THE INVOLIABILITY OF MEDICAL ETHICS

Confidentiality between patient and doctor is a cornerstone of the medical profession worldwide, and the inherent dangers in making exceptions are greatest in a political context. This confidentiality must be respected by any state wishing to have a credible human rights policy, which is why we have often dealt with cases in Turkey.

The issue of confidentiality has now been raised again, but from a part of the world from which we least would have expected it: Germany, Berlin (see article on p. 100). With the political aim of minimizing the increase in the number of refugees, doctors from the so-called Police Medical Service under the German Ministry of the Interior have used highly unacceptable methods to obstruct doctors in assisting Bosnian refugees. The methods were similar to those we have seen at rehabilitation centres in Turkey, and they constitute another example of how doctors’ fundamental right to protect their patients is being undermined. In the case from Berlin, a governmental organization ignored and interrupted ongoing medical treatment, instigated police searches of doctors’ clinics – even during consultation hours – and confiscated patient files. Upon possession of this confidential material, they accused patients of fraud. In this way, existing codices and norms were broken, as political priorities had overruled the opinions of medical experts. Cases have been reported in which the Police Medical Service have handcuffed and abducted refugees who refused to be examined at the Police Medical Service Headquarters.

There is only one positive aspect of this: Germany’s democratic system, which – in contrast to that of Turkey – makes it possible to put pressure on the authorities and to investigate matters more thoroughly. Thus, the official medical bodies in Germany have clearly stated that the events “lack all standards of a professional expert opinion”, administrative courts have concluded that involuntary examination by state authorities is unconstitutional, and the Committee for Health has demanded that the government hand the re-examination of Bosnian refugees over to other public medical services.

Is it possible that the events in Berlin were inspired by the Turkish attacks on doctors and rehabilitation centres? The answer is “No”. It is simply that the bureaucracy in the Ministry of the Interior acts like a state within the state – not accountable to anyone. In 1996, the rehabilitation centre in Adana, Turkey, refused the authorities access to 167 medical records of clients treated at the centre. For this “crime”, Dr Köse was found guilty and fined for not informing the authorities of data pertaining to clients receiving treatment for post-torture complaints. In 1999, Professor Lök and Dr Uzun were subjected to dubious court trials, not only because they diagnose and treat victims of torture, but also because they are doing their duty by treating victims of torture regardless of the political beliefs of their clients. It is a clear message that doctors in Turkey are not only being harressed and in some cases tortured, but they are also being censored. The consequence of this is that torture victims are afraid of seeking the help they need. Therefore, the IRCT has – in collaboration with other organizations, politicians, embassies, medical institutions, and representatives of the World Medical Association – initiated an international campaign regarding Turkey. The campaign puts international pressure on the Turkish authorities in order to stop these crimes. A recent example of the continuous attacks on medical work was when the Turkish Government interfered with a medical meeting on prison health. (see “News in Brief” on p. 124).

The IRCT is seriously concerned about the way in which the trials in Turkey have been conducted and now also about the behaviour of the Berlin Police Medical Service and the German Ministry of the Interior, even if the latter was misinformed by police doctors. The IRCT sees these cases as a further reason for having a Special Rapporteur for Human Rights Defendants. Furthermore, health professionals in particular need support as they are increasingly being identified with the political standing of their patients. This is a serious issue since the non-discrimination of patients is one of the fundamental teachings of the medical profession, be it on the basis of race, belief, or political opinion. In fact, any such dissociation is a serious breach of medical ethics.

H.M.
Dual loyalty – a case in point: German police doctors break medical confidentiality

Christian Pross, MD, Medical Director*

The problem of dual loyalty is demonstrated in an escalating conflict between physicians caring for Bosnian refugees and police doctors in the German capital Berlin. Doctors of the Police Medical Service (PMS) have produced evaluations in a production-line manner which serve as tools for the immigration authorities to repatriate traumatized refugees who are undergoing treatment. The practice of a psychiatrist and a family physician who treat large numbers of Bosnian refugees was searched by the criminal police. During the raid, the police confiscated over 500 patient files. In the course of studying the prosecution documents, the psychiatrist’s defence lawyer found that in the months ahead, police doctors had illegally passed on a large amount of confidential data from evaluation records of Bosnian patients to the criminal police. The evidence was so strong that a state attorney started investigating the conduct of two PMS members due to a suspicion of breach of medical confidentiality.

The roots of the conflict go back to December 1995 when the Dayton Peace Accord was signed. Immediately after the accord, many Bosnian refugees received their summons to return home. Considering that at least 60% of Bosnian refugees in Germany come from the Republic of Srpska, to which they cannot return, the threat of deportation caused reactions of acute anxiety. After long and intense negotiations, doctors and psychologists working with survivors persuaded the State Ministry of the Interior that traumatized Bosnian refugees were to be exempted from repatriation as long as they needed treatment. This decision was a landmark in German immigration policy, because for the first time psychic trauma from persecution was officially acknowledged as legal grounds for asylum. Following the decision, the Berlin Center for the Treatment of Torture Victims (Behandlungszentrum für Folteropfer, BZFO), and other trauma experts made an agreement with the Berlin State Government defining criteria for evaluating Bosnian refugees suffering from PTSD. It was agreed that evaluations from a defined group of specialists would be checked by a psychiatric medical officer in the Ministry of Health of the State of Berlin if they fulfilled all the required criteria of a professional expert opinion. Only in questionable cases would refugees have to re-examined and evaluated for a second opinion. This procedure worked quite smoothly for about a year. In most cases BZFO and other expert opinions were accepted and the patients’ residence permits were prolonged every 6 or 12 months.1

Doctors or agents of the state

In the beginning of 1998, political pressure to repatriate Bosnian refugees more quickly increased. Therefore the Berlin Ministry of the Interior claimed that the Medical Officer of the Ministry of Health was too “soft” and that most of the evaluations from trauma specialists were fabricated, a loophole for malingerers. The “tougher guys” from the PMS were called in to check the evaluations. Gradually, the whole population of about 80 traumatized Bosnian refugees was summoned to the headquarters of the Berlin Police for re-examination and a second opinion by police doctors. In almost all cases the PMS stated that the existing expert opinions were false, that they detected no signs of trauma, and that they found the refugees fit for travelling. They could therefore safely be put on the next plane to Sarajevo.

BZFO psychologist and researcher Angelika Birk recently published a comparative study on the quality of the re-evaluations of the PMS.2 She compared the expert opinions of the PMS with those of psychiatrists who are experts in psycho-traumatology. The sample consisted of 26 traumatized Bosnian refugees. The results showed that the expert opinions of the police doctors lacked most of the required criteria such as a well-documented history, a diagnosis according to the international diagnostic classification for PTSD, and a prognosis. The PMS opinions proved to be superficial, incoherent, and full of contradictions. For example, the typical PTSD symptom of avoidance was falsely judged as a sign of recovery. A causal relationship between traumatic events and the symptomatology of the patient was denied or the symptoms were related to a personality disorder or the difficult living conditions in exile. Traumatic events such as witnessing massacres or the killing of next of kin and maltreatment was classified as ordinary, not-above-average war events. The need for treatment was denied, and if it was acknowledged, only drug treatment was deemed necessary whereas psychotherapy was considered unnecessary and ineffective. The examinations of the PMS were performed without professional interpreters. Instead relatives or children had to serve as interpreters. In one case, an 8-year-old child had to translate her mother’s history of trauma, including details that are often taboo within families. It was obvious that the PMS opinions were not medically oriented, but had been written for the political purpose of overruling the expert opinions of trauma specialists and of justifying repatriation. Instead of

* Center for the Treatment of Torture Victims
Haus 14
DRK-Klinikum Westend
Spandauer Damm 130
14050 Berlin
Germany

TORTURE Volume 10, Number 4 2000
protecting patients, the doctors of the PMS acted as agents of the state.

The examinations by the PMS take place under pressure and cannot be considered voluntary. Refugees are told that if they do not comply, their welfare payments will be cancelled. The doctors at the PMS have no knowledge or training in the diagnosis of PTSD. Interpreters and social workers who accompanied clients to the PMS could tell things which reveal a lot about the attitude of the police doctors. Frequently during examinations police doctors would tell clients: "Germans have also lived through a war, but have not fallen ill and have not escaped. [...] Rape is a terrible thing, but it is no reason to seek asylum in Germany; considering that German women who are raped by foreign immigrants stay in Germany. [...] War is part of life. [...] Therapy only serves to continue digging in wounds. One should rather work and look after one's children. German women also suffered, but they got over it by working. [...]"

Cases were reported where refugees who had refused to be examined by the PMS were forcibly abducted in handcuffs by police officers and taken to the PMS headquarters. Some patients suffered severe relapses of PTSD symptoms, including suicide attempts, after being examined by the PMS.

**Police search doctors' practice**

On several occasions, the Berlin Minister of the Interior, Mr Werthebach, publicly claimed that most expert opinions on traumatized Bosnian refugees by trauma specialists are opinions of "complaisance". The General Assembly of the Berlin Medical Association and its President, Günter Jonitz, took this statement as an attack on the sincerity and reputation of the whole profession. Mr Jonitz publicly declared that the superficial statements of the PMS lack all standards of a professional expert opinion. At a meeting between the PMS, representatives of the Ministry of the Interior, the Medical Director of the Center for the Treatment of Torture Victims, and the President of the Berlin Medical Association, the latter offered to implement a kind of independent arbitrary committee to settle the controversy. However, the Ministry of the Interior showed no willingness to cooperate.

In about 30 court decisions based on a third expert opinion, judges from administrative courts (Verwaltungsgerichte) confirmed the original evaluations of trauma specialists, evaluations that had been overruled by the PMS. In one recent court decision, the judge stated that the involuntary psychiatric examination by state authorities of virtually a whole patient population is unconstitutional.

The situation further escalated in March 2000 when the above-mentioned scientific study by BZFO psychologist Angelika Birck was published. The Assembly of the Berlin Medical Association demanded that the large-scale routine re-examinations of Bosnian refugees by the PMS should be stopped and that independent doctors should only be asked for a second opinion in controversial cases. Only a few days after the study had received broad media attention a special force of the criminal police named "Trauma Commission" searched the practice of the above-mentioned psychiatrist and family physician. The search took place during consultation hours and in the presence of patients. Both doctors care for a very large number of traumatized Bosnian refugees because they speak their native language.

The psychiatrist's defence lawyer reported from the prosecution documents that the "Trauma Commission" previously had only found 14 evaluations that were suspected to be fabricated and that in the months before the raid, the state prosecutor did not see sufficient reason to search the doctors' practice. Only after the extensive news coverage, the same prosecutor suddenly ordered the raid within a couple of hours. It looks as if the police search occurred under political pressure from above and was meant to intimidate the doctors and their patients. What further raises questions about the raid is the fact that an obscure anonymous police informer was involved as well as a witness who was known to be psychotic.

The same prosecutor started investigating against a psychologist and the Medical Director of the PMS for breach of medical confidentiality. The psychologist had passed on detailed clinical records and lists of names of Bosnian clients to the criminal police, although the police had explicitly reminded her of her duty of medical confidentiality. Meanwhile the prosecutor has cancelled his investigations by stating that the psychologist could not be sued because she was not in a position to see the illegal character of her actions, considering that the Medical Director had assured her that they were legal. However, the prosecutor confirmed that an illegal breach of medical confidentiality had taken place. Investigations against the medical director were cancelled because of minor guilt. It cannot be excluded that pressure from above was exerted on the prosecutor to cancel his investigations. The breach of the cornerstone of medical ethics by police doctors can only be understood as an act of anticipatory obedience to state authority. Following the search of the psychiatrist's practice, several of his patients are now being sued for fraud based on the use of false medical opinions in their application for a residence permit.

One wonders whether the authorities ever considered what it means to have a police squad break into a physician's consultation room during opening hours and in front of patients sitting in the waiting room. Have they forgotten that the physician's consultation room and the special, confidential relationship between doctor and patient are protected by the constitution?

**The State Parliament intervenes**

The Committee for Health, Migration and Social Affairs of the State Parliament of Berlin in its session on July 6, 2000 confronted the Minister of the Interior Mr Werthebach with the accusations against the PMS. In a stormy session, the Minister made it clear that he considered the numerous administrative court decisions against PMS evaluations as irrelevant and not binding for his administration, and he insisted that the PMS was acting properly and in accordance with the law. However, the majority of the Committee members were convinced that it was not, and they demanded that the government should take the task of checking evaluations of traumatized refugees away from the PMS and hand it over to other public medical services such as district health officers. Several committee members accused Mr Werthebach of having shown blunt disrespect for the judiciary. In a written statement handed out to the Committee beforehand, the Minister accused a physician, who had publicly criticized the PMS, of not being sufficiently qualified as a doctor. He also indicated that – besides the psychiatrist whose practice was searched – another serbo-croat speaking psychiatrist was under scrutiny for producing opinions of "complaisance". This psychiatrist now fears that her practice will also be searched and has asked the Berlin Medical Association for protection. Outside the Committee meeting information
leaked that the Medical Director of the PMS some time ago had asked police officers to take action against a gynaecologist who for years has been criticizing the PMS publicly for not providing proper health care for refugees in repatriation detention centers. In a police protocol the Director was literally quoted as having asked them to "teach him a lesson". Shortly afterwards the gynaecologist received an official order to stay away from detention centres where he had frequently examined and assisted inmates.

The latest news: Following the recommendations of the Committee of Health, the Committee for Interior Affairs of the Berlin Parliament in its session of September 11 forced the Minister of the Interior to give in. He publicly announced that he is tired of the accusations against the PMS and that the Ministry of Health should now appoint independent doctors to do re-evaluations. The end of November was set as a deadline for finding a new solution. What comes out of it remains to be seen. A most recent press report outing the police psychologist as mentally disturbed. It had for a long time been an open secret among professionals that there was something strange about her methods of investigation and her assessments, and even in police circles there were serious doubts about her credibility. The Minister of the Interior had been informed about this several times. Nevertheless, nothing was done about it. The question must be raised whether the superiors of this psychologist in the Ministry failed to fulfil their duty to properly supervise and care for an obviously incompetent colleague. One must also ask why this person was hired in the first place, considering that a number of refugees have already been repatriated due to her assessments.

It is encouraging that the joint efforts of doctors caring for refugees, of the Berlin Medical Association, and of the media have been strong enough to achieve a compromise with a powerful institution such as the Ministry of the Interior. But a bad feeling remains: The Minister of the Interior showed no respect for the judiciary, physicians who assist torture victims were threatened and intimidated, police broke into the protected environment of a doctor's practice under questionable legal assumptions, etc. So far one has only heard about such events in police states like Turkey. But this is not Turkey, it is the Federal Republic of Germany. Damage has been done to a group of people long aquatinted with persecution and xenophobia. These refugees have had their mental health endangered, ironically, in the process of seeking safety and healing.

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From AI's medical groups towards cross-disciplinary collaboration against torture

An overview through 25 years

Henrik Marcussen, MD, DMSc, Consultant* &
Inge Genefke, MD, DMSc hc, Honorary Secretary-General*

The Danish initiative and the first years
Amnesty International's medical groups, which were created following a Danish initiative, play an essential role among the many functions of Amnesty International. The medical work has developed in many directions, becoming centres of growth and displaying an effectiveness far beyond the framework of human rights organizations. Thus, it is to the medical groups' credit, and not least the Danish group as the initiator, that torture is a recognized modern clinical concept with respect to the diagnosis and treatment of torture sequelae.

The most important results of the Danish initiatives and ideas, which developed in 1974, are the principles for the treatment of torture victims, now used in refugee centres, asylum-seeker centres, by the Red Cross, and not least by the worldwide network of treatment clinics and projects such as those associated with the International Rehabilitation Council for Torture Victims (IRCT).

The medical groups have also been responsible for other tasks and initiatives. Thus, an active group concerned with capital punishment was created in 1981. The best known aspect of the work of the medical groups is no doubt their letter-writing action groups - letters sent to responsible people in authority concerning individuals, often with medical problems, exposed to violations of human rights. There have been close relations with departments of forensic medicine, for which the medical groups in turn have been important sources of inspiration and development. Finally, valuable research has added significantly to the knowledge of torture sequelae, as well as to the knowledge within specialties such as psychiatry, anthropology, sociology, patho-anatomy, and clinical medicine.

A fragile start
Amnesty International (AI) was created in London in 1961 by the 39-year-old lawyer, Peter Beneson. In November 1960 he read a newspaper article about two Portuguese students who had been arrested at a restaurant in Lisbon and sentenced to seven years in prison for having lifted their glasses for a toast to freedom. His reaction led to a full page article, "The forgotten prisoners", in The Observer, and the article was widely referred to by leading newspapers in the West.

In collaboration with international organizations, AI is trying to obtain three goals:

1. International standards for the protection of prisoners.
2. Effective measures to assure adherence to these standards.
3. Influence on and strengthening of international standards to secure human rights.

In 1973, AI suggested collecting signatures for an appeal to condemn torture, to be presented to the UN General Assembly. In Denmark 114,000 signatures were collected. The climax of the campaign was an international conference in Paris 10-11 December 1973, at which medical organizations were encouraged to participate in medical examinations in areas of the world where the extent of torture was most critical. The aim was to help torture victims to prove that torture had taken place - that they had not voluntarily run into walls, thrown themselves down stairs, beaten their heads against walls, cut themselves with knives or razor blades, or burnt themselves with cigarettes. A Danish AI participant, Dr Peter Moltke, wrote a report from this meeting. His colleague, Dr Inge Genefke, a member of the Danish board of AI, wrote an article in the Journal of the Danish Medical Association, in which she called on Danish doctors to take part in this work.

Following this request, four doctors joined the action group. Apart from the two mentioned above, they were Ole Vedel Rasmussen, who later trained as a surgeon and is now working internationally against torture, and Helmut Stadler, now a general practitioner.

An official statutory meeting of this first medical group took place in Copenhagen in October 1974. The group then comprised 10 members; apart from those already mentioned, there were specialists in anatomy, surgery, psychiatry, general practice, neuro-physiology, dermatology, and public health with a background of forensic medicine. It was clear that the group had a broadly based professional background, which was a great strength and the basis for the efficiency of the work to come with respect to the documentation and description of the physical, mental, and social sequelae of torture.

The early torture examinations
The work started in almost completely virgin soil. There was no scientifically based literature about torture as such. There was a lot of information about the "concentration camp syndrome", but there were no systematic medical studies about the extent of torture or its long-term sequelae. The first task
of the medical group was therefore to develop a standard protocol for interviewing and examining torture victims in order to obtain detailed systematic descriptions of torture methods and their immediate and long-term symptoms. The examinations concentrated on refugee contingents, the first being Chileans who poured into Europe, including Denmark, because of the Pinochet dictatorship. Immediately after the fall of the Greek military junta in 1973, examinations were carried out of people who had been tortured during that regime.

Two essential groups of torture victims had already been identified at the time, since, apart from the sequelae of torture, it was possible to notice differences due to the fact that the Chileans were refugees, while the Greeks were living at home with the status of resistance fighters. Several examinations of groups of tortured refugees from Uruguay and Argentina followed in Copenhagen during the next years, and there were examinations in Italy, Latin America, and Northern Ireland, and again in Greece to re-examine the group that was seen soon after the torture seven years earlier. The picture that emerged from these examinations formed the basis of a thesis by Ole Vedel Rasmussen in 1990.

The Athens meeting and evidence of torture
The international work continued with the first scientific meeting, in Athens in March 1978, called: "Violations of human rights: Torture and the medical profession", led by Povl Riis, Denmark, and Herman Van Geuns, Holland, and with 27 presentations, 13 of them by Danes. The AI publication "Evidence of torture" came out the previous year, containing an account of the first studies to be circulated internationally – studies that had already appeared in the Journal of the Danish Medical Association. In this connection, the subject of torture was introduced in an editorial by Professor Povl Riis, which ended: "Perhaps there are colleagues who think that subjects that may have political overtones, such as torture and other forms of persecution, should not be published in a scientific medical journal. [...] No one should declare themselves neutral with respect to fellow human beings in pain or being tortured. Torture therefore is undoubtedly a matter for the medical profession, and therefore the concern of the readers of the Journal of the Danish Medical Association." Now, 22 years later, it seems curious that it was strange to be involved in something which was then considered outside medical research and interest. But the support of Professor Riis was an expression of similar support from the Danish Medical Association, the associations of medical specialties, from journals, journalists, foundations, colleagues, and politicians during those first years.

And this support helped the group to progress.

The Medical Advisory Board and extension of the medical groups
The Medical Advisory Board (MAB) was formed as a medical council for AI's international executive committee concerning medical problems. The Board was created in 1977 and had four members, including two active Danish initiators of the work against torture, Inge Genefke and Erik Karup Pedersen. During the following years, the medical involvement was more and more integrated in the work of AI. Three international working groups were formed to support the rehabilitation of torture victims, to clarify medical ethics, and to prevent torture. At that time, ten medical groups were organized within AI, including a very active Canadian group.

In the wake of the publishing of "Evidence of torture", press conferences were held in Holland, Sweden, and the UK, and this inspired the creation of other medical groups, of which those in France, Switzerland, and Greece were among the first. MAB was a natural creation to stimulate the formation of national medical groups, their organization and coordination.

However, problems arose with the integration of the medical questions within the widely ramified membership organization of AI. An important study to demonstrate the sequelae of electrical torture had started, and it showed that there were differences according to whether direct current, as in battery driven sticks, or alternating current was used. The study involved the use of skin from living pigs under local anaesthesia, but this animal experiment was not acceptable to some AI members. It became necessary to concentrate research experiments outside AI as such experiments were not part of the AI mandate. A purely scientific Danish organization, a working group called "Anti-torture research", was therefore created to work with torture research, and the collection and publication of research results.

But other fields of interest did not naturally belong under the auspices of AI either. Various groupings similar to the above mentioned were therefore created, such as a working group called "Prevention of Torture" with focus on "high risk doctors", i.e. prison and military doctors. A side product from this working group was the film "Your neighbour's son", showing how individuals in a restrictive and military-based closed system can be "brought up" to do the work of torturers.

Examination of torture victims
Working tools
Turning back to the basis of the Danish medical group's work during the first years, one can see the development of an examination technique and standards that were gradually adopted by newly established groups in other countries.

The work of the medical group was developed during the first years in Denmark, a democratic country that saw the results of torture only in those seeking refuge there. For obvious reasons it was difficult to obtain documentation of the immediate clinical picture of torture. However, it was sometimes possible, following liberation actions or flight, to examine the acute, external manifestations. The examinations were therefore mainly based on retrospective information with respect to victims who had been tortured some time before, often many years before. At such a time changes can be seen and information obtained that can be put together as components of a syndrome, often directly related to the torture. Torturers use a technique that gives as few visible sequelae as possible in order to be able to deny that the torture took place. Furthermore, the authorities often use counter arguments: the victims were lying or exaggerating, it was an unusual single case, or, reluctantly, a policeman or prison guard let himself be carried away.

Therefore it was essential for the medical examinations to be carried out on groups, i.e. not based on single cases, and for the examination method to be systematic, uniform, and sufficiently tested. The standard practice was to use a detailed set of questions with respect to previous health, medical treatment and hospital admissions, the situation surrounding the torture, especially the method and duration, and the imprisonment – its physical conditions, duration, availability of primary medical treatment or other help for
physical harm or torture. Finally, symptoms from torture and physical injury, and symptoms and signs during the period between the torture and the present clinical examination, focussing on possible neurological findings. Two doctors, and sometimes a dentist, from the Danish medical group always took part in these basic and primary examinations. Therefore, in the analysis of a complete clinical material, great attention must be paid to obscured components of symptoms, compared with what must be considered the torture's immediate clinical manifestations. This, and the obvious lack of clinically controlled studies, is to some extent compensated by the following: the victims' symptoms are remarkably similar, to a large extent independent of their place of origin. Before the torture, the victims were young, educated, active, involved, with a wide emotional range, i.e. representing a positive, strongly selected group from which one would not expect previous socio-psychological and psychosomatic dysfunctions.

Three surprising discoveries
By registration and systematic collection of the facts about torture, the medical groups have been able to present, study, and analyse the results concerning deaths, brain damage, mental maltreatment, and skin lesions in an international forum of meetings and seminars on forensic medicine, neuro-medicine, and psychiatry. At first the work aimed to help the victims to prove their ordeals, but the systematic investigations went much further. The first surprise was that torture, unbearable and disgusting at the time, continued to persecute the survivors many years later with its physical and mental sequelae. The second was to discover that torture in the modern world is not aimed at obtaining information, as represented in fiction and films. Information, often known beforehand, is a minor aim. The real aim is to break down the victim's personality and identity, such as is possible by forcing the victim to give away confidential material. It also became clear, as the third surprise, that torture is aimed at strong personalities, i.e. people who have shown courage and strength to work against repressive regimes. Breaking down these persons, e.g. advocates of human rights, student leaders, politicians, representatives of ethnic minorities, will frighten the rest of the population, not least by showing their idols as broken down people.

The creation of RCT
The many studies of torture victims gradually created an increasing need for doctors to become involved in their treatment, having concentrated on obtaining the basic knowledge and awareness of torture and its sequelae by describing and systematizing it in detail. But treatment initiatives would also be outside the mandate of AI. At first some treatment took place at the University Hospital in Copenhagen, by permission of its board of directors. However, the demand for treatment was so obvious that a proper treatment centre was created in 1982: The Rehabilitation and Research Centre for Torture Victims (IRCT) in Copenhagen. Soon after, a fourth surprise: treatment gave positive results.

Today there are almost 200 centres and programmes around the world to care for the needs of torture victims. In order to co-ordinate the efforts of these centres, which often work under difficult conditions, particularly in the Third World, to support them in their needs, and to stimulate new initiatives, the International Rehabilitation Council for Torture Victims (IRCT) was created in 1985. Since January 1998 this Council has an independent function, without treatment, but with focus on promotion of treatment and prevention of torture internationally.

Apart from technical and financial support to centres all over the world, IRCT aims to collect and spread information about torture and its sequelae, and the possibilities for treatment of torture victims, and to work for the prevention of torture, for instance by training of police forces.

Cross-disciplinary collaboration
A positive feature now is that the treatment of torture survivors, from being primarily a concern of the health section, has gradually developed to involve other professions, e.g. lawyers, journalists, and other professions that play an important role in this work.

Research and documentation by doctors and other health professionals throughout a quarter of a century has provided new knowledge about torture and its sequelae, and about the ways of handling its injuries. It is this new knowledge that is used to a large extent outside the health sector today. For example, when the work started 25 years ago there was hardly any material about the health aspects of torture. IRCT's International Documentation Centre has today 34,000 units about torture and the treatment of torture victims.

The Torture Symposium in New Delhi
The VIII International Symposium on Torture took place in New Delhi in September 1999. The symposium in India is an example of the development towards involving new professional groups in the work. Until this year the numerous IRCT symposia and seminars have mainly been directed at the health professions, but the spectrum was much wider at the New Delhi symposium. More than 300 participants from 64 countries took part, including lawyers, solicitors, journalists, and other representatives from civilian society. This has added a new dimension to the work and will lead to much stronger joint efforts against torture. It may thus lead to suggestions for better legislation from the lawyers, to go hand in hand with the need for treatment, the effect of which has been documented by the health profession.

The symposium in New Delhi ended with a statement by the official representatives of the Indian authorities to the effect that India would soon ratify the UN Convention against Torture – a decision obliging the government to work against torture and for treatment of the many Indian torture survivors.

Danish support
Amnesty's medical group and the work against torture had its 25th anniversary recently. Such an anniversary does not call for celebrations, but it should be acknowledged that a positive development has taken place during these years, thanks to the engagement of many people, particularly professionals within the health section, but not least Danish politicians and civil servants. This work, which started as a Danish germ, has now increased all around the globe, with involvement and support from people in other countries.

Many goals have been reached, but much more remains to be done. There is need for effort and involvement from many more persons than those who are giving their support today. The latest report from the UN Rapporteur on Torture, Sir Nigel Rodley, documents that torture is practised in 93 countries today. These are 93 too many.
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Remembering and re-story-ing

- an exploration of memory and narrative in relation to psychotherapy with torture survivors

Andrew M. Jefferson, BSc (Hons) Psychology, MA Worldview Studies

Abstract
The aim of this paper is to cast light on the role of memory and narrative in constituting new identities within the context of psychotherapy with torture survivors. First a social constructionist conceptualization of psychotherapy is presented, and then it is juxtaposed with the subjective experience of the torture survivor. Through a consideration of memory and narrative as key to identity and thus to psychotherapy, and with reference to a brief empirical study of intrusive memory conducted at the Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen, Denmark, Casey's concept of traumatic body memory is explored in order to show how memory and processes of remembering are of particular importance to the rehabilitation of the torture survivor. Following these considerations, it is suggested that the processes of remembering and re-story-ing can be restorative within the context of a mutual, connective, therapeutic relationship. Finally, an example from Zimbabwe is given regarding a project in which processes of remembering and re-story-ing can be seen operating at the level of a local society in order to heal social wounds and mend a frayed social fabric.

Psychotherapy – a process-focused conceptualization
Remembering and re-story-ing are two processes vital to the psychotherapeutic endeavour. What is meant by these terms? Drawing on a view of identity as narratively and memorially constituted, psychotherapy is seen as a process of mutual connection between psychotherapist and client whereby the client engages in a confessional, storytelling process.

James Olthuis has described therapy as, among other things, a process of “remembrance and grieving”.2 Therapy can be seen as a process of co-creation of meaning.3 Stories are constructions that help give meaning to our lives. Montgomery has put it this way: “The therapist listens to the client’s story and works together with the client to create new stories, which make new behaviour possible.”3 The term re-story-ing is used not just to connote the narrative aspects of psychotherapy but also to emphasize the “re-”; it is new stories which are told, a restorative process which is engaged in, a new identity – or at least a re-formation of the old – which is constructed mutually through the therapeutic process. Olthuis sees clearly the connection between remembering and renewal. He writes, “Re-story-ing [...] is a process of restoring and restoration.”2

Identity: some theoretical reflections
As mentioned, this conceptualization of therapy is based on a conceptualization of identity as narratively and memorially constituted. Jacques Lacan, the French psychoanalytic philosopher, has written, “my eventual personal identity is the person I remember myself to be.”4 My recollections and re-memories of myself are vital to my present identity. Casey has put it this way: “All that we call the person, personal identity and the like. Everything, in short, that pertains to an individual’s life-history is rooted ultimately in body memory.”4 Identity is thus rooted in memory and, in addition, embedded in narrative. When asked who I am, I will more often than not embark on a short narrative: “My name is [...]. I come from [...], my occupation is [...]. I used to [...].” I will locate the facts of my life within a told account. Narrative is a means of ascribing meaning to experience. Here I am utilizing a naive conception of narrative, i.e. I take narrative to refer to the practice in which humans engage that gives rise to storied experience. I see narrative primarily as a social practice that refers to the stories we tell ourselves and to the stories we tell others that help us make sense of our everyday experiences. Rom Harré goes as far as to say that narrative and self are one and the same thing. It is “narrative, with which [...] one speaks oneself both to oneself and to others”.5 Identity is tied to a meaning-creating and self-creating use of language by virtue of narrative.

Meaning is not pre-given; it is constructed. Polkinghorne has written that “narrative is the form of human expression in which human action is understood and made meaningful.”6 Similarly, Butor has described narrative as “one of the essential components of our understanding of reality” (cited by Murray7). Again, according to Murray, the first collection of essays on narrative psychology written by Sarbin in 1986 sees the project of narrative psychology as “an exploration of the way individuals make sense of their world through stories”(1).7 Therefore it is not surprising that therapy as an endeavour to make meaning of one’s life, or come to terms with one’s suffering or alleviate pain, is a particularly potent instance of the utilization of narrative. Memory and narrative are important in therapy because they are important in life. But what kind of memory, what kind of stories? Memory and acts of remembering (recall, recollection, remembrance, and commemoration) should be considered as thoroughly embodied, not as merely concentrated in “the mind”. Similarly, storytelling/re-story-ing is not about reconstructing original events as they happened in a realist, objectivist sense. Rather, as already mentioned, stories should be seen as constructions enlightening the past (making the past lighter and easier to bear) and giving meaning to the present.
The torture survivor's subjective experience: a study of intrusive memory

Parallel to the above theoretical observations about therapy and identity, it is also relevant to consider the function of memory and narrative in the torture survivors' subjective experience. Many of the torture survivors' symptoms are clearly closely tied to processes of remembering. Presented symptoms often include nightmares, other sleep disturbances, and flashbacks. Dreams/nightmares often consist of direct playback of actual experiences the client has had. There is little in the way of symbolic mediation. Intrusive memory is the term given to the way the past continually re-enters the present without being invited. The past is not recollected; it invades. This type of memory is typically revealed by nightmares and flashbacks and angst-related symptoms triggered by everyday events.

Length of torture memories

A study has been conducted to ascertain the length of time between the experience of torture and the start of treatment, i.e. how long memories have persisted. Twenty client files were surveyed, and descriptive evidence of symptoms relating to intrusive memory was collated. Data was acquired from notes of initial intake interviews and notes written by psychologists either about therapy or from initial assessment interviews. In some instances, data was acquired from other reports contained in the client's journal, e.g. interviews with a doctor, nurse, or rheumatologist. Initial intake reports had primarily been written by psychiatrists or psychologists.

Results

Only three of the 20 randomly chosen files do not offer data relating to intrusive memories. In other words, 85% of files contain descriptive evidence of intrusive memories in the form of nightmares, flashbacks, and other intrusive thoughts triggered by everyday events such as sirens, ticket inspectors, or police officers. The following quotations, each from a different file, illustrate the type of descriptions found (translated from Danish):

When he sees a police officer [...] the sight means he comes to think of torture and his anger is activated.

Dares not sit down because it reminds him of the chairs in which he sat when he was interrogated, and to which electricity was applied.

Difficulties falling asleep are described and he often wakes in the night and experiences the sight of men with dark glasses in front of him.

Has regular re-experiences of the many traumas he has been through, partly due to torture, partly due to the war.

He has many nightmares in which he experiences himself in prison, sees fellow prisoners being executed, etc.

A key, recurring theme is the notion of "re-experience" whereby the client is described in some way re-experiencing the original trauma, and reliving a part of his experience of imprisonment or torture. These thoroughly bodily responses (nightmares, shaking, blushing, heightened heart rate, etc.) must be seen in the context of the fact that the average time elapsed between the subjects' most recent experience of torture and the subjects' entry into treatment was a lengthy 10.75 years.

The descriptive material serves to illustrate the type of symptoms that carry the memories through time; the time span is evidence of the enduring nature and persistence of these particular memories.

Typical defence mechanisms employed by torture survivors

Memory and narrative – in the form of the lack of ability to forget and the lack of ability to incorporate one's experiences of torture into one's life story – play a key role in the symp- toms of the torture survivor. Ironically they also play a key role in the typical coping mechanisms utilized by the survivor in a vain attempt to make sense of their contemporary situation. These coping mechanisms will now be examined. How does the torture survivor attempt to deal with the past?

Many survivors attempt to forget. Torture survivors seem to perceive recollection as a threat to their currently fragile identity, and they therefore maintain a silence about their experience, believing that no one will understand and that no one will be able to contain the pain carried by their stories. A combination of a desire to forget and a desire to protect others – often family members – from pain, as well as feelings of guilt and shame, contributes to a wall of silence. By maintaining this solid wall of silence about their horrific experiences, torture survivors not surprisingly fail to incorporate the torture they have experienced into the broader narrative of their life story. In exile, their lack of a coherent story can particularly have further negative consequences for their identity and result in isolation and depression. A typical response is not to tell stories and to try not to remember. This runs counter to the declared intentions of psychotherapy as conceptualized above.

Remembering: some theoretical reflections

In considering the connections that can be made between memory, narrative, and the above symptoms, the practice of remembering will be examined first.

Casey has offered a novel phenomenological study of remembering, and his notion of body memory offers some significant insights into the study of memory, particularly given the presenting symptoms outlined above. "Body memory" according to Casey "alludes to memory that is intrinsic to the body to its own ways of remembering: how we remember in and through the body."¹ He specifically studied habitual body memory, traumatic body memory, and erotic body memory, his aim being to "pursue memory beyond mind and recover its roots in the world itself." Roughly sketched, his argument runs like this: There is nothing arbitrary about what we remember because it is always something previously lived that we recall or re-experience. All remembering is done through our bodies, which enable us actually to reconstitute and re-enact the past and make memory relevant and real in present experience. Body memories are more than something we have; they are something we are. Habitual body memories involve actions that draw directly but unconsciously on the past. They are memories that are used without conscious thought, and they have a great and powerful immediacy. He illustrates how in our bodies we are able to "re-enact images of the past." This is seen by Casey as a natural and often positive dimension to human life. It means that we do not forget how to swim or ride a bicycle once we have learned it. This is evident in the way our handwriting
remains characteristically the same over time. The movements we make when we write are inscribed in our hands/arms. It is tragically also illustrated by the psychosomatic symptoms and intrusive memories that often follow torture. The sequelae of torture illustrated by the data above are examples of bodily memory in which the “past is as it were sedimented in the body.” This is what Casey names traumatic body memory. The torture survivor’s problem is how to escape this sedimentation which has come about involuntarily as a result of intentional, violent, physical, and psychological torture, the purpose being to destroy the identity of the person. A normal healthy process of bodily remembering is perverted via the horror of torture with the result that the torture experience is repeated over and over again in the torture survivor’s very body. Torture survivors carry their symptoms with them, and they are tragically reactivated by the most trivial of occurrences. The pain (physical and psychological) and history of the torture survivor are carried and revealed in their body.

Casey also explores a defence mechanism relating to traumatic body memories. He believes traumatic body memories are marginalized and kept on the periphery of our lives to protect us from pain. The tragedy is that in the severe cases presented by the survivor of torture, the marginalizing strategies fail to work. Experiences are too well sedimented in the body.

Re-story-ing: some theoretical reflections

What then about narrative? What effects can we see on the torture survivors’ ability to story their life, to find meaning, even to use language? In The body in pain, Elaine Scarry has considered how “physical pain is language destroying,” i.e. physical pain destroys the ability to articulate; pain is resistant to language and unsharable. While my own pain is immanent to me and paradigmatic of absolute certainty, another’s pain is as far from me as possible, despite our shared humanity, and my response to it can be seen as paradigmatic of doubt. Why is physical pain so difficult to articulate? Why is it impossible to convey? Scarry writes that “physical pain – unlike any other state of consciousness – has no referential content. It is not of or for anything. It is precisely because it takes no object that, it [...] resists objectification in language.” This hypothesis presents a challenge to the idea that psychotherapy is about putting pain into words, about re-story-ing pain. However, Scarry herself is interested precisely in how physical pain can be objectified in order for it to be expressed. How can a language of pain be created? Scarry indicates five sources of fragmentary language about pain – the sufferers themselves, the medical disciplines, organizations such as Amnesty International, the courtroom, and artists. Through these voices, pain can be faintly deciphered. Scarry points out, regarding the work of the doctor (and my point is that the same applies for psychotherapy), that the efficacy of therapeutic work “depends on the acuity with which he or she can hear the fragmentary language of pain, coax it into clarity and interpret it.”

Scarry differentiates between physical pain as having no referential content and psychological suffering, which does have referential content. Scarry sees psychological suffering as a form of conscious or unconscious reflection on pain. It is as if she sees psychological suffering as one step removed from physical pain – as in some way a mediating or translating practice. What perhaps is interesting is how physical pain is transformed into psychological suffering and thus becomes expressible. Scarry does not explicitly make clear how this comes about. While paining a picture of pain’s inexpressibility, Scarry simultaneously argues that to lessen pain, language is vital: “Embedded in Amnesty’s work [...] is the assumption that the act of verbally expressing pain is a necessary prelude to the collective task of diminishing pain.”

This is my assumption regarding the importance of re-story-ing. The fragmented language of expressed pain marks an opening to a fuller, more meaning-constitutive re-story-ing. It offers a glimpse, a trace of a bigger picture. The initial stuttering articulations of pain give hope that a broader (though not necessarily in the form of a structural unity) healing narrative can emerge.

A challenge to therapy?

The aims of psychotherapy to encourage remembering and re-story-ing come into conflict with the torture survivors’ apparent chosen methods of coping. Psychotherapy – via a one-on-one interrogation-like procedure – requires the client to remember events that he has spent years trying to shut out. To the client this must seem at best paradoxical, at worst an example of secondary retraumatization! Similarly the silence the client typically has maintained over the years, at great cost to personal and family relationships, is required to be broken. The therapist requires information and wants to hear a story. Again the question is paradox or retraumatization?

In the psychotherapy literature there is a certain degree of discussion about resistance. It is not surprising that there is resistance to a process that goes in direct opposition to the processes one has struggled to implement over, for example, an average of 10.75 years. Even if it is clear to the clients that their coping mechanisms have had limited effect, they have still invested much time and psychological energy in them. These processes of attempting to forget and of keeping silent have perhaps become a part of their identity.

Rescuing therapy – the paradoxical turn back to remembering and re-story-ing

An obvious point to be made regarding the clients’ own coping mechanisms is that, despite trying to forget and refusing to speak, the survivors are often still plagued by the symptoms noted above. In other words, these mechanisms fail to work effectively. Perhaps I have created a false opposition, since it can be clearly seen that the clients’ coping mechanisms are not optimal, and therefore an alternative approach is required. Yet, seen from the clients’ point of view, it is worth bearing the conflict in mind in order to approach the processes of remembering and re-story-ing with sensitivity. Any attempt to impose such processes from above will likely result in retraumatization. Processes of remembering and re-story-ing should be part of a mutual connective relationship, which bears little other than superficial resemblance to the interrogator-victim relationship (2). Casey tentatively recognizes the role re-story-ing plays in dealing with traumatic body memories. While acknowledging that “some traumatic body memories never lose their painful and even devastating sting, especially when they are accompanied by some form of humiliation of one’s person” he is interested in how the pain of the experience can fade over time. This – he believes – is due to “a tendency to transform these memories into reminiscences and recollections [...] they [...] become stories I tell to others.” As we have noted, this does not seem to occur naturally for the torture survivor. The process must be encouraged and facilitated.
In my view, psychotherapy can be conceptualized as a process of remembering and re-story-ing despite apparent paradoxes. The core of the confessional, therapeutic process is working through pain. Recollection is vital to the alleviation of the body's own ways of refusing one the right to forget. Remembering and forgetting are complementary processes. In order to forget, one must first remember and re-story. Even then, perhaps one never really forgets but rather learns to live-with.

**Processes of remembering and re-story-ing at a community or local society level**

Not all survivors of torture have the opportunity to enter into individual psychotherapy. The large extent of torture and organized violence in some parts of the world has left whole communities devastated. Thus it is relevant to consider whether the processes of remembering and re-story-ing, explored above with reference to individual psychotherapy, are applicable at a wider level. In relation to Connerton's ideas pertaining to the way social memory functions to sustain a community's identity via rituals and commemorative ceremonies, which often contain a storytelling element, I will describe a project in south-western Zimbabwe in which processes of collective remembering are being utilized as a means to facilitate change and rebuild the community.

Connerton shows how memory plays a large role in social practices that are relevant to identity formation and sustenance. His primary interest is in studying the "acts of transfer which make remembering possible", i.e. those practices which communicate about the past to others and thus transfer something that can be remembered. He focuses on ceremonies that mark or recall new beginnings. These ceremonies often tend to be celebrations or mourning. They remind one of an ending such that a new beginning can be emphasized, or they mark a break with the past and a new beginning – a redefining moment. While the past is recollected and retold, this is done with the purpose of emphasizing a break with an older social order. This is an attempt to bring about forgetting, i.e. forgetting oppression, forgetting torture experiences, forgetting scenes of abuse, moving beyond these events, and letting them lie historically in the past.

**Rituals**

Ceremonies of this type often consist of rites or ritual action, which according to Connerton "have the capacity to give value and meaning to the life of those who perform them." For Connerton, ritual is a formalized language that is fundamentally performative. This fits nicely with the bodily emphasis of memory explored above. As torture is subsequently revealed in the individual survivor's body, for whole communities who have been subjected to torture or organized violence, it is revealed in the fragmentation of social networks and the body politic. Ritual is a way of acting bodily and in concert in a way that is restorative and counters symptoms suffered by the community. Rituals and commemorative ceremonies typically consist of accounts/recounts of the past (remembering) and languaged liturgies (re-story-ing). Ritualized storytelling has a long tradition. Polkinghorne has made the following observation about the social, intergenerational nature of collective storytelling: "Narrative is a communication not just between contemporaries but also between predecessors and successors [...] Through the transmission of past possibilities to present hearers, the tradition of a historical community's common identity is repeated or retrieved." He recognizes the constituting role of language in community identity formation over time. The stories a community tells contribute to its continuing process of self-definition.

Casey has also considered the areas of commemoration and ritual. He writes: "If body memory anchors human existence and if place memory locates it, commemoration connects it." He, too, indicates the constituting, renewing function of commemorative ceremonies: "Commemorating also creates new forms of sociality, new modes of interconnection; between past and present, self and other, one group and another [...]"

In her paper *Drying the tears of the dead – A way to heal the living*, Shari Eppel gives an example of a broken community trying to piece itself together via commemorative ceremonies which involve retelling and remembering the past.

In Matabeleland, south-western Zimbabwe, communities have been torn apart by torture, killing, and organized violence conducted by two consecutive governments (first under Ian Smith, then under Robert Mugabe) during the last three decades (3). Apart from the fact that the threat of more violence hovers on the horizon, a large contemporary problem is the human remains that lie roughly buried throughout the region. These graves have particular significance due to the religious beliefs of the local population, which stipulate that certain mourning rituals should be carried out when someone dies. If these rituals are not conducted, the spirits of the dead person are not laid to rest, and the family of the person cannot mourn or grieve. Indeed, during some of the massacres conducted by the notorious Fifth Brigade, mourning was forbidden on pain of death. It is as if the perpetrators of the atrocities possessed intuitive knowledge of the community-destroying function of such a prohibition. Not only have family members disappeared via kidnapping or execution, which is traumatizing in itself, but the community has not had the opportunity to mourn, i.e. to engage in the ceremonies that would normally allow the community to redefine itself and move on. Instead, silence has emerged, as well as a refusal to remember horrific events, and a refusal to talk about them.

**Exhumations and reburials**

Here is a parallel situation to that previously considered at the level of the individual torture survivor. Here is a community devastated and damaged and in need of healing. Amani Trust, in the form of the Focused Community Research and Rehabilitation Programme, have become involved in two local village communities and have begun to work at healing the wounds together with them. A project has been set up that involves opening graves, identifying bodies, and reburying with the appropriate attendant rituals, allowing for community participation, mourning, grief, and a chance for the spirits of the dead to be finally laid to rest. The burial service gives the community a chance to meet again, to actively remember, to tell stories about their loved ones, and to talk of the events surrounding their disappearance. Eppel writes: "It has been both heart rending and exhilarating to take part in this process of community witnessing, to see person after person standing up for the first time in front of his or her neighbours and saying 'this happened to me, here are my scars, these are the problems I now face'.” As recently as April 1999, a ceremony was held and a shrine erected to commemorate those killed in a massacre in 1979. This ceremony served as a ritual of renewal and connection, bringing together people who were affected by the massacre but had
never spoken of it in a context in which individual grief could be made collective, thus contributing to the healing of social wounds as well as the wounds of the individual. Amani Trust continue their involvement in the community by facilitating regular community meetings in which processes of remembering and re-story-ing continue. The opportunity for constant retelling, and the often calendrical nature of ceremonies of commemoration, hopefully serve to prevent the emergence of dominant and repressive communal narratives and allow for creative, imaginative deviations and reformations of collective identity. Casey has poignantly written that "when-ever commemoration occurs, a community arises [...]".1

Summary

It has been argued that—despite apparent conflicts—psychotherapy can actively utilize the very structures and processes that are problematic with regard to the torture survivor's identity and coping mechanisms, i.e. narrative and memory, in order to promote healing or at least symptom reduction. The psychotherapeutic endeavour can be seen as a practice whereby active remembering, re-story-ing, and resetting memories can result in active forgetting through the joint creation of new meanings. These processes can also function at a community level to bring hope and healing to whole local societies.

References


Further literature


Notes

(1) Two particularly relevant texts not addressed here are Shotter and Gergen's Texts of identity11 and Rosenwald and Ochberg's Storied Lives: The cultural politics of self-understanding.12
(2) In other words, it would seem at first glance unavoidable that there are two people in a room, one of whom— at least at the start — takes a somewhat questioning role.
Physiotherapy for torture victims (II)

Treatment of chronic pain

Kirstine Anris, MD, Specialist in Internal Medicine, Consultant in Rheumatology,
Senior Stipendiary* & Karen Prip, Chief Physiotherapist*

The treatment of torture victims is different from the treatment of other patients in many ways: Torture victims have been exposed to extreme physical and mental trauma. Many victims live in forced exile and have often lost family and friends, as well as their whole social network. They experience social collapse, suffer from lack of self-esteem, changed identity and have often lost confidence in other people. Treatment of patients from foreign cultures with this background demands a specialized, multidisciplinary effort.

Why physiotherapy?
Several studies of torture victims have shown that physical complaints are common even years after torture and that pain in relation to the musculo-skeletal system is a dominating symptom.1,2 In accordance with these findings, most of the torture victims referred to RCT have wide-spread symptoms from the musculo-skeletal system, including pain and limitation of physical function. Physiotherapy has consequently always played an important role in the multidisciplinary treatment offered at the centre.

When physiotherapy was first introduced in the rehabilitation of torture victims, much attention was paid to specific dysfunctions in the spine, muscles and joints at the clinical examination, as well as during the course of treatment. The aim of the physiotherapy was to restore these dysfunctions in order to free the torture victim from the pain.

Today we realize that torture victims should be considered as chronic pain patients, and that the pain mechanisms are probably more complex than just lesions in the musculo-skeletal system. Aside from the nociceptive pain associated with acute or chronic inflammation due to lesions in the musculo-skeletal system, a considerable neurogenic pain component is presumably present in many of the torture victims.3,4 The physiotherapy has therefore been changed and is now emphasizing active training, the main purpose being to stimulate the torture victim to live an active life despite pain and limitation of physical function. We have developed a treatment programme that includes various manual techniques, relaxation training, a graduated exercise programme and education. Pain-related fear, avoidance behaviour and hypervigilance lead to disuse and disability.5 It is the task of the physiotherapist to help the torture victim to break this "vicious circle" (fig. 1).

Treatment methods used in the physiotherapy at RCT

* RCT
Borgergade 13
P.O. Box 2107
1014 Copenhagen K
Denmark

Hands-on treatment

Various forms of hands-on treatment are used. Some of the treatment methods used are effleurage, myofascial release, and specific mobilizing of joints in the spine or extremities, and Proprioceptive Neuromuscular Facilitation (PNF).

The aim of applying these methods is to provide a certain amount of pain relief and relaxation, and for the therapist to receive information about tissue and pain response. These methods are also excellent means for pure communication through the body.6 The physiotherapist has a continuous dialogue with the patient who often spontaneously tells about his experiences and the pain, from when he was tortured (please see the poem on the next page). All this information helps to form a picture of the pain pattern and the patient's own perception of his body, and the information is incorporated in the treatment.

General physical training and Body-Awareness Therapy (BAT)

Physical training is meant to teach the patients that movements may be associated with good experiences and well-being, and that physical activity is not harmful to the body. The patient participates in cognitive and awareness exercises, and learns how new abilities can be adapted and integrated in his daily life. The training also includes various elements of changes in posture and balance, proprioceptive training and sensory and motor skills by means of rhythmic and coordination exercises. These exercises may be combined with breathing exercises.6,7 Humour and games during training – supported by music – have a motivating and stimulating effect, and thus promote the learning process.

Fig. 1. The fear and avoidance model.
Touch

When I get out
I'm going to ask someone
to touch me
very gently please
and slowly,
touch me
I want
to learn again
how life feels.

I've not been touched
for seven years
for seven years
I've been untouched
out of touch
and I've learnt
to know now
the meaning of
untouchable.

Untouched - not quite
I can count the things
that have touched me

One: fists
at the beginning
fierce mad fists
beating beating
till I remember
screaming
don't touch me
please don't touch me

Two: paws
The first four years of paws
every day
patting paws, searching
- arms up, shoes off
legs apart -
prodding paws, systematic
heavy, indifferent
probing away
all privacy.

I don't want fists and paws
I want
to want to be touched
again
and to touch
I want to feel alive
again
I want to say
when I get out
Here I am
please touch me

* Hugh Lewin

Medical Training Therapy

Training with specialized equipment (Medical Training Equipment) has many advantages. It is specially designed to functional training in movements within the range of motion, where the patients feel secure and experience minimal pain. The movement is carried out without manual interference from the physiotherapist, but under continuous guidance. The choice of exercise is based on the assessment of the patient's functional capacity and should include a variety of functional qualities, which should be adapted during the exercises. These qualities include: neuromuscular training (stabilization, co-ordination and postural balance), joint mobility, and circulation-enhancing exercises. An individual training programme is produced from a specially designed software programme and is tailored to the patient's ability. During the training period the number of exercises, the resistance, and the number of repetitions are increased, and notes are taken to reflect progress and improvement in the patient's physical capacity. This programme, reflecting progress in the patient's physical performance, is highly motivating to continuous training.

Training to improve the general physical condition

The function of several tissues and inner organs are dependent on physical activity. These tissues have a built-in capacity, which adapt to activity or inactivity, e.g. muscles, joints, and circulation. Torture victims with a chronic pain syndrome have often been physically inactive for many years. Training can therefore influence their physical capacity in a positive direction.

Training on a bicycle-ergometer allows working with large muscle groups; the heartbeat is increased and the general blood circulation is improved. The patients train up to their working pulse, which is continuously measured by a Polar Heart Rate monitor. Other ways of improving the general level of fitness is exercise in a rowing machine or walking on a treadmill, which can be adjusted to horizontal and uphill walking. Distance and pace are increased according to the capacity of the patient.

Relaxation

Relaxation exercises are intended to increase awareness of muscular tensions, and to relax the muscles in order to give the patient rest and relief from pain and stress.

Many authors have described the mechanisms that help to give a person a feeling of being relaxed and balanced. Some authors focus on physiological aspects in which the sympathetic and parasympathetic nervous system are involved; other authors focus on psychological elements. Application of either method depends on the patient's ability to integrate the method in his own daily activities.

Some of the most commonly used relaxation methods are autogenic training and progressive relaxation. Autogenic training uses autosuggestion, in which the patient learns to evoke an experience of heaviness and a feeling of warmth and calm. With progressive relaxation, the patient tightens and relaxes groups of muscles in a defined order until complete relaxation of the whole body is obtained.

Relaxation with focus on rhythm, respiration, and body awareness is used when the aim is to influence general muscular defence. The advantage of these methods is that they support self-awareness and give the patients a positive experience when moving their bodies.
Self-management of neurogenic pain

Neurogenic pain differs in many ways from "ordinary" nociceptive pain with respect to pathophysiology, clinical picture, and treatment. The pain is described in different ways but often as diffuse, burning, stinging and/or lancinating following the nerve distribution (neuralgia). Neurogenic pain varies in intensity, but the summation phenomena (increased pain by repeated stimulation) and after-sensations (persistent pain long after stimulation has ceased) are typical. In addition, there may be signs of hyperactivity of the sympathetic nervous system, e.g. increased sweating, change of skin temperature, and trophic and colour changes of the skin. A prominent feature of neurogenic pain is disturbances of sensation, e.g. decreased sensation (hypoesthesia), increased sensation (hyperaesthesia), decreased pain sensation (hypalgesia) and increased pain sensation (hypehralgies). Especially characteristic is allodynia, i.e. pain caused by stimuli that do not usually provoke pain, e.g. pressure, touch, cold, and heat.

Treatment with transcutaneous nerve stimulation (TENS) was relatively contraindicated in the previous guidelines for the treatment of torture victims who had suffered electric torture. They often became highly anxious when they saw the electric equipment. Consequently, the patients were not offered treatment with TENS for many years.

Today the patients receive thorough oral and written information and instruction in self-treatment with TENS. They learn how to place the electrodes in relevant places on their body, and how to regulate the stimulation. Both low and high frequency stimulation are used, depending on the character of pain and the reporting of the effect. It is very rare for the patients not to accept the treatment, even when they have been exposed to electric torture. TENS has now been shown to have a pain-relieving effect on chronic nociceptive as well as neurogenic pain. Another advantage of TENS is that the patients can control the treatment themselves, something that is of great importance for their psychosocial behaviour.

If the patient suffers from allodynia, even loose-hanging clothes may evoke intense pain. The patient is advised to wear a tight vest and tights with a smooth surface, which gives an even, firm pressure on the skin, which has a pain relieving effect. Elastic, slightly compressing bandages on the legs and arms are also used.

Hydrotherapy (training in swimming pool)

The physical qualities of the water and their influence on the body make hydrotherapy a unique treatment method, in which it is possible to vary the training programme with focus on balance, stability, coordination, and relaxation.

The warm water has a pain-relieving effect, and the water makes movement easier and allows freer movements. Special attention is needed for patients who have suffered water torture.

Individual aid devices and ergonomic guidance

In some cases the communities offer special grants to individual aid devices, which will enhance better functional abilities. The physiotherapist helps the patient to apply for such aids. The most commonly granted aids are lumbar elastic corsets (which give lumbar support and relieve pain), shoes with supporting heels and shock absorbing soles, shock absorbing foot orthoses (to relieve pain in the feet and calves and increase walking distance), and beds and mattresses (to support best possible sleeping positions). Special grants are available to the most disabled patients. These include chairs (to enhance a good sitting position) and specially sewn pain bandages (to relieve allodynia).

To encourage the patients to increase their daily activities, ergonomic guidance is given to enhance working routines such as lifting and carrying, as well as the best positions for resting.

**Special treatment/training programme of falanga sequelae**

The most common sequelae of falanga are pain in the feet and lower legs, sensory disturbances in the soles, and poor balance. Walking is painful, and the patient can only walk limited distances. The training of these patients follows a strict programme that aims to increase the walking distance, improve the balance, and relieve the pain.

The programme includes:
- manual treatment of the feet and lower legs, using various soft-tissue techniques
- mobilizing exercises of the ankle and small joints of the feet
- training and stretching the muscles in the feet and lower limbs
- exercises to enhance the circulation
- balance training on the floor with various training tools, e.g. arix cushions, rocker board, mini-trampoline, and other balance tools
- training in how to walk using the foot correctly (with bare feet) and by walking on a treadmill
- guidance in self-treatment with TENS.

**Special treatment/training of sequelae after suspension**

The most common sequelae after suspension by the arms are pain in the shoulder girdle projecting to the upper limbs, reduced range of movement in the shoulder joint, and sensory disturbances in the shoulder region. The training follows a specific programme, which aims to reduce pain and enhance functional capacity.

The programme includes:
- manual treatment of the neck, shoulder girdle and upper limb including various soft-tissue techniques
- stabilizing exercises of the scapula
- co-ordination exercises of the scapula, shoulder joint and upper limb
- stretching and strengthening of relevant muscles
- exercises of upper limb to enhance the circulation
- guidance in self-treatment with TENS.

**Quality assessment and monitoring in the physiotherapy**

Examination and treatment of the individual patient in the physiotherapy at RCT follow guidelines described in a newly published manual. The primary purpose of this manual is to secure a standardized physical examination and standard treatment course, together with continuous monitoring of the treatment outcome, based on repeated assessment of the patient's physical capacity.

**The examination protocol**

A clinical examination is performed at the beginning and at the end of the treatment course. The examination is carried out according to written instructions describing both history-taking and the applied physical examination tests. History and observations made by the physiotherapist are registered in a schematic form in an examination protocol.
The examination consists of:

- **History:** the torture victim’s own estimation of previous and present physical capacity, graded listing of five physical symptoms which impair daily physical activities, pain drawing on a body chart, thorough, meticulous history after falanga and/or suspension by the arms.
- **General objective findings:** general impression, motivation, etc.
- **Specific objective findings:** posture, active mobility of the spine, hips, and knees, stress test of the sacro-iliac joints, tender point examination according to the ACR (American College of Rheumatology) classification criteria for the diagnosis of fibromyalgia,16 tender point examination of neck and face, examination for hypermobility.17
- **Shoulder examination after suspension:** shoulder function, soft tissues, and neurological examination.
- **Examination after falanga torture:** general posture and functional capacity of the foot, soft tissues, and neurological examination.

**Assessment of physical capacity**

The patient’s physical capacity is evaluated at the beginning of treatment and at discharge. Rating scales with self-reporting of physical capacity and various objective, physical tests have been applied for that purpose:

- **Disability Rating Index (DRI)** is an instrument used for the assessment of physical disability. It is a questionnaire covering 12 items concerning daily physical activities, constructed to reflect function of the spine, legs, and arms. The respondent marks on a 100-mm visual analogue scale (VAS), in accordance to his presumed ability to perform the daily physical activity in question. The anchor points on the VAS being “without difficulty” and “not able to”. The DRI reflects the respondent’s opinion of his disability as well as his actual physical capacity.18
- **Disability rating by the physiotherapist.** The patient is asked to perform the physical activities covered by the DRI, while observed by the physiotherapist. The physiotherapist marks on a VAS her assessment of the performance in question.
- **Balance test.**
- **Ergometric bicycle test.**
- **Walking distance** on a treadmill.

Assessment of pain intensity is also done using a:

- **Pain VAS.** The patient is asked to rate his least and average pain over the past two weeks.

Based on the clinical examination and the various physical tests, the physiotherapist makes a written conclusion and plan for the treatment.

**Treatment course in the physiotherapy**

The physiotherapy course usually lasts seven months, and is divided into four phases:

1. Introduction to physiotherapy, completing the clinical examination and physical tests.
2. Individual treatment twice a week for two months. The patient is offered various treatments as mentioned above. At the end of the individual treatment course, the patient's physical condition is evaluated with respect to transferral to a suitable group in the exercise room, and if needed in the hot water pool.
3. Group treatment for four months with attendance once a week and continuation of the individually adapted training programme.
4. The physiotherapist who started the initial, individual treatment will also finalize and discharge the patient. Clinical examination, rating scales, and physical tests are repeated and a summary of the treatment course is written by the physiotherapist. This summary also includes a written evaluation of the treatment outcome by the physiotherapist and by the patient.

At discharge the following will be available as documentation of the treatment course:

- physical examination protocol (clinical examination, rating scales, physical tests) filled in at the beginning and at the end of the treatment
- written, individual training programmes reflecting progress during training
- attendance registration
- aid device registration
- written summary by the physiotherapist
- written evaluation of the treatment outcome by the physiotherapist and the torture victim.

**Conclusion**

The immensely complex problems after torture require very special rehabilitation efforts. Almost all torture victims complain of chronic pain from the musculo-skeletal system, often with neurogenic pain, hyperalgesia, and allodynia. With this in mind, it is not the task of the physiotherapist to make the patient free of pain, but to guide him to a better understanding of the nature of the pain, and the pain influence on physical functions. Active training in order to improve physical ability, correction of inappropriate movement patterns in order to avoid disuse, and relaxation exercises in order to counteract muscular tension and stress, play a key role in the physiotherapy treatment of torture victims.

The many physical complaints, the serious psychological sequelae, and the social problems that follow torture also demand a considerable effort from other professions. To obtain an optimal rehabilitation course demands close multidisciplinary cooperation, in which the patient, and possibly spouse and children, are involved as much as possible. Rehabilitation often takes a long time, but with patience, engagement, and human understanding, the torture victim will get far in this course.

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Note
The first part of this text was published in TURTLE 3/2000 with the title "Physiotherapy for torture victims (I): chronic pain in torture victims: possible mechanisms for the pain".
Is Article 7 of the ICCPR becoming more relevant for health professionals?

Maca Hourihan, Physiotherapist, Clinical teacher*

Introduction
Art. 7 of the United Nations International Covenant on Civil and Political Rights (ICCPR) reads:

“No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.”

In this one article there are two sentences. One aims to protect against torture. The other aims to give protection from experimentation without free consent. Torture, consent, and experimentation are not always synonymous. This raises many questions as to why they should legally be put together. The history of ICCPR art. 7 demonstrates how these sentences came to be associated. It is interesting to note that during the drafting of ICCPR art. 7, the World Health Organisation (WHO) did not want the second sentence included. WHO opposed this inclusion, arguing that it would hamper medical progress. In their booklet, WHO mentioned that “human experimentation is inseparable from advances in knowledge.” WHO advocated medical ethics as a means of protection in preference to law. Is this a good idea in order to protect health? This paper identifies that both law and ethics are running after advances in science, globalization and changes in types of conflicts in an effort to protect health. Sometimes law has lead the way in this regard and sometimes ethics. Both sentences of ICCPR art. 7 are relevant for health professionals and thus for medical ethics. What controversies do both sentences raise for health professionals? Are the issues of torture, consent, and experimentation related? Have they become more relevant for health professionals today? Why are they in the same non-derogable article? What does this mean for implementation of ICCPR art. 7? Is experimentation without consent to be equated with torture?

Dilemmas in definitions for health professionals
Given the advances in technology, it would seem that possibilities for experimentation with or without consent are expanding. The definition of doctor, researcher, patient, and subject is becoming more important to avoid controversies for health professionals.

A closer look at how WHO and World Medical Association (WMA) define torture adds to the dilemmas of health professionals. UN, and thus WHO (being a specialized agency of UN), define torture as:

“[...] 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 him or a third person, or for any other 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 and suffering arising only from, inherent in or incidental to lawful sanctions.”

It has been stated that this definition is broad enough without being explicit, to include medical experimentation without consent. However, this definition excludes judicial corporeal punishment. It also excludes the actions of para-military organizations and other individuals. The law therefore by omission indicates that this kind of torture is different. Not only that; it supports the participation of doctors or indeed anyone else in judicial punishment which, in the view of the WMA, would amount to torture. One reason is that WMA has a different definition of torture. In the Tokyo Declaration (1975), the WMA defines torture as:

“Deliberate, systemic 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, or to make a confession – or for any other reason.”

This appears to include judicial punishment as torture, meaning that ethically the doctor cannot condone this kind of treatment even if it is legally legitimized in ICCPR art. 7. The WMA definition of torture also includes the activities of individuals and para-militaries. What is interesting to note, is that it does not include the participation of doctors in torture by omission. For example, if a doctor does not include a full report on a prisoner, even if the doctor examines the patient and finds evidence of torture. These dilemmas are relevant for health professionals in the implementation of ICCPR art. 7. The dilemmas indicate why ICCPR art. 7 is an important non-derogable right which links torture, consent, and experimentation in two sentences of one article. It is also reminiscent of the legacy left by Nuremberg, particularly for health professionals.

* School of Physiotherapy
Trinity College Dublin
Dublin 2
Republic of Ireland

TORTURE Volume 10, Number 4 2000 117
DE JURE, DECLARATIONS, ETC.

ICCPR art. 7 was drafted in 1966. Have technology, time or globalization altered its relevance? What is the role of WHO, UN, and the WMA in all of this? Is ICCPR art. 7 always in line with medical ethics? – If not; are there any recommendations that could help to bring legal instruments, including ICCPR art. 7 in line with medical ethics? Are there any recommendations for better implementation of both (medical ethics and ICCPR art. 7)? ICCPR art. 7 is part of a legally binding treaty and is a UN instrument. This poses the question as to whether medical ethics can be institutionalized and implemented? Is this more relevant for health professionals today?

ICCPR art. 7 in relation to the Geneva Convention, UDHR, ECHR, UNCAC and ECPT

The denial of fundamental rights, large scale discrimination and exclusion from the decision-making processes of society are the root causes of many grave crises today. Armed conflicts demonstrate the indivisibility and interdependence of all human rights. Donnelly has made the argument that human rights are interdependent, indivisible, and universal. ICCPR art. 7 is no different in this respect. However, with regard to ICCPR art. 7, the argument as to whether the rights included in the International Covenant on Economic, Social and Cultural Rights (ICESCR) should be given priority over those included in ICCPR, pales when it is realized that ICCPR art. 4.2 names art. 7 as one of only seven non-derogable rights. This means that it can be invoked prior to and also during times when International Humanitarian Law can be used. It is important to note that ICCPR art. 7 continues to be in force even during times of civil unrest when it may not be possible to cite International Humanitarian Law because the level of unrest has not reached such a level to be recognized as an armed conflict. This gives ICCPR art. 7 a special quality of inherent priority over other derogable rights.

Why is ICCPR art. 7 special with regard to similar rights expressed in other declarations and conventions? Firstly, as mentioned, it is a non-derogable right.

In addition, today internal conflict is becoming more prevalent. It can be argued that Human Rights Law as opposed to International Humanitarian Law (with reference particularly to ICCPR art. 7) is thus becoming more relied on for protection. Using ICCPR art. 7 as one example of human rights law and comparing it to an example of International Humanitarian Law; the Geneva Convention does not mention experimentation or consent.

However, the Geneva Convention common art. 3 forbids cruel treatment and outrages on personal dignity. Whether lack of consent for experimentation is equivalent to “cruel treatment and outrages on personal dignity” is open to debate. ICCPR art. 7 has been ratified by 140 States whereas the Geneva Conventions (I, II, III and IV) boast 188. It would appear then that the common art. 3 of the Geneva Conventions holds more relevance. However, it can be argued that in contrast to ICCPR art. 7, the Geneva Conventions are not instruments of the UN. The UN, having outlawed war, bowed out of the drafting of the Geneva Conventions. Given the situations in today’s conflicts it can be seen that International Humanitarian Law has increasingly moved in to the human rights arena. The mandate of the United Nations remains from the UN Charter to promote and protect human rights.

The WHO, as mentioned above, is a specialized agency of the UN. It is interesting to note that the UN is not itself party to the Geneva Conventions although many of its member States are. The Geneva Conventions are instruments of the International Committee of the Red Cross (ICRC) which itself has weak implementation mechanisms. The ICRC relies on the political will of States and non-State Parties for implementation of these Conventions. In fact, globalization and increased armed conflict affecting mainly civilians means that the ICRC relies increasingly on UN mechanisms including Special Rapporteurs and Independent Experts, the ad hoc International Criminal Tribunals for Yugoslavia and Rwanda and the new International Criminal Court (ICC) for implementation of the Geneva Conventions. Furthermore, in order to maintain its neutrality, confidentiality, and access to future victims, the ICRC has requested that its delegates not be asked to testify in this regard. If other organizations get this requested immunity, it could lead to an increased perception of impunity for perpetrators. The ICC could then appear like ‘the dog with no teeth’. The implementation of the ICCPR art. 7 relies on UN mechanisms and on the ethics of health professionals through individuals and WMA. Precisely because ICCPR art. 7 is in force at all times even when the Geneva Conventions are not, it can give the ICC at least one ‘permanent’ tooth. (Whether this is of the ‘wisdom’ variety remains to be seen).

Looking at another instrument, the Universal Declaration of Human Rights (UDHR), art. 5 states: “no one should be subjected to torture or to cruel, inhuman or degrading treatment or punishment”. This is not a legally binding treaty, but its source as customary law is recognized and documented. In contrast, ICCPR art. 7 is legally binding. Let us compare implementation of ICCPR art. 7 to another legally binding Convention.

In order to become a member of the Council of Europe, the State must sign up to the European Convention on Human Rights (ECHR). Art. 3 simply states: “no one shall be subjected to torture, inhuman or degrading treatment or punishment”. Two other conventions deserve mention here with regard to torture. The UN Convention against Torture (UNCAT) which currently has 119 ratifications and the European Convention for the Prevention of Torture (ECPT) which currently has 41 ratifications. In order to implement it, UNCAT has a Committee against Torture (CAT). There is also a Special Rapporteur to the UN on Torture. The ECPT, like the UNCAT, has a Committee. The ECPT intentionally has no definition of torture so that the committee members can set the limits of ill-treatment. This means that the ECPT in order to be effective relies on the professional integrity of Committee members. This Committee connected with the ECPT is called the Committee for the Prevention of Torture (CPT). This Committee is different from that of the UN in that it is not implementive. Rather it is preventive. In this respect, cooperation and confidentiality is essential between States. Thus it can be seen that there is a difference between the two Committees supplementing each other, but not overlapping. Why are there two Conventions and two Committees? This is because it was considered insufficient to stop the impunity of torturers through UNCAT. In addition, it was considered necessary to put an end to torture altogether. Thus the work of the CPT supplements the work of
CAT. Is there a similar situation between medical ethics and the law with regard to ICCPR art. 7? Is the work of WHO and WMA supplementary?

Why art. 7 has two sentences – the issues for health professionals

Looking at ICCPR art. 7 it can be seen that other conventions do not make the same link explicitly between torture, consent, and experimentation. This is particularly relevant for scientists, researchers, and health professionals. Controversies for health professionals surrounding ICCPR art. 7 involve an explanation of the relevance of medical ethics. Although technology has advanced quickly, the legal mechanisms to implement the second sentence in ICCPR art. 7 have not always developed at the same speed. Medical ethics and codes of conduct have sometimes had to lead the way, although they too seem to address problems which have already occurred, being reactive as opposed to proactive. Their implementation mechanisms are weak and rely on strong leadership of national medical associations and the WMA. This in turn increases the relevance of ICCPR art. 7 for health professionals involved.

Looking at the history of the development of ICCPR art. 7 and its relevance to medical practitioners makes it easier to understand why both sentences are included in the one article. It can also lead to a discussion on other conventions/declarations supporting the second part of ICCPR art. 7. Can medical ethics be instrumentalized and implemented through ICCPR art. 7? What are the issues involved for health professionals?

To keep pace with advances in science and globalization, guidelines for certain situations have expanded the codes of ethics for health professionals. The law in some respects has tried to support these professional codes by incorporating them in instruments. Has this worked? As mentioned previously, the historical development of medical ethics and legal instruments is interesting because they have all come about in response to situations, i.e. after the fact.

In many ways the medical profession, particularly through the WMA, has taken the initiative preceding the legal reinforcement. For example, the WMA Helsinki Declaration of 1964 set down guidelines for research that involves human subjects. It preceded the 1966 UN art. 7 of the ICCPR. Historically, violations have happened during times of conflict even when International Humanitarian Law was in effect. Not only was human rights law violated, but International Humanitarian Law was also violated in these instances. Descriptions of the types of experiments chronicled in the Doctors Trials at Nuremberg are well documented. It is easy to see then, how torture and experimentation on humans came to be associated and articulated in ICCPR art. 7. In addition, ICCPR art. 4.2 states that there can be no derogation from art. 7. It would appear that this reflected the importance of both parts of ICCPR art. 7 after the connection between both was made.

Is the association of both sentences in the one article a good idea? This author feels that the answer to this question is a definitive ‘yes’. This is because of the increased relevance of ICCPR art. 7.

Since 1996, there have been 140 ratifications of ICCPR which makes its art. 7 more relevant today for health professionals working within these States. The increased numbers of refugees, asylum seekers, and internally displaced persons in general makes the article more relevant empirically. Specifically for health professionals, improvements in transport and globalization have made this article more important because it is more likely that an increased number of health professionals will come into contact with affected or potentially affected subjects. Thus the relevance of ICCPR art. 7 has increased because of the change in the type of conflicts seen today and also because of the speed of the technological development, leaving individuals increasingly open to experimentation without consent. There is increased reliance on ICCPR art. 7 because of its non-derogability even during times of civil unrest, which does not amount to armed conflict. This is becoming more relevant today with regard to torture. In addition, experimentation is often done in places where there is not even what could be classified as ‘civil unrest’. To avoid impunity of perpetrators, it is important that this consent for experimentation is also recognized as non-derogable. This association of torture and experimentation without consent cannot be seen so explicitly in other Conventions like for example the European Convention on Human Rights which came in 1950 i.e. only two and three years after the Nuremberg Code and the UDHR respectively.

What has happened that the two sentences seem to have been separated? Is ICCPR art. 7 not important for health professionals today? With the passage of time, the increase in technology and globalization do medical ethics, which concur with medical practice, always concur with ICCPR art. 7? If domestic law does not support ICCPR art. 7, where does this leave the medical practitioner who has to practice according to medical ethics? ICCPR art. 7 can be controversial today because of the association of both sentences and because of the relevance of both topics to health care professionals. Torture, consent, and experimentation are real issues for health professionals today – real issues becoming more controversial as technology and globalization advance. The location of these words in the same article is a stern reminder of the legacy of Nuremberg and particularly sensitive topics which involve health professionals today in areas hitherto unknown. However, ICCPR art. 7 does not always concur with ethics and can leave doctors and other health professionals with dilemmas.

Legal instruments and medical ethics – a race?

Gaps between medical ethics and the law means that sometimes the one and sometimes the other is seen to lead the way in the pursuit of protection of health. Should one be given priority over the other? Let us examine the development so far.

The legal instruments and codes of ethics have attempted to chase advances in science. This is depicted in the 1966 International Covenant on Economic, Social and Cultural Rights art. 15(1)b where it states that "State Parties to the present Covenant recognise the right of everyone: [...] b) to enjoy the benefits of scientific progress and its applications".16

In another example of this race after the advances in science, the Council for International Organisations of Medical Sciences (CIOMS), in collaboration with WHO, described how to apply the WMA’s 1964 Declaration of Helsinki in the 1993 ‘International Guidelines for Biomedical Research Involving Human Subjects’17 What is remarkable
about these 1993 UN Guidelines is that it is a joint effort between CIOMS and WHO. CIOMS includes representa-
tives from national medical associations and representatives from WMA.

The WMA is normally associated with declarations which are
ethically, but not necessarily legally, binding. This is a
good example of how both together are chasing advances in
science. The fact that the race is run together means that
there should be no competition between ethics and the law.
In chasing problems associated with science, globalization, and
new conflicts, it must be noted that it is not WHO or
WMA which started this. Rather it is the technology avail-
able, and its associated potential for abuse, which started
the race in the first place.

Legal instruments and codes of ethics are also chasing
globalization and changes in the types of conflicts. This is be-
cause both globalization and conflicts of today are increas-
ingly involving non-state actors. These changes have seen
more abuses of human rights with seemingly increased im-
punity. The changes in the types of conflicts have resulted in
the ad hoc International Criminal Tribunals and a call for
the International Criminal Court to put an end to impunity.
The advances in globalization, technology, and science leave
underdeveloped countries especially vulnerable to exploita-
tion by unscrupulous researchers including medical re-
searchers, transnational corporations, and big businesses, i.e.
more non-state actors. Even the CIOMS and WHO Ethical
Guidelines of 1993 admit that "Certain areas of research do
not receive special mention in these guidelines; they include human
genetic research, embryo and foetal research and foetal tissue
research. These represent research areas in rapid evolution and
in various respects controversial. The Steering Committee considered
that since there is not universal agreement on all ethical issues
raised by these research areas, it would be premature to try to cover
them in the present guidelines."17

The question is asked as to whether there has to be ethical
consensus before balanced legislation? With reference to the
race between WMA, being associated with ethics, and
the WHO, being associated with the law, perhaps this could
indicate a case of the blind leading the blind with technology
being the potential winner. The question of impunity of non-
state actors is not addressed either. As Johnathan Mann so
elegantly put it: "While human rights law primarily focuses on
the relationship between individuals and states, awareness is
increasing that other societal institutions and systems, such as
transnational business, may strongly influence the capacity for
realisation of rights, yet they may elude state control."18 On
the other hand, Montgomery put it that "there is no enforceable
claim on a government to spend a certain amount on health, there-
fore the state can spend what it politically chooses."19 The WMA
and the WHO can be thought of as reflecting the quotations
from Mann and Montgomery. Being a transnational organi-
zation, the WMA can elude state control. Meanwhile, the
WHO (being under the control of the UN member States)
is only able to spend on health what is politically chosen by
those States.

Conclusion

For historical reasons the association of two sentences in one
ICCPR art. 7 would appear to have been important at the
time of the drafting of ICCPR art. 7, but not later in the
drafting of other instruments – at least not important enough
to include both. This essay has demonstrated the increased
relevance of ICCPR art. 7 today for health professionals.

The different definitions of torture by WHO and WMA
mean that ICCPR art. 7 is not always in concurrence with
medical ethics. This leaves dilemmas for doctors and other
health professionals. Having legal standards may do away
with doctors' visible dilemmas, but it may not always be in
the best interest of the patient. This highlights some gaps be-
tween medical ethics and the law. Identifying new dilemmas
within the health arena adds to the increased relevance
of ICCPR art. 7 for health professionals.

As ICCPR art. 7 becomes more relevant, so too do the
activities of WHO and WMA. This makes ICCPR art. 7 of
increased relevance to health professionals. Thus it can be
argued that health professionals have an increased respon-
sibility to participate in the monitoring and implementation
of ICCPR art. 7 through the activities of WHO and WMA.

There is already a UN Special Rapporteur to investigate
allegations of torture. One suggestion is that a post for an
additional UN Special Rapporteur be created to investigate
the independence of medical neutrality in conjunction with
WHO and WMA in order to help both organizations to col-
laborate more closely, implementing medical ethics and
Human Rights Law at the same time.20

The linking of the words 'consent' and 'experimentation'
with the word 'torture' in the non-dereciable ICCPR art. 7
should alert the community of health professionals to the
importance and increased relevance today of the implementa-
tion of this instrument in concurrence with ethical practice.

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TORTURE Volume 10, Number 4 2000
Counselling strategies for refugees


An objective, systematic, and multidisciplinary approach of the mental health care of refugees has become a priority in a growing field and in a globalized world, which is shrinking due to the ease of communication.

During the last 20 years, migration of a different kind: victims of war, organized violence and forced displacement has acquired dimensions never imagined by the "modern western" societies in terms of its impact on the intimate dynamics of their own populations, their economies, cultures, rituals, and customs.

As a humane consequence, many organizations and professional groups have developed different theoretical and empirical approaches for the management and treatment of sequel of trauma. These schools have used diverse orientations whose origin has been different to the area of trauma or whose concept originated in a different perspective. For example, the conception of repression in Freudian theory was linked primarily to the predominant force used to account for "unconscious mental processes", and this was linked to the so-called "seduction theory".

In an up-to-date perspective, the above mentioned theory has been developed into more practical applications, as a view of damage and process of reparation, where the process of traumatization is a sequence of phases where the repeated reliving of traumatic experiences serves the purpose of assimilation.

Multidisciplinary theories with a profound knowledge of psycho-social schools, and at the same time a punctual and practical way of putting in practice that knowledge, are necessary in order to confront the diversified spectrum of clinical manifestations that are consequences of the worst experiences a human being is able to tolerate. This volume, whose author is an academic with affiliation to the Pharos Foundation for Refugee Health Care in Amsterdam, The Netherlands, and a consultant in various countries in conflict, surpasses such a goal.

The comprehensive use of six of the most important trends in the area of psychology/psychiatry (psychiatric classification, developmental psychology, psychodynamic, family therapy, learning theory and cognitive approaches), allows the author to weave clinical vignettes into the text, to exemplify the relationship between the theoretical frame and the everyday practice.

Furthermore, Professor van der Veer deals with the diverse experiences of refugees and their possible clinical derivations, how to approximate them with patience, precision, and a humanistic mark which is characteristic to all involved in the attention of asylum seekers and refugees.

This book constitutes, despite its size, a thorough analysis of the diverse steps to be taken into account in the contact with survivors of violence: from diagnostic issues to the specific treatment of cultural, gender, and age differences; and it also considers relevant issues to those who devote their professional (and sometimes personal) life to their attention.

This volume is oriented to all those professionals, from social and medical disciplines, involved in the care of refugees.

References

Identification of torture victims among refugees


This is a publication of the extended master's thesis written by a psychologist currently working at the Center for the Treatment of Torture Victims in Berlin, Germany. It may not be common that master's theses gain such international acclaim, but as long as this topic is ignored by university researchers, particularly in German-speaking countries, systematic studies such as the one reviewed here will have to be performed by graduate researchers.

The author's aim is to work out the inhibitive and restrictive aspects of the asylum procedure when dealing with victims of torture. He studied the documentation of 40 torture victims treated at the Center for the Treatment of Torture Victims in Berlin in 1995 and conducted additional interviews with survivors of torture.
BOOK REVIEWS

The book contains six chapters presenting the issue in a systematic way. The author defines and explains the relevant terms in the first chapter and helps us to understand the law and the legal view of the asylum procedure in Germany. The politics with regard to asylum in Germany are described and discussed in the second chapter. The current issues and changes (mid-1990s) are well represented. The asylum procedure itself is addressed in a short third chapter. The topic of extreme traumatization of refugees is introduced in the fourth chapter. Here the author summarizes the research literature on torture, on its consequences, and on the monitoring of the consequences of torture. The author's empirical analysis of 40 protocols of asylum interviews and asylum decisions is presented in the fifth chapter. A specific analysis of the role of the torture biography in the asylum procedure is described in the sixth chapter.

The actual empirical work of the author, presented in the fifth and sixth chapters, deals with the key issue in the asylum procedure, the 'trustworthiness'. In alphabetical order the author selected the first 40 patients treated at the Treatment Centre in Berlin for his analysis. He sorted these documents into those describing the chosen population sample, those monitoring the asylum interview lead by the federal office, and those referring to the asylum decision and its justification.

In describing in detail the circumstances of the federal office asylum interview, the author is interested in finding whether the possible experience of torture and the resulting communicative incompetence and interactional disorder were addressed. The findings are listed in the sixth chapter.

The author tells us that although the interview by the federal office is very important for the refugees as it determines the course of their whole future life, two thirds of the refugees were not asked whether their health condition allowed them to face such an interview.

In addition, the author describes a substantial amount of incompetence in conducting such an interview, psychological ignorance, and procedural mistakes. However, the most discouraging are the following results: The Center for the Treatment of Torture Victims assessed all 40 of these refugees as survivors of torture (seven of them with the reservation 'probably'). As the centre is run by academically educated professionals and not by political activists it has to be understood that their professional prestige is at stake and that with the slightest doubt - as in scientific reasoning - they would qualify their judgement as 'probably'. Nevertheless, the decision by the federal office was to send 25 of these refugees and torture survivors back (they refused to recognize the torture experience). Only 11 refugees were granted asylum.

As the author describes in his introductory chapters, surviving torture is not reason enough to be granted asylum. However, recognizing torture survivors and sending them back with all their psycho-social and perhaps even somatic trauma is against all humanitarian principles. Whatever the migration policy or asylum policy is, this is a different issue. Refusing help to those who suffer deep psychological traumatization - from torture - is difficult to justify. Although some assessments of the proportion of torture traumatized refugees in the whole refugee population are quite high, the actual number of those in need of special treatment and help is much lower than what refugee statistics document. Consequently, these people must receive a different and humanita-
**NEWS IN BRIEF**

**Turkish Government interferes in medical meeting**

Physicians for Human Rights (PHR) witnessed the Turkish Government's interference with the annual Turkish Medical Association (TMA) meeting on prison health last week. Early in the week of October 16, the governor of Izmir sent the TMA a formal letter stating that their meeting scheduled for later that week was illegal. Police came to the TMA meeting on Friday, October 20, and demanded that they be present during the meeting and be allowed to videotape the proceedings. The TMA subsequently cancelled their meeting. PHR is deeply concerned at this interference in a medical group meeting by the Turkish Government. This Government interference is yet another example of the already existing long list of the Turkish Government's attempts to crack-down on medical professional integrity. Over the past few years, the Turkish Medical Association and the Human Rights Foundation of Turkey have become particular targets of unjustified attacks, while both of these organizations contribute in a consistent and responsible manner to the promotion and protection of health and human rights in Turkey.

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**ANNOUNCEMENTS**

**Professor Bent Sørensen’s Travel Grants**

Professor Bent Sørensen*’s Travel Grants in Support of Medical Doctors’ and other Health Professionals’ Participation in International Activities to Combat Torture and its Consequences were established under the RCT on the occasion of former president of RCT (1984-90) Bent Sørensen’s 70th birthday, March 8, 1994.

A number of travel grants will be available next year to enable medical doctors and other health professionals from all parts of the world to participate in international activities aiming at combating the practice of torture and providing appropriate care and assistance to victims of torture.

These travel grants will be awarded to cover the cost of participation in scientific or professional meetings as well as in fact finding missions and study trips relating to torture and its consequences. Travel grants may also be awarded to allow participation in relevant education and training activities either as faculty or student.

The grants will be awarded by a review committee appointed by the board of the RCT and will be based on written applications received before March 1, 2001. The applications should contain:

1. Purpose
2. Budget
3. C.V.

and should be sent to:

Professor Bent Sørensen’s Travel Grants
Rehabilitation and Research Centre for Torture Victims
Borgergade 13
DK-1300 Copenhagen K
Denmark

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* Bent Sørensen, Professor, MD, DMSoc, former President of RCT, former Vice-Chairman of the UN Committee Against Torture (CAT) and former Member of the Council of Europe’s Committee for the Prevention of Torture (CPT).

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**CD-ROM from CPT**

CPT has launched a CD-ROM containing a complete copy of the CPT’s website as of January 2000. This could be of interest to organizations without access to the Internet or where such access is very expensive.

The CD-ROM includes:

- details of the CPT’s visits
- press releases
- CPT reports to governments
- government responses
- CPT annual reports
- CPT reference documents.

To visit the website online, go to: www.cpt.coe.int.
# INDEX VOLUME 10, 2000

## A

<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allodi, Federico</td>
<td>The First International Conference</td>
<td>88</td>
</tr>
<tr>
<td>Almendares, Juan</td>
<td>Love incarnate</td>
<td>93</td>
</tr>
<tr>
<td>Amris, Kirstine &amp; Karen Prip</td>
<td>Physiotherapy for torture victims (I): Chronic pain in torture victims: possible mechanisms for the pain</td>
<td>73</td>
</tr>
<tr>
<td>Amris, Kirstine &amp; Karen Prip</td>
<td>Physiotherapy for torture victims (II): Treatment of chronic pain</td>
<td>112</td>
</tr>
<tr>
<td>Chapman AR, Rubenstein LS</td>
<td>Caring for victims of torture and organized violence</td>
<td>28</td>
</tr>
<tr>
<td>Guha S</td>
<td>Battle of &quot;Archana Guha case&quot; against torture in police custody: arguments, counter-arguments and judgement at the trial court</td>
<td>27</td>
</tr>
<tr>
<td>Jaranson JM, Popkin MK</td>
<td>Caring for victims of torture</td>
<td>27</td>
</tr>
<tr>
<td>Karukhin E</td>
<td>Home care for the elderly</td>
<td>61</td>
</tr>
<tr>
<td>Rodley NS</td>
<td>The treatment of prisoners under international law, 2nd edition</td>
<td>29</td>
</tr>
<tr>
<td>Salinsky M, Miller C</td>
<td>Staying alive by accident: torture survivors from Turkey in the UK</td>
<td>94</td>
</tr>
<tr>
<td>Veer G. van der</td>
<td>Counselling and therapy with refugees and victims of trauma: psychological problems of victims of war, torture and repression</td>
<td>122</td>
</tr>
<tr>
<td>Weber R</td>
<td>Extremtraumatisierte Flüchtlinge in Deutschland: Asylrecht und Asylverfahren</td>
<td>122</td>
</tr>
</tbody>
</table>

## B

### BOOK REVIEWS

- Chapman AR, Rubenstein LS, editors. Human rights and health: the legacy of apartheid
- Guha S, editor. Battle of "Archana Guha case" against torture in police custody: arguments, counter-arguments and judgement at the trial court
- Jaranson JM, Popkin MK, editors. Caring for victims of torture
- Karukhin E, editor. Home care for the elderly
- Rodley NS. The treatment of prisoners under international law, 2nd edition
- Salinsky M, Miller C. Staying alive by accident: torture survivors from Turkey in the UK
- Veer G. van der. Counselling and therapy with refugees and victims of trauma: psychological problems of victims of war, torture and repression
- Weber R. Extremtraumatisierte Flüchtlinge in Deutschland: Asylrecht und Asylverfahren

## C

<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chakrabarty, Tapas</td>
<td>The Archana Guha case</td>
<td>59</td>
</tr>
</tbody>
</table>

### CONFERENCE REPORTS

- Caring for victims of torture and organized violence: 26 November 1999, Ramallah, West Bank
- European conference: Empowerment of traumatized refugee families: 21-23 October 1999, Copenhagen, Denmark
- Report from the VIII International Symposium on Torture as a Challenge to the Health, Legal and Other Professions: 22-25 September 1999, New Delhi, India

## D

### DE JURE, DECLARATIONS, ETC

- Delhi Declaration on Freedom from Torture | 25 |
- International Criminal Court (ICC): an end to the culture of impunity? The 50-year vision of the ICC comes true | 56 |
- Is Article 7 of the ICCPR becoming more relevant for health professionals | 117 |
- Reparation for victims of torture: some definitions and questions | 89 |

<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dasta, Menahik</td>
<td>The politics of trauma</td>
<td>59</td>
</tr>
</tbody>
</table>

### DOCUMENTATION AND BACKGROUND

- Dual loyalty – a case in point: German police doctors break medical confidentiality | 100 |
- Empowerment of traumatized refugees: a developmental approach to prevention and treatment | 8 |
- From AI's medical groups towards cross-disciplinary collaboration against torture | 103 |
- Psycho-political challenges in the forensic documentation of torture: the role of psychological evidence | 68 |
- Torture at the threshold of the new millennium | 36 |
- Torturing Turkey acknowledges widespread violations of human rights in case raised by Denmark: The European Court of Human Rights in Strasbourg established friendly settlement between Denmark and Turkey, but torture of Turkish doctors continues | 54 |
- Turkey continues harassment, arrests, and torture of medical doctors: Outstanding Turkish medical professor prohibited from commenting on torture for five years | 53 |
- Visits to detained torture victims by the ICRC (I): Management, documentation and follow-up | 4 |
- Visits to detained torture victims by the ICRC (II): The psychological impact of visits and interviews with detained torture victims | 41 |

<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drees, Alfred</td>
<td>Intuitive dialogues in the field of victims of torture</td>
<td>77</td>
</tr>
<tr>
<td>Dual loyalty – a case in point: German police doctors break medical confidentiality</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Döcher, Henrik</td>
<td>Torturing Turkey acknowledges widespread violations of human rights in case raised by Denmark: The European Court of Human Rights in Strasbourg established friendly settlement between Denmark and Turkey, but torture of Turkish doctors continues</td>
<td>54</td>
</tr>
<tr>
<td>Döcher, Henrik</td>
<td>Turkey continues harassment, arrests, and torture of medical doctors: Outstanding Turkish medical professor prohibited from commenting on torture for five years</td>
<td>53</td>
</tr>
</tbody>
</table>

### EDITORIALS

- Is it of any use? | 35 |
- Reflections at the turn of the millennium | 3 |
- The inviolability of medical ethics | 99 |
- The power of artistic expression | 67 |

### EDUCATIONAL

- Helpful tips for living a new life | 26 |
- Empowerment of traumatized refugees: a developmental approach to prevention and treatment | 8 |
FROM AI'S MEDICAL GROUPS TOWARDS CROSS-DISCIPLINARY COLLABORATION AGAINST TORTURE ........................................ 103

DUAL LOYALTY – A CASE IN POINT: GERMAN POLICE DOCTORS BREAK MEDICAL CONFIDENTIALITY ........................................ 100

INTER-MEETING COURT ON HUMAN RIGHTS CONDEMNS THE STATE OF GUATEMALA FOR THE BRUTAL MURDER AND TORTURE OF FIVE STREET YOUTHS ........................................ 18

INTUITIVE DIALOGUES IN THE FIELD OF VICTIMS OF TORTURE ........................................ 77

INVESTIGATIONS AND RESULTS

INTUITIVE DIALOGUES IN THE FIELD OF VICTIMS OF TORTURE ........................................ 77

PHYSIOTHERAPY FOR TORTURE VICTIMS (I): CHRONIC PAIN IN TORTURE VICTIMS: POSSIBLE MECHANISMS FOR THE PAIN ........................................ 73

PHYSIOTHERAPY FOR TORTURE VICTIMS (II): TREATMENT OF CHRONIC PAIN ........................................ 112

POST-TRAUMATIC TORMURE DISORDERS IN UGANDA: A THREE-YEAR RETROSPECTIVE STUDY OF PATIENT RECORDS AT A SPECIALIZED TORMURE TREATMENT CENTRE IN KAMPALA, UGANDA ........................................ 81

REMEMBERING AND RE-STORY-ING: AN EXPLORATION OF MEMORY AND NARRATIVE IN RELATION TO PSYCHOThERAPY WITH TORTURE SURVIVORS ........................................ 107

THE PHYSICAL AND PSYCHOLOGICAL FINDINGS FOLLOWING THE LATE EXAMINATION OF VICTIMS OF TORTURE ........................................ 12

PSYCHO-POLITICAL CHALLENGES IN THE FORENSIC DOCUMENTATION OF TORTURE: THE ROLE OF PSYCHOLOGICAL EVIDENCE ........................................ 68

REMEMBERING AND RE-STORY-ING: AN EXPLORATION OF MEMORY AND NARRATIVE IN RELATION TO PSYCHOThERAPY WITH TORTURE SURVIVORS ........................................ 107

THE ARCHANA GAHA CASE ........................................ 59

THE FIRST INTERNATIONAL CONFERENCE "CARING FOR VICTIMS OF TORTURE AND ORGANIZED VIOLENCE" ........................................ 88

THE POLITICS OF TRAUMA ........................................ 59

MARCUSS, HENRIK & INGE GANAFHE: FROM AI'S MEDICAL GROUPS TOWARDS CROSS-DISCIPLINARY COLLABORATION AGAINST TORTURE ........................................ 103

MARCUSS, HENRIK: IS IT OF ANY USE? ........................................ 35

MARCUSS, HENRIK: REFLECTIONS AT THE TURN OF THE MILLENNIUM ........................................ 3

MARCUSS, HENRIK: THE INVIOABILITY OF MEDICAL ETHICS ........................................ 99

MARCUSS, HENRIK: THE POWER OF ARTISTIC EXPRESSION ........................................ 67

MOSSALLANEJAD, ESAT: TORTURE AT THE THRESHOLD OF THE NEW MILLENNIUM ........................................ 81

MUSISI, SEGANE, EUGINE KINYANDA, HELEN LIEBLING & R. MAYENGÓ-KIZAIR: POST-TRAUMATIC TORMURE DISORDERS IN UGANDA: A THREE-YEAR RETROSPECTIVE STUDY OF PATIENT RECORDS AT A SPECIALIZED TORMURE TREATMENT CENTRE IN KAMPALA, UGANDA ........................................ 81

NETHERLANDS

EMPOWERMENT OF TRAUMATIZED REFUGEES: A DEVELOPMENTAL APPROACH TO PREVENTION AND TREATMENT ........................................ 8

NEW PUBLICATIONS FROM IRCt

INTERNATIONAL REHABILITATION COUNCIL FOR TORTURE VICTIMS (IRCT). REHABILITATION OF TORTURE VICTIMS: CENTRES AND PROGRAMMES WORLDWIDE ........................................ 63

NEWS FROM CAT AND CPT

CAT ELECTIONS ........................................ 16

CD-ROM FROM CPT ........................................ 124

NEW DANISH DOCTOR IN CAT ........................................ 62

RESIGNATION OF PROFESSOR BENT SORENSEN FROM CAT ........................................ 16

PEEL, MICHAEL, HILIAN HINSHEDWICK & DUNCAN FORKES: THE PHYSICAL AND PSYCHOLOGICAL FINDINGS FOLLOWING THE LATE EXAMINATION OF VICTIMS OF TORTURE ........................................ 12

PHYSICAL AND PSYCHOLOGICAL FINDINGS FOLLOWING THE LATE EXAMINATION OF VICTIMS OF TORTURE ........................................ 12

PHYSIOTHERAPY FOR TORTURE VICTIMS (I): CHRONIC PAIN IN TORTURE VICTIMS: POSSIBLE MECHANISMS FOR THE PAIN ........................................ 73

PHYSIOTHERAPY FOR TORTURE VICTIMS (II): TREATMENT OF CHRONIC PAIN ........................................ 112

POST-TRAUMATIC TORMURE DISORDERS IN UGANDA: A THREE-YEAR RETROSPECTIVE STUDY OF PATIENT RECORDS AT A SPECIALIZED TORMURE TREATMENT CENTRE IN KAMPALA, UGANDA ........................................ 81

PROSS, CHRISTIAN: DUAL LOYALTY – A CASE IN POINT: GERMAN POLICE DOCTORS BREAK MEDICAL CONFIDENTIALITY ........................................ 100

PSYCHO-POLITICAL CHALLENGES IN THE FORENSIC DOCUMENTATION OF TORTURE: THE ROLE OF PSYCHOLOGICAL EVIDENCE ........................................ 68

REMEMBERING AND RE-STORY-ING: AN EXPLORATION OF MEMORY AND NARRATIVE IN RELATION TO PSYCHOThERAPY WITH TORTURE SURVIVORS ........................................ 107

STAFF, MARINA: VISITS TO DETAINED TORTURE VICTIMS BY THE ICRC (I): MANAGEMENT, DOCUMENTATION AND FOLLOW-UP ........................................ 4

STAFF, MARINA: VISITS TO DETAINED TORTURE VICTIMS BY THE ICRC (II): THE PSYCHOLOGICAL IMPACT OF VISITS AND INTERVIEWS WITH DETAINED TORTURE VICTIMS ........................................ 41

TORTURE AT THE THRESHOLD OF THE NEW MILLENNIUM ........................................ 36

TORTURE WORLDWIDE

CASES OF ORGANIZED VIOLENCE AND TORTURE IN ZIMBABWE IN 1999 ........................................ 17

INTER-AMERICAN COURT ON HUMAN RIGHTS CONDEMNS THE STATE OF GUATEMALA FOR THE BRUTAL MURDER AND TORTURE OF FIVE STREET YOUTHS ........................................ 18

TORTURING TURKEY ACKNOWLEDGES WIDESPREAD VIOLATIONS OF HUMAN RIGHTS IN CASE RAISED BY DENMARK: THE EUROPEAN COURT OF HUMAN RIGHTS IN STRASBOURG ESTABLISHED FRIENDLY SETTLEMENT BETWEEN DENMARK AND TURKEY, BUT TORTURE OF TURKISH DOCTORS CONTINUES ........................................ 54

TURKEY

TORTURING TURKEY ACKNOWLEDGES WIDESPREAD VIOLATIONS OF HUMAN RIGHTS IN CASE RAISED BY DENMARK: THE EUROPEAN COURT OF HUMAN RIGHTS IN STRASBOURG ESTABLISHED FRIENDLY SETTLEMENT BETWEEN DENMARK AND TURKEY, BUT TORTURE OF TURKISH DOCTORS CONTINUES ........................................ 54
Turkey continues harassment, arrests, and torture of medical doctors: Outstanding Turkish medical professor prohibited from commenting on torture for five years .................................................................................................................. 53

Turkey continues harassment, arrests, and torture of medical doctors: Outstanding Turkish medical professor prohibited from commenting on torture for five years .................................................................................................................. 53

UGANDA

Post-traumatic torture disorders in Uganda: a three-year retrospective study of patient records at a specialized torture treatment centre in Kampala, Uganda .......................................................................................................................... 81

V-W

Veer, Guus van der: Empowerment of traumatized refugees: a developmental approach to prevention and treatment .......................................................... 8

Visits to detained torture victims by the ICRC (I): Management, documentation and follow-up ......................................................................................... 4

Visits to detained torture victims by the ICRC (II): The psychological impact of visits and interviews with detained torture victims ......................................................................................... 41

Z

ZIMBABWE

Cases of organized violence and torture in Zimbabwe in 1999 ................................................................................................................................. 17

IRCT Annual Report 1999 – Executive Summary .......................................................................................................................... 45
Oxford, UK
2-20 July 2001

12th International Summer School in Forced Migration

First Announcement

Topics dealt with at the Summer School:
• The nature of forced migration
• Causes, patterns and consequences of forced migration
• Responses

Further information:
The International Summer School Administrator
Refugee Studies Centre
Queen Elizabeth House
University of Oxford
21 St Giles
Oxford, OX1 3LA
United Kingdom
Phone: +44 1865 270722
Fax: +44 1865 270721
E-Mail: summer.school@qeh.ox.ac.uk
http://www.qeh.ox.ac.uk/rsc

The IRCT is a private non-profit foundation, that was created in 1985 by The Rehabilitation and Research Centre for Torture Victims (RCT), Copenhagen.

The objectives of the foundation is on an international basis to promote the provision of specialized treatment and rehabilitation services for victims of torture and to contribute to the prevention of torture globally.

To further these goals the IRCT seeks on an international basis

• to develop and maintain an advocacy programme that accumulates, processes, and disseminates information about torture as well as the consequences and the rehabilitation of torture
• to operate a documentation centre about torture and related topics
• to establish international funding for rehabilitation services and programmes for the prevention of torture
• to promote education and training of relevant professions in the medical as well as social, legal, and ethical aspects of torture
• to encourage the establishment and maintenance of rehabilitation services
• to establish and expand institutional relations in the international effort to abolish the practice of torture, and
• to support all other activities that may contribute to the prevention of torture.