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Psychiatric aspects of the Truth and Reconciliation Commission in South Africa

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Around the world, the recent emergence of new democracies has raised questions about how best to deal with the atrocities and human rights violations of past regimes (Weschler, 1990; Boraine & Levy, 1995). One country grappling with this question in a particularly interesting way is South Africa. In response to the gross violations of human rights in the past, the post-apartheid government passed the Promotion of National Unity and Reconciliation Act making provision for a Truth and Reconciliation Commission (TRC).

According to the Act, the objectives of the TRC were "to promote national unity and reconciliation in a spirit of understanding which transcends the conflicts and divisions of the past". This would be achieved by establishing "as complete a picture as possible of the nature, causes and extent of gross violations of human rights" during past political conflict, by facilitating amnesty of perpetrators "who make full disclosure of all the relevant facts relating to acts associated with a political objective", and by giving victims an opportunity to relate the violations they suffered and restoring "human and civil dignity".

The Act was a negotiated settlement between representatives of the old and the new regimes. Thus, the Act stayed away from the notion of retributive justice for past crimes (as in the Nuremberg trials) and rather adopted a prudential focus on the common good and future injustice (allowing amnesty) (Boraine & Levy, 1995; Boraine *et al*, 1997). As the vice-chairperson of the TRC, Boraine, said in a lecture distributed on the Internet (http://www.truth.org.za/reading/speechol.htm), "South Africa has decided to say no to amnesia and yes to remembrance; to say no to full-scale prosecutions and yes to forgiveness".

Of course, much of the testimony at the TRC has centred around the issues of psychological trauma, with perpetrators admitting to their deeds in order to obtain amnesty and victims recalling their traumas in order to obtain reparations. The TRC may be a useful exemplar for considering various issues in contemporary psychiatry. In this paper the overlap between the TRC and psychiatry is explored.

THERAPEUTIC VALUE OF TESTIMONY

Although there is no reference in the Promotion of National Unity and Reconciliation Act to mental health, psychology or psychiatry, the TRC recognised the importance of providing psychological support to those who testified before it and consulted with mental health professionals about the way in which testimony should be taken and psychological support provided. A number of the 15 commissioners were mental health professionals, and the TRC utilised professional psychological help to train its staff on issues pertinent to psychological support.

The informal mandate to ensure such support had several components. Statement-takers were trained in basic counselling skills and were also trained to identify those who needed referral for counselling (Orr, 1998). In addition, those who testified publicly were briefed before and debriefed afterwards. Finally, applicants were encouraged to form support groups and appropriate people (e.g. doctors, clergy) were encouraged to assist by providing their services.

An important question here is whether recounting past trauma is in and of itself therapeutic for the individual, or whether such testimony risks the possibility of secondary traumatisation. Drawing on a cathartic model of psychotherapy, many treatment programmes for post-traumatic stress disorder (PTSD) insist that patients verbalise their past traumas. Furthermore, society has long given importance to the dramatisation of experiences of trauma. Indeed, some evidence suggests that testifying about past abuse is in fact therapeutic (Agger & Jensen, 1990).

Later psychodynamic models of the mind, however, have emphasised the importance of the relationships in which psychopathology and psychotherapy are based. In this model, the relationship between the testifying victim and his or her listeners is itself crucial. Having to talk about the trauma to an unempathic audience may result in secondary traumatisation. Individuals who participate in the rituals of national healing are not necessarily helped by the process (Swartz, 1998).

It seems reasonable to argue that the testimony in and of itself does not clearly have a psychotherapeutic effect. The needs of witnesses who suffer from PTSD go beyond a single opportunity to testify before a commission. The occasional attempts by the TRC to bring together perpetrators and victims "to seek reconciliation" may well have been an overly optimistic strategy. Nevertheless, the TRC recognised the importance of psychological support for witnesses and provided a dignified forum for those who appeared before it. Some have stated that the opportunity to articulate their pain and suffering before the nation has allowed them to move forward effectively with their lives (Orr, 1998). Similarly, for the nation as a whole, the TRC process may have had positive, perhaps even therapeutic, impact.

To date, there has been no formal study to determine the therapeutic effects of the TRC. Nevertheless, if the anecdotal evidence that testimony was empowering is true for some, this constitutes an important lesson for psychiatry. Arguably, social structures can theoretically exert a more important influence on post-traumatic reactions than individual psychotherapy interventions.

THERAPEUTIC VALUE OF TRUTH

Boraine, in the Internet lecture cited earlier, has adopted the metaphors of medicine in writing about the TRC, arguing that:

> "One of the ways in which to start the healing process in South Africa is an honest assessment and diagnosis of the sickness within our society in an attempt to give people, both perpetrators and victims, an opportunity to face the past and its consequences and to start afresh".

Certainly, there are schools of philosophy and psychotherapy which hold that the truth comprises objective data 'out there'

which can readily be determined using the scientific method, and which emphasise the importance of closely examining reality and correcting irrational thoughts. However, others have noted that data are always collected and described within a social narrative that is 'meaning-making', and have emphasised the importance of establishing a therapeutic narrative and making sense of the past, rather than of ascertaining 'the truth'.

It is doubtful that the significance of the TRC rests solely on accurate determination of any objective 'truth'. For one thing, gross violations of human rights in South Africa have been widely known and published by critics of apartheid for years. In addition, the abuses of apartheid went far beyond gross violations of human rights; apartheid penetrated the day-to-day lives of all South Africans in an obvious and negative way.

One critic has argued that the TRC does not so much allow truth and reconciliation as knowledge and acknowledgement (Ash, 1997). Certainly, large segments of the population have criticised the TRC for being a 'witch-hunt' or for failing to provide retributive justice. However, it seems significant that so many appear to have been willing to accept the process of the TRC as a valid approach to the past, one that makes meaning of past struggles.

PSYCHIATRY AND VICTIMS: THE NATURE OF POST-TRAUMATIC STRESS

The subject of PTSD has been raised a number of times in the TRC hearings. At hearings on conscription by the apartheid military, for example, a white psychologist in the former South African Defence force described his personal experiences and the symptoms of PTSD, emphasising the long-term negative impact that exposure to violence may have. Indeed, there is a long tradition of 'progressive' mental health practitioners in South Africa arguing that apartheid resulted in pathological chronic stress responses (Swartz, 1998).

PTSD has also been raised as a defence by perpetrators at the hearings. For example, Jeffrey Benzien, a security policeman who tortured many political activists, claimed that PTSD accounted for his loss of memory and consequent gaps in his testimony. Furthermore, post-traumatic stress (albeit not PTSD) has been raised several times by victims in order to emphasise the need for reparations.

The classical view of PTSD is that this is a normal, if exaggerated, emotional response to severe stress. The arguments of progressive practitioners that apartheid resulted in a chronic PTSD in many South Africans is certainly consistent with this view. However, evidence about PTSD suggests that this condition is in fact an unusual and abnormal response, with specific biological underpinnings that differ from those responsible for other disorders (Yehuda & McFarlane, 1995).

The TRC arguably failed to recognise the specific nature of PTSD. For example, in a draft paper prepared by the Reparations Committee of the TRC, there was a split between medical and emotional reparations. It was argued that reparations are either for medical traumas (e.g. witnesses requiring surgery) or for emotional traumas (e.g. witnesses requiring counselling). The implicit failure to recognise PTSD as a complex psychobiological phenomenon may have fostered under-recognition of PTSD and contributed to a failure to intervene appropriately.

Nevertheless, one of the lessons of the TRC for psychiatry may be the importance of focusing not so much on traumatic stress as on resilience. It has been argued that the revenge of those who survived the Holocaust was not the Nuremberg trials, but rather going forward and succeeding with life. Similarly, the emphasis of the TRC on the normality of emotional responses to trauma, and the expectation that the TRC itself will lead to social normalisation, are consistent with a view that emphasises resilience rather than psychopathology. Schwartz & Levett (1989) note that, "It is a serious fallacy to assume that if something is wrong within the society, then this must be reflected necessarily within the psychopathological make-up of individuals". Much as it is important for clinicians not to underdiagnose psychopathology, so too is it paramount to recognise and encourage the strengths and resilience of patients.

PSYCHIATRY AND PERPETRATORS: THE NATURE OF PSYCHOPATHY

In the aftermath of the Second World War, the psychological literature saw a great deal of debate about the nature of those who had committed gross atrocities. Outstanding works include Adorno's research on the authoritarian personality (Adorno *et al*, 1950), Arendt's speculations on the banality of evil (Arendt, 1994), as well as a range of later contributions to this area.

One crucial question is whether those who have perpetrated gross violations of human rights are psychopathic. There is a group of perpetrators who have failed to show genuine remorse before the TRC for any of their actions. These perpetrators blamed their actions on the orders of superiors and emphasised that they were engaged in a war. While such witnesses may not meet current diagnostic criteria for antisocial personality disorder, they arguably fall within broader characterisations of the psychopathic personality (Kernberg, 1975). At the very least, the behaviour of those who are able to commit torture in the name of ideals such as country and God raises important questions about dissociative mechanisms and self-deception.

On the other hand, a number of perpetrators have expressed remorse for their actions and have begged for forgiveness. Some of these witnesses noted that they accepted the political dispensation of the day, but also described points at which they realised that what they were doing was unconscionable. Such witnesses arguably do not meet diagnostic criteria for antisocial personality disorder and have relatively mature personality structures. The apparently genuine shift in the world view of some testifiers raises important questions about the mechanisms underlying psychological change and maturation.

Closer study of perpetrators may shed further light on our understanding of antisocial personality disorder and related personality disturbances. Psychiatry has arguably not devoted sufficient attention to evidence that societal factors influence the prevalence of psychopathic behaviours. Authoritarian societies have often been argued to encourage certain kinds of primitive behaviours. Under peer pressure certain kinds of personality all too readily demonstrate a propensity for engaging in psychopathic behaviour. Such phenomena deserve more attention from clinicians.

PSYCHIATRIC PRACTICE

A particularly important hearing from the viewpoint of medicine and psychiatry was

a special session devoted to the health sector. The failure of the Medical Association of South Africa (MASA) during the years of apartheid to condemn those who allowed the torture and killing of political prisoners, like Steve Biko, is well known. At the health sector hearings, a range of evidence for the involvement of health professionals and their organisations in human rights abuses was presented by various witnesses.

Similarly, several well-known indictments of South African psychiatry have been delivered in the past, including that of the American Psychiatric Association (APA) in 1979. An APA delegation to South Africa condemned inferior medical and psychiatric care for Black people and pointed out the destructive impact of apartheid on the mental health of Black South Africans. Similar evidence was submitted about psychiatry during apartheid at the health sector hearings. At no time, however, was evidence raised that psychiatrists had used psychiatric diagnoses for political repression.

In their submission to the TRC, MASA repeated much information from an earlier formal apology for acts of commission and omission during the years of apartheid (Federal Council, 1995). Although MASA was not directly involved in gross violations, it practised racial discrimination and closed ranks in protection of doctors guilty of misconduct. The Society of Psychiatrists did not deliver oral testimony before the TRC, but similarly acknowledged in writing that opposition by the Society to apartheid practices had invariably been elicited only after the application of external pressures.

South African psychiatrists may have been guilty of ignoring the effects of apartheid on mental health and of failing to mount sufficient criticism against this system. While some mental health professionals in South Africa were vocal in criticising apartheid and gross violations of human rights (Forster *et al*, 1987), such criticism was likely too little and too late.

What are the lessons from the TRC for psychiatry in other parts of the world? Although the political issues in many areas are not perhaps as stark as those faced by psychiatrists during apartheid, there are clearly many important social issues which affect patients and which need to be addressed. Such issues include the impact of managed care on patients and the effects of pharmaceutical industry practices on the profession. Although psychiatrists may have no more powers than any other citizens to change society, the TRC reminds us to continuously bear in mind this question – what would we say a few decades from now if we, as physicians and psychiatrists, were interrogated by a commission of truth and reconciliation?

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