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The Role of Physiotherapy in Direct Assistance to Victims of Torture: A Holistic Approach to Healing and Wellbeing

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"The pain is not like ordinary pain. With this, something happens in your heart."

Summary

Physiotherapy is considered a healthcare profession concerned with human function and movement, and maximising potential. It normally uses physical approaches to promote, maintain, and restore physical, psychological, and social well-being, taking account of the variations in health status. The human function is more than just a physical and movement issue. Physiotherapy plays a unique role in the rehabilitation of people who have been profoundly traumatised. Certain precautions are needed when handling survivors of torture, but sensitive physical techniques can relieve the legacies of severe pain, dysfunction, and stress. The physical medium is especially effective for people who are unable to speak of their experiences. (*Hough, 1992*) Trauma, especially those who have experienced torture and considerable life-threatening violence presents a very wide range of responses from an individual - responses that often include family members and close relationships. The *Humane to Humane* Transcultural Centre for Torture Victims in Manipur has been providing direct assistance to over 450 clients and their families in support with the UN Torture Fund since 2009.

Working with people who have been tortured has similarities to working with intensive care patients. There is a need for acute sensitivity to the client's responses, an extra awareness of the importance of autonomy, and an understanding of issues of power and helplessness. A multidisciplinary approach was adopted that included medical, psychological, creative movement therapy, social and financial assistance. Physiotherapy constituted an important component of the services provided by the centre, providing a vital link in rebuilding the personality of survivors of torture because trust can be fostered in the context of physical contact. Close liaison between the physiotherapist and other therapists is needed in this area of work. A combined approach is essential in the work and the support team also indulges in caring for each other and the luxury of co-working. The intimacy of our relationship with survivors of torture is matched by the perverted intimacy of their previous relationship with the torturer, and extra care is needed in this context.

This paper elaborates on the range of psychosocial, physical, and emotional responses to torture, the methodologies adopted, and the results obtained in our centre.

Introduction and Background

According to the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (commonly known as the United Nations Convention against Torture (UNCAT), the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions. Torture is often used as a political instrument to help a country's rulers keep control by breaking down the personality of individuals. (*UN General Assembly, 1984*)

Within the ambit of international humanitarian law, "the Geneva Conventions of 1949 and their Additional Protocols of 8 June 1977 contain a number of provisions that absolutely prohibit torture and other cruel or inhuman treatment and outrages upon individual dignity."

Source:https://www.icrc.org/eng/resources/documents/faq/torture-law-2011-06-24.htm

Torture is characterised as physical and/or psychological; most commonly survivors of torture have been exposed to both forms of torture. As a consequence of these experiences, the treatment and rehabilitation especially designed for torture survivors is a combination of several complementary therapies with an emphasis on complementary medical treatment, psychotherapeutic support, and physiotherapy, aided by socio-economic and legal assistance, commonly known as a multidisciplinary treatment. (*Danneskiold-Samsøe, et al, 2007*)

The *Humane to Humane* Transcultural Centre for Torture Victims (H2H) in Manipur has been providing direct assistance to over 450 client survivors of torture and related violent trauma and their families since 2009. The centre is an independent health and humanitarian service providing a programme of the Centre for Organisation Research & Education (CORE), a national NGO of India, based in Manipur, in Special Consultative Relationship with the Economic and Social Council (ECOSOC) of the United Nations. The centre seeks to address an existing gap of comprehensive and effective institution-based healthcare response to the high prevalence of widespread trauma and torture, and their consequences on the people of Manipur in the context of long-standing political violence, internal armed conflicts, and escalating targeted criminal violence. The centre

has been supported by the UN Voluntary Fund for Victims of Torture since 2010, along with other international humanitarian foundations.

The effects of protracted low-level and high-level conflicts, worldwide, "go beyond the loss of life, [*property, physical injury*] and destruction of infrastructure; and the distressing consequences of protracted conflict appear in the social and cultural fabrics of people, their identity, and their values system. The long-term effects have often been reduced by medical professionals to the individual level, through establishing a direct linkage between the traumatic experiences and certain symptoms. However, symptoms are not necessarily accompanied by psychopathology, but rather fall within the range of normal response to overwhelming events. Trauma during protracted conflicts is repetitive, multiple, continuous and trans-generational, and it must be examined not only from the perspective of individual disorders but also at the family and collective level. The disintegration of family and social networks, disruption of local economics, inter-individual and family violence, and spreading of fear and uncertainty all have implications for the health and well-being of survivors." (*Sjölund, et.al., 2009*)

In our centre, torture is understood more 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." (*World Medical Association, 1975, revised 2016*) This is because, in a complex protracted violent conflict setting, many kinds of "authority" emerge and fade over time, and torture is perpetrated by the different state and non-state authorities or organisations in Manipur.

The holistically framed foundations of the services provided by H2H are, briefly:

- *Health, Human Rights and Humane Values:* rights-based, and motivated by concern with the alleviation of suffering
- *Cultural Competence:* skills, knowledge, and understanding about client's culture in order to assess and intervene in a culturally appropriate manner
- *Universal Ethics:* principles of client self-determination, truth-telling, do no harm, do good, justice, and promise keeping
- *Minimum Standards:* internationally accepted and peer-approved client monitoring & evaluation (M&E) guidelines and protocols
- *Interdisciplinary Therapeutic Model:* an integrated menu of modern and alternative client-centred therapies
- *Rehabilitation and Redress:* empowering the torture survivor to resume as full a life as possible, relieving the suffering of and affording justice to victims by removing or redressing, to the extent possible, the consequence of the wrongful act

The approach of physiotherapy for torture survivors

"The body does not lie."
(Martha Graham)

Traditionally, physiotherapy is practiced in a hospital or clinical setting, with occasional home visits, using various different devices of treatment, such as interferential therapy, ultrasound therapy (massage), electronic muscles stimulator, short-wave diathermy, traction, heat and cold (ice, wax, and water) therapy, and physical manipulations and exercises under the supervision of a physiotherapist. Treatment duration may vary according to the types of disorder or deformity the patient or the client is suffering from.

The role of a physiotherapist is to help the client recover and rehabilitate, to help the client gain optimal functional movement of the body and prevention of further injury. In order to achieve these goals, mental readiness of the client is very important for physiotherapeutic treatment. Mental and emotional readiness or willingness to the treatment, especially for the torture survivors, is normally encountered challenge to the physiotherapist. Hospitals and clinic-setting centred institutions can be reminiscent of prisons, detention environments, interrogation centres or other torture settings. Being led down corridors by a stranger may provoke intense discomfort and even flashbacks. Similarly, white coats, uniforms, and electrical equipment may recall and re-live torture experiences to survivor clients. Awareness of this and, particularly, care establishing trust and explaining procedures to the patients can help them to focus on the session and ensure there is no fear in returning for subsequent sessions or visits. (*Franklin, 2001*)

In our centre, torture victims we encounter have experienced various forms of torture, such as severe forms of cruel and humiliating verbal abuse, prolonged isolation, blindfolding, forced abduction from home,

beatings with hands or blunt weapons (non-systematic and systematic), electric shock torture, mock execution, water boarding, sleep deprivation, burning (with cigarette), food/water deprivation, and being forced to listen to the agonising sounds of others being tortured. Joint mobility restriction, bursitis, tendonitis, sequelae of breaking of bones, tearing of ligaments, general body pain/aches, pain due to postural defects, lingering pain at the site of injury, shoulder pain, neck pain, back ache, and post-surgery pain are some of the effects of torture which require physiotherapy encountered in our centre.

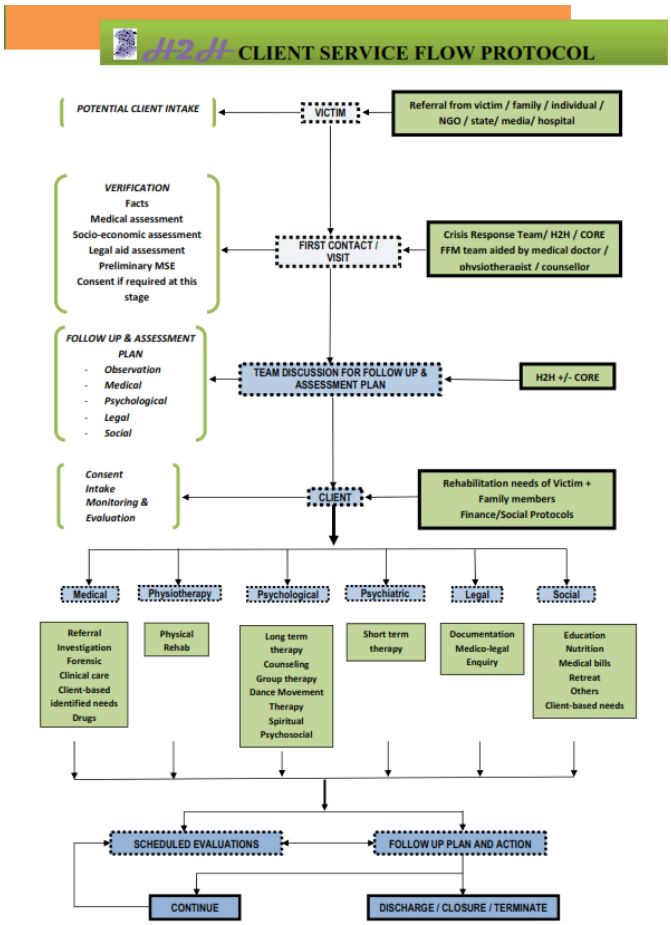
Pain, particularly chronic pain, is a critical and central component of the symptomatology encountered among torture survivors. Pain is a disturbed sensation that may cause disability, suffering, or distress. Pain is also a sensory and emotional experience that is associated with actual or potential tissue damage. In our practice, the care model for torture survivors is not merely psychologically informed for psychological risk factors and modified treatment to address those factors but by trauma-informed care, where our organisational structure and treatment framework has evolved towards understanding, recognising and responding to the effects of various kinds of trauma. This model of care for torture victims has been authenticated by experiences elsewhere. (*Dee & Gamble, undated*) Such a model or approach to care can be implemented in multiple types of service or setting or organising; it is different from trauma-specific interventions. (*Laifungbam, 2016*)

"Suffering is deeply imprinted in the body because reactions involving the brain (sympathetic nervous system and hypothalamus-pituitary-adrenal axis) spread throughout the body. The body's stress mechanisms are activated when traumatic experiences threaten one's sense of safety, satisfaction, and connection. A loss of balance between the sympathetic and parasympathetic nervous system over time leads to illness. Cumulative negative experiences and resultant negative emotions (fear, anger, sadness, etc.) create this loss of balance. The immune system is weakened and a wide range of health problems ensue." (*O'Sullivan, 2017*)

Methodology

The methods we use in physiotherapy are to coordinate and facilitate the restoration of balance and integration of the mind and body of the client, and to re-connect with the family and his social environment**.**

Figure 1



Our centre uses a collectively developed "protocol" for the services we provide. The protocol developed is a paced one with the maximal client, family, and team participation at every level. **Figure 1** gives a graphic representation of the protocol.

The intake procedure is based on the Istanbul Protocol, the first international guidelines adopted in 1999 for the assessment of persons who allege torture and ill-treatment, for investigating cases of alleged torture and for reporting findings to the judiciary or any other investigative body. The manual includes principles for the effective investigation and documentation of torture and ill-treatment and has been adapted for use by the H2H in Manipur. (*OHCHR, 2004*) The Adapted Istanbul Protocol used by the centre adds emphasis on physical rehabilitation evaluation as well as socio-economic assessments.

For every client we register in our centre, fully informed and prior consent from the client is a must, followed by medical, psychological, and physiotherapeutic assessments and also socio-economic and medico-legal evaluations. The result of the assessments determines the management plan the centre has to offer for the particular client.

The physiotherapist creates a trusting relationship with the client so as to smoothly carry out the treatment procedures. Treatment

in our centre is not restricted to just physiotherapy or the use of physiotherapeutic equipment, but we also use expressive/creative therapy such as Dance and Movement Therapy and Creative Art Therapy according to the needs of the client.

Physiotherapy treatment for torture survivors

Ambulatory care management is the rule in our centre; there are no in-patient care facilities. Clients needing hospitalisation are referred to an institution for their specific needs. From the physiotherapy point of view, privacy and space ambience are crucial in establishing trust and calming fears of public humiliation, particularly if clients are required to undress. Deprivation of clothing is a common experience in the tortured environment and being asked to undress can seem threatening. It may be helpful to provide or suggest bringing loose clothing for exercises, stretches, and relaxation sessions. Lying prone or supine, for someone who has been tied or even raped in that position, can also feel quite threatening; again we use judgement and check that clients are comfortable. If in doubt, we delay that approach for one, two or even several sessions.

Verbal consent is always sought first for physical examination or touch, particularly interventions that require touching or approaching from behind. Consent of the client is not a one-time formal agreement but a continuous process of trust building and maintenance. If the client brings a family member, trusted friend or advocate he or she should be able to accompany the client (although not be expected to translate, if the translation is required). Survivors are given ample time to decide and respond to a seeking of consent. Especially while treating a juvenile or child client, a caretaker or a trusted parent, guardian or assistant is always recommended.

The treatment room must be well ventilated yet afford privacy, eye-pleasing, clean, safe, and non-threatening. We avoid very bright lights (natural light is preferred), loud sounds, abrupt verbal commands and consistently use gentle moderated voice while communication with the client.

Group therapy sessions are normally done in a large room or hall as programmes that are carefully scheduled and prepared by a team of complementing therapists including the physiotherapist. The groups are chose with great care, keeping in mind the age, sex, community (or ethnicity) and nature of needs to be addressed. Consent is again sought and taken. Medical evaluation and individual counselling are included in the programme.

Results

The centred has 459 registered client survivors of torture and related violent traumata since 2010, of which 81 are children below the age of 18 years of age. The rest (378) are adults. (See **Table No.1** below)

Table No.1
Clients registered since 2010

Child		***Adult***		***Total***
Female	Male	Female	Male	
46	35	169	209	459
10%	7.6%	36.8%	45.6%	100%

All the clients registered are, by birth, native residents of Manipur, and self-identified as indigenous and tribal persons. We have not disaggregated the clients according to their specific ethnic identity. All had been exposed to a mixture of physical and psychological torture, cruel and/or degrading ill-treatment, or related violent trauma. Registered torture methods experienced by the clients were studied. **Table No.2**summarises the findings of this study.

Table No.2
Forms of torture and the number of studied clients exposed to these

Method of torture and ill-treatment	***Number (459)***	***% (100)***
Blind-folding and physical manhandling	112	24
Blows (beaten up) unsystematically applied	152	33
Blows (beaten up) systematically applied	44	10
Burning (cigarette)	2	0.5
Rape	2	0.5
Food/water deprivation	26	6
Forced abduction from home	22	5

Forced or violent eviction	88	19
Isolation and exhaustion	8	2
Made to listen to others being tortured	1	0.2
Mock execution	6	1.3
Severe mental distress caused by abduction or enforced disappearance or extrajudicial execution of a family member	56	12
Sleep deprivation	24	5
Tying, binding or handcuffing	18	4
Violent and degrading verbal abuse torture	139	30
Violent Injury (e.g. Bomb blast, bullet injury, tear gas cannister injury)	51	11
Water boarding	20	4

Clearly, from the study of our experience among our registered client's injuries and consequences of the torture methods we have encountered, there is little evidence to show that a single kind of treatment approach can fully and satisfactorily address the needs of torture survivors. Certain methods such as beatings (of all kinds) show the highest level of frequency, with understandable and obvious physical effects, followed by methods that lead to moderate to severe psychological stress. The emotional dimensions of these injuries and methods of torture are most difficult to evaluate; yet, they form a most important component of the overall symptomatology of torture.

Discussion and Conclusion

From the therapeutic point of view, the traditional approach to the treatment of torture survivors, particularly in the Western countries, has been through the primary, and sometimes sole, use of medication. (*Sjölund, et.al., 2009*)

However, the efficacy of this monomodal approach has been increasingly questioned as the experience of treating torture survivors increased worldwide. It is well documented that pharmacotherapy is useful in treating post-traumatic stress problems, such as PTSD, but convincing evidence does not exist to verify the efficacy of this approach alone, especially among survivors of torture. More disciplined and focussed research is sorely needed.

Chronic pain, the most commonly encountered complaint, continued to be a primary reason for morbidity and inability to perform daily routine tasks or work among torture survivors. This affects the family's social and economic as well as financial status significantly. The emotional milieu in this context is complex and challenges those treating the survivor of torture at many levels. Firstly, there is the emotional component of the humiliating experience of torture that is a deeply seated one. Secondly, the emotional reaction to pain that is difficult to pinpoint a source, particularly of chronic pain, is a continuous one that has its "ups and downs." Thirdly, the emotional atmosphere generated by a psychologically or physically disabled member, often a key member of the family, that has a long-standing and ill-understood functional infirmity often leads towards a familial dysfunction and diminishing collective wellbeing.

The chronicity of the problems associated with torture, we find, is best handled from a multidisciplinary approach where many professional actors have roles to play. The role of the physiotherapist in this multidisciplinary team that approaches the problem from a trauma-informed care model is quite central, with the aid of other complementing therapists.

"As a basic principle of good rehabilitation practice, emotional agendas need resolution before physical goals can be achieved." (*Andrew Frank [UK], in a special report of the International Conference, "Rehabilitating Torture Survivors", Rehabilitation and Research Centre for Torture Victims in collaboration with Centre for Transcultural Psychiatry, Rigshospitalet, Copenhagen, Denmark, December 2008. Sjölund, et.al., 2009*)Addressing the "emotional agendas" is, in our experience, easier said than done. Social and family integration of the torture survivor is a fundamental goal of treatment, along with the physical and psychological modifications. In such a priority of need, the physiotherapist alone is not always the best first step to make in assisting the survivor. This is because the skills and expertise of the physiotherapist must be complemented by psychological support. Furthermore, in our experience in Manipur, though there are many physical rehabilitation

professionals in practice in the state or private clinics, there is still a vast amount of work still undone to sensitise them to psychosocial communication skills, including referral skills that are essential in the treatment of the torture survivor.

The physiotherapist is a moving caregiver who relies on touch for healing. The crossing of the barrier of touch for a torture survivor can be a very important milestone in the long journey to wellbeing. The consolidated team approach, in which the physiotherapist plays a prominent role, is better able to address this complex and lingering posttraumatic problem.

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