

### Health-Related Considerations

#### *Remarks of Nora Sveaass\**

I WOULD LIKE TO THANK AMERICAN UNIVERSITY AND APT for getting us all together today and inviting me to be here and present some of my thoughts.

Many challenging questions have been raised today and I was very glad to hear that in addition to discussing the importance of having the legal framework, we also discussed the nature of public opinion, or as I was thinking, the important question of attitudes in relation to torture. This is particularly important now in connection to the questions often raised in the public debate, namely whether torture in any way can be justified in the context of actions against terrorist attacks. A strong public opinion against torture, emphasizing the absolute prohibition against torture is very significant in any discussion on the prevention of torture.

I found the references to ‘24,’ the television series, highly relevant – a TV show that could well be titled “Torture Works.” This show is also seen in Europe, and very easily, in discussion on torture, reference to what happens in this show is made. And this may well contribute to attitudes towards torture as something that, under extreme conditions may be necessary, and thus acceptable. So, if anything can be done to the way that torture is portrayed in the public arena, it would be important, and I think that we all have important work to do in relation to this.

My focus here today will be on two issues: First I will discuss the relationship between health and torture – that is, on torture as a serious threat to health in the widest sense of the word, including quality of life, meaning, and human integrity. Then I will reflect upon the important role of health professionals in all endeavors to prevent torture, to detect torture and to deal with the sequelae of torture, in the context of treatment and rehabilitation, as well as in the context of reporting, and claiming reforms and accountability.

As so very clearly expressed by Mark Schneider in his luncheon address to us today, torture always leaves scars. Not always the kind of scars that will be visible to others, or necessarily noticed by others in the daily life, but there will always be scars: in the mind as intrusive memories, nightmares, feelings of loss and humiliation, and there will be bodily scars. Even when these have gone, the body remembers the pain, and one of the long term consequences of torture is related to this. This is about how events, new situations, movements, or physical contact and sensations may bring the torture and the pain back – both into the body and into the mind. So, even if people do manage to live



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Courtesy of Rick Reinhard

a daily life in their families and in their communities, there will be, paraphrasing the song, “always something there to remind them.” And such reminders in forms of images, sensations and flashbacks may come very quickly and very strongly.

The actual infliction of pain, be it the attacks on the body or the systematic destruction of dignity and meaning, often takes place under conditions that in themselves may be regarded as torture or ill-treatment. And we are not necessarily talking about the situation that at first glance may seem brutal or destructive, as would for instance small and dirty cells (as already mentioned here several times), bad sanitation, or food and temperature regulation. I’m also referring to aspects such as communication with and contact with persons deprived of their liberty. For instance, severe lack of information; or confusing and contradicting information given; negative and degrading talk; exposure to false or impossible choices; extreme passivity;

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lack of human contacts; demands or questions being ignored or overlooked; disrespectful and humiliating treatment as part of the daily activities, for instance, surrounding food delivery and toilet visits. All these events contain elements that are systematically used in psychological torture, but they are not always easy to detect at first glance compared to some of the other problems first described. But nevertheless, long time exposure to these kinds of stimuli represents serious psychological hazards that may be detrimental to psychological functioning.

These situations, or examples of degrading ways of handling people, can well be found in situations where there is not actual torture taking place, but where the conditions, the insecurity created by such means, the disrespect and humiliation, can amount to treatment that violate human rights principles. And such conditions may be found in prisons, in asylum centers, in psychiatric hospitals – also in places or countries where one does not expect this to happen. The danger lies in the fact that this kind of violence does not easily lend itself to registration and observation. Situations ranging from intentional infliction of pain with specific purposes, to the creation of environments that lend themselves to ill-treatment, severe disrespect and humiliation – can cause a lot of pain and reactions in the person, such as: helplessness, feelings of total disempowerment (remember how the Special Rapporteur today particularly focused on lack of control and disempowerment), the creation of severe anxiety and sense of meaninglessness that may affect the lives of persons for years. And furthermore, the feelings of worthlessness, problems of trust, difficulties in creating relationships and constant exposure to intrusive memories are events that do change the ways which life and relations are perceived, and also the way in which pain is experienced. Torture may render people more vulnerable in the aftermath, and this may imply not only that the health condition may be seriously damaged after torture, but the more global aspects like integrity, dignity, self respect and meaning in life may undergo dramatic and permanent changes.

When reactions after torture are considered, particularly when the person is evaluated on the basis of psychiatric diagnosis, many of these aspects that I have referred to are not sufficiently covered or described in the terms that we know as psychiatric diagnosis. This is also why the application of psychiatric diagnosis in torture cases has often been criticized for being a way of reducing social, political and ethical problems into medical and individual problems, and indirectly also neutralizing them. Nevertheless, the many studies done on the effects of torture using the available internationally applied diagnostic procedures show that persons exposed to torture present reactions that meet the criteria for serious psychological distress, such as Post Traumatic Stress Disorder (PTSD), anxiety disorder and depression. Furthermore, that there is a high level of co-morbidity, especially between PTSD and depression, meaning that the same person may fulfill the criteria for several disorders at the same time. Studies also show that these reactions, composed of severe pain, feelings of inadequacy and intrusive memories may last for many years after the actual torture has happened (underscoring perhaps also that the vulnerability for stresses in the aftermath) (see Quiroga & Jaranson, 2005; Basoglu, 2007; Silove, 1999; Mollica, 2004; Sveaass, 1994).

Studies of traumatized Cambodian refugees 20 years after resettlement to the U.S. (Marshall, Schell, Elliot et al., 2005), or Bosnian refugees 14 years after torture (Alexander & Bernstein, 2007), and a number of other similar studies, are serious reminders that torture lasts long, and health services are needed for a long time. But such studies are also able to tell us about factors that may moderate these effects, such as social support, meaningful activity, health-care and rehabilitation programs. And we're also waiting for more evidence as to the effect of justice in the aftermath of gross human rights violations (see Basic principles and guidelines, OHCHR, 2006). We think, and I'm convinced, that it is important, but we still lack good enough studies to document this specific point, but I'm sure it will come.

Today we have discussed the many legal aspects of torture, but I would like to get to the importance of the health personnel as well. And as it said here, it is a requirement under the Convention that also health personnel should be acquainted with the legal provisions of the convention, but they should also have the knowledge about ways of detecting, investigating and documenting signs of torture. When reports are considered under the Torture Convention, the state parties are frequently asked about the actual application of the Istanbul Protocol in order to detect and document torture. This is now also referred to the General Comment to Article 2 of the Convention against Torture as a tool in the prevention of torture. The Istanbul Protocol, or The Manual on Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment from 2001 (OHCHR, 2001) is developed to serve both legal and medical professionals in their efforts to investigate and document torture, and there are numerous initiatives to make this a standard instrument in the context of asylum procedures.

And I'll also take the opportunity to refer to the publication from APT on "Visiting places of detention. What role for physicians and other health professionals?" This is a very good discussion on the role of the physicians and other health personnel in this important work of prevention, where references are made to different guidelines and manuals developed for documentation and assessment purposes.

There are many conditions that have to be in place in order for the health professionals to be able to do the work that is required of them as a part of the Convention against Torture. One of them is that there the professional ethics must be in place – that is available and respected. Furthermore there must be the necessary expertise in order to deal both with the psychological and the physical or somatic aspects of torture. There must be sufficient expertise to assess and detect not only the visible and the physical signs of torture but also social and psychological stressors in the environment that may represent threats to health and integrity. There has to be access to all places of detention where the prisoners are held, and also conditions that permit medical and psychological examinations. This is particularly important because this has to do, not only with a room that is secluded from anything else, but it also has to do with time and the ability to create alliance and trust. People exposed to torture are very often more anxious and more reluctant to talk than other people. The whole process of being able to create an

atmosphere, even a working alliance, in which reactions, pain and thoughts related to torture and abuse may be explored and recorded is very important and it takes time, skill and (of course) a physical place in which one is safe. There have to be good reporting procedures, and again, referring to the publication from APT, there must be possibilities to respond with medical or psychological care where such is needed, there must be channels to communicate suggested and necessary changes, and also allow for follow up procedures.

I will now, in the minutes that are left, focus particularly on ethics, professional skills, documentation and training.

Ethics – despite the old principle of ‘do no harm’ as imperative in all health professionals, we know that doctors, nurses, psychologists have been involved in torture for many years and in many different cases. This has happened either directly in acts of torture, or as supervisors or consultants to those who are inflicting pain, or as part of teams monitoring and advising on harsh interrogation methods.

Many initiatives have been taken also among health professional – to counteract this particular abuse of our profession. For instance, the book “Breaking of Body of Mind” many years ago was written with the aim of discussing how it was possible that professionals whose main objective was care and relief of pain, engaged themselves in the production of pain and suffering, as in torture and other forms of abuses (Stover & Nightingale, 1985). And in the book, there was a focus on the many documented situations where health personnel actively had been involved in torture.

In 1975, the World Medical Association adopted the Tokyo Declaration, stating that “Doctors shall not countenance, condone, or participate in the practice of torture, or other forms of cruel, inhumane or degrading procedures, whatever the offense in which the victim of such procedures is suspected, accused or guilty; or whatever the victim’s beliefs or motives, and in all situations, including armed conflict and civil strife.” The Tokyo Declaration has recently been updated and represents a clear and very important position for healthcare personnel.

The UN principles on medical ethics relevant to the role of health personnel – particularly physicians – in the protection of prisoners and detainees against torture and other cruel, inhuman and degrading treatment or punishment was adopted by the General Assembly Resolution in ’82. These principles offer explicit guidance for all health personnel, underlining the duty to protect health and provide treatment. The document also states that it’s a gross contravention of medical ethics, as well as an offense under applicable international instruments, for health personnel – particularly physicians – to engage actively or passively in actions which constitute participation in, complicity in, incitement to, or in attempts to commit torture or other cruel, inhuman and degrading treatment or punishment.

Despite these important declarations, and there are a few others also, if one looks into the particular codes of ethics for health personnel in the different countries, for instance the national ethical code for professionals, there is very little reference to torture, prohibition against torture and other ill-treatment. The reference to abuses are often quite indirect, and many of us are working at an international level to try to have the reference to

the prohibition of torture and other human rights abuses more directly stated and included in the codes of ethics of health professionals. This discussion has of course been very heated in the U.S., particularly in relation to the American Psychological Association (APA), and their position on psychologists and interrogation.

Both in the U.S. and in Great Britain, the doctors as well as the psychiatrists formulated very clear stances against participation in interrogation of terror suspects in relation to cases of national security. But APA, the psychologists nevertheless, chose another position. A task force was established and a report delivered – the Presidential Task Force on Psychological Ethics and National Security, and the so called “PENS” report. The aim of this work was to define ethical guidelines with respect to psychologist participation in national security matters, and in practice this report endorsed psychologists’ participation in the national security issues by monitoring interrogations of terror suspects, advising interrogators on how best to obtain information from prisoners, and being part of the so-called behavioral science consultant team, (“Biscuits”). And we all know that this debate has been very, very strong both within the APA but also on an international level (see Olson, Soldz, & Davis, 2008; Physicians for Human Rights, 2005)

But we also know that the APA in their last meeting in August last year, again formulated a resolution moving further against these positions (APA, 2008). Despite a much clearer stance on prohibited methods of interrogation, including waterboarding, inducing fear, isolation etc. more work has to be done to clarify an absolute prohibition against psychologist or health care participation in anything other than health care in institutions where all legal measures are in line with international standards, or as part of independent investigation teams.

It is an international challenge for all professional organizations to develop codes of ethics that explicitly create an absolute prohibition against torture, and where violations of this are dealt with, not only through professional bodies, but also handled in the context of law.

I will now try to move briefly to contributions from research in the field of psychotrauma and the advances in research both in relation to understand the etiology, gain insight in prevalence and knowledge about assessment and treatment. To me, as a health professional myself, actively engaged in work with torture and trauma victims, it is interesting to have been here the whole day, listening to very interesting presentations on torture and prevention, without once having heard mention of PTSD, which, in other professional contexts would have been a frequently used concept.

There has over the years been a growing focus on the post traumatic reactions people have after extreme stresses. The PTSD diagnosis first described in 1980, was new in the sense that the diagnostic label was a new one, but the psychological phenomena that it covered had been clinically known for a lot time, already observed and described during World War I. The interesting observation here is that it was returning war veterans from Vietnam to the U.S., that were first studied and given this diagnosis, and most of them had experienced long term, complex and multiple traumatic events. But despite this beginning, a

lot of the research on PTSD since, has been single event trauma, as in accidents, aggravated assaults, etc. This means that some of the cases that we deal with in relation to persons who have been tortured and imprisoned for a long time under very different kinds of extreme stresses, are not very well covered in the literature on PTSD. But, with the always growing interest for torture, political violence and the comprehensive health consequences of such events, more focus has lately been on what is often termed as Complex PTSD (see Herman, 1992 & van der Kolk, Roth, Pelcovitz et al., 2005).

Furthermore research in this area has also given us more tools and skills in relation to assessment and also to therapeutic interventions of different kinds. I have already referred to the kind of assessment that is especially important as part of documentation, and here I have mentioned manuals for documentation of torture, the Istanbul Protocol. But there are others, for instance Guidelines for the examination of survivors of torture, developed by Medical Foundation. The purpose of these may be both to assess for treatment and to document for national procedures, for international procedures, in asylum cases. The Istanbul Protocol is not only a manual explaining how this can

be conducted, there is also reference material guiding the professionals and it is endorsed by the High Commissioner for Human Rights. In order to do such work on needs not only manuals and guidelines but also training and working conditions that allow one to do this kind of work. I consider it a very important part of the state parties' obligation to prevent torture to provide sufficient training for the personnel to detect and to document, but also to set into motion treatment and therapy for those groups that are in need after torture and ill treatment.

I just want to finalize by referring to a resource database developed in order to make information and background material on psychosocial work with persons exposed to human rights violations, more accessible for health personnel world wide – and this can easy be looked into on the following address – [www.hhri.org](http://www.hhri.org).

Well, I think I will stop here. A lot more could be said, but I hope that I been able to point out some of the important roles and challenges involved in the health and torture and that I have been able to make my point clear, that strengthening the health professional's role and participation in the prevention of torture is an issue of high priority. Thank you very much. **HRB**

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