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EDITORIAL

RAHAT Medical Journal (RMJ) provides a pedestal to healthcare and allied medical professionals, in communicating ideas related to the experiences from their personal spheres with other fellow professionals. A wide array of contributions articles, research papers, and reports are published in order to address human rights, torture and the role of medical professionals.

This issue starts with a contribution by Dr. Farooq Mehdi, where he highlights various efforts that have been made by RAHAT, to help the refugees out of their sorry state of affairs. It does bring into account the experiences of this organization, which have been on the way since its creation. It thus provides a broader picture of the dilemma of the refugees.

The provocative debate regarding the definition of torture has been carried further in a more lucid and a precise manner through "Dialogue: Definition of Torture." The authors, Dr. Farooq Mehdi & Wajid Pirzada, have in a pragmatic manner, tossed some of the most widely and internationally accepted definitions of torture. Further there is an nudging of the discussion to a focal point, making the reader realize that there necessarily is a strong need for re-visiting the definition of torture.

An incisive and novel idea has been propounded by Emmanuel Didier, regarding the courtroom procedures, in his manuscript "The Examination and Cross-examination of Victims and Perpetrators of Acts of Torture." It argues the rules of evidence and procedure that may be adopted in order to prevent the torture victims from facing serious dilemmas, while being probed in the foreign courts. This dexterously deals with the rules that need be emphasized in order to get a stress-free trial of the refugees; the reason; however, remains that this fact cannot easily be evaluated by the judges, who appear to be blindfolded to the health-related issues of the victims, being interrogated.

Research study, "Prevention of Injuries Matted out by Torture: BRCT Experiences" has been presented sharing the experiences from Bangladesh. This report does highlight the brutal and degrading ways of torture that are employed to punish fellow beings. It does clearly narrate the psychological and physical aftermaths of torture, by bringing into account, two of the case studies. Integrated Prevention Approach and Integrated Rehabilitation Approach have been put forward that kindles further the idea of having such coordinated efforts, so as to maintain care-giving environment to the bereaved. The provision of legal, medical, and therapeutic, intervention and their effects, and keeping the victims in contact and making them feel a part of the society may add to the aggravating situation of the victim.

"Relationship Between Psychological Adjustment and Domestic Violence Among Housewives," by Fizza Sabir and Sereena Nizam, is another research conducted to explore the relationship between domestic violence and the psychological adjustment among housewives. The research however, explores the score of torture in context with the nuclear and the joint family systems. Similarly, the effect of education and vigilance has been worked out.

“Learning About Falanga” is a research study that dissects the problems faced by the victims of falanga torture; which has remained a typical example of physical maltreatment with potentially lethal effects. Case studies have been put forth, so as to identify the deep-rooted effects of falanga thus making it workable to find out the causes and the effects of this form of torture. The cases have been thoroughly examined and the problems identified, making it more convenient to plan the way out. It thus appears to emphasize the need to get the society to a point of shunning falanga.

There is a contribution by KRCT, where they have evaluated the effects of Melosovic's trial, on the patients, already treated for PTSD, as to what was the effect of re-living the same traumatic happening. Similarly, facing the criminal, led to nostalgic feeling, amounting to nervousness, thus it has been emphasized that there needs be a psychological counseling of the victims before standing trial.

Such contributions nonetheless, serve as a starry phase that may prove beneficial in instructing the medical and allied connoisseurs to get a more lucid picture of the problems being encountered in different parts of the globe, thus providing yet another opportunity to contribute to the well-being in a more better, positive and a decisive fashion.

Refugees, PTSD, and RAHAT

Dr. Farooq Mehdi & Uzma Ishaque

There have ever been efforts to wrench the bereaved out of the quagmire of traumas, which surrounded the wretched humanity, in one form or the other. Humanity has been a witness to holocaust of many such wanton wars. And it is these horrific combats that have not only blurred the face of humanity but also subjected the poor lot to long-lasting psychological muddles.

The sense of homelessness and being deprived of basic legal rights leads refugees to stress and anxiety. This cannot only be dangerous for their physical health but also for their mental and psychological health. This dilemma may impair the personality due to the persistent stress and trauma. In case of homeless people, RAHAT implies certain measuring tools or instruments with which to gauge the intensity of posttraumatic stress symptoms. Trauma-focused interventions, psychotherapeutic and medical treatments, are provided after assessing the level of PTSD. RAHAT works for the well-being of communities that have been forcefully displaced, and helps them achieving a useful, effective, and a healthy status amongst the comity societies.

World Health Organization declared that “health” is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Generally health is considered in reference to the physical health of a person, while the emotional, mental, and social aspect is generally ignored. But in practice, there is a reciprocity in action of the psychological and physical health; one necessarily leaves a paramount impact on the other and vice versa. For example, a person having pain in heart may start thinking that he is now counting his days; and it is this thinking that ultimately makes the person obsessed with the same idea, resulting in degeneration of the physical health as well.

Displaced persons or refugees have proven to be the most vulnerable of all, regarding their liability of getting an easy exposure to torture. In the Convention Relating to the Status of Refugees, 1951, a “refugee” is said to be a person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country.”

“Forcibly displaced populations” include asylum seekers, refugees, internally displaced, repatriated persons, and other non-displaced populations affected by persecution, war, and conflicts. "Mental Health Resources" include individual, family, community, psychological, social, and economic strengths, which can help individuals and groups of people cope with stress, trauma and suffering. This also includes human, financial, and institutional resources (including policies and action plans) which can be mobilized to support the establishment of mental health programs.

“Conflict” as used herein includes war, civil war, conflict (ethnic, military or religious), post-conflict, other unstable and violent situations and complex emergencies. It is more than probable that after being affected by such trauma, there is an even more likelihood of developing PTSD that can in turn lead to multiple psychiatric illnesses. These psychopathologies or psychological dysfunctions may utterly destroy the person. “Complex Humanitarian Emergency” characterizes a situation of political instability leading to unrest or civil strive, internal or cross border population movements, severe economic recession, and subsequent excess morbidity and mortality. [1]

Posttraumatic Stress Disorder (PTSD)

Posttraumatic stress disorder is defined in terms of the trauma itself and the person's response to the trauma. When one has confronted a terrible event, one may be threatened by events, such as physical or psychological injury, military combats, natural disasters, terrorist incidents, serious accidents, or violent personal assaults; response are likely to be that of intense fear, helplessness, and/or horror. Those who suffer PTSD, do experience flashbacks, nightmares, insomnia, detached or estranged feelings for long intervals of time.

PTSD is marked by clear biological changes as well as psychological symptoms, and is complicated by the fact that it frequently occurs in conjunction with related disorders such as depression, substance abuse, problems of memory and cognition, and other problems related to the mental and physical health. The disorder is also associated with impairment of the person's ability to move free in social or family life, including occupational instability, marital problems, family discord, and difficulties in parenting.

Refugees at RAHAT

RAHAT deals with the traumatized persons in wide-ranging problems regardless of their ethnicity. Victims are treated with empathy and with utmost care at RAHAT. It may be considered a stride that needs to be multiplicated in other parts of the world as well. This service of humanity may be deemed as a beacon of light for other human rights activists as well.
Nationalities of Torture Victims Provided With Rehabilitation at RAHAT

1. Afghans 2. Bengalese 3. Burmese 4. Chinese
5. Iranians 6. Iraqis 7. Kashmiris 8. Kurds
9. Pakistanis 10. Somalians 11. Tajiks

Post Afghan War and PTSD

Aftermaths of the long and bloody successive wars can be witnessed throughout Afghanistan. As a result of fierce fighting's, millions have been made homeless and countless forced to flee to neighboring countries because their homes have been looted or destroyed and their families abducted or killed. Not only the houses, hospitals, worship places, towns, and cities have been converted to rubble, there has been an even worse

form of long-lasting damage, invisible to the naked eye the deep psychological wounds, still oozing after the lapse of 25 years of war and terror. The war trodden Afghans have lived under the threat of death and spent long periods of time in hiding. Most have lived in refugee camps for more than a decade. Thus the uprooting has posed challenging problems, which of course hinders the normal pace of life.

Symptoms of PTSD Among Refugees

Not surprisingly, there is a high incidence of post-traumatic stress disorder (PTSD) among refugees. In general, posttraumatic stress disorder is seen as an irresistibility of the body's normal psychological defenses against stress. Thus, after the trauma dysfunction of the normal defense systems takes place, resulting in certain a peculiar symptomotology. The symptoms are produced in three different ways:

1. Re-experiencing Trauma

Memories of the trauma reoccur unexpectedly, and episodes called "flashbacks" intrude into current lives of refugees. This happens in sudden, vivid memories that are accompanied by painful emotions, taking over the victim's attention. It may be so strong that the victims almost feel like they are actually experiencing the trauma again.

2. Persistent Avoidance

The person almost becomes reclusive, avoiding ties with family members, colleagues, and friends. At first, the person feels numb, with diminished emotions, and completes only routine or mechanical activities. However, some may feel guilty because they survived the disaster whereas, others friends or family did not.

3. Increased Arousal

As a result of PTSD, the person may develop insomnia. The cause of this problem is rooted in the past memories; the memories that one can neither forget nor avoid. As a result, unprovoked, irritable or explosive behaviors are witnessed. The affected may have trouble concentrating or remembering current information, due to their terrifying flashbacks.

Generally the refugees show the following symptoms due to the severity of trauma:

- Anxiety
- Depression
- Fear
- Irritability
- Disturbed memory
- Headaches
- Sexual dysfunctions
- Lethargy
- Introversion
- Loss of concentration

Visual impairments, etc.

In case of child refugees, anxiety, grief, and nightmares, and bedwetting may be experienced.

Ninety percent of the refugees were affected by PTSD, depression/anxiety or bereavement, and "the psychological trauma endured by the Afghans is undoubtedly tremendous and needs urgent recognition and help," there were even more urgent requirements, so that "psychiatric help comes last on the list."[1]

Rehabilitation of Refugees at RAHAT

Everyone who experiences trauma does not necessarily recover by the help of family members or friends; a lot many do need professional treatment to recover from the psychological mire, resulting from either from direct or indirect exposure to torture.

Strict confidentiality of the victim is ensured while the person is being psychologically explored so as to provide one with required therapy. Treatment provided, may be psychological or physical in nature the aspects that do need to be taken care of at the same time.

Any examinations or therapy requiring movements or manipulations that may appear to be resembling torture to the client, must be avoided as much as possible.
Physical and psychological treatment on an outpatient basis should proceed concurrently.
Treatment should not only include the survivor but also other members of the family.
After setting the rules of the treatment, procedural rehabilitation programs are initiated.
Every phase of rehabilitation is selected on the basis of condition of the survivor refugee.

I. Assessment phase
II. Medical treatment
III. Psychotherapeutic treatment

I. Assessment Phase

At RAHAT, the torture-survivor refugees first encounter the therapist. The victims talk about torture in detail, and once the defense mechanisms have been overcome, they re-live and re-experience the emotions attached to the memories.

First session may last for hours during which the whole situation of survivors is assessed in a friendly atmosphere. Higher priority is given to comfortable seating, in bright pleasant surroundings, contrasting with horrible torture situation. All relevant information about the method, duration, and the nature of torture employed, is attained; while the respondents feel free to refuse, if they do not choose to answer any specific question.

At the onset of session, survivors are thoroughly explained the principles and mode of implementation of treatment. Having assured that the therapist, the interpreter and the Centre as a whole will provide absolute confidentiality, history of client is systematically reviewed.

The incoming patients are introduced to all the staff members at RAHAT, and are provided with an opportunity to become acclimatized to the surroundings. This helps in gaining confidence of survivor that provides a ground for upcoming phases of treatment.

II. Medical Treatment

As in all other therapist-patient contacts, the medical history is of crucial importance. Introduction to the previous medical history of the victim can go a long way in making the therapist help the victim.

Interviews spotlight the presence and severity of elements from the general stress picture, as well as specific organ-related complaints. Knowledge of torture in general, and that of specific torture methods in particular, facilitate both questioning and interpretation of the information obtained.
In addition to the diagnostic information, torture history calls attention to special considerations, which must be taken while subjecting the patient to various medical tests, diagnostic procedures, and treatment methods. Thereby uncontrollable anxiety may be avoided that otherwise can amount to irreparable loss of confidence in the therapist. Only thorough attention to the history ensures the minimization of such risks. Attention is paid to psychosomatic disorders. Separation of body from mind is nowhere less appropriate than in treatment of torture survivors, where the body has been abused to gain access to the mind.

At RAHAT, much emphasis is not given to medications, since the PTSD patients more actively participate in the psychotherapeutic category of treatment. Certain antidepressants may be particularly helpful in treating the core symptoms of PTSD, especially depression.

Physiotherapy of Torture Survivors at RAHAT

The goal of physiotherapy at RAHAT is to restore the individual identity of patients and enable them re-live an active social life. Before initiating treatment the therapist goes through the reports that have carefully been prepared by the doctor and the psychologists.

Physiotherapy is based on traditional therapy below the threshold of pain. The patients have experienced so much pain and sufferings that we seek to inflict no pain or as little pain as possible.

Physiotherapy at RAHAT may take a longer time, lasting for several months because of combination of physical complaints and mental sequel. Many victims have suffered a

change in body image, and in some cases a survivor cannot tolerate even a touch. During physiotherapy sessions body image is gradually restored. However, a combination of physio- and psycho-therapy may prove to be more productive.

Most frequently applied methods of physiotherapy at RAHAT are gentle massage, stretching, ultrasonic treatment, and muscle exercise. For acute PTSD, medication, critical incident stress debriefing, and group and individual psychotherapy should be started in combination.

III. Psychotherapeutic Treatment

Psychotherapeutic treatment aims to eradicate mental disorders, using psychological means. The main purpose of psychotherapy is to reintegrate the survivors in society, to reinstate their feeling of dignity and restoring their faith in humanity. This treatment is given, bearing in mind the severity of symptoms and the condition of the patient. Long-term therapy is usually suggested for patients who have encountered severe mental pressures or experiences. The duration of therapy depends on how well it's affecting the patients' physical well-being. For most sufferers of PTSD, however, a combination of cognitive and behavioral psychotherapies is used.

Various types of psychotherapy used for torture victims are:
i. Individual Therapy
ii. Group Therapy
iii. Family Therapy
iv. Insight or Exposure Therapy
v. Cognitive Therapy

Through psychotherapy patients have to learn that they are no longer victims, but survivors. They have to start living their lives in a manner that anxiety, suspiciousness and sadness should no longer hold a grip on their actions and emotions.

Usually relations between PTSD sufferers and their family are on the rocks. This is because these patients have to go through severe mental trauma, owing to which relations with other family members suffer. Family therapy proves to be helpful in reestablishing relations between different members of the family.

Group therapy encourages survivors of similar traumatic events to share their experiences. Group members help one another realize that they are not alone in their struggles and that many others like them are also going through the same ordeal everyday. It is usually easier to deal with their pain if patients know that someone else has probably been through worse. Numbing symptoms are amongst the most difficult symptoms to treat. For these symptoms, peer group support is extremely important, like wise many other symptoms can be treated easily if the patient has support of others.

Exposure therapy consists of recounting the past trauma in graduated doses, so that it is not very painful for the patient to remember the traumatic experience. education about

common reactions to trauma, breathing retraining, (such as breath counting and deep breathing), and repeated exposure to the past trauma in graduated doses. As a result of exposure therapy, the traumatic issue or event can be remembered without the anxiety or panic resulting.

Cognitive therapy involves separating disturbing thoughts from the associated anxiety that they produce. It involves changing the sequence of thought pattern that occurs whenever the survivor is exposed to the traumatic stimulus. Cognitive therapy also helps them who show any type of avoidance, since this therapy makes the patients bold enough not to avoid situations or places that may be reminders of past trauma.

Stress Reduction Therapy at RAHAT

This therapy is unique in nature for it is the first of its kind that serves a duel purpose; it works with both the mind and body of torture victims. On the body it works with the muscles through the hands of the therapist, no instruments or medications are used in this. It works on the mind by providing a listening ear, understanding, and a supporting attitude to the victim. The main aim of this kind of therapy is to provide solace to the victim, both mentally and physically.

Our Stress Tension Reduction Therapy (STRT) Department is equipped with all the necessary equipment for carrying out this therapy, wooden rollers, sticks, hoops, mattresses and balls of different sizes all are used for therapy. This equipment is used for group exercises that are designed specifically for survivors who are tense or stressed. These exercises also help the patients to interact with each other, which as I mentioned earlier helps them to deal with their woes.

Patients arriving at our centre are first examined by a doctor and then by a psychologist. They have twelve sessions of therapy, once or twice a week, depending upon the state, the patients are in. During these therapeutic sessions the patients undergo an inner transformation, making them attuned to their inner-self. An underlined effort is on the way so as to make the persons expressive and more interactive. In doing so they are made to get mixed up with more and more individuals. The idea behind this is to make patients share experiences with each other. Another main reason for forming a support group is to provide exercises for these men and women. At this stage, we do not encourage individual therapy but help them develop a sense of well being in their bodies through our specific group exercises. Special care is taken that the exercises planned for the recipients do not extend their physical capacities.

Caution is observed while giving patients regular therapy that they do not become dependent on these sessions. It is often observed that patients start thinking they will return back to their original state if their therapy is stopped or that they can function normally only as long as these sessions continue. To discourage these feeling, we emphasize our patients to do regular exercises on their own, so that they do not form a dependency on therapy sessions alone.

The STRT, with all its unique benefits has proved workable for patients, as when they arrive, they are broken from inside and have given up on life. But this therapy helps them to look at themselves in a different light and to start taking charge of their lives.

Beside these therapeutic treatments some other helpful and effective methods of treatment are used at RAHAT to make the survivors realize that they can return back to being normal and healthy persons of society. Some of these are discussed below.

1. Social Counselling

Social counseling is a must for all torture survivors, because physically, mentally and socially their bodies as well as their minds have been dented. Victims usually find themselves shunned by their near and dear ones; this aggravates an already bad situation. Victims are faced with an overwhelming quagmire of obstacles; therefore, they need extra help in overcoming them. The goal of social counseling is to ensure that torture survivors are not disadvantaged in comparison with other human beings.

2. Visualizing Technique

Other types of therapy that are useful for anxiety are visualization techniques and confidence builders, such as positive self-talk and social skills training. In visualization techniques, torture survivors train themselves to recall and visualize a particularly peaceful or pleasant place or situation, whenever thoughts of the trauma occur. This helps in blocking all the bad memories and in their place peaceful and serene moments are remembered.

3. Role Playing Technique

Role playing technique can be used for the management of anxiety and stress. This technique includes relaxation and entertainment. It also involves carefully monitoring the survivor's thoughts that follow from thinking about the traumatic event. Then, when thoughts of the trauma do occur, the survivor is asked to play a role of some body else who has never received any kind of torture and never faced stress and depression. At first, the survivors may even need to imagine themselves as someone else (role playing) to bring about this change in their thought pattern. But gradually, role-playing becomes the reality.

Follow up Visits of Survivors to RAHAT

Survivors visit RAHAT for therapy sessions on a weekly or fortnightly basis, depending upon their physical and mental condition. They receive medical, psychological, stress tension reduction, and physiotherapy therapy sessions. A good response is expected from patients suffering from posttraumatic syndrome expect within 3 months, as long as they do not have any other severe psychiatric illness like substance abuse, depressive disorder, bipolar disorder (manic depressive), or some other maladaptive personality disorders, such as antisocial personality disorder. However, a small percentage of patients with

PTSD, especially those with some other associated psychiatric disorder, remain quite symptomatic for longer periods of time.

While RAHAT has completed its fifteen Years of life, we undertake to further accelerate our efforts for providing rehabilitation and health aid facilities to the torture survivors and their families in Pakistan.

Reference

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The Examination and Cross-examination of Victims and Perpetrators of Acts of Torture

*Emmanuel Didier1

In our world of subjugations, violations of rights, crushing of the emotions of the deprived and discrimination, there has to be a shield for the protection of the rights of vulnerable. The establishment of courts may provide solace to many, who may perceive them as a safe heaven for the bereaved, where the victims would be able to find a sort of justice, and would be able to get a guard against the pounces of the mighty.

But victims are not always provided the space they need, and are often left to gather the effects of an ovetrly mechanistic judicial process.

Victims and perpetrators of acts of torture are usually poor witnesses in a courtroom, whereas they stand to gain a lot from a judicial process that is properly used so as, firstly, to maximize the efficiency of the evidence gathering process and, secondly, to provide therapeutic justice.

During the examination of the accusations concerning Kosovo, Milosevic's speaking time was 153 hours, friends of the Court had 16 hours and the Prosecutor only 110 hours. For the victims, the effect was devastating. A Kosovar peasant who survived a carnage said, in shock : Are you really uninterested to hear my story? [2]

The hearing of "K12" lasted a few minutes only. At the first question of prosecutor Geoffrey Nice, who was asking him routinely to confirm that he had effectively accomplished his military service in 1977, the witness "broke down." "Tell the Prosecutor that I have had enough with the psychological nightmare that has been imposed on me over the last two days. Leave me alone. I will become crazy if it goes on like that!", the person did yell at the Judges. But instead of answering his distress with an open hand, the judges threatened him to charge him for contempt of Court. "This is one of our prerogatives, if you persist in refusing to answer the questions," did Justice Richard May firmly explain to him.[3]

A - Problems Faced in the Hearing Room

Victims and perpetrators of acts of torture face two types of problems in the hearing rooms:

1. problems specific to the legal system.
2. problems specific to themselves.

1. Problems Specific to the Legal System

Courtroom procedure, as an evidence gathering tool, is poorly geared towards the specific needs of victims and perpetrators of acts of torture. The fundamental flaws are three in number :

First, and foremost, courtroom procedures are not tailored to the specific psychological and physical needs of individual witnesses. Rules of procedure and evidence are similar for all, on the assumption that "one size fits all" and that all witnesses or parties are similar. But what may seem to be an act of striking equality amongst the public may also, in practise, prove to be more rigid than desired.

Second, courtroom procedures are inherently stressful. 4

Thirdly, courtroom procedures are usually adversarial, pitting one party against the other, while being in a contest, where there must be a winner and a loser. It is only in exceptional cases, such as the proceedings as they should be held before the Immigration and Refugee Board of Canada, that the ordinary rule is relaxed and the hearing is non-adversarial, although it can become so when the President of the tribunal decides that it should.

But, refugees and victims of acts of torture compose a group whose members have very little in common with "ordinary" litigants, who are reasonably well educated, healthy and wealthy. Refugees, on the other hand, are often little educated, frail due to economic problems, and poor because of being uprooted. Contrary to “normal” parties, refugees and victims of torture often cumulate - as a class - multiple handicaps that seriously hinder the efficiency and the ease of communication with the court, lawyers and other interveners in the judicial process.

The greatest problems faced by the victims in the legal process are:

Linguistic disabilities: refugees and victims of torture rarely speak the official language of the court, and thus rely nearly entirely on the ability of official or amateur interpreters to plead their case;

Physical disabilities: torture victims and refugees are often disabled to a lesser or greater extent, either by diseases or chronic conditions, such as AIDS, infections, pain, psychological and other physical sequels of traumatic stress and torture, or by unhealthy conditions of traveling or living;

Financial disabilities: refugees and victims of torture are often in precarious financial conditions that prevent them from obtaining the best possible professional resources;

Social and family disabilities: refugees and victims of torture are often incapable of understanding the subtle, but pervasive, network of values, words and images that permeate the language and thoughts of other operators in the judicial system, in general, and in the courtroom in particular. They are also, frequently, deeply distressed by their lack of knowledge of the conditions, or their knowledge of the poor conditions, in which the members of their families are living.

2. Problems Specific to Victims of Torture

The individual conditions of refugees and victims of torture vary enormously from one individual to another. Victims of torture also suffer from specific handicaps, which render the giving of evidence, particularly difficult, painful and often an uncertain process. 5

The French psychiatrist Françoise Sironi has described the symptoms and signs of torture, for medical professionals as follows: [6]

Signs Concerning Effraction

Jumping, crying or shouting, shaking, uncontrollable fear;
Headaches, skin problems (itching, eczema, etc.), Ulceres;
Self-doubt, feeling of strangeness, isolation, pain related to feeling of differentiation from others;
Memory and focusing problems;
Nightmares;
Self-accusation and guilt for having a distinctive identity;
Fear to have one's thoughts read, to be transparent and to be influenced;

Signs Concerning the Influence of the Torturer

Sadness, lack of initiative, apathy, asthenia;
Uncontrollable aggressiveness, feeling of lack of self-control;
Impossibility to think;
Troubled sleep and nightmares, at night;
Traumatic recollections during the day;
Hypertension, diffused and changing pains, dizziness, falls, feeling of a frog in one's throat;
Changes in personality;

Signs Concerning the Access to Hidden Knowledge 7

Systematic search for the interlocutor's intention;
Premonitory dreams;
Unsettling coincidences in daily life;
Perception of events at a distance;
Discovery of new abilities;
Attraction for strange or unexplained things.

Victims of torture suffer also from a loss of confidence in public authorities, which derives directly from the abuse of trust and traumatization that have been inflicted upon them by the governmental authorities in their country of origin. 8

Basically, torture aims at breaking the will and the autonomy of the individual, through the forceful imposition of absolute subservience by brute physical or psychological force.

Torture is NOT a method of intelligence-gathering, it is fundamentally an act of imposition of authority, and not less than this.[9]

The shattering of trust and confidence can be presumed to extend also to the authorities of the country, where the refugees sought asylum. In most cases, public authorities are viewed by refugees or victims of torture rightfully or wrongfully as obstacles, rather than facilitators, in their search for a safe haven.

Practically, the recollection of cognitive information - whether visual, olfactory or other - inside or outside of the courtroom, related to public authorities, and especially police and military forces, is frequently connected with the uncontrollable resurgence of overwhelming emotions and symptoms, i.e; post-traumatic stress syndrome.

Victims of torture also suffer from the consequences of the two cognitive biases of self-complacency and causality; the first emanating from themselves and the second emanating from the members of their families. 10

According to the first bias, we try to explain our successes by our personal qualities and our failures by external causes. Thus, in case of success we put every other thing aside, keeping our own merits in view and avoiding the ponderation of the external agents that may help us being successful. And in adversity, we have a tendency to resort to explanations that involve the supernatural, or put the blame on others.

According to the second bias, we try to explain events by chains of rational causalities, even when they are effectively caused by chance or fate. Thus, we try to find logical bases for natural happenings which might not have a true rational ground, or which do not necessarily need a logical measure to be sifted upon.

Then, torture victims are profoundly hurt when they are accused by their own families of being the source of their own sufferings; especially where the reality is that they have simply been victims of fate - by being at the wrong place at the wrong time or the victims of the systemic cruelty of a political system.

Evidence gathering is the foundation of the legal process that culminates in the granting of a status such as refugee - or resources such as financial or material help - that will help the resettlement or the healing process. But such gathering cannott be dissociated from the recollection of very painful memories associated with the destabilization of the ego.

Thus, victims of torture are bad witnesses because they find it extremely difficult to accept, or to withstand, the overwhelming emotions and destabilization that are associated with the recollection of the memories which are the evidentiary foundation of their case, and thus of their own future.[11]

Gustave-Nicolas Fischer,[12] a French social psychologist specialized in victims of torture, emphasizes also the heightened risks of re-victimization, later in the lives of

torture victims, associated with prior traumatization. Such risks are increased if the procedural and evidentiary rules used in the courtroom are not tailored to minimize both, the trauma of recollection, and the mechanisms of blame-laying, associated with an adversarial procedure.

B - The Objectives

With regard to refugees and victims of torture, the rules of evidence and procedure must have two distinctive, although not mutually incompatible purposes: first, the optimization in quality and maximization in quantity, of the evidence gathered; second, the minimization of the pysical and psychological cost for the witness.

A useful effect of the attaining of such purposes is the attainment of therapeutic justice, which provides torture victims with a justification for the continuation of their lives, despite their wounds.

1. Optimization of the Quality and Quantity of the Evidence Gathered

The purpose of the court system is the resolution of differences by the gathering of elements of evidence that will provide the factual foundation of the legal syllogism:

A refugee is whomsoever can prove according to the balance of probabilities that he or she can reasonably fear to be persecuted for one of the motives set out in the 1951 convention on refugees; Mr. or Ms. X is bringing such evidence by his or her testimony, thus he or she is a refugee. 13

The judge or the lawyer is NOT a doctor. His or her mandate is NOT to cure the psychological ills of the party or the witness. Of course, to harvest any such expectation out of them would not be just.

However, the judge or the lawyer must work, taking all parameters including himself or herself - into consideration, so as to elicit the best possible evidence from the witness, while minimizing the psychological, physical and social prejudice that the latter will suffer in consequence of the stress inherent to the judicial process.

2. Therapeutic Justice

The two quotations from witnesses before the International Tribunals for Yugoslavia provide convincing corroboration for the evidence concerning the devastating effects for the mental and physical health of a witness, and the credibility of a judicial institution, of failed communication between the judge and the victim of torture.[3] Similarly, evidences of the healing effects of a well-understood and well-conducted testimonial experience have been recorded.15

In short, even if it does not erase the pain or the injuries, a properly-led judicial procedure allows the victim, first, to escape the status of an individual who has been impaired for

the whole of his life and, second, to seize back the status of a full, active, and an engaging citizen.

C - The Solutions

The gravity of the problem need be addressed in a very dexterous and a proficient manner. There is an easy, efficient and inexpensive way to tailor the hearing process to the specific needs of victims of torture: it is to adapt the legal processes, while adapting at the same time the minds of the participants:

1. Adapting the Rules of Procedure and Evidence

The cardinal principles concerning the organization of courtroom relationships must be the re-establishment of trust, and the elimination of stress.

In order to achieve these goals, procedures involving victims of post-traumatic disorder, must be non-adversarial.

Even in the case of the torturer, the procedure need not be confrontation but can be psychologically inducive, even though it is legally adversarial.16

The judge must induce maximum cooperation and transparency of all participants in the proceedings. Many methods that can serve that purpose :

a - The Proper Preparation of the Hearing

It is essential to come into the hearing thoroughly prepared. Such preparation must include both the file and the participants.

Prior to the hearing, it is essential to consult verbally or, preferably, in writing the representative and the doctor or psychologist in charge of the witness, in order to obtain their informed opinions as to the mental and physical condition of the witness, the potential mental or physical problems that may arise during the interview, the possible solutions to these problems, and the follow-up of the interview.

It will also be essential to ensure that all participants to the hearing, including the lawyers and interpreters, are properly trained and prepared to deal with the challenges of dealing with victims of traumatic stress. A refresher in the theoretical aspects of psychological trauma may be very useful then.
A complete and detailed evidentiary file must be prepared, containing all available evidence concerning the witness and parties, and the factual (legal, social, political, economic, historical, and cultural) context of the case.

However, in the case of victims of torture one can safely consider that there is NEVER enough information available. Since the factual basis of the claim may be such as to make it very hard to collect the required information about, or human factors may serve as a

hurdle in the acquisition of facts, utmost care must be adopted in the preparation of such a file.

b - The Setting of a Favorable Physical Environment

In order to obtain a maximal flow of trustworthy information of the best possible quality, a proper physical environment will help reducing the psychological and physical stress on the witness, and thus will be more conducive to the reduction of psychological obstacles.

The ordinary courtroom setting may be replaced by a round or an oval table in a normal room, so as to foster the feelings of intimacy and control by the witness-victim.

Sometimes, especially in the case of witnesses who are also perpetrators of war crimes or crimes against humanity, it may become necessary to place conspicuously some security personnel to act as a deterrent to possible aggression and to ensure peacefulness of the proceedings.

c - The Establishment of Clear Rules of Procedure

Two important sources of unnecessary stress for the victim of torture are the fear of the authorities, and the lack of control over his/her own destiny.

In order to counter these sources of stress, the judge can reinforce both the mutual trust between the participants, and the feeling of control by the witness, by explaining the fundamental human rights of the witness-party, as grounded in the Universal declaration of Rights and the Canadian Charter of Rights, as well as the respective roles of the participants, the lawyers and the judge.

The judge must also explain the non-adversarial, or adversarial nature of the proceeding17, the nature of the consequences of the proceedings and the possibility for the witness to suspend or stop the proceedings on demand.
Finally, all legal and health professionals involved must work as a team, in unison, and collaborate in the pursuit of the truth.

These simple measures will go a long way in the building of confidence by the participants, and thus will also go a long way in achieving a high-valued and objective judgment thereafter.

d - The Establishment of Clear Rules of Evidence

The judge must remind all participants of the legal rules regarding the admissibility of evidence and the burden of proof.

e - The Minimization of the Influence over the Witness of the Behavior of Judge, Lawyers and Parties

Recent findings in the field of cognitive sciences[18] have established the frailty of the recollection process. Since, in most legal proceedings involving refugees or victims of torture, the only reliable source of evidence in the case is the victim, it is essential, in order to elicit a fair judgment, to ensure that the information flowing from that witness is as complete, reliable and untainted as possible.

Therefore, the judge should give much attention to the use of a proper methodology of examination and a proper attitude of the examiners, in order to bring about the strictest possible control of verbal and gestural interactions.

With regards to the methodology of examination, there is simply no substitute to the use of the enhanced cognitive interview.[19]

According to such technique, leading questions must be avoided and the witness will be asked to recollect the incident as a whole, in its proper context. The recollection must be in a discontinuous chronological order; with as much cognitive details (sounds, smells, colors, etc.) as possible; and from different perspectives, such as that of a third party or that of the perpetrator.[20]

All participants must avoid any implicit, explicit, public or private judgment about the witness. Especially, the victim must not be blamed; nor should there be any attempt to "save" the victim, to tell her what to do, or to suggest him any sort of ready-made solution. And to avoid unnecessary stress, there should not be any undue delay in decision-making during the trial, or at the end of it.

On the other side, while dealing with the victim, it will be important for the judge to manifest understanding and compassion, and to allow the victim to manifest his or her emotions.

Finally, it is known that vocal and gestural feedback from participants to an interview influence the content of the interviewees recollections, and then in turn the interviewers' perception of the interviewee's credibility.[21]

Thus, in order to avoid influencing the mood of the witness and the content of the latter's recollections, care must be given to the control of the form of the verbal and gestural

interactions among the participants, and especially the tone, voice, and gestures of the victim, the interpreter and other participants.

f- The Purpose and the Rules of Examination-in-Chief

The examination-in-chief should aim at eliciting as much direct evidence as possible, from the personal recollections of the witness.

Thus the examination must bear on the facts known by the witness, without any implications as to the meaning of those facts, which implications are left exclusively to the expert-witness.

The best technique to elicit good verbal evidence is to open the testimony in a general manner and let the witness speak at his or her own pace. The attorney or the judge should avoid any interruption or comment, except in order to give new dynamism to a fledgeling testimony, or to bring a meandering witness back unto the path of relevance.

The judge or the attorney is not in the court room to hear his or her own version of the facts, but that of the witness! Although this may seem obvious, it is not. The most frequent error made by lawyers or judges alike is to interpret what they hear from the witness: “he must have meant this”, or “she certainly said that”!

g - The Purpose and the Rules of Cross-examination

Cross-examination aims at testing the scope and the exactness of the witness' recollections.

Contrary to the television's representation of courtroom interaction, the best cross-examination is one that reveals the weaknesses of a previous testimony with minimal opposition from that witness.

Especially with victims of torture, it is unnecessary to antagonize or to stress the witness. Thus, the cross-examiner should keep a careful control of one's voice, and avoid any form of personalization of the attacks.

The contradiction of the victim's testimony must be limited to the FACTS, including the physical and psychological abilities of the witness, and never extended to a moral or political judgment of the appropriateness of his or her actions. Thus, the weaknesses in the testimony will originate in the witness, and not in the aggressiveness, or bad faith, of the cross-examiner.

h-The Purpose and the Rules of Examination of a Potential War Criminal

In most cases, perpetrators of war crimes or acts of torture are traumatized by their own actions in the same manner as their victims. Thus the same methods of examination and cross-examination should be used with them as with victims.

With two exceptions, the commission of war crimes or acts of torture leaves profound marks on the psyche.

But the repetition of atrocities quickly reduces the level of the psychological trauma they provoke. And torturers who are convinced of the justness of their cause are very unlikely to develop any trauma after their aggressions.[22]

The most important clues of commission of grave crimes in the testimony of a witness will be psychological and factual inconsistencies.

Psychological inconsistencies are the result of various reasons such as the abandonment without reason of the members of the family; or the emphasis placed, during the examination, upon the lack of comfort in the hotels during the flight to the country of refuge. Factual inconsistencies may be revealed by such clues as the imprisonment of the subject after the liberation of his country; the use of particular categories of weapons; or the presence of the subject in places and at times where one should not have been.

The presence of such "red flags" in a testimony, imposes a careful search of the facts, in order to find potential contradictions, as well as a thorough cross-examination that will last as long as it is necessary in order to resolve any question concerning the facts, or the identity of the subject.

2. Opening the minds

The fundamental objective of the presiding judge and the participating lawyers must be to understand the victim. The cognitive bases of such understanding are:

Neutrality,
Serenity, and
Knowledge of the facts.

a - Neutrality

The neutrality of the hearing and its participants is essential to avoid the contamination of the memories and of the recollection process. Such neutrality is itself based upon a double mental attitude of openness, both physical and psychological; and complete availability to the flow of information coming from the witness.

Openness is a proper mental and physical posture. Thus the judge must be physically straight in his or her chair, relaxed and attentive. Feet and hands must be kept under control, since they can influence the testimony and, retroactively, the judge himself or herself!

Availability to absorb any and all details from a testimony, flows from both the permanency and the completeness of the listening posture.

In particular, the judge must not only listen to the witness, but also receive all information available on other communication channels, namely, visual (gestural clues, colours, etc.), olfactory, spatial (use of space around), and auditory (tone of voice, speed of speech, etc.) .

In order to maintain this openness, it is better to rely on one's memory and take cryptic notes that will be completed after the hearing, or even to rely upon mechanical means of

recording, such as sound or video recording. One must avoid to keep the head down while writing notes, which has the effect of interrupting the flow of information from the witness on all non-vocal channels.

Similarly, the judge must keep his or her mind free from prejudices about the witness and accept any information at its face value.

Most often, people tell the truth but we cannot see it because we superimpose our own prejudices over this information, and it is this fact that leads to a distortion of the original situation. It is thus essential to accept the testimony as it is, rather than what we think it should have been.

b - Serenity

It is impossible to hear someone else when one's attention is already monopolized by oneself!

Thus, real listening is possible only if one is at peace with the self. Such peace is possible only when one is ready to be totally attentive to the immediate testimony, and not overwhelmed by personal emotions or ideas.

Meditation and proper control of breathing can be extremely useful in order to ensure inner peace and stability before and after the proceedings.

And after the judgment, it is also essential to improve the understanding of oneself, through a systematic and honest process of self-appraisal and criticism, if possible after each hearing. Without such systematic and honest feedback, it is impossible to understand one's actions, nor to improve with experience.

c - Knowledge

A good judge does not write a judgment, but simply puts into writing what the witness-party has said during the examination or cross-examination. In other words, the party writes his or her own judgment.

But in order to understand what the witness has said, that is to distinguish what is relevant from what is not, the judge and the lawyer must extend his or her understanding of the case to the totality of the witness and the global context to which the witness has been exposed.

Thus, the necessity of a systematic research and understanding of the individual characteristics of that person, i.e; the medical, psychological, procedural and factual records. And a thorough exploration of all the social, economic, political and cultural circumstances in which the witness has lived.

A comprehension of basic principles of human communication and of Human Universals provides a useful basis to understand the scope, and the limits, of the knowledge that one can acquire about others.

We can never know the whole truth concerning any individual, including ourselves, but there is a very high probability that an act of communication is genuine and conveys a maximum of information, if after a thorough check upon the transparency of the conditions of communication,

The witness is in harmony with himself or herself;
The story is possible according to the laws of nature;
The story is coherent with previous stories from the same witness; and
The story is coherent with the cultural, economic, social and political context in which the witness has acted.

D - Conclusion

The examination or cross-examination of a victim or a perpetrator of torture or international crimes is a very challenging experience. But it is by no means impossible or repulsive, even though it can be unpleasant.

The foundations of a humane and efficient examination are the use of a proper methodology, thoroughness, and self-control.
The use of such tools will maximize the quality and the quantity of the information obtained, while minimizing the stress for all the parties involved.

But isn't that, precisely, the very foundation of JUSTICE?

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Dialogue: Redefining Torture

Farooq Mehdi & Wajid H.Pirzada

Through ages it has been known that the human knowledge multiplies through experience; and it is the human experience that does enable a person to have a broader and a mature view of the state of affairs.

RAHAT, based upon its years of working experience with torture victims, from a diverse set of communities, in terms of socioeconomic, sociopolitical and psychosocial context, has come to realize that the current definition of torture does not map the probable requirements both in scope and focus, thus making one realize that there is a strong need to probe into and even to redefine the established definition of torture.

Mehboob Mehdi, Founder Director of RAHAT, about ten years back, initiated an intellectual dialogue on the issue during his course of address in UN. Since then RAHAT has been engaged formally and informally, carrying this debate forward, so as to make it more pithy and encompassing.

RAHAT has reiterated the need to redefine torture and has instigated a focused dialogue on this issue. The whole effort originates from witnessing the plight of torture survivors and their families over years, and the extent to which torture has become ingrained in the fabric of societies.

The word "torture" as we know, originates from the Latin word "tortura", implying twist, torment, rack, or to intimidate, and the World Medical Association in its declaration of Tokyo, 1975, defines torture 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".

Declaration of Kuwait (1981), deals with ethics of medicine in the light of Islamic law. It states: "The physician shall not permit any of his special knowledge to be used to harm, destroy or inflict damage on the body, mind or spirit whatever the military or political issues."[2]

The Declaration of Kuwait does not take into consideration the plight of vulnerable in our communities, and the torture inflicted by military, non-military, or political affiliates, for the causes known to them. Similarly, absence of, or inadequacy of medical attention to prisoners and the use of drugs to paralyze human will, without inflicting any suffering also comes within the sphere of torture.

The United Nations Convention Against Torture and Punishment, adopted on 10th December 1984, defined torture as, "Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on the person for the purpose as obtaining from him, or a third person, information or confession, punishing him for an act he or the

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.

Article 2 of the Convention stipulates, "Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction. No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency may be invoked as a justification of torture."

Fifteen years ago, on June 26, 1987, the Convention Against Torture entered into force. Despite numerous commitments by all governments to ratify it, the Convention Against Torture remains the least ratified of the six international human rights treaties with only 129 states parties.

Torture is expressly prohibited by the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the Convention on the Rights of the Child, various international standards, and regional human rights treaties. Prohibition of torture is also part of international customary law.

The Convention Against Torture contains detailed steps that state parties must take in carrying out their obligation to prohibit and prevent torture. It also establishes the Committee against Torture, consisting of ten independent experts, to monitor state parties' compliance with their obligations under the Convention. The Committee carries out its mandate by reviewing state party periodic reports, deciding on individual complaints and carrying out confidential inquiries. To date only 50 states have made the declaration to Article 22 to provide for individual complaints. The constitution of the kingdom of Nepal, 1990, prohibits use of torture even during the state of emergency." This definition appears to have been lacking in some basic areas, because it does not deal with the pain or suffering arising from, inherent in incidental or lawful sanctions as a form or fragment of torture. This deficit in the protection of human rights is due to the conflicting concepts of international organizations on the one hand, and state sovereignty on the other.

"Pain and suffering arising from, inherent in or incidental to lawful sanctions, does necessarily remain a form of torture. Thus it becomes clear that torture is a purposeful and a deliberate act that is even exportable, being internationalized and institutionalized through the provision of experts, training, and equipment from certain governments to others.

Visualizing the fact that the above-mentioned definitions do not appear to be encompassing the whole sorry state of affairs, and the liberties enjoyed by torturers, one

can feel that the amount of work required to uphold the cause of human rights, and gigantic task of rehabilitation of torture survivors and their families, is even more necessary today than it had been in the past, since torture has become so deep-rooted in our societies."[3]

Definition offered by Wikipedia Encyclopedia "the infliction of severe physical or psychological pain as a means of cruelty, intimidation punishment or for the extraction of a confession or information," seems to be quite relevant to debate [5]. This source probes the very soul of torture and shows that it relies on both the psychological and the physical aspects, thus further enriching the debate. It states that psychological suffering refers to pain caused by psychological stress and by the emotional trauma, as distinct from that caused by the physiological injuries and syndromes. Thus two of these can be referred to as very distinct traits, though not differentiated very often.

A person's body or physical self is a unique temple, the integrity of which needs not be intruded. The torturer invades, defiles and desecrates this shrine. He does so publicly, deliberately, repeatedly and, often, sadistically and sexually, with undisguised pleasure. Hence the all-pervasive, long-lasting, and frequently irreversible effects and outcomes of torture are witnessed.

In a way, the torture victim's own body proves to the worst enemy by itself. Since it is the corporeal agony that compels the sufferer to mutate his identity to fragments, and his ideals and principles to crumble. The body becomes an accomplice of the tormentor, an uninterruptible channel of communication, and a treasonous, poisoned territory. It fosters a humiliating dependency of the abused on the perpetrator. Bodily needs denied - sleep, toilet, food, water - are wrongly perceived by the victim as the direct causes of his degradation and maltreatment. As it appears, the victim is rendered bestial not by the sadistic bullies around, but by ones own flesh.
The concept of "body" can easily be extended to "family", or "home". Torture is often applied to kin and kith, compatriots, or colleagues. This intends to disrupt the continuity of "surroundings, habits, appearance, or relations with others", as CIA quoted in one of its journals[2]. A sense of cohesive self-identity depends crucially on the familiar and the continuous. By attacking both one's biological self and the "social body", the victim's psyche is strained to the point of dissociation.

Beatrice Patsalides describes this transmogrification in "Ethics of the Unspeakable: Torture Survivors in Psychoanalytic Treatment": "As the gap between the 'I' and the 'me' deepens, dissociation and alienation increase. The subject that, under torture, was forced into the position of pure object has lost his or her sense of inferiority, intimacy, and privacy. Time is experienced now, in the present only, and perspective - that which allows for a sense of relativity - is foreclosed. Thoughts and dreams attack the mind and invade the body as if the protective skin that normally contains our thoughts, gives us space to breathe in between the thought and the thing being thought about, and separates between inside and outside, past and present, me and you, was lost."

Torture robs the victim of the most basic modes of relating to reality and, thus, is the equivalent of cognitive death? Space and time are warped by sleep deprivation. The self ("I") is shattered. The tortured have nothing familiar to hold on to: family, home, personal belongings, loved ones, language, name. Gradually, they lose their mental resilience and sense of freedom. They feel alien unable to communicate, relate, attach, or empathize with others.

Torture splinters early childhood grandiose narcissistic fantasies of uniqueness, omnipotence, invulnerability, and impenetrability. But it enhances the fantasy of merger with an idealized and omnipotent (though not benign) other the inflictor of agony. The twin processes of individuation and separation are reversed.

Torture is the ultimate act of perverted intimacy. The torturer invades the victim's body, pervades his psyche, and possesses his mind. Deprived of contact with others and starved for human interactions, the prey bonds with the predator. "Traumatic bonding", akin to the Stockholm syndrome, is about hope and the search for meaning in the brutal and indifferent and nightmarish universe of the torture cell.

The abuser however, becomes the black hole at the center of the victim's surrealistic galaxy, sucking in the sufferer's universal need for solace. The victim tries to "control" his tormentor by becoming one with him (introjecting him) and by appealing to the monster's presumably dormant humanity and empathy. This bonding is especially strong when the torturer and the tortured form a dyad and "collaborate" in the rituals and acts of torture (for instance, when the victim is coerced into selecting the torture implements and the types of torment to be inflicted, or to choose between two evils).

The psychologist, Shirley Spitz, offers this powerful overview of the contradictory nature of torture in a seminar "The Psychology of Torture" (1989), "Torture is an obscenity in that it joins what is most private with what is most public. Torture entails all the isolation and extreme solitude of privacy with none of the usual security embodied therein ... Torture entails at the same time all the self-exposure of the utterly public with none of its possibilities for camaraderie or shared experience. (The presence of an all-powerful other with whom to merge, without the security of the other's benign intentions). A further obscenity of torture is the inversion it makes of intimate human relationships. The interrogation is a form of social encounter in which the normal rules of communicating, of relating, of intimacy are manipulated. Dependency needs are elicited by the interrogator, but not so, they may be met as in close relationships, but to weaken and confuse. Independence that is offered in return for "betrayal" is a lie. Silence is intentionally misinterpreted either as confirmation of information or as guilt for 'complicity'.

Torture combines complete humiliating exposure with utter devastating isolation. The final products and outcome of torture are a scarred and often shattered victim, and an empty display of the fiction of power."

Obsessed by endless ruminations, demented by pain and a continuum of sleeplessness the victim regresses, shedding all but the most primitive defense mechanisms splitting, narcissism, dissociation, projective identification, introjections, and cognitive dissonance. The victim constructs an alternative world, often suffering from depersonalization and derealization, hallucinations, ideas of reference, delusions, and psychotic episodes. Sometimes, the victim comes to crave pain very much as self-mutilators do because it is a proof and a reminder of his individuated existence, otherwise blurred by the incessant torture. Pain shields the sufferer from disintegration and capitulation. It preserves the veracity of his unthinkable and unspeakable experiences.

This dual process of the victim's alienation and addiction to anguish complements the perpetrator's view of his quarry as "inhuman", or "subhuman". The torturer assumes the position of the sole authority, the exclusive fount of meaning and interpretation, the source of both evil and good. Torture is about reprogramming the victim to succumb to an alternative exegesis of the world, proffered by the abuser. It is an act of deep, indelible, traumatic indoctrination. The abused also swallows whole and assimilates the torturer's negative view of him and often, as a result, is rendered suicidal, self-destructive, or self-defeating; thus torture has no cutoff date. The sounds, the voices, the smells, the sensations reverberate long after the episode has ended both in nightmares and in waking moments.

The victim's ability to trust other people i.e., to assume that their motives are at least rational, if not necessarily benign, has been irrevocably undermined. Social institutions are perceived as precariously poised on the verge of an ominous, Kafkaesque mutation. Nothing is either safe, or credible anymore. Victims typically react by undulating between emotional numbing and increased arousal: insomnia, irritability, restlessness, and attention deficits.

Recollections of the traumatic events intrude in the form of dreams, night terrors, flashbacks, and distressing associations. The tortured develop compulsive rituals to fend off obsessive thoughts. Other psychological squeals reported, include cognitive impairment, reduced capacity to learn, memory disorders, sexual dysfunction, social withdrawal, inability to maintain long-term relationships, or even mere intimacy, phobias, ideas of reference and superstitions, delusions, hallucinations, psychotic micro episodes, and emotional flatness. Depression and anxiety are very common. These are forms and manifestations of self-directed aggression. The sufferer rages at his own victimhood and resulting multiple dysfunctions. He feels shamed by his new disabilities and responsible, or even guilty, somehow, for his predicament and the dire consequences borne by his nearest and dearest. His sense of self-worth and self-esteem are crippled. In nutshell, torture victims suffer from post-traumatic stress disorder (PTSD).

Their strong feelings of anxiety, guilt, and shame are also typical of victims of childhood abuse, domestic violence, and rape. They feel anxious because the perpetrator's behavior is seemingly arbitrary and unpredictable or mechanically and inhumanly regular. They feel guilty and disgraced because, to restore a semblance of order to their shattered world

and a modicum of dominion over their chaotic life, they need to transform themselves into the cause of their own degradation and the accomplices of their tormentors.

The CIA manual (1983), summed up the theory of coercion as: “The purpose of all coercive techniques is to induce psychological regression in the subject by bringing a superior outside force to bear on his will to resist. Regression is basically a loss of autonomy, a reversion to an earlier behavioral level. As the subject regresses, his learned personality traits fall away in reverse chronological order. He begins to lose the capacity to carry out the highest creative activities, to deal with complex situations, or to cope with stressful interpersonal relationships or repeated frustrations.”

Inevitably, in the aftermath of torture, it's victims feel helpless and powerless. This loss of control over one's life and body is manifested physically in impotence, attention deficits, and insomnia. This is often exacerbated by the disbelief, many torture victims encounter, especially if they are unable to produce scars, or other “objective” proof of their ordeal. Language cannot communicate such an intensely private experience as pain. Spitz makes the following observation: “Pain is also unsharable in that it is resistant to language ... All our interior states of consciousness emotional, perceptual, cognitive and somatic, can be described as having an object in the external world ... This affirms our capacity to move beyond the boundaries of our body into the external, sharable world. This is the space in which we interact and communicate with our environment. But when we explore the interior state of physical pain, we find that there is no object “out there,” no external, referential content. Pain is not of, or for, anything. Pain is. And it draws us away from the space of interaction, the sharable world, inwards. It draws us into the boundaries of our body.”

Bystanders resent the tortured because they make them feel guilty and ashamed for having done nothing to prevent the atrocity. The victims threaten their sense of security and their much-needed belief in predictability, justice, and the rule of law. The victims, on their part, do not believe that it is possible to effectively communicate to “outsiders” what they have been through. The torture chambers are “another galaxy”. This is how Auschwitz was described by the author K. Zetnik, in his testimony, in the Eichmann trial at Jerusalem, in 1961. Kenneth Pope in “Torture”, a chapter, he wrote for the “Encyclopedia of Women and Gender: Sex Similarities and Differences and the Impact of Society on Gender”, quotes Harvard psychiatrist, Judith Herman: “It is very tempting to take the side of the perpetrator. All the perpetrator asks is that the bystander do nothing. He appeals to the universal desire to see, hear, and speak no evil. The victim, on the contrary, asks the bystander to share the burden of pain. The victim demands action, engagement, and remembering.”

But, more often, continued attempts to repress fearful memories result in psychosomatic illnesses (conversion). The victim wishes to forget the torture, to avoid re-experiencing the often life-threatening abuse and to shield his human environment from the horrors. In conjunction with the victim's pervasive distrust, this is frequently interpreted as hyper vigilance, or even paranoia. It seems that the victims can't win.

Torture is forever. It is encouraging that debate on this issue has now been taken up at highest echelons in the edifice of UN, as UN Human Rights Chief, called for an expanded definition of torture, in New York on April 28, 2003.

While torture remains a controversial subject, active research and dialogue on as to whether or not certain acts constitutes torture, whether torture could ever be justified in any of its forms, and which socio-political settings used torture; and or breed and nurture torture and for what purposes could further enlighten and inform all stakeholders in redefining torture.

RMJ welcomes your contribution to this debate in the form of articles and comments.

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Corrigendum:

In the previous issue, the manuscript "Psychological Consequences of Political Imprisonment" was published; however, the name of the co-author was left out.

Complete authorship: "Julia Muller & Andreas Maercker."

Prevention of Injuries Matted out by Torture: BRCT Experiences

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Introduction

Torture is one of the most common of methods applied to inflict torture; same is true for Bangladesh. BRCT is a treatment-based Human Rights organization established in 1992, working both for the torture victims who suffer at the hands of the law enforcing agencies, and for the victims of organized violence as well.

BRCT statistics shows that in the year 2002, about 1276 persons, and in 2003, about 1306 persons were tortured by the law enforcing agencies, trend of which has been on an increase. In the year 2002 and 2003, BRCT was able to treat only 496 and 489 victims respectively. Victims are tortured in various systematic methods like blindfolding with black cloth, tying of both the hands behind the back, giving electric shock, pinching in sensitive parts of body with tongs, beating with rifle butts, sticks, bamboos, or pressing toes with boots. Torture method also includes sexual harassment, like stripping naked, keeping undressed, squeezing the testicles, or rape etc.

Psychological torture includes verbal abuse, forcing to watch others being tortured, threats to more torture and death, sleep deprivation, deprivations of meeting the family members, or refusal for providing judicial help.

Torture causes both physical and psychological injury. Four major types of physical injury are soft-tissue injury, bone-tissue injury, muscle injury, and nerve injury; these injuries are capable of developing physical symptomatology. Common physical symptoms are chronic, persistent or intermittent pattern of pain; various joint or muscloskeletal manifestations; chest complications like shortness of breath or chest pain with or without pulmonary infection; genito-urological complications like kidney complications, persistent urinary complications; sexual inability; gastrointestinal disorder like anorexia, changed bowel pattern, indigestion; neurological complications like pain, headache, insomnia, loss of sensation in any part, etc.
Sequels of torture depend on torture method and the site of the body. Victims do develop some psychological symptoms as well. Common psychological symptoms include flashbacks, nightmares, phobias, low mood, anxiety, loss of trust, feeling of guilt, insecurity feeling, feeling of shame and detachment from society, low self-esteem, loss of self-confidence, hopelessness, helplessness, reduction of activities, problem solving deficit, irritability and anger outbursts, attention and concentration difficulties, marital problem, sexual dysfunction, psychosomatic problem, drug dependency or excessive smoking, fatigue etc.

BRCT Definition of Rehabilitation of Victims of Torture and Organized Violence

Rehabilitation means fullest integration of the victims into his/her own community. The rehabilitation starts from (Integrated Rehabilitation Approach) IRA at BRCT Centre and extends to the community people who are to undertake further responsibility of taking care of the victim. It is thus unto the community to ensure dialogue and communication with the victim, so that the sufferer starts dialogue with the community in reciprocity, showing and feeling full integration into the community.

BRCT provides support for tortured victims through a unique multidisciplinary method named as Integrated Rehabilitation Approach (IRA). Integrated Rehabilitation Approach (IRA) includes bed and breakfast, medical treatment, physiotherapy, psychotherapy, social counseling, legal counseling, economic reintegration, home-visit program, referral service, etc.

BRCT works for the prevention of torture through Integrated Prevention Approach (IPA). IPA includes:

Task Force Against Torture.
Fact-finding & urgent appeal.
Awareness program on Human Rights Education (Door-to-Door Campaign Against Torture DDCAT).
Legal aid.
Campaign and lobbying.
Research & Documentation, Newsletters, etc.
Hotline & Networking.

Objectives

To evaluate the efficacy of Integrated Rehabilitation Approach (IRA) and Integrated Prevention Approach (IPA) of BRCT for the prevention of torture and injury.

To disseminate knowledge, skills and experiences of BRCT on IRA and IPA.

Method

This study has been conducted by BRCT. It is a qualitative research study, for which data has been collected through case studies.

Case Study-I

A 48-year-old Muslim male, married, lawyer clerk, who passed his HSC examination, attended BRCT on September 11, 2003, after being tortured by police.

Social History

Earlier the person was found to be quite active and social. He was the chairman of a local mosque, and was widely appreciated not only by the family members but also by the society, for the social activities he was actively engaged in.

Torture History

On March 11, 2003, the police and army tortured the victim on suspicion of being a terrorist. He was beaten with roller stick in his elbows and hips and was kicked by boot.

Physical Consequences

As a result of torture, some of the physical problems originated that include pain in the elbow joint, low back pain, headache, and sleep disturbance.

Psychological Consequences

Some of the psychological problems originated as a consequence of torture. The client developed some psychological discrepancies, including loss of interest, low mood, loss of confidence, anxiety due to physical problem, financial crisis, fear of police, nightmares, irritability, low self-esteem, suicidal ideation, crying spells, sleeping difficulties, feelings of hopelessness, feelings of shame, humiliation, withdrawal from social activities, reduced activities, etc.

A self-rating scale was administered, where the client was asked to rate some condition in a 0 through 10 point scale, where '0' means no problem and '10' means most severe form of the problem. The client rated his pain at 9, self-confidence at 0, views about self at 2, and mood at 1.

INTERVENTIONS

Medical Intervention

The doctor prescribed painkillers to the client.

Physiotherapeutic Intervention

Physiotherapy is one kind of treatment that does not necessarily require medication. It is only with the help of some equipment that the physical exercises and manipulations for therapeutic purposes are made possible. Physiotherapy is used for various problems like neurological, musculoskeletal, respiratory, pediatric problems etc.

Physiotherapy was provided to the victim, including thermo therapy, hydrotherapy, and other exercises, according to the nature of the problems.

Door-to-Door Campaign Against Torture (DDCAT)

DDCAT comprises of certain instructs that have been taken from the constitution of Bagladesh, the domestic laws of the country, UDHR, CAT, written in simple and an easy-to-understand diction. It does help in promoting awareness among people regarding their basic legal and human rights. General public does necessarily need to control the untoward event, taking place in the surroundings [2,3], and for this reason, the DDCAT helps raising the awareness; this method is thought to be helpful in furnishing a sense of control.

Enlisting him in the Victims Association

The association has been established as a human shield against torture and does sensitize the community about the rights of people. Lack of social support is thought to contribute to the expectations and hopelessness of the victim [6]; however, having enlisted with an association working for torture victims may help victims in getting social support.

Psychotherapeutic Intervention

Psychological intervention is a procedure that helps a person getting rid of emotional distress, behavioral maladjustment, cognitive dysfunction, and inner conflicts, in a way so that one may learn more effective ways of perceiving, evaluating and behaving, and is able to make adjustment with other people in the society, can face the challenges of life, is in a position of coping up more effectively with psychological distress. The person learns how to minimize or eliminate environmental conditions that may be the causative agents of the problem.

In the above case, the therapist empathetically listened to the victim, provided one with emotional support, helped to ventilate the inner feelings, provided psychological edification. The victim was assured of organizational support at the same time. Therapy focused on to reduce his fear and feeling of helplessness, in turn giving boost to his confidence and mental strength thus making him more strong, able to avert any mis-happening in future. Therapist worked on empowering the client, building hope and reducing his stress and normalizing his problem by helping him see that there are many who are suffering, thus making him realize that he is not the only victim. Therapy thus went a long way reducing feeling of shame and an increase in the social activity was witnessed; thus it can be concluded that therapy focused on increasing the occupational activities. Therapist identified and challenged negative thoughts and helped him adopting realistic, positive, and adoptive thoughts.

A Self-rating scale was administered, and the client was asked to rate at a 0 to 10 point scale. He rated his pain at 3, self-confidence at 7, views about self at 8, and mood at 8.

Results

Towards the end of the treatment the victim felt much better. He became quite hopeful and felt supported. He was in a position to understand what he would in future. He decided that either he would make a phone call or would send someone to this

organization if he ever happens to fall in this type of danger again. The client decided that he would not commit suicide and would be going for alternative ways to lead a proper and a successful life. He was found to be assertive and was in a position where he could not only challenge police for their misdeeds, but could as well sensitize people against any kind of police aggression. Furthermore, the client was able to seek explanation from an SI for illegally arresting the local innocent people, and was well in a position to tell him that he would complain the higher authorities about his misbehavior, which made the SI apologize and ultimately release the illegal detainees. The client started joining the preventive activities of BRCT.

Case study-II

Ms. Y, an 18-year-old Hindu, unmarried, female college student; who came to BRCT on May 14, 2003.

Family & Social History

She is the only daughter of her parents, having one brother. The girl belongs to an economically solvent family. She is a meritorious student, who earlier had a pretty happy and a socially active life.

Torture History

A gang of terrorists kidnapped college-going "Y" while she was on her way to tutor's center at Bagerhat district on April 21, 2003. The terrorists of BNP party had ravished the victim for 8 days. The whole body of the ill-fated girl was cut with sharp weapons and burned with cigarettes. After 8 days she was rescued from the court premises of Khulna. It was found that the poor girl has been raped as well.

Psychological Consequences of Torture

Her psychological problems include feeling of insecurity, inferiority feeling, feelings of shame and worthless, hopelessness, loss of interest, reduction of daily activities, suicidal thoughts, getting isolated from others, feeling sad, crying spells, withdrawing all activities including recreational activities and hobbies, feeling irritable, getting anxious about imminent H.S.C examination, difficulties in concentrating while studying, and the like.

Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI), developed by Aaron T. Beck (1979), were administered to the victim. Her score was 43 and 36 respectively, which indicates severe depression and anxiety.

Physical Consequences of Torture

The victim developed the following physical problems like headache, generalized weakness, loss of appetite, incidental injury by knife over scapular regions. She was also found to have peptic ulcer disease.

INTERVENTION

Fact-finding Mission

The Fact-finding team received information from a local network member. The fact-finding team had reached the place of happening within 48 hours of the breaking of news. BRCT conducted a four-party fact-finding mission on the incident.

1st party: the victim and the family
2nd party: the perpetrator
3rd party: the witness of the incident
4th party: the local administration/authority

The team discussed the security of "Y" with the Deputy Commissioner (DC) and the Superintendent of Police (SP) of the district.

The team met the local media men to brief then about the mission's findings, and prioritized plan for the victim, which got published in the national and regional dailies.

The team also had a meeting with the local lawyers so as to discuss about the issue and requested them to stand beside the victim for justice from the court and to bring the criminals to justice.

Follow-up Through Home-Visit Program

The fact-finding team visited the home of the victim on May 26, 2003. The team exchanged views with the local administrators, police officials, public representatives, lawyers, journalists, social workers, and human rights activists about the prevailing situation. At the same time it did compel the local community to stand beside the victim.

The DC arranged a separate room for the victim during her examination. The SP deployed special police team for her security.

Legal Aid

A case was filed against the perpetrator on April 22, 2003, at Chitalmari Police Station, Bagerhat (Chitalmari Thana Case No: 14/39 under Section 7/30 Women & Children Repression Act 2000).

Medical Intervention

A doctor was detailed to treat her with infusion, antibiotics, painkillers, anti-ulcer medication and vitamins.

Psychotherapeutic Intervention

The psychotherapist built a sort of rapport with the victim. The therapist then empathetically listened to the victim and provided her with emotional support, helped to ventilate her feelings, provided psychological edification; and was assured all sorts of organizational support. The therapy focused on the reduction of her fear and helpless feelings, and bringing her to a normal and a stable state by making her realize that she is not the only victim. The therapist bolstered her hope and helped her to reduce the feelings of shame; thus it was a constant effort to empower the client. The therapist identified and challenged negative thoughts and helped her to adopt positive, realistic, and adoptive thoughts. The victim was also motivated to increase her recreational, social, and daily activities. Therapy however, focused on the past performances, achievements, and an increase in the self-esteem. The fact however remains that the self-esteem is thought to serve a stress-buffering function.[4]

Results

In the month of October, the culprit was caught and sent to the jail custody. "Y" secured 2nd grade in her H.S.C examination, held on October 13, 2003. Her BDI score (18) and BAI score (15) indicates reduction of depression and anxiety. The client did not have suicidal thoughts and started her daily activities in a normal fashion. She was willing to be a human rights activist and to work for the prevention of torture.

Discussion

BRCT helps prevent people from being exposed to torture and injury by the application of various methods. It does empower people so that they are in a position to cope up both physically and psychologically with the existing problems in the society. The treatment motivates people to settle and work effectively in the social settings. BRCT does sensitize people about their legal rights, and their obligations towards the society and the public. Therapeutic interventions do change and shape up the emotions and feelings in a realistic manner.

Integrated Rehabilitation Approach (IRA) and Integrated Prevention Approach (IPA) of BRCT are helpful for those having experienced torture and stress. It is the stress that amounts to the destruction of the self-esteem and self-concept; which in turn leads to suicidal thoughts, feelings of worthlessness, hopelessness, and the like. In these circumstances the therapeutic treatments of BRCT help them overcome these feelings. The thing to be worked out is that how these methods (IRA, IPA) can be integrated in the government hospitals and the Medical Colleges, and can help in the establishment of a crisis center for the victims. Similarly, there must be an inclusion of awareness about torture, laws, declarations, and instruments dealing with the prohibition of torture. There is a dire need of defining a role of the professionals to rectify the reservations on Article 14 of the Convention Against Torture (CAT).

Conclusion

Prevention is possible through rehabilitation; but there is an intense need of a declaration so as to shield the personal liberty, security and identity of the vulnerable from being exposed to torture. By enforcing such laws it would be possible to attain a society that in real sense is torture-free. Such efforts may appear to be miniature in bulk, but they can tantamount to larger and effective proportions, with very small strides.

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Relationship Between Psychological Adjustment and Domestic Violence Among Housewives

Fizza Sabir & Sereena Nizam

ABSTRACT

Though both women and men can be victims of domestic violence, the present research has focused on this specific direction of violence i.e; violence committed by men towards women particularly spotlighting husband-wife relation. This study has been conducted to explore the relationship between domestic violence and psychological adjustment among housewives. For this purpose two instruments have been used. Psychological adjustment of the participants has been assessed with the help of Psychological Adjustment Scale developed by Sabir (1999). Domestic violence has been has been measured with the help of another instrument developed by Hussein in 1998. The Pearson correlation between the two variables has been found as -0.52 that shows that women who have to face domestic violence are having low level of psychological adjustment but this research does not show any cause-effect relationship between the two variables. Housewives living in joint family system have high score on domestic violence as compared to those living in nuclear family system. Women living in nuclear families have relatively high score on psychological adjustment as compared to those who are living in joint family system. Housewives with lower educational level scored less on psychological adjustment and more on domestic violence while women who were more educated scored more on psychological adjustment and less on domestic violence.

Woman in South Asia is viewed dependent on her male counterpart for her protection and survival. She exists as reflection of the male either as his mother, sister, daughter or wife. She doesn't have an identity of her own. Man therefore, exploits her various roles and one form of this exploitation is the domestic violence. It is not “natural” or born of biological determinism. The system of male dominance is historically located and its functions and manifestations change over time. Domestic violence is as old as the urge to control. It thrives where that urge intersects an imbalance of power. It becomes a way of life when society accepts it and tacitly tolerates it as a private family matter. Domestic violence is a health, legal, economic, educational, developmental and above all, human rights issue.

Violence may be defined as “an overt expression of physical force” or “Any exercise of force in an attempt to inflict an injury or damage to another person”[8]. One of the specified types of violence is domestic violence. It is defined as “the chronic, physical, sexual and psychological maltreatment of one family member by another with the intent to control. This misuse of power harms the psychological, social, economic, sexual and physical well being of the victim”[1].

Domestic Violence is global issue. According to a study [4], 93% of the women reported experiencing verbal, emotional, and physical abuse. Of these, 76.6% felt that verbal and emotional abuse was either just as different or more difficult to deal with than physical

violence. Over 70% reported that the first incident of violence occurs in the first two years of their relationship.

In Pakistan, domestic violence is a problem of mammoth proportions, and one that has been ignored by society at large, by the government institutions and to an extent, by women's groups. There have been no comprehensive studies of domestic violence as such. The main method of gauging domestic violence in the country is by interviewing women in shelters, collecting data from newspaper reports and from interviewing the police and doctors who come in contact with the victims in extreme cases. From conversation with women at social gatherings, in shelters, in prisons, in government, in the profession of law and women organized into professional and social welfare groups, it seems that the abuse of women in the home, and wife beating in particular, is quite commonplace.

The reluctance of society to recognize the prevalence of violence in marriage and to interfere with the privacy of the family is best illustrated by the inability to obtain data on incidents of marital violence. Obvious sources like police, attendants in hospital emergency rooms, the district attorney, private physicians; the courts, social workers, family service counselors and other mental health professionals do not keep such records.

It must be kept in mind that everywhere, in both rural as well as urban settings, Pakistan remains rigidly patriarchal society in which women are treated as chattel, 'given' or 'acquired' through arranged marriages, to spend their lives in the service of a male dominated system. We live in a society where men are incharge of majority of institutions. Economically women are discriminated in the job market. Until recently women did not have the right to decide whether they would continue a pregnancy or terminate it.

In Pakistan, woman battering is one of the most frequent violations of the human rights of women. 80% of violence is of a domestic nature at different degrees, irrespective of class, education, religion or whether it is in rural or urban areas. As many as 12000 to 18000 cases of woman battering occur annually in Pakistan.

Domestic violence can be of many types that is physical, sexual, emotional/verbal, economic, and social and spiritual. It is important that many examples can be put into more than one category, like emotional abuse plays on the women's feelings while psychological alters their reality and sexual often does both.

Victims of domestic violence usually avoid complaining against their husbands and other family members and develop the feelings of helplessness. A woman is considered as safe and honorable if she spends her life in the secure boundaries of home according to her husband's wishes. She must tolerate for the sake of her family's honor. Such compromises may affect her physical health but also damage her emotional well being which is very alarming not only for the sufferer but also for the coming generations. Feelings of utter

frustration, worthlessness, and alienation may affect her inner strengths and slow down the recovery process.

Violence against women in the family and society is pervasive across lines of income, class and culture. The case analysis of 365 women who came to Bedari for crisis intervention between August 1992 and December 1995 showed that more than half of the women were victims of domestic violence.

This study has been conducted in Mardan, a comparatively backward and conservative city of Pakistan. It has particular culture and values. People, here, are not that much educated as in some other more developed big cities. It has particular culture, values, educational level and various other factors. Here the literacy rate is very low. The rate of women employment is lower as compared to more modern cities of Pakistan. Women are usually restricted to few professions as teaching, nursing, etc. They are generally discouraged by their families and society as a whole to do a job outside her home. They are considered as homemakers only. Findings of this study will give us an idea about prevalence of domestic violence among housewives of Mardan and their emotional health.

Abusive relationships have a powerful psychological impact on the victims. Victims of an abusive relationship may experience some of the following emotions and behaviors: agitation, anxiety and chronic apprehension, constant state of alertness that makes it difficult for them to relax or sleep, a sense of hopelessness, or despair because the victims believe they will never escape the control of their abuser, fear that one cannot protect oneself or one's children. Such persons will turn down the assistance offered by relatives, friends or professionals, Feeling paralyzed by fear to make decisions or protect oneself, A belief that one deserves the abuse, A belief that one is responsible for the abuse, Flashbacks, recurrent thoughts and memories of the violence and nightmares of the violence, Emotional reactions to reminders of domestic violence.

Victims of domestic violence can also have physical symptoms that aren't directly caused by physical abuse. The constant stress and tension of living in an abusive relationship instead cause these symptoms: Headaches, Asthma, Gastrointestinal symptoms, chronic pain, Restless sleep or inability to sleep, Genital soreness, Pelvic pain and Back pain. All victims of domestic violence can be physically and emotionally injured. However, because of general strength differences between men and women, women are six to seven times more likely to receive serious physical injuries than are men.

Because women are so often the victims, more is known about their psychological injuries. Psychologist Lenore Walker studied female victims and described a "battered woman syndrome." She found those women who repeatedly experience physical, sexual and/or serious emotional abuse tend to be affected in common ways, and begins to show similar behavior. These battered women:

Minimize and deny the abuse.
Block the abuse incidents from their memory.

Have anxiety, fearfulness or panic because of constant stress.
Numb them to avoid dealing with the situation.
Have recurrent flashbacks of battering episodes.
Have specific fears and are continually watching out for signs of further harm.

The literature documents the negative mental health effects of domestic violence. These include:

Suicide - international figures suggest that 1/4 of suicides of women in America, 1/2 of all suicides by African American women and 41% among Fiji Indian women are related to domestic violence [2].

Alcohol abuse up to one third of abused women will abuse drugs or alcohol as a way of coping with abuse [4]. A number of studies have suggested that most abused women only begin drinking heavily after the abuse has started.

Mental illness diagnoses may include major depression, trauma and anxiety disorders etc. Women living in abusive relationship may also have problems such as eating disorders, generalized anxiety, obsessive-compulsive disorder, multiple personality and personality disorders. Other presenting issues, from the literature, associated with victimization may be: sleeping disorders, self-neglect, malnutrition, panic attacks, aggression towards one-self and/or others, dissociative states, repeated self injury, chronic pain, compulsive sexual behaviors, sexual dysfunction or pain and poor adherence to medical recommendations. Many battered women suffer from post-traumatic stress disorder (PTSD). The likelihood of a PTSD diagnosis and severe PTSD symptoms is correlated with more severe domestic violence experiences.

The present study aimed at including the women from normal population, and the aim was to correlate the domestic violence and the level of psychological adjustment. This term 'psychological adjustment' has been variously defined.

Studies conducted in 1967, revealed satisfactory or ideal adjustment does not correspond to any unique state of the individual and his environment. Neither does it constitute a single process or even identifiable set of processes or relationships between the individual and his surroundings along a single dimension. Adjustment is multidimensional and can be described only in terms of a number of interacting variables [8].

Although many long lists of personality traits and adjustment variables have been developed but in the year 1967 [8], have discussed adjustment in terms of six dimensions: (1). Selective awareness (2). Tolerance, (3). Autonomy, (4). Personal integration, (5). Behavior and impulse control, and (6). Self-realization. The same way, Haber & Runyon have talked about five dimensions including: accurate perception of reality, ability to cope with stress and anxiety, a positive self-image, ability to express the full range of emotions, good interpersonal relationships [3].

METHOD

Hypotheses

There would be a negative correlation between domestic violence and psychological adjustment.
Housewives who live in joint family system will have high scores on the domestic violence questionnaire and low scores on psychological adjustment scale as compared to housewives who live in nuclear families.
Housewives who are highly educated will have high scores on psychological adjustment scale and lower scores on domestic violence questionnaire.

Definition of Variables

The variables of this study have been defined as follows;

Domestic Violence

"Any form of systematic violence (sexual, physical, emotional, and economic) against a wife by her husband. The violence may be systematic in the sense that it happens to a particular woman time after time."

Psychological Adjustment

Those factors have been included in the definition of psychological adjustment, which have been described by Haber and Runyon [3].

a Accurate Perception of Reality

An accurate perception of reality is a prerequisite to good adjustment, for example, if the majority of an individual's acquaintances see him as warm, accepting, and outgoing. It will be assumed that this is a valid description of that individual. By seeing things as they are, one's adjustments are more likely to be appropriate to the realities of the situation. The well-adjusted individual always sets realistic goals that he or she actively pursues and has ability to recognize the consequences of his or her actions and to guide his or her behavior accordingly.

b Ability to Cope with Stress and Anxiety

Successfully coping includes one acknowledging that pursuits of long term goals gives direction to life and makes one better able to withstand the inevitable reversals, frustrations, and stresses that occur along the way.

c A Positive Self-image

When various perceptions of self are harmonious, the probability is higher that the individual's adjustment is satisfactory. Effective adjustment also requires that one have a positive self-image. Moreover, one should be aware of and acknowledge one's

weaknesses as well as strengths but should not dwell on those aspects of oneself that one finds undesirable. Rather, one should attempt to modify them to the extent that they are changeable.

d Ability to Express the Full Range of Emotions

Problems of emotional expression include over-control and under-control. Over-control leads to a blunted affect; under-control to excessive emotional expression. Either may signal potential adjustment problems. Healthy adjustment requires that a balance be struck between over and under-control. Emotionally healthy people are able to feel and express the full spectrum of emotions and feelings. However, their displays of emotions are both realistic and generally under their own control.

e Good Interpersonal Relationships

Humans are preeminently social beings. From the moment of conception on, we are dependent on others to fill our needs physical, social, and emotional. Well-adjusted people are able to achieve appropriate degrees of intimacy in the social relationships. They are both competent and comfortable with others. They enjoy being liked and respected by them. In turn, they enjoy and respect other people. They derive pleasure from making others comfortable in their presence.

Sample

The sample consisted of 70 married women belonging to different locations of Mardan. All the subjects were from general population. Their ages varied from 18 to 52 years of age and educational level was matric and above. They were married for at least two years and living with their husbands. They were living in single/nuclear family system or joint family system. They were selected on random basis.

INSTRUMENTS

Domestic Violence Scale

This scale has bee developed by Hussein in 1998, to measure domestic violence. The original scale contained 35 statements all in one direction i.e., negative covering the five forms of violence and were provided with four response options which are “never”, “seldom”, “usually” and “always”. The scoring ranged from 1-4, i.e., 1 for never and 4 for always. It contained 8 statements for the physical violence, 7 for social violence, 7 for emotional, 7 for economic violence and 6 for sexual violence along with general demographic information at the end of the scale and an open ended question which asked them the perceived reasons for domestic violence and its frequency in society.

In the modified form there are 35 statements all in one direction. It contains 3 statements for social abuse, 14 statements for psychological /emotional abuse, 7 statements for economic abuse, 4 statements for sexual abuse and 7 statements for physical abuse with

response category as “yes” and “no”. Reliability of this scale is found to be 0.70. The face validity and construct validity is high making it a valid questionnaire assessing the presence of domestic violence.

Psychological Adjustment Scale

The psychological adjustment of women has been measured with Psychological Adjustment Scale developed by Sabir in 1999. The reliability was found to be 0.83. Item total correlation coefficient values calculated separately for the five scales of PAS show that the content validity of all the subscales is high. The construct validity is also high. The scale is based on five-point scale, i.e., “agree”, “strongly agree”, “neither agree nor disagree”, “disagree” and “strongly disagree.” It contained both positively phrased items and negatively phrased items. The scale was scored as 5 for strongly agree, 4 for agree, 3 for neither agree nor disagree, 2 for disagree and 1 for strongly disagree for positively stated items and in reverse direction for negative items. Cut off point is 80 while highest score on this scale is 135. Items related to “accurate perception of reality” are four in number, six items for “ability to cope with stress and anxiety”, 7 items for “positive self image”, 6 items for “ability to express the full range of emotions” while 4 items for “good interpersonal relationships.”

Procedure

The data was collected individually after establishing the rapport with the sample selected. They were told that their information would be kept confidential and would be used for research purposes only. They were given the information about the purpose of this research that is to see the relationship between psychological adjustment and domestic violence. The data was analyzed according to different variables. The statistics was applied to see whether there is any relationship between domestic violence and psychological adjustment of women. The data was also analyzed to see differences with respect to family system and education on both the scales.

Discussion and Conclusion

The Pearson correlation calculated to check the relationship between the two variables, i.e., domestic violence and psychological adjustment is found to be 0.52, which shows that there is a negative relationship between these two variables. If women's husbands abuse them, they tend to have poor psychological adjustment and emotional well being. They are unable to manage their lives due to their inability to face stressful situations and failures but it's difficult to claim that domestic violence is the sole reason of this. Thus, we cannot say that the variable of domestic violence and psychological adjustment are dependent on each other or one cannot occur without the other variable. We cannot say exactly whether domestic violence always leads to poor psychological adjustment or whether poor psychological adjustment is always the result of domestic violence.

Walker (1979), a feminist psychologist explained the situation of abuse with the help of learned helplessness, which was presented by Martin Seligman. According

to this theory, once these women start believing that they cannot control what happens to them, it becomes difficult for them to believe that they can ever help the situation, even if they later experience a favorable outcome. This can be observed in these women who do not attempt to free themselves from a battering relationship. Actually these housewives have control over response-outcome but they believe that they do not, they tend to respond with learned helplessness phenomenon [10].
Repeated violence diminishes the housewives' motivation to respond to this inhuman act that may lower their self-respect.

Disruption of social relationships can occur as a result of isolation from family and friends. Some abusers make deliberate efforts to cut off their partner's contact with family and friends, intercept their mail, listen to or limit phone conversations, and forbid private visiting with others. Embarrassment or efforts to keep the violence private may also lead victims to withdraw from their family and friends.

Table 1 shows score on domestic violence and psychological adjustment scale with respect to the family system. 29 housewives living in nuclear family have mean scores equal to 7.21 and standard deviation equal to 7.25. Whereas 41 housewives living in joint family have mean score equal to 9.59 and standard deviation equal to 6.50. More housewives living in joint family have high scores on domestic violence questionnaire that means that housewives in joint families are more targeted by their husbands as compared to housewives living in single families. Because husbands in joint families share greater responsibilities as compared to husbands living in nuclear families.

The joint family system is more prevalent in Mardan, which shows their adherence to their cultural norms. People living in single families are more of those who have come from villages for the purpose of earning. So husbands in joint family systems are more affected by suggestive people around them. They are actually reinforced for their actions as compared to nuclear family system.

The housewives living in nuclear families have mean score on this scale equal to 93.66 and standard deviation 16.06 whereas the mean score of housewives living in joint families is 87.24 and standard deviation equal to 15.19. The difference is due to the fact that living in joint families has increased their burden and responsibilities. They have negative self-image. They give greater weightage to their failures and less to their favorable outcomes. And because of their negative self-image they are unable to meet the stresses of life. They are unable to express their emotions freely in the presence of their elders, which is restricted due to the societal norms.

There is significant difference on the psychological adjustment score according to their educational level. The housewives who are matriculated scored lower on this scale as compared to the housewives who have master degree. They have better understanding of situation when they face it. They are able to achieve appropriate degree of intimacy in their relationships with their family members due to awareness and exposure. They are better able to deal with the stresses and their reality-based goals give direction to them in their life.

	Family system	*N*	*Mean*	*SD*	*T-value*	*P*
Domestic violence	*Nuclear families*	29	7.21	7.25	-1.437	0.155
	Joint families	41	9.59	6.50		
Psychological adjustment	*Nuclear families*	29	93.66	16.06	1.699	0.094
	Joint families	41	87.24	15.19		

Table 1: *Mean scores on domestic violence and psychological adjustment scale with respect to family systems*

	Educational level	N	Mean	SD
Psychological adjustment scale	Matric	15	89.33	16.02
	F.A/F.Sc	22	84.14	14.63
	B.A/B.Sc	20	90.45	17.32
	M.A/M.Sc	13	99.46	10.92
	Total	70	89.90	15.76

Table 2: *Mean scores on psychological adjustment scale with respect to educational level*

The difference with respect to education is significant on domestic violence questionnaire as shown in Table 3. Women, who are more educated, have low score on this scale and this score gets higher as the education level of women decreases.

	Educational level	N	Mean	SD
Domestic violence questionnaire	Matric	15	10.13	6.61
	F.A/F.Sc	22	9.14	7.44
	B.A/B.Sc	20	9.60	7.29
	M.A/M.Sc	13	4.38	3.91
	Total	70	8.60	6.87

Table3*: Mean scores on domestic violence with respect to educational level*

The present research though has been conducted with a small sample size and that too on a limited canvas, covering only a particular region in Pakistan, but the findings are interesting, since the relationship between psychological adjustment and domestic violence has been found out to be negative. The study may be extended to a more abstract level, where one comes across generalized concepts and ultimately revelations, adding further to the expertise of the professionals concerned.

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Learning About Falanga-
A Physiotherapy Approach

Zakeya Zaman

Abstract

In Bangaldesh Rehabilitation Center for Trauma victims (BRCT) 7% among the torture survivors comes with the late complaints of falanga. The purpose of the study was to evaluate the efficacy of the physiotherapy intervention in the later stage of falanga torture. The study was carried out at the physiotherapy unit of BRCT. Two cases have been portrayed to illustrate the significant improvement in the functioning and quality of life through appropriate screening, assessment, and suitable physiotherapeutic intervention by ultrasound, soft tissue manipulation, mobilization, balance, and grounding exercise, gait training, wit regular monitoring by Disability Rating Index and also by Pain Scale. Timely rehabilitation program has made the victims restore an optimum functional life within 34 months' time. Nonetheless, access to an appropriate rehabilitation approach of physiotherapy can make the falanga victim able to lead a better life, while untreated falanga can lead to greater complications.

Falanga or Falaga is a method that is employed for torturous physical punishments where victim is beaten on the soles of the feet, using roller sticks, chains, cables, bamboo sticks iron bars, wooden bars, or hot water. Falanga is still being employed as a tool meant to torture innocent, partly because the effects are difficult to identify medically.1

Falanga has been known to have its origins in Turkey but at the same time is told to have been originated in the Far East. Persians (now Iran) favored bastinado, where the victim was gently and rhythmically beaten with a lightweight stick or bamboo on the soles of the feet. Continued bastinado resulted in uncontrollable hysteria and eventually lead to mental collapse. However, in the middle ages, falanga had been used as a punishment, often used on traders who were dishonest.

During falanga, the victim is usually tied with elevated feet, and there is a shower of blows either on the bare sole of the foot or through the victim's boot or shoes. The victim may be forced to lie down on the floor or a table. The victim may also be forced to walk around on his painful feet, immediately after being beaten. In certain cases the victims are aerially suspended and then beaten. Similarly, one might be forced to walk on splintered glass. The brutality may be seen in cases where salt may be put in to fresh wound.2

Report on UK Immigration & Nationality Directorate Fact-finding Mission to Turkey, expresses the reported methods of inflicting "torture and other forms of cruel, inhuman and degrading treatments" used on the applicants to the HRFT Treatment and Rehabilitation Centre in 1999. In their report the percentage of falanga among their clients was 7.5%.

Report on the 1980s disturbances in Matabalands and Midlands, compiled by the Catholic Commission for Justice and Peace in Zimbabwe, March 1997, reports the alarmingly high rate of falanga torture in Zimbabwe, which was almost 29 %.

At BRCT, during the period of January April 2003, about 5% of the total torture survivors complained of falanga torture, and 7% of the reported cases from May to December 2003 were victims of bastinado.

Symptoms

Following falanga torture the immediate effects are pains with bleeding. There is oedema in the tissue and compartments of the sole of the feet, which spreads gradually up to knee. The victim has to adopt altered or compensatory gait pattern due to instability and problematic gait. Symptomatology of an aggravating paresthesia -- tingling or pricking sensation on the feet has been noted in the victims of falanga. Altered autonomic reactions like increased sweating occurs due to Reflex Sympathetic Dystrophy (RSD)3. The symptoms that developed over time are chronic pain in the feet and calves, which sometimes intensifies with muscle activity and weight bearing, and difficulty in walking. Sometimes painful scars are also seen on the cutis and sub-cutis of the feet. There may be pain in the ankle, knee and lower limbs with a feeling of tiredness or heaviness in the thigh/legs. Cramping pain at the thighs or lumbar pain has also been observed.

Examination

The victims of falanga are found to have smashed or punctured feet due to rupture of the adipose fat cells under the heel and forefeet. Oedema leads to the detachment of the cutis and sub-cutis, resulting in loosening of the skin under the soles of the feet, which can well be examined during palpation. There is a hyper-mobility of the MTP joints noted as well. Aponeuritis is caused where the whole sole of the foot has become painful. Sometimes flat foot appears with the flattening of the medial arch and the displacement of the navicular bone medially and downwards. There may be painful trigger points present over the anterior tibialis, ilio-tibial region, biceps femoris and tensor fascia latae; hard and rough scars may also present. Impaired nail growth and changes in the distribution of hair may be found. Fractures of the bones of feet are rarely seen.

Physiotherapy Intervention

Physiotherapy focuses on:

- Relieving pain
- Improve function

Methods

- Soft-tissue manipulation: Effleurage, Kneading
- Tissue stretching in different directions: for plantar fascia
- Ultrasound Therapy (UST): to reduce pain and to stimulate circulation
- Joint mobilization: ankle, subpatellar, talocalcaneaonavicular
- Strengthening of the weak muscles: AHL, QP, FHL, TP, PL
- Stretching of muscles: TA, gastronomies, hamstring, TFL
- Stabilization

- Training of balance and proprioception: Balancing exercises in different directions
- Special aids: Special shoes, elastic bandages etc.
- Re-education of normal gait pattern
- Home advice and regular follow-up

Potential Complications

The most severe complication of falanga is closed compartment syndrome,4 which can cause muscle necrosis, vascular obstruction and gangrene of the distal portion of the foot or that of the toes. Permanent deformities of the feet are uncommon but do occur as well, as do fractures of the carpals, metacarpals and phalanges are noted.

Case Report-1

History

The victim was a 19-year-old male student. He was arrested by police from his house on March 2003 for being suspected as a terrorist. He was then sent to the local police station and kept in jail for 13 days; during his captivity he was taken in remand for 3 days. During police remand the person was tied up with rope and tortured severely many a times. The victim was put in the lying position with his feet up and then beaten with roller stick on the plantar region.

Post-torture Symptoms

According to the victim, swelling was present up to the both knee joints. While he was having rest, he complained pain in the heel, sole of the feet and on the both calves, which extends up to the knee joints while walking. There was slight paresthesia up to the knee. However, he was only given painkillers in jail as treatment.

Symptoms During Examination

After six months, he was first investigated and treated by the BRCT Mobile Treatment clinic. The victims complained of pain, weakness of the both muscles of the feet and soles of both the feet. In general, he had also depression, headache, and visual disturbance.

On examination, he had tenderness and swelling on the head of the both metatarsals, and pain on the heel at rest. There was tightness on the Tendo-Achilis. There was also weakness on the left quadriceps (grade 3+). Left ankle joint had limited range of motion (ROM) in dorsi- and plantar-flexion and mild on inversion. Fascia plantaris was uneven on palpation with the presence of scars; heel pad was normal. On standing there was no varus or valgas deformity but he felt pain when on left heel and toes while walking and standing. He had also a tendency to cold feet and excessive sweating.

The victim was examined by the use of "Disability Rating Index" (DRI) 10, which was 20% on the first day. Pain of the victim was assessed by using numerical and verbal rating scale, which were 4 and "moderate" respectively.

Treatment

The victim was prescribed with soft-tissue manipulation which included finger kneading, friction to reduce scar tissue, and gentle effleurage to reduce swelling. Stretching of the Tendo-Achilis and strengthening exercise of the left quadriceps were also performed. Infrared Radiation (IRR) was given for 10 minutes over left ankle joint to minimize pain. The patient was provided with home advice to perform active stretching of the left Tendo-Achilis, strengthening of the left quadriceps and hydrotherapy was also suggested to relieve pain of left ankle and both feet. The victim was then advised to come to the BRCT center, Dhaka, for regular follow-ups, and the person came to BRCT after 7 days.

At the BRCT, the victims' condition was almost similar with a slight reduction of pain and there was loosening of the Tendo-Achilis.

The victim was examined also by the use of "Disability Rating Index" (DRI), which was 20%, the first day. Pain of the victim was assessed by using numerical and verbal rating scale which were 3 and "slight" respectively.

Physiotherapy intervention was changed with the implementation of Ultrasound Therapy (UST) over the plantar aspect of the left foot for about 5 minutes a day. The intensity was 3 MHz at 0.3 Watt/cm2. He was treated for consecutive three days. Left ankle joint mobilization was performed with all other previous exercises. The victim was given follow-up date of 1 month interval.

Result

At the last treatment session the victim appeared with no pain and with optimum functional ability.

Critical Review

It will be very effective if the client comes for treatment at the very onset of the problem, so that the cause may be detected at the very initial stage. If possible, the treatment may be provided on everyday bases. So it will be helpful if the client can receive treatment while being in his own community.

Case Report-2

History

A 38-year-old man was arrested, while watching television, by the police from his house, and tortured severely at the spot on November 2002. He was then taken to the local

police station, was tied to the chair and beaten all over the body, including chest area, with roller stick and riffle butt. He was also tortured with hot water over the legs, dorsum and the sole of the feet. He was kept in the PS for 24 hours. The victim was sent to the Magura Jail, and was released on bail after 7 days.

Post-torture Symptoms

According to the victim, extensive swelling was seen over the dorsum of both feet, mainly the right foot. He also stated about feelings of numbness below the right-knee joint up to the sole of foot; he also felt painless as all the layers of sole of his foot were lacerated. The victim however, received no treatment at jail; and took painkillers after being relieved.

Symptoms During Examination

On October 2003, the victim came to BRCT with a prop, since he was having weakness, pain, and discomfort in the right lower limb.

The victim complained of heaviness, pain and numbness in right lower limb, while he termed it to be the paralysis of the right lower limb. Moreover, he also complained of suffering from flashbacks, sleep disorders, sexual disturbances, and diminished vision.

On examination there was swelling on right sole of foot. Sensory disturbance was found to be present from knee to toe of left lower limb and lateral side of thigh, and to the knee on right. Similarly, there was absence of sweating in both the thighs and the legs.

The heel and the forefoot pad was punctured/smashed and there was less elasticity observed. Fascia plantaris was uneven on palpation with the presence of hard scars on the sole of feet. There was muscular imbalance noticed. There were painful trigger points presents over the ilio-tibial region and biceps femoris, which resulted in the tightness of right hamstring. On standing there was no varus or valgas deformity but he felt pain while on his right heel and toes when walking or standing. He had also a tendency to cold feet and excessive sweating.

On neurological examination, there was absence of sensation on light-touch from knee to toes of the right lower limb. Thermal sensation was also diminished. There was loss of proprioception under the sole of right foot.

The victim was also examined by the use of “Disability Rating Index” (DRI), which was 33% at the first day. Using numerical- and verbal-rating scale the pain of the victim was assessed to be 7 and “severe” respectively.

Treatment

The victim was prescribed with soft-tissue manipulation. At first, he was given gentle effleurage to reduce swelling. The patient was however, suggested to develop an adaptation with the physiotherapist by being in contact with him.

He was also given proprioceptive stimulation to regain it by keeping feet on the floor. Ultrasound Therapy (UST) over the plantar aspect of the left foot was performed for about 5 minutes; the intensity was 3 MHz at 0.3 Watt/cm2.

Mobilization was performed for the small joint of the feet and for tibio-fibular joint. He was also given stretching of right hamstring and ilio-tibial region.
The victim was taught the balancing and grounding exercises to increase the proprioception and correction of balance.

The victim was treated for 1 week at BRCT, having regular physiotherapy in two sessions. In the last session he gained his DRI to 25% and expressed pain as "slight" verbally and 4 numerically; and ultimately got the confidence to walk without crutch.

He was practiced to step up and down on stair, and stepper. The patient was also given the home advice to follow the exercises regularly and to practice walking on uneven or rough surface. At the same time, the victim was advised to come for follow-up at a regular interval of 15 days, at BRCT. During follow-up the victim had "slight" pain verbally, and 3 numerically, with improvement in the functional ability which was 20%.

The client was given awareness about posture and gait training. Running on the treadmill and cycling on the static bicycle, was practiced for 2 days. There was pain on the lateral side of the sole of right foot, and the victim was taught to perform hydrotherapy/hot compression at home.

The victim was asked to follow-up after 1 month, while being on treatment.

Result

In the last treatment session, he was assessed by DRI, it was 7% and pain was "none" during examination and he complained that pain occurs occasionally on the sole of the foot after a long walk.

Critical Review

Had the patient been early for the treatment, it would have been very handy to get an early detection of the problem/disease. Similarly, it would have been easy on our part to provide treatment on regular bases. It would however, be quite helpful if the client can receive treatment at his own community.

Discussion

Falanga is a typical example of a physical maltreatment, which leads to specific fatal injuries, depending on the structure and function of the tissues involved. Despite the frequency of these torture incidents, the potentially lethal or disabling outcomes have prompted physiotherapists to recommend the RCT screening form for the victims of falanga torture.
The improved functional status of the victims presented in these two cases, justifies the use of BRCT screening and assessment formats, for the falanga victims with a subsequent physiotherapy intervention. In reality, these two cases have served to highlight potential threats posed to tortured people of Bangladesh. Fortunately, most of the victims can become symptom-less with the significant improvement of their life style. Untreated falanga will progressively cause slow degeneration of the soft plantar tissues. Therefore, early and subtle signs of falanga must be taken into account by a professional physiotherapist. However, the fact remains that the victims must not expect the full restoration of their physical capabilities, bearing in mind that through a suitable and comprehensive physiotherapy intervention, they would be able to lead a functionally independent life. Therefore, all physiotherapists should have a sound knowledge about that issue as well as other symptoms of torture victim.

Conclusions

Physiotherapists have become an integral part of the interdisciplinary team, working for the torture survivors, especially for the falanga cases. The vital components are their sensitive and clever hands, combined with the expertise and knowledge, implemented at the suitable time during treatment. It is for the physiotherapist to decide the order in which treatment methods are to be employed, but as a rule, pain relieving methods and relaxation are appropriate to begin with; however, the manual methods should be gentle and reassuring.

Recommendations

Further research is required to replicate the physiotherapy intervention on a larger sample of falanga victims so as to determine the optimum physiotherapy results.

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Re-traumatization of the Traumatized – The Trial Process of Miloscevic in the Hague

Enver Cesko

Abstract

The present study was conducted to show the influences of the judicial trial of Milosevic on the traumatic and psychological state of the clients, who have suffered signs and symptoms of the post-traumatic stress disorder (PTSD) under the treatment of the KRCT, of the witnesses and of the population. One fifty treated clients with signs of PTSD were involved. The results have shown that trial process is directly manipulated frustration and anxiety of the traumatic feelings in the clients who have suffered PTSD. The symptoms as memory flashbacks and sleep disorders were increased in the clients during the trial process.

The Milosevic trial gives an insight into the grave crimes committed in Kosovo and other former Yugoslavian Republics; it shows the entire world, as to how the civil and human rights of people have been trampled. Such trials increase the value and consistency of the punishment for inhuman acts and actions, crimes against humanity, homicide, and individual and collective violations. Such trials will restore the faith of people in legal institutions and create feelings of mutual security and faith, aiming at the development of the civil and democratic society in the right direction.

During the course of the trial, respective psychological situations of the accused, witness, and all others involved, present different psychosocial outlines.

Frequently, for the accused person, the act of killing exposes the disordered personality, as well as psychopathological tendencies, acting as defence mechanisms in the course of the trial. Thus the psychology of the accused will be interpreted in this way, while that of the witness will be interpreted as an aversive feeling towards the accused.

This trial that took place in The Hague was a historical one, not only for the Albanians but also for the whole human race, because it showed how injustice never goes unpunished. Unfortunately, for a greater part of Kosovo's population, this trial healed only the physical wounds; however, the psychological scars will

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take much longer to heal. Around 8204 patients, suffering from multiple spiritual and psychological disorders, have been worked with, and according to all the patients, the main perpetrator of their ailments has been found to be, Milosevic.

The ambiance and the presence of the judicial body, the possibility given to Miloscevic to present himself in the old gesticulative style, as well as the maintenance of eye-to-eye contact of the witnesses, creates the possibility of an ego-activation and encouragement for one party, while the emotional decomposition of the other.

The unprepared and undefended exposition of some of the witnesses before a criminal is also a motivating factor in the ongoing judicial process. Till now no witness has ever been psychologically prepared and protected for a historical trial. Almost all witnesses, psychologically, have had a very high level of trauma, whereas the presence of the criminal himself caused a new trauma to them, staring at their faces.

Rationale

Relevant facts presented during the trial by the prosecutors, witnesses, and judges, may give the possibility that the character and the structure of the accused's personality will be entrenched inside the facts. Therefore, based upon the psychological motives of the judicial process itself, KRCT in Prishtina, decided to perform a study regarding the psychosocial situation of the clients, who had already been treated due to different psychological disorders, generally seen in war torture survivors. In this way, the situation and exposition of the witnesses in the court will cause renewed trauma to already-traumatized persons.

Methodology

Study Objectives

The purpose of the present study is to consider the effects and influence of the judicial process of the Miloscevic's trial on the psychological situation of the clients under treatment at the KRCT, of the witnesses and of the population.

Based on the principal aim of the study, the derived objective are:

1. Define the level of severity of PTSD during the trial process of the treated clients.
2. Evaluate the emotional situation of the previously treated clients, witnesses, and the population during the trial process.

3. Increase the awareness regarding the effects, this trial has in re-traumatizing the already-treated clients, witnesses and population.

Study Hypotheses

- After the initiation of Milosevic's trial in The Hague, clients identified with PTSD will had flashbacks from the past traumatic events.
- The trial will cause no re-traumatizing of a significant scale, but only threaten the psychological stability of previous patients; those not identified with PTSD are less likely to experience any problems.

Sample

The target population consisted of PTSD patients who had previously been treated for a period of one year; their papers were thoroughly processed for documentation till the initiation of the trial. The client's record included the medical file where all data regarding the treatment of PTSD was described. The study population was composed up of around 2300 clients, treated in regions and villages most involved during the war, as well as clients treated inside the centre. Only 150 clients were included in the study from out of the entire group of 2300.

Instruments

Two measuring instruments were used during the course of this study. PTSD was evaluated using DSM IV [1], attached to the medical file, where a thorough examination of the traumatic situation was done, during the medical and psychological treatment. The second instrument was presented in the form of a questionnaire, of the type 'closed' 'non-standardized', and ad hoc compiled.*

For data collection, we used the procedure of following-up with the clients' situation according to the symptomatic progression of PTSD, as per medical files, and the interviews based on the questionnaire, comprising nine questions, formulated precisely by the medical staff of KRCT. The questionnaire was in the form of a test. This form of questionnaire was selected because of its higher methodological efficacy and more consistent concentration of the interviewed on the traumatic event. The analysis and the interpretation of the results of the study were analysed both qualitatively and quantitatively.

* The second instrument was prepared from Mr.Sci. Enver Çesko, psychologist and psychotherapeutics; Dr. Melita Kallaba, psychiatrist; Dr. Vjosa Devaja, gynaecologist; Dr. Agim Selimi, psychiatrist; Dr. Shaban Jashari, neuropsychiatry; and Dr. Merita Emini, medical coordinator.

The results achieved by the statistical data have been elaborated and analysed in a professional manner, justifying the attained results, scientifically. The evaluation was done with a re-test of the psychological situation of the clients during the trial process. There were occasions when the clients were directly involved in the trial and there was a need to be in touch with them.

Results and Discussions

No.	POSTTRAUMATIC STRESS DISORDER	1-Not at all	2-Little	3-Sufficiently	4-Much
1.	Flashback and intrusive remembrances	2.06%	19.5%	19.5%	28%
2.	Awful repetitive dreaming related with the trauma	12.03%	27.8%	38.1%	21.6%
3.	Feeling and behaviour as the traumatic event is impending	29.9%	22.6%	36.08%	11.34%
4.	Remembering the traumatic event	26.85%	21.6%	41.2%	10.3%
5.	Preoccupations vs. different stimulants that remember the traumatic Event	30.9%	26.8%	38.1%	4.1%
6.	Tentative to avoid thoughts, feelings or conversations related to the trauma	20%	27.3%	46.2%	6.3%
7.	Tentative to leave the place or persons that cause a remembering of the trauma	42.2%	21.6%	36.08%	0%
8.	Inability to remember some important element of the trauma	54%	24%	31.48%	5.5%

Table -1 *PTSD manifestations of the clients and the influence of trial process at their PTSD situation*

1.Do you think that the trial process began at the right moment?

a- yes	77.46%
b- the time is not suitable	14.7%
c- no	7.7%

2.What are you feeling by following the trial process?

a- nervous	30.23%
b- annoyed	0.1%
c- anger and fury	0.04%
d- exasperation	13.02%
e- expression of grief	13.4%
f- hate	6.9%
g- detestation	11.6%
h- pleasure	3.7%
i- no emotions at all	3.2%

3.Are you able to stare at the face of the accused person?

a- yes	27.4%
b- with difficulty, having no other choice	34.2%
c- no	38.3%

4.Do you think that the accused person as the person who gave the orders and the perpetrator as a crime executor is at an equal position?

a- yes	85.6%
b- no	14.4%

5.The facial expression of the accused person seems to you like...

a- a normal person	0%
b- sanguineous person	82.89%
c- mentally insane patient	17.1%

6.Do you think that the witnesses have to receive psychological assistance prior to their participation in the trial?

a- yes	83.97%
b- it's not important	12.2%
c- no	3.2%

7.If you're traumatized from the war do you think that by looking or participating at the trial you'll become re-traumatized?

a- yes, very much	62.2%
b- not at all	9.6%
c- yes, in the average	28%

8.Do you feel stressed when the accused person makes questions to the witnesses?	
a- yes, very much	77.4%
b- not at all	6.16%
c- yes, in the average	16.4%
9.Do you think that the majority of the people looking the trial feel themselves satisfied with the testimonies from the witnesses?	
a- yes, very much	42.5%
b- not at all	17.5%
c- yes, in the average	52%

Table - 2 *Percentages of the clients thought for the questions of the questionnaire*

If in any situation or environment, a person is able to create a highly dramatic situation, the person will be able to make the counterpart irritable up to the probability of psycho-physiological changes, becoming dominant. These changes at the psycho-physiological aspect have been seen among the witnesses, presented in the trial of Miloscevic.

The results achieved in the study showed that more than half of those, under psychosocial treatment, earlier experienced violent flashbacks of the traumatic event with the beginning of the trial. Almost 90% of the clients suffered nightmares and awful dreaming, these were caused because of the presence of Milosevic himself and the questions he directed towards them. All this triggered a stressful reaction with dissociative manifestations, characteristic to posttraumatic stress disorder. Many results from the research done in states of ex-Yugoslavia among persons who survived the war in Bosnia, Herzegovina and Croatia, showed that the number of persons with PTSD was on an increase, because of the revival and reappearance of the stressful situations, reminding them of the traumatic events.[2,3]

In this direction, 51.4% of the clients with PTSD during the trial declared that by being present in the courtroom or simply by watching the trial on TV, caused them to have more flashbacks. Therefore, the re-traumatized clients from the direct stimulation tried to avoid the thoughts, feelings, places, and conversations related to the traumatic event (52.6%). Also a considerable number of them (36.9%) manifest an inability in remembering some important elements from the trauma, probably because they suffer persistently from trauma, which impregnates indelibly their memories.

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More than 77% of the contacted clients in seven regions of Kosovo, agreed that the trial began at the right moment; however, only 21.7% thought that the time of the trial was unsuitable. The timing of the trial and participation in it, caused irritability in 30% of the clients, whereas for 45.7% of them, the trial created negative emotions, such as annoyance, rage, anger, crying, hate, and revenge. Only 3.7% of the clients had positive emotions, presented with a feeling of pleasure.

More than 72% were unable to look at the face of the accused person during the trial; which was the outcome of either feelings of fear or horror. This result correlates with the outcome of the question, whether the patients had any association with the facial expression of the accused person or not; with more than 82% of the clients thinking that the facial expression presented elements of a sanguineous person, whereas 17% of them thought that the perpetrator of those inhuman acts had the face of a mentally insane person.

Interesting is the statement of a 29-year-old, widowed female saying: "*each time I look at Milosevic in the TV, I want to break the screen… If I'd be next to him and would have been permitted, I know I would have strangled him… exactly how he choked our men, how he massacred our pregnant women and took out the foetuses from their bodies, how he wounded our eyes, noses, ears, burned and buried us alive, I'd have taken off his skin and for each bit of that I'd keep on asking him how he feels.*"

During the judicial procedure, the perpetrator and the person who ordered the committing of a crime, underwent a penal procedure and were found to be responsible for the crime. According to the opinion of 85.6% of the clients, responsibility for the crimes committed was the same, whether committed on the directives of someone or on ones own accord.

One of the study hypotheses was that the clients with PTSD manifestations would become re-traumatized much more with the beginning of the trial. The result of this study showed that 62% of the clients felt much more traumatized and 28% of them partially traumatized, as compared to the beginning of the trial. According to emotional changes of re-traumatized clients with PTSD, results similar to ours have been observed. [4,5]

Conclusions

The present study shows that a secondary stress situation is caused from a secondary trauma, due to the revival of old memories related to war. The study analysis shows that the beginning of the trial directly influenced the frustration of the traumatic feelings of the clients who have suffered from PTSD. Due to their

past traumatic condition, patients have been unable to accept or deal with the revival of old memories causing nightmares and flashbacks of the traumatic event. In this way, a great number of clients felt themselves to be traumatized by the trial. This can be explained by the fact that the testimonies they presented during the trial were used by the accused against them. Witnesses, who had not had any psychological preparation before standing trial, were unable to give satisfactory testimonies because they were not adequately prepared to face Milosevic. More than half of the clients think that they are only partially content with the offered testimonies from the witnesses, and such a result stands for the need of a psychological preparation of the witnesses before standing trial.

Recommendations

- The need for a psychological preparation of the witnesses before they may stand a trial, so that the witnesses will not be nervous.
- The work with traumatized persons, before and after the finishing of the trial, has to go on in a consultative way, aiming at the monitoring of the psychological situation and its pertaining changes.
- Moral, social, patriotic and psychological support should be given to the witnesses who are testifying at The Hague tribunal, so that they are not traumatized. Secondly, knowing that secondary traumas might just be more severe than the direct ones, the family members should be told to treat the patients with special care.

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