prevention of torture. An example is the Association for the Prevention of Torture (APT) with a central office in Geneva; the IRCT network in Copenhagen; and the International Society for Health and Human Rights, with a secretariat that changes between general assemblies every three or four years. These organizations could initiate actions, individually and collectively, that can be taken up by their network members. The IRCT could take a lead in this activity, and has done so with the first commemoration of "26 June - United Nations International Day in Support of Victims of Torture" in 1998.

The goals would include:

- Ratification of the Convention against Torture, recognition of the CAT, and encouragement to provide periodic reports on progress.
- The adoption of an Optional Protocol to the Convention against Torture, which is intended to establish a preventive system of regular visits to places of detention promoted by the Association for the Prevention of Torture (Asociacion para la Prevencion de la Tortura, 1995).
- Ratification of the treaty for the new International Criminal Court.

The UN Secretary-General Kofi Annan described the Court as "a gift of hope to future generations and a giant step forward in the march toward universal human rights and the rule of law" (Turner, 1998).

17.4. Primary prevention at the national and local level

In countries of refuge or resettlement, the services should be involved in prevention, and this can occur in several ways, depending on the local situation. If their government has not ratified any of the relevant treaties and protocols, then they should, in concert with domestic and international allies, put pressure on their government to ratify and implement the treaties in domestic law and law enforcement and military regulations. They can also pursue any of the AI 12 steps that are not in place. They can request that their government adopt the "Rights way to Development" approach (The Human Rights Council of Australia, 1995; Alston, 1995; Frankovits and Earle, 1998) and include torture issues in any aid dialogue, offer support at the appropriate time, and ask for feedback after the dialogue has been held. These actions can involve politicians, public officials, and the media. Refugee communities can be assisted to take action and to flex their political power.

Rehabilitation of torture institutions/programmes and human rights NGOs are very active around the world in countries with different types of governments: 1) governments with ongoing repression, 2) countries in transition to democracy, and 3) countries with democratically elected governments.

In countries where torture continues to be used, or has just recently ceased, the actions need to be balanced against the possibilities and dangers. Again, change is more likely to come when many voices say the same thing, so allies are essential. Services can use their particular knowledge and information to educate the public and provide ammunition for more overtly political organizations and so indirectly put

pressure on the government. They can ensure that the international community is aware of the situation and the possibilities and timing for effective external action.

Governments who practise torture have tremendous power and often disregard international law and world opinion. Nevertheless, they have their weaknesses. Some of them are sensitive to international pressure or to the action of local structures of recognized power and prestige. Religious institutions are one of these local powers. The Catholic Church in Latin America is a good example. They are unable to stop torture or abuse, but they are powerful enough to protect human rights organizations under their umbrella and to give medical, psychological, and legal care to the survivors and their families. Another example of this is the Vicaria of Solidarity in Chile. This protection is never complete and there are multiple examples of human rights workers who have been harassed, detained, tortured, and killed because of their activities. Human Rights Watch used to publish an annual worldwide report of human rights monitors who had been persecuted (Human Rights Watch, 1987).

It is difficult to write recommendations for preventive measures in these three different political settings. In all cases, prevention should be an important part of any torture rehabilitation programme, but the situations in each country are so particular that they defy any type of generalization. Therefore the appropriate prevention activities have to be tailored to the reality of each country.

The following are areas of possible action:

- Ratification of international human rights covenants and protocols, and particularly the Convention against Torture and the International Criminal Court.
- Implementation of the international human rights covenants in the national legislation.
- Promote the revision of penal and judicial codes.
- Promote the establishment of regular visits to places of detention by independent observers to study the conditions there and the treatment of prisoners to prevent acts of torture.
- Promote support for community complaints, reporting, and appeals against torture practices.
- Promote the effective investigation of torture allegations and the prosecution of those responsible, and revocation of any amnesty law that protects violators of human rights laws.
- Document and denounce human rights violations. Medical documentation of cases of torture should follow clear guidelines that ensure independence and confidentiality of the examination. Amnesty International has published some basic principles to provide a framework to carry out such examinations, or assess the quality of investigations done by governments and courts (Amnesty International, 1997 (b)).
- Promote the creation of a strong network of local NGOs, and the use of the mass media when possible, to denounce violations, encourage social mobilization, and lobby for the respect for human rights.
- Educate and train law enforcement personnel and the military involved in the investigation and supervision of the detained. Educate and train members of the judicial system.
- Educate and train health professionals and students on human rights, the medical and psychological sequelae of torture, and treatment.
- Educate members of the Immigration Department involved in deciding requests of political asylum of survivors of torture.

- Educate the general public to create awareness and mobilization on human rights.
- Document and research human rights violations, the medical and psychological consequences of torture, treatment effectiveness, cost efficacy of treatments, and different rehabilitation approaches to maximize effectiveness in that particular environment.

Funding organizations should be aware that the skills and personalities of people who select to run a good clinical service, or a good public relations and political programme, are very different. It is rare to find both sets of knowledge, skills, and relevant experiences in the same person. Thus, if funding organizations want political and promotional activity, then special funding for a specialist senior person to lead this activity (or vice versa) should be supplied or high level training provided. To just have an expectation of quality output may be setting the recipient organization up for non-productive stress and failure.

18. COMPENSATION FOR TORTURE

The right to compensation is part of legal international standards, and Article 14 of the Convention against Torture states: Each State Party shall ensure [...] redress and [...] adequate compensation, including [...] as full rehabilitation as possible: [...].

Few countries in the world have established a system of compensation for torture survivors or other victims of organized violence. Chile, by law, defined the concept of victims of organized violence and established a pension, free education, medical and psychological medical care for families of disappeared, detained, or politically killed persons, and torture survivors. Argentina paid, by law, a monetary compensation to the families of the disappeared in the dirty war, and compensation for each day of unlawful detention to the ex-detained. Argentina also paid several million dollars to Jose Siderman, a survivor of torture, in a settlement before the High District Court in Los Angeles, California. In Uruguay, some families of victims of extra-judicial executions received compensation in a settlement before the court. The Inter-American Court has reached decisions for compensation for the families of several cases involving the disappeared in Honduras, Argentina and Guatemala. Germany approved monetary compensation for victims of torture and detention by the communist regime. Hungary has compensated victims of unlawful detention (Bronkhorst, 1995). Zimbabwe established a War Victims' Compensation Act and a fund to redress victims of the conflict. The act should be amended to include some categories of victims not currently defined within the act (Amani Trust, 1997). Services, where it is possible, should promote the establishment of compensation mechanisms and equal access to rehabilitation and health care for all victims of organized violence.

South Africa, where a large part of the population has been traumatized, has followed a different approach. The negotiations among the political parties and social forces in the early 1990s resulted in a series of compromises, such as the creation of a Government of National Unity and a Truth and Reconciliation Commission (TRC). The TRC has three committees: one for hearing human rights violations, one for the hearing of amnesty applications and the third that takes measures oriented towards the reparation of the survivors in spite of insufficient resources for this.

"The basis of the compromise which was reached, was that

amnesty would be given only on an individual basis, following full and open disclosure of the crime. This would apply both to the enforcers of the apartheid law and to members of the liberation movement" (Bird and Garda, 1998).

19. IMPUNITY

Many countries under repressive governments have negotiated the transition to democracy, replacing justice with impunity as a way to obtain reconciliation, avoiding confrontation with the military power in the name of social peace. The target of the repression generally has been oriented towards a selected group of the population. The rest of society may deny the existence of victims of the repression, because they supported the military, or they are indifferent because repression did not affect them. This majority, which did not understand the needs of the victims, has been able to approve popular plebiscites in favour of impunity, as has happened in Uruguay.

Impunity interrupts the normal process of healing of the survivor of repression, the grief of the families of disappeared victims, and the process of social reparation. Impunity prolongs the psychopathological consequences of repression, both in the individual and in the society. Impunity is an illegitimate legal process and produces loss of credibility in the legal system (Becker et al., 1988; Becker et al., 1990; Kordon et al., 1998).

20. TRAINING ISSUES

20.1. International training

International training seems to have consisted of meetings and conferences that have presented papers on clinical issues and "show and tell" sessions about service activities. There does not seem to have been much systematic or structured training of potential service directors, senior staff or management committees members, yet if we are to avoid some of the problems that have arisen so far (Westermeyer and Lam, 1989), this would seem to be a good investment.

While there is no recipe to be followed in setting up new services or reviewing established ones, there are emerging principles and growing experiences that appear useful to share with people interested in setting up or reviewing services. Intensive international participative workshops, along the lines of MBA degree courses, with case studies and basic inputs on areas of clinical knowledge, organizational design and development, management issues, public relations and advocacy, would be most helpful. The goal would be to give the participants a range of frameworks in which to think about the solutions for their different environments, and hopefully inspire them to get more training in their areas of weakness, which could be done locally, if available. The workshops would need to be facilitated by people with a cross cultural awareness and who would value contributions from all participants. It is noted that the RCT held their first seminar on administration for leaders and staff from some of the RCT's collaborating rehabilitation centres in 1997. This is a good start, but more training is required to develop the sophisticated management that torture services need, which goes well beyond basic administration.

Most clinicians who end up in management positions in mainstream medical services arrive with no formal management training, but even clinicians are now concluding that this is not a good idea. Many existing torture treatment ser-

vices are in this position, and the managers of the programmes would benefit from some management training, which may not be available locally. Thus the above workshops should be open to current managers to encourage them to review their services and to stimulate the workshop with experiences.

Another good way of training across country boundaries is to send key staff on training visits to well-run services for direct observation and involvement over a reasonable period of time (at least a week). It is usually better to send two or more people together, so that they can reinforce each other when trying to bring about change at home (all systems resist change at some level).

20.2. Local direct service training

It is obvious from all the above information that providing services for survivors is a complex activity, and many skills are required if it is to be done well. Thus all staff, whether paid or volunteer, need as much education and training in knowledge, skills, and competencies as they can reasonably absorb and use, with updates over time. Apart from general training, some staff will need to be recruited with specific knowledge and skills, or be sent for education to develop that knowledge and skills. In services using bi-cultural workers who are themselves refugees it may be important for them to be involved in mainstream vocational educational programmes to give them a qualification recognized in their new home country. This will allow them to receive better recognition for their work, improve their rates of pay, and prevent them from being trapped into continuing to work for the torture service.

A lesson learnt from studies on the training of mental health staff is that imparting information does not change practice unless the practice is supervised. In a severely under-resourced public mental health service it was found, by action research, that pulling supervisors back from a heavy direct workload to spending more time supervising junior staff resulted in higher morale and greater productivity due to the increased application of theoretical knowledge and increased confidence in junior staff. In an even more complex area, such as torture services, this is also likely to be true.

In environments where there is a more basic "first aid" approach, training needs to start at a basic level, with progressive improvement in skills and sophistication in service delivery as the country development process allows.

20.3. Management training

In some situations the board has people with management knowledge and experience, but having good frameworks for thinking, planning, and action is desirable for the person running the organization on a day-to-day basis. Consideration should be given to sending the director, other senior staff, and governing board members, to locally available generic or health service management training courses and workshops.

20.4. Evaluation training

There is a dearth of information in the literature about service evaluation and little clinical research. Apart from the problems of immediate clinical demand squeezing other worthwhile activities, the lack of systematic information gathering, analysis systems, and evaluation expertise strongly contributes to this situation. Yet evaluation may become a very important factor in the long-term sustainability of torture services. Thus, consideration should be given to training

in this area either locally or internationally. Funding support for computer technology and software may also be a good investment by funding organizations if the local environment is ready and able to use it.

20.5. Political, public relations, advocacy, lobbying, and fundraising skills training

Some torture services have been started by politically savvy individuals or groups, while others have had altruistic motives, but little political experience or public relations skills. In non-democratic and transition to democracy countries, more skill is needed to test and push the edges of safe behaviour in networking, publicizing, and promoting torture services and torture prevention activities. Apart from trying to ensure the survival of the service, there are many possible useful functions that a torture service can provide to the local and international communities through developing community awareness, community education, advocacy, lobbying, prevention activities, international networking, and coordinated international action, etc. These activities can be dramatically improved with training, as one of the authors found in work with AI groups and other NGOs. Again, funding organizations should consider investing in training in this area, either locally or internationally.

Organizations that fund torture services should realize that it is in their interest to invest in training and to actively promote and support the concept of the learning organization, the dividends being cost-effectiveness and excellence.

21. SUSTAINABILITY

21.1. International funding

The total funds needed to finance the rehabilitation of survivors of torture worldwide is unknown, because we do not know the number nor the proportion of survivors who need treatment, and the level of treatment required. However, what we do know is that we are a long way from meeting the needs of the survivors who are seeking treatment and we know that there are many areas of the world without accessible services. There is no reason why people in developing countries should receive a lower standard of interventions, as the severe cases will still need time-consuming therapies, based on current knowledge. The differences are in how the triaging and selection occur for the different levels of need and relevant interventions.

Thus the resources required vary enormously in both developed and developing countries, because of varying numbers, levels of need, and the geographic spread affecting access.

For many developing countries and actively repressive countries, there will be a long-term need for bilateral or multilateral funding sources. For some countries, bilateral funding from donors perceived to be overtly or covertly supportive of torture or repression is viewed with suspicion and disdain, so that funding from a multilateral source such as the UN Voluntary Fund for Victims of Torture is more acceptable. However, as mentioned above, donations to countries or agencies within countries should involve a dialogue with the recipient government, if possible.

There is no reason why the UN should not also be involved in this process and follow the international agreements. It seems that they are moving in this direction in the document "Integrating human rights with sustainable human development: A UNDP policy document" (United Nations, 1998).

Recommendation

Initiate a concerted effort to increase the amount of the donation and the number of member states that contribute to the United Nations Voluntary Fund for Victims of Torture as a way to finance torture rehabilitation programmes around the world.

21.2. National funding

Obtaining sustainability, based on a share of the national budget, is basically a political process requiring the achievement of recognition of the needs of survivors in comparison with competing needs and convincing clinicians to actually provide therapy. In repressive countries there are obviously additional barriers. These issues can be addressed at many levels, because there are many levels of decision-making about resource use, even in repressive regimes.

An individual clinician has to make a decision about treating torture survivors and developing the knowledge and skills to do so, as we see very clearly in developed countries. We help them to decide in a positive way by showing them how, that it can be effective, that it can be personally rewarding and that their fears and anxieties are recognized and can be managed. We also use the values of our society to shame them in general if they do not help. Because survivors have a lot of somatization symptoms, they will be presenting to mainstream clinicians, who, if they recognize the cause, can at least provide first aid therapies, such as psychosocial education and appropriate medications for symptom reduction, even in repressive regimes. An analysis of volunteer clinicians who are involved in more specific therapies would show that they are people who have a strong political involvement against repression, and such people are very limited in number and there are not enough to sustain the services for the long period necessary. Thus, part of sustainability is to get knowledge, training, and practical experience incorporated into normal clinical training programmes for the relevant disciplines. This means working on the academic political systems, and hence our suggestions about trying to get universities as partners or collaborators in particular programme aspects.

The bureaucrats also need attention, as they need to be convinced of the value of survivor services so that they give the right advice to the Minister. This convincing involves all the issues of motivation from the rational arguments (often of low effectiveness) to how it will assist with the individual bureaucrat's motivations and ambitions (e.g. enlarge his department or power, improve image, etc.). This process is assisted by having as many relevant opinion-makers as possible giving the same advice to the bureaucracy, so that they feel they cannot be left behind in the new wave of opinion.

Finally, we come to the politicians, whether elected or not, and, as AI has found in trying to get repressive governments to change their minds in individual cases or in policy terms, we need to consider that they are all humans and would usually prefer people to love them and value their greatness. Thus, we always need to put the right spin on approaches, to frame requests in a way that finds an adequate compromise between their needs for power and the empowering care of the survivors. Politicians are always trying to please their support networks, and even soldiers have families, so again finding a whole range of levels to address and re-frame the issues for those levels to educate them and reduce resistance or even prompt them into action is how sustainability will finally be achieved.

The fulfilment of these processes is independent of the

structure of a survivor service and dependent on attitudes, the sophistication of the use of resources, and the recruitment of the right public relations skills.

The ideal should be to obtain the funds from the government to sustain rehabilitation programmes for torture survivors such as in Australia and the Netherlands. This approach has pros and cons:

Advantages

- Permanent source of funding.
- Avoids the daily fight for survival of the programme and the use of health and other professionals in the task of writing proposals and fundraising activities.
- Possibility of integration of the rehabilitation programme in the health system of the country with the possibility to extend the programme to rural areas and use the National Health Service for expensive medical care, inpatient care, and specialist referral.
- It is possible that the government accepts an independent managerial body to administer the rehabilitation programme as done in Australia.
- This approach could have the advantage of using an existing infrastructure and better access to the kind of multifaceted medical care needed for survivors of torture.

Disadvantages

- Survivors may not accept a government sanctioned programme.
- The government may impose restrictions such as to give care only to legal residents in countries of resettlement.
- The government will not allow a structure with appropriate checks and balances, so the bureaucracy or Minister interferes in the performance of the programme.

In countries under oppressive governments who practise systematic torture, this approach is not usually possible, because such governments are not willing to finance the treatment of survivors of torture who are members of the opposition. In countries in transition to democracy or with a democratic government, but without the necessary resources willingness or infrastructure to sustain such a programme, the rehabilitation programmes need private and international financial support.

When it is possible, the donor agency needs to initiate a dialogue with the government early in the process in order to ensure sustainability after the assistance has ended (Frankovits and Earle, 1998).

Formal or informal cooperation agreements with other institutions (networking) that fulfil the objectives of the programme could create a stable framework of activities and funding. An example is the contracting out, by a government or a private fund, of medical and psychological care for refugees to an organization such as Omega in Austria, or the education of the police to a private organization.

Sustainability is closely related to ownership, because ownership promotes sustainability. An approach is to promote programmes with membership organizations that economically support the programme. This is possible in countries of resettlement, but it is not possible in Third World countries. Local ownership can be enhanced with the active participation of survivors and community organizations in the service formulation and execution.

22. LEVEL OF KNOWLEDGE AND RECOMMENDATIONS FOR RESEARCH

Most of the information published on torture survival is descriptive. Few clinical outcome studies exist (Basoglu, 1998; Mollica et al., 1990). These studies have limitations due to the lack of control groups, definitions of diagnostic criteria, validation of assessment instruments, etc. Until now, in this new field of psychology and medicine, we have more questions than answers. Studies are needed in several areas. Some examples are:

- Epidemiological studies of the prevalence of torture and torture sequelae in different groups, regions, and countries.
- Studies of the effectiveness of the different models of organization of torture rehabilitation services.
- Studies of the efficacy of different treatment approaches.
- Studies of the criteria for successful outcomes in treatment and the duration of achieving these outcomes.
- Studies of the cost-effectiveness of the different treatment approaches.
- Many countries suffering under repressive governments or war have significant numbers of survivors of torture who are in need of help in a relatively short period of time. Are the current approaches useful in this situation?
- Studies of the cultural influences on the response to trauma.
- Studies on how the majority of people, in different cultures, who never receive treatment, cope with their trauma.
- Studies on intervention strategies for the prevention of the onset, the reduction of the severity, or the prevention of the recurrence of mental health sequelae in torture survivors.
- Studies on specific high-risk groups among victims of organized violence, such as women, rape victims, children, orphans, family members, ex-soldiers, etc.
- Studies to separate the medical and psychological sequelae of torture from the sequelae of refugee trauma.
- Studies of the efficacy of different methods to avoid burn-out among mental health providers.
- Studies on resilience factors and an elucidation of why not all exposed to severe trauma develop long-lasting conditions. (Kastrup, 1998).
- "Westernized" approaches, i.e. what are the respective advantages and disadvantages of the different approaches? (Kastrup, 1998).
- Studies on the coping strategies of the second generation of torture survivors, and on integrative problems to elucidate how the impact of trauma is transmitted to the next generation. (Kastrup, 1998).

These studies require rigorous research methodology, adequate research budgets (comparatively costly), a network of services to achieve adequate sample sizes, and possibly an association with an academic centre. Most services do not have the skilled research manpower or the budget. Most donor organizations give funds only for the direct care of survivors, and they are not willing to finance necessary infrastructures or scientific research.

A good example of funding for high quality research is the Request for Applications (RFA) published by the USA National Institute of Mental Health (NIMH) in February 1998. NIMH intends to "encourage investigator-initiated research to enhance the scientific understanding of the extent and nature of torture related mental health problems". The NIMH allocated USD 1.2 million for 4-8 awards for 1998

(National Institute of Mental Health, 1998), but this money is only available for studies in the USA, which only includes research in certain refugee populations.

A worldwide, coordinated approach to research and approaches to large foundations, (such as the Ford Foundation, the Robert Wood Johnson Foundation, or European foundations), with international tendering to answer outstanding questions, might be productive. An international panel of experts to commission research and to referee research proposals for methodological rigor would give funding bodies more confidence in giving money for research and make the process internationally competitive.

23. CONCLUSION

This study has identified many challenges to be met in providing sufficient, appropriate, and high quality services for the survivors of torture and their families. We still have a great deal to learn.

The even greater challenge is to prevent torture, to implement the international laws now available to governments and citizens in our global village. This will only come about if we can activate the many international mechanisms and opportunities to negotiate change and to create and support new mechanisms for international legal redress.

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The IRCT is a private non-profit foundation, that was created in 1985 by The Rehabilitation and Research Centre for Torture Victims (RCT), Copenhagen.

The objectives of the foundation is on an international basis to promote the provision of specialized 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 operate a documentation centre about torture and related topics
- to establish international funding for rehabilitation services and programmes for the prevention of torture
- to promote education and training of relevant professions 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.