Health and human rights

Overcoming obstacles in confronting torture

Television images of torture chambers in Iraq and reports of the escalating use of torture in Zimbabwe remind us that this form of state-sponsored abuse continues unabated in many parts of the world. At the same time, there are growing allegations[1] that some developed nations with a tradition of defending human rights might be sanctioning the use of coercive measures akin to torture in dealing with suspected terrorists. It is timely, therefore, to consider the reasons for the inadequate attention given to the topic by health professionals.

Despite progress in apprehending and prosecuting perpetrators, torture continues to be used by more than 100 governments and by non-state actors such as armed militia in around 40 countries.[2] Though much remains to be done, substantial progress has been made in the past decade in investigating the mental health consequences of torture.[3,4] A consistent picture emerges of torture as a powerful risk factor in generating mental disturbance. In a study of Turkish ex-prisoners, participants who had been tortured showed pronounced increases in mental disorder.[4] In a refugee camp in Nepal, torture greatly increased the risks of post-traumatic stress disorder (PTSD), depression, and anxiety.[5] In four conflict affected countries, torture was a specific risk factor for PTSD in all but one population.[3] Among Tamil refugees, of a wide array of war traumas, torture was the most powerful determinant of chronic PTSD.[6] Although these studies are few in number, the consistency of the findings, especially in conjunction with documentation by human rights organisations, builds a picture of torture as a threat to the psychosocial wellbeing of vulnerable communities.

If torture is a global health problem, why does it not feature more prominently in medical and psychiatric textbooks and in teaching and training programmes for health professionals? One obvious reason is the difficulty in obtaining access to torture victims held in prisons or living under oppressive regimes. Nevertheless, although research in such settings is difficult, it is not impossible.[3,4] An additional challenge might be the discomfort many health professionals feel in confronting the reality of torture.[7] Overcoming a natural tendency to recoil with disbelief and aversion to accounts of grotesque human cruelty is made harder for health professionals by the knowledge that colleagues in some countries are directly implicated in perpetrating torture. Strong psychological defences can be mobilised by health workers that encourage avoidance of the problem.[7] Health workers may reassure themselves that torture is a political, not a medical problem, that such cruelty occurs in distant and foreign places and is not relevant to practitioners working in democratic countries, and that there is nothing that they can do to prevent such abuses.

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Identity document from suspected torture chamber, Iraq

What, then, can health professionals realistically do? Strategies that help them to overcome their own avoidance of the topic could be the first step in mobilising collective action aimed at devising effective global strategies for prevention and treatment. To sensitise but not overwhelm health professionals, training in areas such as forensic assessment of torture victims should focus equally on the anxieties of the inexperienced professional as well as on technical expertise. Informed and well directed advocacy is critical. Although the main objection to torture is grounded in human rights principles, health professionals have sufficient information to state with authority that torture is damaging to the health and psychosocial wellbeing of survivors, a message that needs to be conveyed regularly and clearly at all levels of society. In practical terms, international health associations can have an active role in advocating for closer scrutiny of high-risk institutions such as prisons and detention centres.

Attention is needed in educating research-granting authorities of the importance of scientific investigations into all health aspects of torture and the associated logistical and ethical constraints. Topics warranting attention are the evaluation of existing models of health care for torture survivors to clarify what works, and identification of personal, cultural, social, and institutional factors that build resiliency in survivors. By focusing on issues of adaptation, researchers and clinicians can portray a message of hope that depicts torture victims as people who can overcome their experiences to live meaningful, productive lives if they are offered appropriate conditions that promote recovery.

Torture continues to be mysterious and foreboding, even for health professionals. The biggest challenge for the medical profession is not to succumb to feelings of helplessness and avoidance. We know enough about the health consequences of torture to indicate clearly that campaigns to prevent torture and to rehabilitate survivors should be a key mission for global public health. If we turn our backs on the problem, we play into the hands of perpetrators who flourish under conditions of international neglect and secrecy.

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