# Position statement on 'Torture and psychiatry'

## Prepared by the Special Committee on Unethical Psychiatric Practices

Article 1 of the 1984 UN Convention provides the most comprehensive definition available:

> "... 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."

Notwithstanding Article 5 of the United Nations Declaration of Human Rights that: "No-one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment", torture has assumed epidemic proportions since the 2nd World War; Amnesty International has documented its occurrence in no less than 66 countries.[1]

Apart from the humanitarian requirement that the psychiatrist *qua* citizen should be aware of, and act upon, this blatant violation of human rights, the profession as a whole can be involved in at least three ways:

(a) The findings of behavioural science research, particularly knowledge about the psychological effects of isolation, sensory deprivation and sleep deprivation, have been applied by the torturer.

(b) Torture has been shown in several studies to exert profound and enduring psychiatric morbidity on its victims and their families.[2]

(c) The perplexing question as to how people become psychologically equipped to carry out the grisly task of inflicting physical and psychological pain on their fellows is beginning to be studied systematically (see for example Lifton,[3] and Milgram[4]).

Several *ethical implications* stem from these forms of involvement, implications relevant to the individual practising psychiatrist and to the College as a whole. These are dealt with below, and each is accompanied by the corresponding moral position that the Committee feels psychiatrists should adopt and adhere to:

### (a) *Professional participation in torture*

The psychiatrist may be called upon, directly or indirectly, to contribute his skills and knowledge to the process of torture. For example, professional advice may be sought regarding the application of drugs to facilitate interrogation or a medical opinion may be required concerning the fitness of a detainee to withstand a further bout of torture.[5] There can be no ethical basis for such contributions. Even a hint of co-operation is tantamount to collusion, and reflects the total neglect of professional ethics.

The British Medical Association's[6] emphasis on the issue of medical participation at *any* stage of interrogation or torture should be echoed by the College. Thus, "It is unethical for a doctor to carry out an examination on a person before that person is interrogated under duress or tortured. Even though the doctor takes no part in the interrogation or torture, his examination of the patient prior to the interrogation could be interpreted as condoning it". Similarly, the College should affirm that article in the Declaration of Tokyo,[7] the code concerned with ethical aspects of torture, which states that the doctor should not provide any "premises, instruments, substances or knowledge to facilitate the practise of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment".

### (b) *Evaluation of the psychiatric consequences of torture*

Systematic and comprehensive evaluation of the psychiatric consequences of torture may be necessary in a number of situations, e.g. in the course of legal proceedings at a national or international level (e.g. European Court of Human Rights), in relation to a demand for compensation or to support a request for asylum and refugee status. In such circumstances the psychiatrist is not directly in a therapeutic role, but prepares an objective report for the authorities. Nevertheless, experience shows that documentation of the torture experience and its sequelae can have a therapeutic effect on victims. Recognition and confirmation of their suffering is an essential part of the rehabilitation process and specifically helps to overcome the shame and guilt experienced by torture victims.

## (c) *The psychiatrist's role in the treatment of victims of torture*

Although psychiatrists should never participate in any way in the procedure of torture, they are necessarily obliged to come to the professional aid of the victim of torture when he is psychologically affected by his experience. In such situations, the psychiatrist should insist on *total professional autonomy* such that the interests of his prospective patients are, and always remain, paramount. Preservation of this unqualified clinical freedom is crucial in order that medical treatment may be provided free of any pressures or influences which are not respectful of the patient's basic interest.

To pre-empt any conflict of interest, such as might occur wittingly or unwittingly in the psychiatrist serving the military or the prison service, the provider of treatment should, if at all possible, be the personal choice of the torture victim and his family.

## (d) *The psychiatrist's role in the campaign to abolish torture*

Since there is overwhelming evidence that torture can lead to serious and/or chronic psychiatric morbidity even in previously psychologically robust persons, it follows that the post traumatic stress disorder consequent upon torture is an entirely preventable syndrome, through the eradication of its prime cause.[8]

This exercise in 'preventive psychiatry' should be but one argument in the College's overall contribution to the campaign to abolish torture. As participants in this campaign, psychiatrists should also stress the broader psychological effects on society of the State's sanction of barbaric cruelty. They should also help to shed light on the psychological factors that facilitate the perpetration of torture, in order that Governments might act to minimise those factors.

In the final analysis, it is probable that torture will only be eradicated when Governments take appropriate political and legislative action, and international moral pressure is exerted on those States that flout the United Nations Covenant Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.[2]

But, psychiatrists as responsible citizens and the College as an influential professional association concerned with violations of fundamental rights should be involved in the relevant political, legal and ethical arenas, and should make public their position.

## *References*

[1]Martin Robertson & Amnesty International (1984) *Torture in the Eighties*. London.

[2]Stover, E. & Nightingale, E. O. (1985) (eds) *The Breaking of Bodies and Minds*. New York: Freeman.

[3]Lifton, R. J. (1986) *The Nazi Doctors: A Study of the Psychology of Evil*. London: Macmillan.

[4]Milgram, S. (1974) *Obedience to Authority*. New York: Harper & Row.

[5]UN General Assembly Resolution, 37/194, Adopted 18 December 1982.

[6]British Medical Association (1981) *Handbook of Medical Ethics*. London. p. 49.

[7]Declaration of Tokyo (1985) In *The Breaking of Bodies and Minds*. (eds. E. Stover & E. O. Nightingale). New York: Freeman. Pp. 272–273.

[8]Daly, R. (1980) Compensation and rehabilitation of victims of torture. An example of preventive psychiatry. *Danish Medical Bulletin*, **27**, 245–248.

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