

From the Encyclopedia of Psychological Trauma:

TORTURE

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Torture

Torture is the most serious violation of a person's fundamental right to personal integrity and a pathological form of human interaction.

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

For the purpose of this Convention, the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purpose as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed, or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by, or at the instigation of, or with the consent or acquiescence of, a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to lawful sanctions (United Nations, 1995, pp. 294-300).

This definition has been universally accepted by the 146 countries that have currently ratified the Convention. In summary, torture is defined as a political act inflicted by a public official, with the intent and purpose of extracting a confession or information, punishment, intimidation, coercion, or discrimination. The most important criteria in the definition of torture are the intention and purpose, not the severity of the pain. In

addition, torture occurs during detention when the prisoner is powerless and under the control of authorities. The use of force and the infliction of pain under these circumstances violate the principle of proportionality, forbidden by international law (Nowak, 2006). Torture has been defined by other organizations, such as the World Medical Association, and by individual countries in their national laws, but the UN definition is the most applicable and widely accepted for governments (Quiroga & Jaranson, 2005).

Amnesty International, in a worldwide survey in 2000, found that 75% of countries practice torture systematically despite the **absolute prohibition** of torture and cruel and inhuman treatment under international law, even though these countries have signed the CAT (Amnesty International, 2000).

Most countries in their domestic laws criminalize torture but not cruel, inhuman or degrading treatment or punishment (CIDT). The countries that practice torture use a more restrictive definition of torture and make the severity of pain the most important criterion of the definition. Later these countries may increase the threshold of severe pain to just short of organ failure. This allows the practice of torture to continue while officially denying its use.

Recently, during the so-called "Global War on Terrorism", some countries have developed a number of methods to circumvent the **absolute prohibition** to practicing torture or CIDT. People have been forcefully abducted and detained in secret detention centers around the world. Torture methods are practiced in these places but called "enhanced interrogation techniques." Detainees have been sent by secret flights to other countries for interrogation using torture, a practice known as "extraordinary rendition." All of these practices are illegal under international law. According to international human rights law and humanitarian law the prohibition of torture and all others forms of CIDT is absolute and non-derogable. No exception is permitted under any circumstance, not even an emergency.

Although torture has been practiced for millennia, knowledge about perpetrators of torture and how they are trained has been difficult to find. Manuals on techniques for interrogation and curricula for training intelligence officers have been classified until recently. Psychologically, perpetrators are usually "normal" but subjected to brainwashing or a dissociative process (Quiroga & Jaranson, 2005).

Assessment of torture survivors has only recently been systematized. The Istanbul Protocol is a manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment. It includes modules for medical, psychological, and legal professionals. The Protocol was approved as an International instrument by the General Assembly of the United Nations resolution 55/89 on December 4, 2000 (OHCHR, 2001).

The mental health consequences of torture to the individual are usually more persistent and protracted than the physical aftereffects. The psychological problems most often reported are psychological symptoms (anxiety, depression, irritability/aggressiveness, emotional lability, self isolation, withdrawal); cognitive symptoms (confusion/disorientation; memory and concentration impairments); and neurovegetative symptoms (lack of energy, insomnia, nightmares, sexual dysfunction). The most frequent psychiatric diagnoses are posttraumatic stress disorder (PTSD) and major depression, which have a high level of co-morbidity. Other anxiety disorders besides PTSD, such as panic disorder and generalized anxiety

disorder, are frequently diagnosed. In some samples, substance abuse is a problem. Longer-term effects include changes in personality or worldview, which are not adequately described in the diagnostic nomenclature. The socio-political context of torture and the culture of those tortured affect the way in which survivors respond to the experience. Complex PTSD and related concepts have been proposed to identify some of these responses (Quiroga & Jaranson, 2005).

Studies show that perceived distress and controllability of torture stressors, not just exposure to them, is associated with greater likelihood of PTSD and depression. Higher resilience levels, meaning greater ability to exercise control over the torture stressors, is associated with less perceived distress during torture and less PTSD subsequently (Basoglu & Paker, 1995; Basoglu, Livanou, & Crnobaric, 2007).

A recent study shows that the division of torture methods into physical and non-physical (psychological) methods is artificial because, from the point of view of the psychological impact, both produce similar levels of symptoms. The division between torture and CIDT is also artificial because both methods produce similar psychological consequences (Basoglu et al., 2007).

The most important physical consequence of torture is chronic, long-lasting, pain experienced in multiple sites. A recent study shows that after ten years pain is still highly prevalent. Survivors also experience diverse psychophysiological symptoms. All of the victims of physical abuse show some acute injuries, sometimes temporary, such as bruises, hematomas, lacerations, cuts, burns, and fractures of teeth or bones, if examined close to the trauma episode. Permanent lesions, such as skin scars on different parts of the body, have been found in 40% to 70% of the victims. Complex lesions with temporary or permanent disability have rarely been documented (Quiroga & Jaranson, 2005).

A few medical consequences of torture have been clearly identified and well-documented. Falanga, beating the sole of the feet with a wooden or metallic baton, has been studied extensively. Survivors complain of chronic pain, a burning sensation. The MRI shows thickness of the plantar aponeurosis (Skylv, 1995). Acute renal failure secondary to rhabdomyolysis is a possible consequence of severe beating involving damage to muscle tissue. The condition can be fatal without hemodialysis (Malik et al. 1995).

A severe traumatic brain injury that is caused by a blow or jolt to the head or a penetrating head injury that disrupts the function of the brain, fracture of the skull, brain hemorrhage, brain edema, seizure and dementia have been documented. The effect of minor brain injury has not been well studied. Peripheral neuropathies have been documented in cases where victims have been suspended by their arms, while handcuff neuropathies have been documented due to tight handcuffing (Moreno & Grodin, 2002)

Treatment for torture survivors ideally requires a multidisciplinary approach, since the sequelae of torture are acute and chronic, and may include physical, psychological, cognitive and socio-political problems. Treatment also requires a long-term approach. The approaches are many, little consensus exists, and treatment effectiveness has not been scientifically validated by treatment outcomes studies (Quiroga & Jaranson, 2005).

Jaranson's general treatment approach for severely traumatized patients also applies to torture survivors. The basic principles are 1) do not harm, 2) focus treatment on the individual treatment needs, 3) have a single professional act as a case manager, 4) aggressively treat pharmacologically the intrusive symptoms of impaired sleep, nightmares, hyperarousal, startle reactions, and irritability, 5) provide supportive therapy, 6) support the physical, social, and medical needs of survivors, 7) do not refocus on the trauma until the intrusive symptoms are decreased, 8) do not encourage or discourage political activities or public activism until survivors are ready, 9) use groups for socializing and supportive activities to reestablish a sense of family and cultural values, and 10) support the traditional religious beliefs of the victim (Jaranson et al., 2001).

The medical, psychiatric, and social needs may be multiple and persistent or easily exacerbated. Specific physical treatment modalities include physiotherapy and medical care for specific conditions. Individual psychotherapeutic approaches include psychotherapy and pharmacotherapy. Of the psychotherapies, cognitive behavioral therapy (CBT) is well-documented as effective. Psychotropic medications, most frequently antidepressants, may facilitate psychotherapy by reducing symptoms. Psychosocial interventions are community-based rather than individually-based (Quiroga & Jaranson, 2005).

The movement for the rehabilitation of torture survivors began at the end of the seventies in Latin America. By the early 1980s a handful of centers operated in Europe and North America. Today nearly 250 centers or programs have been identified in the world, 143 of them accredited as members of the international network known as the International Rehabilitation Council of Torture Victims (IRCT), which has its secretariat in Copenhagen (IRCT, 2006). Since torture adversely affects not only survivors, but their families and societies, many centers treat not only the individual but confront larger social issues related to torture, such as reparation, impunity, and the ultimate goal of preventing torture.

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