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CONTENTS

EDITORIAL
Promising initiatives on the way .............................................. 67

DOCUMENTATION AND BACKGROUND
Psycho-education with refugee children
Ask Eikli ................................................................. 68
Wraparound approach for the treatment of torture survivors:
an innovative initiative
Ibrahim Aref Kira ..................................................... 75
Principles of documenting psychological evidence of torture
(Part I)
Uwe Jacobs, F Barton Evans III & Beatrice Patsalides .............. 85

PROJECT DESCRIPTIONS
Danish support to Bangladesh to establish DNA laboratory ........ 90

LETTERS TO THE EDITOR
Another call for action to the IRCT network ......................... 91

BOOK REVIEWS
Tortura en Euskal Herria, Informe 2000 ............................... 92
Making standards work .................................................... 92

FROM THE MEDIA
Increasing sale of torture instruments ................................ 93
Forthcoming conferences and seminars ............................... 96
Selected list of publications .............................................. 74, 89, 91, 93, 94, 95

IRCT Annual Report 2000 – Executive summary .................. 77-84

TORTURE Volume 11, Number 3 2001
PROMISING INITIATIVES ON THE WAY

Breaches of laws and violations of human rights have a destructive and subversive effect on society— and on international order. The resulting pain is a barrier to democratic consensus, reconciliation, and national integration. To a certain extent this situation has resulted in an attempt to (re)establish a democratic rule. For the first time since the Nuremberg trial after the Second World War, international punishment of gross violations of international humanitarian law has now been organized through the International Criminal Tribunal for the former Yugoslavia (ICTY) in The Hague and the court rulings at the International Criminal Tribunal for Rwanda in Arusha, Tanzania (ICTR). But punishment in itself does not create democracy. However, a progress towards democracy could be established with the removal of impunity, leading to truth, justice, and reparation for society.

Let us not forget that massacres, torture, and human rights violations must not solely be condemned as being the results of a single individual’s malicious intentions. It is important to address those who represent the government structure, political intentions, and ideas.

In favour of the International Criminal Court we find a certain educational effect and a responsibility towards the global population. In other words, the focus on these issues might enhance the degree of global, public attention. These trials are important because they are indicators of the increasing importance of human rights, as opposed to the sovereignty of the state, which among other things implies that the international judiciary system has widened its range of action.

The case of the extradition of Slobodan Milosevic, who has been charged with war crimes committed while he was the Head of State of the Federal Republic of Yugoslavia, was made possible because the Statute of the ICTY explicitly states that there can be no immunity from prosecution for crimes described in the Statute, not even for Heads of State. A case-law precedent has already been created in the case of Augusto Pinochet, the former dictator in Chile, to the effect that a status as a former head of state does not automatically exempt a person from criminal prosecution for the rest of his or her life. However, these encouraging judicial efforts are as yet only the first step on the way, as more requirements need to be met before the world may witness a number of international figures lined up for similar judicial procedures. The accompanying and subsequent follow-up is just as essential for the population and the country’s reputation in this settlement with the past.

A good example of how to implement the next phase is the 1998 Rome Statute of the International Criminal Court (ICC). The treaty has been signed by 139 State parties and will enter into force when it has been ratified by 60 State parties. So far 39 State parties (as per 27 September 2001) have ratified it. The successful elaboration of the statute must not least be owed to the enormously efficient and unremitting efforts of numerous NGOs. At the current rate of progress, it is anticipated that the 60 ratifications necessary for the ICC to be established will be reached in the course of 2002, as requested in the letter to the editor (page 91). But the establishment of the ICC is only one step, albeit a very significant one, in a long journey. First, the treaty only covers torture and mistreatment committed under war-like circumstances. Second, and just as significantly, the treaty only applies to crimes committed after it enters into force. There is a need for further initiatives to ensure that all human rights violations are properly addressed and that just reparation and redress is provided to victims of previously committed violations. This means, not least, that renewed efforts should be made to promote compliance by State parties with obligations in the Convention against Torture to investigate allegations of torture and to prosecute those believed to be responsible.

In Argentina, 6 March this year became such a red-letter day, as a historic ruling was passed invalidating the laws known as Punto Final, which had previously put a stop to the prosecution of torturers during the dictatorship. This reversal is particularly due to the persistent mothers and grandmothers from Plaza de Mayo.

This tendency is now establishing itself in other parts of South America, where ex-dictators, presidents, generals, and executioners must realize that the populations of their countries have decided that the time has come to face the past. The Pinochet case in Chile and the subsequent discussions and reflections of the Chilean people is the most well known example. The recent regime change in Peru and the, albeit still unfinished, work of establishing a truth commission is another less known case. However, the Chilean case also shows that this confrontation goes beyond the prosecution of single individuals. As an example of this, the Chilean Ministry of Health held a conference in June with participation of local NGOs, including an invitation to the IRCT, in order to establish a truth, justice, and reconciliation commission and to form a working group to improve the health of torture survivors and their families.

This is a beautiful example of a constructive solution to the problem of how a government in collaboration with local and international NGOs, and in this case with representatives from the Chilean Medical Association, takes an important step towards reconciliation with a cruel past.

H.M.
Psycho-education with refugee children

Ask Elklit, Psychologist, Associate Professor*

Abstract

Screening studies have revealed that a large number of displaced refugees and their children have been exposed to many severe traumatic events and that many of them suffer from psychological sequelae. Despite this, only a few psychosocial and prophylactic programmes for refugee children have been developed, described, and systematically studied. This article presents the main studies in the field including an evaluation by the author of a psycho-educational programme run by the Danish Red Cross. Organizational and clinical implications are discussed.

Introduction

Every year thousands of children are displaced and become refugees, fleeing from war and atrocities, leaving destroyed homes, villages, family and friendship networks, the social fabric and culture of which they were a part. They have to start adapting to a new culture, a new language, and new educational challenges in a situation where their parents and families often are not able to support them efficiently because of their own worries and losses. Many refugee children have no one to turn to when they want to share their losses and misery. Many host countries take care of housing, food, medical treatment, and educational needs for the children, but the psychological problems associated with trauma are often not attended to. There is a growing awareness among professional mental health workers that an important task lies in relating to the psychological problems of refugee children. In the same way that local professionals are beginning to reflect on how to solve the task, a similar process, according to Ajduković, is taking place in international, humanitarian organizations. Most of these organizations have a limited experience in developing and carrying out psychosocial remedial programmes, which is also evident from the very limited literature available within this area.

A literature search on PsycINFO from the period 1992-2001 only gave five references when using the search words “psycho-education” and “refugee”. None of these five references had any relevance for the present article. This article will address the following questions: In which situations are psychosocial programmes necessary for helping refugee children and their families? How can we ensure that they are effective? Which children and adults will profit most from them? The article will also outline the experiences of a psycho-educational project from the Danish Red Cross.

The problems of the children and their families

The quality of life of the refugee children and their resilience is connected with the distress their parents are exposed to, and with the parents’ capacity to protect their children and mitigate the most damaging effects of the horrors they have lived through. This experience stems from the work of Freud and Burlingham with English children during the Second World War, which showed that the parents’ emotional reactions were a better predictor of symptom development in the children than the actual horrors the children had experienced.

Besides the parents’ emotional reactions, the degree of destruction of the social system also plays an important role. This was proven by Galante and Foa, who studied 300 Italian school children after an earthquake, a type I trauma. They found that a psycho-educational programme resulted in reducing fears of earthquakes. They expected that the degree of destruction in the villages would prove to be connected to the children’s subsequent neurotic or antisocial problems. This turned out not to be the case, but in return they concluded that the critical factor of the occurrence of pathology in the children was connected to how much time the local society needed to reorganize after the catastrophe.

After clinical experiences with refugees in need of treatment, Dahl, Hauff, Sveaass, and Lavik stated that of the many traumas which accompany the flight process, the loss trauma is the most important. There is no detailed definition of this trauma, but loss of network and image of oneself, loss of the continuous cultural self-affirmation, competence, social status, house, and home are important. It must be assumed that the authors see “loss traumas” as the opposite of “danger traumas”, when they subsequently discuss traumas caused by political persecution, imprisonment, maltreatment, and torture.

A study which involved the screening of the psychological and somatic state of 1,224 children and adolescents from Kosovo offered a unique opportunity to study empirically the above-mentioned assumption. The conclusion was that torture, living a period at the absolute subsistence level, and a long flight period (including the many dangers this involves) were very decisive for symptom development occurring immediately after the refugees have arrived safely in another country. In comparison, losses did not have the same importance at that point of time. That does not mean that losses will not dominate at a later time in the life of a refugee child or its parents, when some of the “danger traumas” recede into the background.

From a developmental psychological point of view, four conditions must be emphasized as being particularly relevant in order to limit the negative influence of war trauma in refugee children (cf. Cichetti, Toth, and Lynch):

1. The quality of the child’s attachment to a parental figure is very important. Loss of attachment figures may lead to
severe psychological disturbance and even to physiological damages similar to that which is seen in PTSD (cf. van der Kolk). Secure attachment is a very strong resource in children, which would make new attempts of attachment more successful. Insecure attachment might make short term adaptation easier due to lower expectations, but at the same time be equivalent to interpersonal problems later on.

b) Can the child's affects be regulated? Does the child have the opportunity for continuous talks about the feelings that arise, and are tensions, losses, and conflicts processed? Are feelings suppressed in misunderstood consideration, or are they acted out?

c) To what extent is the individual child (and all the family members) allowed to choose friends, activities, and points of view? Loyalty to the culture that has been left is likely to be important for the feeling of continuity and having roots, but maintained in a rigid way it could at the same time be a hindrance to an adaptation to the new culture.

d) As part of a normal development children choose to engage themselves, to invest in school and leisure activities, and through such activities achieve competence in skills and subjects. This process can be seen as a (long) intermediate phase, through which the child builds up sufficient resources to be able to leave the original core family for the benefit of a broader social network. Heavily strained families can see this process as a threat to the existence of the family, and underachievement in school and work competence can be a strategy for some children to solve such a dilemma.

Ajduković studied how 58 refugee mothers, who were situated in an asylum centre in Croatia, experienced their children's psychosocial difficulties. During a period of six months, it was evident that the mothers spoke less with their children and became more nervous themselves. The children's most common difficulties were loss of appetite, anxiety at night, sleep problems, sweating, fear of being separated from their mothers, and general timidity. As time went by, the prevalence of reported distress symptoms decreased. There was a close association between the adaptation of the mothers, their contact with their children, and the frequency of problems with the children. Separation from the father was also a factor implying a higher problem rate with the children.

During and after a war, both parents are likely to be deeply influenced in a way that reduces their ability to be attentive to the psychological needs of their children. There are almost no studies of fathers who have been soldiers and return to their families in a war-ravaged country. One relevant study is done by Bucat, Frančišković, and Moro, who worked in a psychiatric clinic at the University Hospital in Rijeka in Croatia. They described how war veterans and (war) traumatized people normally obtain the support and help they need from their existing social network in order to establish a good adaptation. Still, it is their experience that between 10-15% develop some kind of PTSD, and that between 20 and 30% of the war veterans show adaptation difficulties and need psychiatric help. Apart from a reduction in PTSD symptoms resulting from the trauma processing, they emphasized, among other things, an increased self-acceptance and ability to talk about the trauma, which they see as respectively an affective and a behavioural adaptation.

A study conducted at the Center for Crisis Psychology in Bergen showed that Bosnian refugee children had received little or no explanation or dialogue about what had happened during the war, during the evacuation, or the time after.

Ajduković emphasizes that based on her experiences with refugee families in Croatia, the situation which is particularly distressing to a child is when the parents are overwhelmed by their own feelings, and are unable to satisfy the child's increasing emotional need. Many refugee mothers suffer from depression, anxiety, and various somatic problems, which sometimes may develop into a disease. The parent who has emotional or somatic problems often neglects the child's needs, while also displaying a low tolerance towards the child's behaviour, illustrated by increased irritability and a punishing attitude in the upbringing of the child.

Ajduković mentions three maladaptive strategies used by the parents: a) underestimating the child's difficulties and misinterpreting its behaviour as disobedience or laziness, b) overprotective reactions and making the child the centre of the adult's life, and c) trying to solve their own problems through the child, for example by expecting the child to fulfill the dreams that the parents were unable to materialize. Refugee parents living under difficult conditions often suppress both their own and their children's emotional problems. The parents do not see the problems of the child, e.g. the loss of a family member or a home, because the parents are not capable of facing the loss themselves.

**Systematic evaluation**

Slovec stated that "in a number of Western countries specialized centres have been established to counsel and rehabilitate survivors of torture". Unfortunately, he continues, "the initiatives that were planned to develop screening programs at arrival have not occurred mainly because of inadequate co-ordination between the immigration authorities and the organisations responsible for the psychological and mental treatment."

Wolter stresses that the long-term effects of traumatic events on the children are still inadequately understood. Wolter agrees with Udwin that "there are only few reports available about which treatment strategies are suitable for children suffering from post-traumatic stress reactions, and basically no systematic evaluations of methods are used today".

In a pilot study of 246 unaccompanied refugee children, of which 26% had received special care or treatment, Stuehr, Lindskov, and Carey concluded that "the results give rise to considerations of extending screening interviews with regard to traumatic experiences and psychological symptoms with a view to an early intervention in the pre-asylum phase. On this basis it was recommended to develop a structured questionnaire to use for screening in order to find vulnerable persons at an early stage and prevent them from developing more symptoms. Furthermore, such a tool can be used in developing differentiated psychosocial measurements and this implies that concrete measurements of implemented arrangements will be possible."

Williams was one of very few who at an early stage wrote an overview article about preventive intervention for young refugees. She showed that despite an increasing interest there hardly exists even one single programme primarily for intervention for refugee children. Almost a decade later the situation is just a little better, as today only a few descriptions of programmes exist and evaluations of these programmes are available. Williams strongly emphasized that to call a pro-
gramme preventive does not necessarily mean that it will reduce the number of mental problems. Limited results can sometimes be used to justify the closing of a programme with a reference to the limited resources.

Stuvland\textsuperscript{17} advocates an environmental orientated trauma psychology that acknowledges the importance of individual experiences by focusing on the events that caused the post-traumatic reactions. Some therapists' resistance against looking at traumas at all, to perceiving PTSD as far too limited a perspective, or the widespread interest in the resistance of children can, according to Stuvland, be seen as an expression of ignorance. However, it can also often be seen as examples of counter-transference, protecting the therapists from the extremely painful feelings, which normally accompany intense traumatic experiences. The problem, Stuvland wrote, is not that too many adults talk too much with the children about their traumatic experiences, but that too many completely overlook or avoid talking directly to the children or listening to their stories.

Treatment principles

Despite our limited knowledge of long-term effects of intervention, there is today among professionals a widespread consensus on the need to implement preventive interventions. Several in the field have stressed that before intervention begins, staff qualifications need improving. In a conference report from 1993 concerning "The emotional needs of refugee children and their families: Implications for professionals", James\textsuperscript{18} concluded that the lack of concern will be expensive for society in the long run. The conference recommended that all personnel groups should be trained in identifying the various problems caused by children's war experiences. More specifically, the conference recommended that a simple evaluation, for example in the form of a questionnaire, should be developed in order to ensure that the children receive the necessary help.

Pupavac\textsuperscript{19} drew attention to her experiences with trauma work for children and adolescents in the "Suncokret" project in Zagreb, where non-professional and para-professional helpers could be ignorant about the complexity or the possibilities available in trauma treatment. Consequently, an essential part of their project consisted of developing the resources of the staff through: 1) two-day introduction workshops, 2) systematic training and continuous supervision, and 3) programme specific workshops, e.g. for personnel working with a certain age group.

The main principles for the chosen treatment strategies will in many cases be: 1) group-oriented due to resource and therapeutic reasons, 2) trauma-focused and coping/resource oriented - in order to verbalize and share painful experiences in a future-oriented context, and 3) in cooperation with the family - in order to obtain an open dialogue and to secure the child more relevant support.

The pivotal process in psycho-education starts by supplying the children and the adults with relevant information, which enables them to understand and interpret their own reactions. By supplying them with a knowledge of various coping skills, the internal healing forces are stimulated and their expectations of once again getting better are increased.\textsuperscript{20} Pfefferbaum\textsuperscript{21} emphasized in her review article that group treatment is ideal for teaching young people about trauma symptoms and, adjusted to their age, can explain to them about post-traumatic reactions, mechanisms, and courses. It can be supportive to the children who have difficulties telling about their worries, or who think that their experience is so unique that they are unable to share their experiences with others who have been in a similar situation (cf. Yule and Williams\textsuperscript{22}). The group format offers an opportunity to remember and examine loss, to observe different coping strategies, to see others at different levels as regards to processing the traumas, and to experience the happiness that stems from helping others. The group treatment is also an efficient method when it comes to identifying children who need a more intensive treatment (cf. Gillis\textsuperscript{23}).

However, there are also disadvantages of using a group format. Not all children feel comfortable telling about their horrors in a group - in some cases a more detailed description of new, unknown, and violent horrors can reinforce the children's traumatization, and without adequate support in processing from the adults in the group some children may experience a worsening of their condition.

Children can also preventively begin to use coping strategies, which they have heard other children talking about, before they themselves have examined their own reactions. It is also important that the therapists can define limits for outlets of aggression which can create anxiety in others in the group and in some cases can necessitate individual therapy (cf. Gillis\textsuperscript{23}).

In an article about "Group Work with Distressed Children", Ajudkovic\textsuperscript{24} put forward the following principles for structuring group work with refugee children:

1) The meetings should be held in the same room, and there must be space for the children to work, play, move freely, and sit in a circle.
2) The ideal group size is 8-10 children.
3) It is desirable that there is stable participation.
4) Children in the latency age (9-11 years) prefer group members to be of the same sex.
5) Each child should feel accepted and have a feeling of belonging to the group.
6) The group leader must create a feeling of trust and safety in the following ways:
   • the group starts and finishes on time and is consistently held at the same time
   • the leader along with the children defines the rules of acceptable behaviour for both the leader and the children
   • the leader ensures the personal safety of all concerned
   • the leader pays attention to every child's emotional state, without necessarily sharing these observations with the group, for the proper regulation and direction that the group should take.
7) It is advisable that there are two co-leaders in the group.
8) The phases in the group work should follow carefully selected teamwork activities for each group meeting.
9) One should pay attention to the goals for each planned exercise.

Measuring of the programme effect

Ajudkovic and Ajudkovic\textsuperscript{25} mentioned the difficulties of estimating the effects of psychosocial support on refugee children and their families through a decrease in their distress symptoms. Ideally, a classical experimental design with control groups is demanded. However, such a research model might be unethical to heavily traumatized groups, if it results in someone very much in need receiving no or delayed treatment. It might also be difficult to establish treatment and
research which follows a standard protocol, as the entire society structure can be ruined and very few things might function as expected. If the treatment takes place in the host country, the future prospects of the individual might also be very different, depending on the degree of destruction of the local community, the total number of losses, the possibility of repatriation, asylum status, and the integration politics of the receiving country. All these aspects can hamper the research process in confounders.

To which extent is information based on different data sources reliable? Different studies have shown that the degree of consensus among e.g. children and parents depends on the type of problem. Consequently, there is much more agreement when it comes to manifested behaviour, less consensus with depressive symptoms, and least consensus with anxiety.26,27 Parents are not necessarily the best informants because they will often have a strong desire for their children to be free of serious problems. Teachers and health staff will often be directed by different perspectives (“silence in the classroom to be able to teach”; “does this suffering need to be treated?”), which can make the comprehensive understanding of the individual child more difficult. Counter-transference and lack of relevant education can also partly explain the limitations of some staff groups when it comes to obtaining knowledge of traumatization. Children can also be limited in their capacity to report emotional conditions and assess their general state.

Ajdukovic and Buško28 described a school based intervention programme for Croatian children in a war-ravaged area. After developing work material and exercises in a pilot project, a 20-week project for 1,200 pupils was started, in which the teachers – supported whenever possible by a school psychologist or another colleague – for 2 hours per week focused on the children's emotional experiences, their resources, and their ethnic attitudes. Prior to the project the teachers had participated in a five-day training programme, and they received supervision twice a week. During the period there was a significant decrease in the symptom level of the children who participated in the programme. There was also a significant increase in the children's self-esteem, just as the children's attitudes to ethical conflict solving changed in a positive way. The study also showed that there were essential differences depending on locality.28

Ispanovic-Radojkovic, Davis, Mincio, Tenjovic, and Wolf29 studied the effect of common youth club activities for 128 young refugees in Belgrade. The aim of the club activities was to activate the person's coping competence and avoid activating the weak and vulnerable sides of the personality. The participation in the club activities took place over a year and was then compared with a control group. They found a substantial decrease in social withdrawal and an increase in self-esteem for both genders. The boys had a decrease in the occurrence of depression and the girls a decrease in the prevalence of social problems.

However, there was a small, but not significant, increase in the Impact of Event scores for those who attended the youth club. Ispanovic-Radojkovic et al.29 explained this result as the young people subjectively feeling better and having a higher self-esteem, at the same time as their traumatization level was unchanged or had even increased with the intervention. Participation in the club activities may possibly have strengthened the youngsters by enabling them to start confronting themselves with the as yet suppressed, painful memories in an attempt to integrate them. Whether club activities are sufficient to secure the psychological health of the adolescents in the long run or whether some of them at a later point need therapeutic intervention cannot be answered through this study.

The Danish Kosovo Refugee Psycho-educational Project
As a part of the Danish Red Cross' psychosocial work for the Kosovo refugees, the preventive work started with the development of a research instrument and an examination of the need for treatment. An action plan in the form of a psycho-educative programme was planned and implemented, and the result of the efforts was recorded and analyzed. This dialectic work form can be described as action research ad modum Kurt Lewin.30 In order to maintain the acquired experiences, to develop the programme, and to assess the strengths and weaknesses with special reference to future programmes, it was important to carry out a systematic evaluation which: 1) included all the participants in the field, 2) built on a multivariat principle (i.e. several different methods complementing each other), and 3) examined the programme both from a process and a product perspective (including the feedback of the participants based on the presented results). The systematic approach was considered very important. Descriptive studies can be inspiring and informative, but they have difficulties procuring knowledge which can be generalized to comply with other groups of children or to other studies due to the idiosyncratic methods used to decide symptoms and effect (cf. Lonigan, Shannon, Daugherty, and Taylor31).

On the basis of a screening study32 showing that approximately 70% of the children and 20% of the adults suffered from PTSD, the Danish Red Cross implemented a psycho-education programme33 which included 490 children and their parents accommodated in asylum centres in Denmark. For the youngsters (7-18 years) the programme consisted of three two-hour sessions and two parental meetings. The programme reached between 83% and 93% of the children. In total there were 43 groups, of which 11 were aimed at parents with small children in the age group 3-6 years. Psychologists ran the 32 groups for the youngsters, who were divided into age groups. Furthermore, interpreters, health nurses, and pedagogues participated. The average size of each group was 12 children. A natural control group was established due to the fact that another organization than the Danish Red Cross accommodated part of the refugees and did not run a psycho-educational programme.

The overall aim of the programme, i.e. reaching a large number of children and parents at a relatively early stage, was accomplished. Many parents stated that they would have liked a similar offer. This information may be an incentive to expand this part of similar programmes in the future.

The participation in the psycho-educative programme had the effect that the level of intrusive memories and the level of hypervigilance decreased significantly (the IES total score went down by two points), as did self-satisfaction.34 The direct focusing on the war traumas apparently resulted in a better direct contact with intrusive memories and hypervigilance, and the tendency to be on guard all the time. The improved contact with the vulnerable parts was probably the reason for the decrease in satisfaction with oneself. In many cases the programme caused an opening to strong emotions, but it did not last long enough to ensure an even greater reduction in the traumatization level.
Besides the measured outcome, the parents and the different staff groups have mentioned a number of examples of not only the children's improved functioning, greater happiness, and concern for others, but also of a larger degree of contact with anger and mourning. A typical parental statement was: "The children sleep better, they have fewer nightmares. We now know more about what to do when we can feel that they are going through a hard time." A typical staff statement (from a pedagogue): "Sometimes we have a certain eye contact due to the fact that we have shared something very important."

The staff as a whole has had a common assignment of an intense nature. This has influenced the team spirit in a positive direction. The knowledge of the other participants has increased. A common understanding has arisen that to a larger extent it has become acceptable to talk about the intense traumas, which otherwise had a tendency to be avoided. Even though the organizational cooperation across the professional groupings all in all has worked well, there is no reason to think that a certain staff formula is the only right one. One might consider limiting the number of staff present in the group so that the children would not have to relate to so many adults at once; on the other side, the value of the improved cooperation and the increased knowledge of the children must be considered. A very strong desire has been to receive supervision. A more extensive introduction and continuous staff supervision would also be in line with the recommendations a number of international studies have put forward (cf. above).

The critique of the use of the IES questionnaire has been substantial. One main point was that it has taken valued time from the therapeutic work. Another main point was that the youngest children had great difficulties in understanding it. Consequently, one should be careful when trying to compare the results, especially those regarding the youngest children, with other similar situations. Dyregrov, Gupta, Gjestad, and Mukanohe35 applied IES-R in a study of 1,830 Rwanda children, ranging from 8-19 years of age, almost one year after the genocide. The average values for the sub-scales Invasion and Avoidance were 2.4 times and 1.6 times higher for the Kosovo children than for the Rwandan children.

As opposed to Dyregrov et al.35 we found a strong positive association between the sub-scales of Avoidance and Hyper-vigilance, and a high positive association between Invasion and Avoidance at the arrival 7 months later. The latter result can be interpreted as an expression of avoidance being a factor that develops relatively independently some time after the traumatizing event (cf. Creamer, Burgess, and Pattison36). Compared to Ispanovic-Radojkovic et al.29 our results were quite diametrical: they had an increase in the degree of traumatization (measured by IES) and a rise in self-esteem. This difference might be due to the different foci of the two projects: to address trauma and coping in a direct way vs. strengthening coping resources via play and competence activities and avoiding to address traumas. But other variables as age, cultural differences, etc. may also play a role in explaining the differences.

The present report builds on a number of the above-mentioned treatment principles. The psycho-educative programme has only been one element in the total package of psycho-social initiatives, which the Danish Red Cross supplied to the refugee group. It is also important to remember that each psychologist and programme group has adapted to the children and situation in question. The programme has taken place in an interdisciplinary cooperation run by the health nurses. It has demanded an extensive work effort regarding planning and organization. The screening element is hardly mentioned in the feedback from the professional groups, whereas almost everybody describes the outcome, the process, and the difficulties of the programme. This may reflect the fact that the energy has been used to create and implement the programme.

The asylum work of the Danish Red Cross and of other large humanitarian organizations seems to change from exclusively emergency tasks to taking care of refugees and asylum seekers for long periods of time. This change makes demands on the entire organization, its management, and the individual employees. If psychological intervention in the future becomes a part of a standard programme, it requires new staff skills, new closer forms of cooperation, a more intense focus on the individual client, better communication, and passing on of the acquired information to a third party (e.g. GP's, social services, etc.). The significant workload and the great enthusiasm which has been put into implementing the psycho-educative programme seems to show that the particular organization is progressing in this process.

It may seem ambitious to try to measure the effect of a short-term programme because six hours may seem like a drop in the ocean compared to the many horrors the children and their parents have been through. When the outcome of the Danish Red Cross' psycho-educative programme for Kosovo-refugees was added up, the impression was quite positive. Psychologists and health nurses described the results as important; the interpreters who were culturally and linguistically closer to the refugees were, just as the parents, very positive. The pedagogues were the only group who was less sure of the outcome; however, this could also reflect the less central placing of this staff group in the programme. From the children's report it appeared that there was a small, but significant decrease in the traumatization symptoms. This decrease must be due to the programme as the degree of traumatization ascended in the control group. However, as mentioned before we also see other effects, including a decrease in the self-satisfaction, which may be interpreted as an effect of the programme: The traumatic memories were opened up, but there was not enough time to help the children reorganize their experiences.

**Recommendations**

This final section builds on the experiences in Elklat,37 who made an external evaluation of the project based on interviews of all the staff groups and parental focus groups, plus feedback from the participants in two large evaluation conferences:

1) Screening tools should be developed and improved – if possible as an international cooperation – so they are ready to be used in a number of languages.

2) Assessment questionnaires should be completed in such a way that:
   a) they do not take time from the other activities in the programme.
   b) they are placed in another context outside the programme.
   c) special research instruments for children 10 years and younger should be developed.

3) General plans should be made with instructions for preparation, implementation, and evaluation of new pro-
grammes. Apart from the acquired experiences mentioned above it is suggested to use the experience that Ajduković 38 has described. It is also suggested to include the kind of activities and exercises which Ajduković and Bullko 39 have described.

4) Furthermore, it is suggested that the programme activities should be related to developmental psychology (cf. Cicchetti et al. 40), which is mentioned above. A core concept could be the “identity”, which is the comprehensive concept of the psychosocial intervention project for school refugee children which the Victoria Foundation in Melbourne carries out. 39-41 The use of different models may open up to new experiences.

5) Future programmes should involve resource persons among the refugees.

6) Compulsory supervision should be implemented for all staff groups working with refugees.

7) The responsibility of the centre leaders of coordinating activities should be clarified; the programme can run without any internal organizational obstacles.

8) The responsible organization should hire or select psychologists who can professionally run the psycho-educative programmes, in order to have a stock of stable and experienced people available, who have a knowledge about clinical, developmental, and social psychology.

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Wraparound approach for the treatment of torture survivors

—an innovative initiative

Ibrahim Aref Kira, PhD*

The literature on assessment and treatment of torture survivors indicates major deficiencies in two areas. These areas include lack of cultural sensitivity and lack of alternative theoretical perspectives that help devise new innovative approaches and techniques. The theoretical and conceptual framework of understanding and for devising effective intervention strategies must accommodate and respond to the complexity of this phenomenon. The cumulative effects of other previous and subsequent traumas determine the final state of health and adaptation capacities of trauma survivors.1-3 The accumulative effects of multiple traumas generate a vicious loop, which adds to the problems of the survivor. Traditional approaches and techniques, for example exposure and other cognitive behaviour techniques that work with victims of single traumas (type I or type II), are not as effective with cumulative trauma victims. Torture survivors suffer from multiple, severe, repeated, and prolonged sequelae of traumas that affect their cognitive, emotional, social, and work functioning. A great percentage of them and their families suffer from type III trauma and cumulative trauma disorders or complex PTSD.1,4,5 They have been involuntarily uprooted from their own natural support systems at home, and often suffer from isolation in a new and very different culture, language, and value system that sometimes stereotypes them. These people come, mostly, from collective cultures that value social bonds more than individualistic enterprises. Due to the severity of symptoms that usually result from cumulative trauma, effective treatment strategies with cumulative trauma victims need a more creative multi-method,4,6 multi-systemic outreach, as well as wraparound, community- and family-based interventions, which use social support and social action as one component in a global treatment strategy. This approach addresses social factors, which are particularly important for collective cultures, as part of a holistic multi-method, multi-system intervention.

Research suggests that negative responses to traumatic events can be prevented, or mitigated, by a supportive and empowering post-trauma environment. Social support has been found to prevent the development or exacerbation of symptoms.7-9 Social recovery, community support, and other integrative models of treatment – as for example assertive community treatment (ACT), psychosocial rehabilitation, therapeutic communities, and the wraparound approach – have proved to be effective. They are applicable to victims of cumulative traumas, such as torture survivors.10-11 A wraparound approach, proven to be effective with children and adolescent victims of cumulative trauma, has been modified for treating cumulative trauma disorders in refugee and torture survivors.4

The wraparound model provides a conceptual and pragmatic alternative to traditional treatment approaches for torture survivors. Conceptually, it is based on the integrative capacity of a combination of ecological systems, macrosystems, and field of systems theories.12 It is also based on critical and constructive paradigms. Empirically, it is based on research on the effectiveness of social support, especially with refugees. Some of the most important psychological symptoms in torture survivors may be alleviated by programmes which pay attention to social support. Gorst-Unsworth and Goldenberg13 found that social support factors are more effective than psychotherapy with refugee Iraqi torture survivors. Research provides evidence of the effectiveness of community-based programmes, for instance the wraparound approach, active community treatment (ACT), and home-based programmes,14-15 in treating severe attachment disorders. The wraparound approach has proved to be effective with children who have severe emotional difficulties. It has proved to be particularly successful with those hard to reach and to treat, and those who have multiple needs and complex traumas. The inclusion of community and religious leaders to provide support and guidance proved to be effective and culturally appropriate to refugees.

On the level of service delivery, the wraparound approach, as presented here, is a new, innovative, flexible, unique, dynamic, and holistic/comprehensive community-based process of service delivery. It can be modified to fit culturally different communities and populations. It is more problem-focused. It is an alternative to traditional long-term hospitalization or residential treatment. It is a strength- and empowerment-based process that taps and develops the strengths of the torture survivor and his family. It encourages the participation of key players in the survivor’s life and his family’s. It is based on the principle of unconditional care and community support. This process includes:

1. Development of a community team, which builds a system of collaboration and includes representatives from formal and informal networks, such as agencies and com-

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This process includes a variety of procedures that include:

1. Strength-based assessment.
2. Comprehensive clinical assessment of trauma based on the new trauma matrix assessment tool. 2-3
3. Establishing and facilitating inter-agency treatment teams.
4. An individualized, person-centred/family-centred plan of care that includes life-domain planning, safety, natural support networks, advocacy, and individual one-on-one services.
5. It is community-based in that it involves home-based intervention when needed.
6. Stress reduction. Meeting survivors’ different needs contributes to the stress reduction process that is targeted in therapy.
7. Relational services by key players, who target inclusion, and support by the community is an important component of wraparound treatment. The feeling of being connected/reconnected in these involuntarily uprooted refugees is an important outcome measure of this paradigm. The relationship context of family and community as a network of supportive systems is as important in treatment as the individual factors, Survivors need to feel unconditional care and support.
8. Community and religious leaders’ (formal and informal) inclusion in the process has considerable influence on torture survivors.
9. Follow-up and monitoring.

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Political, religious, cultural, and ideological stereotypes, as well as community politics and value systems are issues to be addressed in the wraparound treatment process. The wraparound process engages the survivor and his family as decision-making participants in their services and their community. It uses naturally occurring strengths to wrap individualized support around the survivor and his family.

References

INTRODUCTION
by the IRCT President

The 2000 Annual Report documents the developments, achievements, and challenges experienced by the IRCT during the past year. Together, they reflect one of the greatest strengths of the IRCT: the ability to adapt to the changing needs, demands, and opportunities we face in the work against torture.

In June 2000, the IRCT Executive Committee appointed Dr Jens Modvig as Secretary-General. As the former IRCT Medical Director, Dr Modvig's experience and vision are guiding the IRCT in addressing rehabilitation and prevention needs in the world. The Executive Committee also promoted former Secretary-General Dr Inge Genefke to the position of Honorary Secretary-General. Since assuming this position, Dr Genefke has dedicated herself to international advocacy and fundraising initiatives.

The IRCT continues to pressure governments to provide for the rehabilitation of torture victims and to bring an end to impunity. For many years now, we have witnessed the inability or unwillingness of governments to act against torture. We have a social responsibility to bring these issues to the attention of the world, and to inform and educate citizens of the global community about the prevalence of torture. We ask you to join us as we work towards making our vision of a world without torture a reality.

Maria Piniou-Kalli, MD
President

REPORT
by the IRCT Secretary-General

During the year 2000, the IRCT succeeded in strengthening the work against torture by adapting to a constantly changing global environment. The IRCT worked to secure the political will to implement legislative measures and to allocate necessary funding for rehabilitation and prevention activities. This is reflected in our advocacy, project development, and funding strategies in support of torture victims worldwide.

In 2000, the IRCT conducted an intensive campaign to increase awareness of, and support for, the rehabilitation needs of torture victims by Members of the European Parliament. The IRCT also continued to monitor and bring pressure to bear on governments' contributions to the UNVFVT. Another key focus of the IRCT is to monitor the status of ratification of the UN Convention against Torture and to assist governments in ensuring their compliance with their international obligations.

The Regional Strengthening Programme, which was supported by the EU, the UNVFVT, and the Oak Foundation, helped the IRCT continue to strengthen its support to rehabilitation centres. The IRCT strengthened their institutional capacity and cross-centre collaboration through the development of (sub)regional networks and the implementation of regional training seminars worldwide.

In 2000, the IRCT continued to raise awareness and to secure increased protection for caregivers at risk, to establish informal protection networks, and to educate and train health professionals. The IRCT implemented several urgent action missions and campaigns in 2000, as health professionals and other caregivers in Indonesia (Aceh), Zimbabwe, and Turkey faced increased harassment and insecurity.

The IRCT initiated the Global Torture Victims Information System (GTIS) in 2000. The GTIS represents the first comprehensive monitoring and documenting system of its kind, with the capacity to document individual cases of torture, methods of torture, and the effects of rehabilitation.

In 2000, the IRCT launched a prevention project which aims to improve the Ukraine's adherence to UN principles of human rights and appropriate measures to eradicate the practice of torture. In East Timor, the IRCT completed a National Psychosocial Needs Assessment, the result of which formed the basis of a programme providing psychosocial support to traumatized children.

On 26 June 2000, the IRCT mobilized more than 155 organizations to commemorate the UN International Day in Support of Victims of Torture. The global campaign is one of many advocacy and information activities conducted by the IRCT. Through media activities, publications, and the IRCT website, the IRCT promoted understanding of the work against torture.

The IRCT General Secretariat will continue to strengthen its technical capacity, to improve access to and utilization of funds, and to increase the protection of health professionals and other caregivers at risk.

Jens Modvig, MD, PhD
Secretary-General
SUPPORT FOR HEALTH PROFESSIONALS AND OTHER HUMAN RIGHTS DEFENDERS

For many years, we have advocated that torture is the most shocking of all human rights offences. In this context, the persecution of health professionals working to alleviate the wounds of torture is a matter of serious and ongoing concern. In a number of countries, health professionals are targeted because they take seriously their obligation under the Hippocratic oath, or because they can identify and document cases of torture.

In June 2000, the IRCT conducted an Urgent Action Mission in Zimbabwe, uncovering evidence indicating that large-scale physical and psychological intimidation was taking place. Reliable reports also revealed that health workers were prevented from assisting victims of violence, and that doctors and other health professionals had themselves been intimidated and attacked. The report on the findings of the mission received national and international coverage, placing pressure on the Zimbabwean Government.

The IRCT continues to send observers to trials brought against doctors in Turkey. Questionable charges have been brought against Turkish doctors as part of an apparent attempt to obstruct their critical work. This type of state-sanctioned harassment of health professionals is completely unacceptable, and it is in precisely these circumstances that health professional colleagues around the world must act.

Doctors and other health professionals engaged in rehabilitation work worldwide must be free to provide treatment without fear of harassment or prosecution. Doctors must never be forced into performing procedures, disclosing client details, or engaging in any other practices that contravene principles of medical ethics. Indeed they deserve our support.

Inge Geneffeke, MD, DMSc hc
Honorary Secretary-General

COMMEMORATING 26 JUNE

In 2000, the IRCT coordinated its third consecutive global campaign to commemorate the UN International Day in Support of Victims of Torture – 26 June. The 2000 campaign, in which more than 155 organizations from 84 countries worldwide participated, focused on Reparation. Events held in 2000 included media events, public seminars, award ceremonies, music and theatre performances, art exhibitions, poetry readings, tree-planting ceremonies, candlelight processions, and peaceful street marches.

The IRCT again produced a wide range of campaign materials, including press kits, campaign kits, T-shirts, posters, and essay competition kits. A special CD, Breaking the Silence, was produced, featuring music written and performed by torture victims from Namibia.

The global launch of the 26 June 2000 campaign took place in Pristina, Kosovo. The event culminated in the adoption of the Pristina Declaration on National Psychosocial Rehabilitation, Peaceful Co-existence and Prevention of Torture, signed by leading members of Kosovo civil society and representatives of the international community.

The Declaration establishes a framework in a post-conflict society for responding to the needs of victims of torture and extreme trauma.

REPORT FROM THE 2000 IRCT COUNCIL MEETING

At the IRCT Council's annual meeting, held in Copenhagen, Denmark, in October 2000, the President, Dr Maria Piniou-Kalli, highlighted the achievements of 2000: the extensive efforts in working for financial sustainability; the revised IRCT Statutes and By-laws; and the strengthening of relations with health and human rights NGOs. Special attention was drawn to the increased need for the protection of health professionals in many parts of the world, including Gaza, Turkey, and Zimbabwe.

The Secretary-General, Dr Jens Modvig, reported on the activities of the IRCT during 2000. Major achievements included the strategic development of priorities and recommendations to the Council, guiding the IRCT's work into the year 2001 and beyond.

The IRCT Council adopted the revised IRCT Statutes and By-laws, together with a new IRCT Mission Statement, Vision, and Values. The new Statutes provide a strengthened framework to meet the IRCT's present and future aims, aspirations, and challenges. The IRCT Council also adopted the Copenhagen Declaration on Cross-Cultural Respect and Collaboration in the Global Work against Torture in recognition of the need to respect differences relating to language, culture, customs, and experiences.

CENTRE SUPPORT AND DEVELOPMENT

The 1999-2000 Regional Strengthening Programme (RSP), which was supported by the EU, the UNVFVT, and the Oak Foundation, aimed to strengthen the capacity of existing rehabilitation centres and programmes, and to establish new centres and programmes in areas where no such treatment existed for torture victims.

Representatives of Kosovo civil society and the international community, together with Dr Feride Rushiti, Medical Director of the KRCT, and Dr Jens Modvig, commemorate the UN International Day in Support of Victims of Torture with a minute's silence, 26 June, 2000, Kosovo.
Under the RSP, the IRCT supported the establishment of 15 new rehabilitation centres or programmes by the end of 2000. In a number of newly established projects, community-based approaches enabled local partners to reach large numbers of torture victims. These projects promote training of both health professionals and other human rights and humanitarian workers.

In 2000, the IRCT continued to provide professional and technical support to rehabilitation centres and networks. These activities supported the strengthening of the financial, administrative, and human resources management of centres and contributed to identifying long-term efforts aimed at securing sustainability. During the year, the IRCT implemented 15 local and eight regional training seminars on rehabilitation and prevention issues.

Under the RSP, the IRCT supported the establishment of seven (sub)regional networks to promote professional development and sustainability within and between collaborating rehabilitation centres.

ASIA

Throughout the year, serious human rights problems continued to plague the Asian region. Some were linked to separatist or nationalist movements, or to the abuse of internal security laws by national governments to detain, torture, or kill suspected political opponents. Some were classic examples of the refusal of authoritarian governments to tolerate peaceful political opposition. Torture and ill treatment in police custody is also commonplace in many Asian countries.

Those most at risk of torture are frequently poor or marginalized, or those who already suffer other forms of discrimination in society. In ongoing conflicts, civilian populations are at risk of torture from both state agents and opposition forces. Serious human rights violations continue to be carried out by the security forces as a form of intimidation and as punishment.

The human rights situation in the Indonesian province of Aceh, which deteriorated further in 2000, is a serious and ongoing cause for concern. In December 2000, three field workers from the RATA centre were tortured and killed. The IRCT is committed to providing protection and support for RATA staff and their families, and will continue to monitor the Indonesian Government's investigation into the murders to ensure that those responsible are brought to justice.

In June-July 2000, the IRCT conducted a National Psychosocial Needs Assessment in East Timor, at the request of UNTAET. The survey results revealed a highly traumatized population, with an overwhelming 97% of respondents having experienced at least one type of trauma event in the past 25 years.

In September 2000, a combined training and network meeting took place in Nagarkot, Nepal, attended by representatives from 14 organizations in nine Asian countries.

SUB SAHARAN AFRICA

During 2000, the prevailing conflicts in 21 of the 48 Sub Saharan African countries continued unabated. In addition, there were significant deteriorations in the human rights situation in Zimbabwe, the Democratic Republic of the Congo (DRC), and Burundi, while conditions also remained volatile in Nigeria. In South Africa, the incidence of torture in detention is continuing to increase. Conflicts in the Great Lakes region are creating many casualties among the civilian population.

The Africa Network of rehabilitation centres and programmes (later renamed SSANTO) was formed in February 2000. Additionally, two subregional networks were formed: the Western and Central Africa network, and the Eastern Africa, Great Lakes and Horn of Africa network.

In March 2000, the IRCT carried out a pre-investigation mission to Zambia. With the assistance of the Oak Foundation, emergency funding was made available during the year to support struggling centres in Ethiopia, the DRC, and Rwanda. In February 2000, the IRCT participated in a World Health Organization (WHO) meeting in Harare on community-based psychosocial rehabilitation in post-conflict countries.

In May-June 2000, the IRCT carried out an urgent mission to Zimbabwe in order to investigate allegations that health workers had become targets for torture and violence, that health services for victims of violence had been disrupted, and that health workers had been prevented from treating victims. The report of the mission team's findings documents specific cases of torture and violence, including violence targeting health professionals, and provides evidence that an organized campaign of psychological intimidation and violence was being conducted in Zimbabwe in the months leading up to the national elections.

LATIN AMERICA AND THE CARIBBEAN

The majority of the countries in the Latin American and the Caribbean region are now considered democracies with human rights guarantees incorporated into national legislation. Human rights organizations can now operate freely in the region. However, many countries are still experiencing instability and unrest. As long as human rights violators continue to escape prosecution, newly established democracies in the region will remain vulnerable ones.

Designing the strategy, Dili, East Timor.
During 2000, the IRCT worked to address these challenges by promoting networking and exchange of information between centres in the region, by undertaking training activities, and by supporting new rehabilitation programmes in Paraguay, Mexico, and other countries.

Two network meetings were held, one in Guatemala in April 2000, and the second in Brazil in October 2000, where a regional strategy and plan of action were elaborated. These meetings were held in conjunction with regional seminars attended by more than 25 organizations. Topics discussed included the treatment of torture victims, impunity, and prevention, as well as strategies for increasing collaboration, information exchange, and joint training initiatives among centres in the region.

In 2000, the IRCT continued to provide support for the ATYHA rehabilitation centre in Paraguay, and the IRCT supported the establishment of community work and a local training programme. In Mexico, the IRCT provided support for PAIST, the newly established mental health team of ACAT. A collaborative pilot project resulted in about 100 torture victims and 250 family members receiving treatment in Mexico City and in the state of Oaxaca.

Exploratory visits carried out in Bolivia during 1999 were followed up in 2000 by two training seminars, which were held in cooperation with local human rights groups.

THE MIDDLE EAST AND NORTH AFRICA

One constant in the Middle Eastern political environment is its volatility. Throughout the year, torture and other forms of cruel, inhuman, or degrading treatment or punishment continued to be regularly practised by many governments in the region. Other issues facing the region are widespread economic hardship, internal conflicts, the effects of numerous military and theocratic regimes in the region, the ethnic cleansing of minorities (as in Sudan and Iraq), the deepening crisis in Palestine, and continuing disagreements over power-sharing arrangements among neighbouring countries in Kurdistan.

The AMAN regional network, established in 1999, is comprised of 11 centres and programmes from eight countries. Three centres and programmes joined the network during 2000, helping to improve the geographical reach of the network. A meeting of the network was held in Tripoli, Lebanon, in July 2000, where an ambitious plan of action was elaborated, and tasks for follow-up were allocated to network members.

In collaboration with the AMAN network, the IRCT organized one regional seminar on treatment methods in rehabilitation work in July 2000, and one local training seminar in November 2000, both in Lebanon. The IRCT also worked closely with the network in planning and carrying out an explorative mission in Syria in November 2000, and in providing emergency assistance to the rehabilitation centre in Casablanca, Morocco.

A pilot rehabilitation project was launched in Khartoum, Sudan, in November 2000. The programme is the first of its kind ever to be established in Sudan. In collaboration with the AMAN regional network, the IRCT is providing continuous technical assistance to the Khartoum centre, including training of its medical and administrative team.

CENTRAL & EASTERN EUROPE AND NEW INDEPENDENT STATES

The problem of state-sanctioned torture in Central & Eastern Europe and the New Independent States remains formidable. Firstly, the region has a history of authoritarian and repressive rule. Secondly, the post-Cold War geopolitical situation in the region is complex, and many of the legacies of the Cold War era are yet to be properly addressed.

Even in those countries where democratic institutions have been established, many of the elements of the former repressive state apparatus remain in place. Two factors in particular, the political and institutional legacy of the past and the policies towards ethnic minorities, combine to perpetuate the practice of state-sanctioned torture in the region.

The IRCT's activities during 2000 focused mainly on rehabilitation activities, and were divided into two categories: the initiation of new rehabilitation projects, and the establishment and consolidation of sub-regional networks. At the end of 2000, 22 rehabilitation centres were operating in 16 countries in this region, and three subregional networks have been established.

During 2000, the IRCT assisted in the establishment of four new rehabilitation centres in the region. Training seminars were organized for the staff of the St Petersburg, Tbilisi, and Yerevan centres in the areas of diagnosis of torture victims, treatment, management, and administrative and financial management.

The IRCT assisted in the establishment of the NISNET subregional network, formed in Kiev, Ukraine, in October 2000, and in the further consolidation of the BAN and CENENET networks. Network meetings were held for each
of the three networks during the year, and problem analysis workshops were conducted to develop short- and long-term consolidation strategies.

OTHER IRCT ACTIVITIES
Throughout 2000, the IRCT promoted the rehabilitation of torture victims and the prevention of torture in a range of international forums. In April 2000, the IRCT made oral interventions during the 56th Session of the UN Commission on Human Rights under items 11, Civil and Political Rights, and 17, Human Rights Defenders. The IRCT also participated in a parallel session on the issue of reparations, organized by the Coalition of International NGOs Against Torture (CINAT). The IRCT continued to monitor the activities of various UN bodies and mechanisms, including the Working Group on the Draft Optional Protocol to the Convention against Torture, the Committee Against Torture, and the UN Special Rapporteur on Torture.

In 2000, the IRCT also strengthened its efforts in the field of research, education, and prevention on torture-related issues, in collaboration with IRCT-affiliated centres as well as intergovernmental organizations, universities, and other non-governmental organizations. In June 2000, the second IRCT International Research Seminar was held at Porto Heli, Greece, addressing research needs and opportunities in the Balkans. The IRCT also launched a 12-week training programme for IRCT project coordinators, external medical consultants, and other health professionals in the fields of research, training, and project development. Throughout 2000, the IRCT provided education to law enforcement personnel, health professionals, and school children.

The IRCT Documentation Centre responded to requests for information from users in 55 different countries during 2000. The Global Torture Victims Information System (GTIS) was also under development during 2000. The GTIS is an information system which will enable the scientific monitoring, documentation, analysis, and reporting of the prevalence of torture, rehabilitation needs, present treatment capacities, and the effects of treatment. In 2000, four issues of the IRCT’s quarterly journal Torture were distributed to more than 6,200 individuals and organizations in over 165 countries worldwide. In September 2000, the IRCT published 2,500 copies of Rehabilitation of Torture Victims: Centres and Programmes Worldwide, which provides a global overview of rehabilitation services available to victims of torture, based on information received from centres and programmes worldwide.

FINDING A SUSTAINABLE BALANCE
The absolute need for rehabilitation cannot be quantified in a meaningful way, and conservative estimates are that less than 10% of the global need of torture victims is currently being met. Consequently, the IRCT has had to adopt a funding strategy aimed at securing predictability and sustainability for rehabilitation centres and programmes in both the short and the longer term. The IRCT’s short-term strategy deals with the current capacity of existing or planned centres and programmes. The IRCT’s long-term strategy aims to raise the global capacity to a level which will effectively bring rehabilitation treatment and services to those victims who are presently excluded from treatment.

A number of EU Parliamentarians supported the efforts of the IRCT to draw attention to the funding crisis facing rehabilitation centres. In September 2000, the IRCT organized a Special Hearing on Rehabilitation of Torture Victims, which served to increase the support of European Parliamentary Members for continued funding for rehabilitation services.

Throughout 2000, the IRCT continued to receive direct support from the Danish Ministry of Foreign Affairs, the Oak Foundation, the United Nations Voluntary Fund for Victims of Torture (UNVFVT), and the European Union (EU). As a result of greater recognition of the need for assisting victims of torture, global funds available for rehabilitation are gradually increasing.

The Oak Foundation supports the institutional capacity building of the IRCT and provides direct support to rehabilitation centres. Without this support, a number of centres would not have survived, and the organizational support provided by the IRCT to centres worldwide would have severely suffered.

While the year 2000 presented a number of substantial achievements in the funding of rehabilitation, and the immediate future signals further improvement, the IRCT accepts that the need for rehabilitation by far exceeds the available treatment capacity. No organization has had the capacity to assess the exact funding needs required for all victims. However, we can all work to increase the existing capacity; bringing hope to those who remain in critical need; and to bring pressure to bear on institutions and governments for increased support. Reducing the gap between the global needs and the existing capacity depends on us all.

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# STATEMENT OF FINANCIAL POSITION

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<td>– 2001 centre support</td>
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# STATEMENT OF ACTIVITIES

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## EXPENDITURES

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<tr>
<td><strong>Total expenditures</strong></td>
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**Net result of the year**

<table>
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<th>Year</th>
<th>2000</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>37,159</td>
<td>(18,784)</td>
</tr>
</tbody>
</table>

as at 31 December 2000 and 1999
International Rehabilitation Council for Torture Victims

NGO in special consultative status with the Economic and Social Council of the United Nations

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Introduction
The gathering of forensic medical and psychological evidence of torture is an undertaking of vital importance. It not only documents the reality of torture in political contexts generally but also specifically, in the context of immigration procedures for asylum seekers in countries of refuge. This paper is concerned with the effective documentation of psychological evidence of torture for immigration courts. Not only realistic documentation of torture but also information on how it profoundly affects the asylum seeker is frequently crucial to the success of asylum claims in countries of refuge. For most torture survivors, nothing is more important than to obtain political asylum and to achieve a lasting assurance that they are finally safe. On the other hand, documentation of psychological evidence for the legal setting is a difficult subject and requires special treatment beyond what is required in clinical psychological or psychiatric evaluations.

In a recent letter to the editor, Peel, Hinselwood & Duncan responded to Jacobs' earlier article concerning the importance of psychological evidence in the forensic documentation of torture by raising a number of critical issues and questions. This paper is not least an acknowledgement of the validity of these questions and a response spelling and documented.

which both post-torture symptomatology itself and the assessor's attitudes may become obstacles to the task. We believe that the time has come to discuss these issues by providing more specific guidelines within the framework of forensic psychological practice. Little has so far been published that reports for immigration authorities in charge of adjudicating claims of torture. We are aware that the guidelines offered may not be compatible with all legal conditions and standards of practice in other countries. The context we have to write from is the situation in the USA and we hope that, with the appropriate modifications, the ideas presented apply in other regions of the world as well.

Advocacy versus independence: the first contradiction to be resolved
As Peel et al. and others point out, the job of the forensic evaluator is to render an independent expert opinion that relies as much as possible on objective findings. Government agencies and courts everywhere are increasingly sceptical of opinions generated by advocacy groups for torture victims, to the extent that they reiterate information already found in the asylum seeker's affidavit and testimony. Unless we demonstrate that we do not merely push a political agenda, but follow procedures to safeguard and maximize objectivity, we paradoxically risk the ultimate goal of creditable refugees obtaining asylum. As stated previously, the question of objectivity is a seemingly more difficult issue in the case of psychological evidence than in the case of physical evidence, even if this perspective is only partly justified.

Clinicians involved in the torture rehabilitation movement have rightly conceived their role as being advocates for the rights of a seriously violated group of persons, whose plight has not been adequately recognized. In this context, the role that is required of the independent examiner is one that appears more easily adopted by physicians examining physical evidence than for psychologists or psychiatrists, who face a decidedly intersubjective task. Reconciling empathy and good listening skills with suspension of judgement and probing for potential inconsistencies or problems in a potential torture victim's testimony is not easy to accomplish. Nevertheless, this balance must be achieved, if a psychological examination aspires to be more than a sympathetic retelling of the asylum applicant's story or a simple list of reported symptoms, without attention to the critical legal issue of the nexus between the symptoms and the reported trauma.

Initial procedures and role definitions
Defining the role of the forensic examiner through informed consent at the outset of the evaluation serves a very important function in making sure that all parties are clear about what the examiner can and cannot do. It is vital for the psychological expert to spell out to all parties that the evaluation is being undertaken without guaranteeing a favourable finding, and that any fees charged (if applicable) for the evaluation are not dependent on the result of the examination.
Further, the difference between a forensic psychological evaluation and mental health treatment must be made clear to all participants, especially the client who alleges a history of torture. This principle of neutrality central to forensic psychological evaluation, in our experience, is sometimes disregarded by mental health professionals involved in the advocacy and treatment of torture victims, which in turn invites skepticism, or even disbelief, by government representatives and the court.

The distinction between clinical and forensic roles is critical. When professionals associated with treatment centres for torture victims provide mental health treatment and subsequently offer written affidavits for their patients, a blurring of the boundaries between clinical and forensic roles occurs, which can have unintended negative consequences. This becomes particularly problematical when such treatment centres do not offer medico-legal and psycho-legal evaluations outside the context of treatment, which appears to be an uncommon practice. Asylum applicants and their community representatives have been known to report that many survivors underwent treatment only because they were hoping to be helped in getting political asylum by being provided with medical or psychological affidavits. Responding to their request more directly is, in our view, both ethical and good practice. Torture treatment centres are in many ways most suitable for this task, as long as the distinctions between advocacy, treatment, and forensic practice are properly maintained.

As in other forensic situations, a review of the medical and psychological treatment record is an essential part of evidence gathering. Thus, records or statements from treating clinicians provide useful corroborative data in the context of an overall forensic psychological assessment. However, the treating clinician should not be confused for an independent examiner. Even if the treating clinician has the most detailed and compelling knowledge of the case, this knowledge is best integrated into a larger, independently conducted evaluation. The forensic examiner will obtain the client's permission to review records and discuss the case with the treating clinician, as well as perform a direct examination of the client.

The examiner can provide another important protection for the asylum seeker. By establishing a contract with the asylum applicant's attorney as the client, all communications between the examiner and the attorney become part of the attorney-work-product privilege, an even more protective privilege than the doctor-patient privilege. If the attorney does not believe that the independent report will be useful to the asylum applicant's case, the attorney can decide not to enter the report into evidence or even seek another professional opinion.

The question of independence and neutrality

The requirement of objectivity and neutrality can never be taken to extreme levels, particularly in the case of torture. The vulnerability of torture victims necessitates that evaluators are not unduly removed and critical and avoid creating an atmosphere that replicates the frequently adversarial nature of the asylum and court proceedings. The recent scandal involving the use of police physicians and psychologists in Berlin, Germany, demonstrates the devastating effects of using insensitive and insufficiently trained professionals, whose alliance rests with the government. While this is actually an example of the absence of neutrality and of government partisanship, it is also inadvisable to use examiners who have no familiarity with the problem of torture, and one does not acquire expertise in this area and remain "neutral" in the political sense.

Haenel likens the role of the assessor to the role of the therapist and states: "Like psychotherapists, assessors must possess the ability to assume a position midway between the extreme countertransference poles of too great and too little distance, which can be described as "the greatest possible empathy combined with the greatest possible distance"." We believe that Haenel captures something essential for both clinical and forensic contexts, but does not quite take the crucial difference between therapeutic and forensic roles into account. It is the clinician's job to suspend a preoccupation with facts and discuss only as much of a person's trauma history as is in the best interest of the treatment. This direction may in some cases mean not to discuss it at all or not discuss it for a long time. Particularly within the psychanalytic and psychodynamic frameworks many of us operate in clinically, it is psychic reality that counts, not simply the reality of facts. This stance is good for treatment but only a part of what concerns the forensic evaluator. It is the examiner's job to be helpful to the finder of fact, i.e. the court. Evans has suggested the term "benevolent neutrality" to describe an attitude that safeguards against a non-adversarial atmosphere, while allowing a suspension of judgement with regard to the facts until completion of the assessment.

It is crucial to clarify what the evidentiary standards are that courts require in adjudicating asylum claims. For example, in order to show past persecution for asylum claims in the USA, the applicant has the burden of proof, i.e. the burden of producing evidence that should be reasonably available to support a positive credibility finding. Asylum applicants also have the burden of persuasion. This means that if a judge feels that he/she cannot tell whether asylum seekers are telling the truth, the judge does not have to give them the benefit of the doubt. A further standard applies when a judge is trying to assess the likelihood of future persecution: For regular asylum claims it must be shown that a reasonable person in similar circumstances would fear persecution (or at least 10% chance of future persecution). In cases arguing for withholding/restriction on removal, the clear probability of persecution (more likely than not) must be demonstrated. Medical and psychological experts should familiarize themselves with the applicable standards in their respective countries and regions.

As the standards just outlined demonstrate, the forensic expert is offering professional expertise to the court in order to find whether it is likely, or more likely than not, that torture occurred and might occur again. A requirement of absolute certainty is not realistic and would actually be out of step with the law. For all practical purposes, the court is looking to the expert to provide evidence that: a) corroborates the claim from the perspective of detailed history taking; b) offers evidence concerning the credibility of the claimant; c) offers evidence of any psychological problems experienced, and d) that discusses the "nexus" issue, i.e. the likelihood of torture (rather than other factors) as a cause of the problems reported and observed. We shall now address these aspects of documentation in order.

Taking a history

Medical and psychological examiners alike consider taking a detailed history the centrepiece of any forensic evaluation. In order to do justice to this task, several hours are required. The length of time will vary depending on whether an inter-
TORTURE which is very important in assessing the noti­

fying any inconsistencies or additions, or the referring attorneys prior to the evaluation. Whenever to the history obtained during his/her own interview, duly inquiry into the day-to-day functioning in education, work, and

quired about the survivor's functioning prior to being exposed to torture to establish the nexus criterion. It is not necessary explained from the outset, so that the examinee, who may be .

psychological evidence, because the examiner must gather on physical evidence of torture, it is important for collecting physical evidence, seasoned experts may take an average of 4-6 hours for the history alone. 10

In forensic practice as well as in clinical practice, good rapport is essential for obtaining a good history (6). This is where the advantage lies that a good clinician has over immigration officials and judges. The legal context is the least conducive environment for achieving these conditions of confidence, and the more traumatized an individual the more true this becomes. 11 We would like to repeat that the suspension of judgement and a stance of objectivity concerning the facts is not the same as a cold and adversarial attitude. Sensitivity in the interview and good rapport provides an important protection in the objective examination, both to the mental state of the asylum seeker and the discovery of the facts of the case. Establishing rapport is aided by spelling out the conditions of the examination in detail. This includes informing the examinee that the interview can be terminated by him/her at any point for no stated reason and that this would have no negative consequences whatsoever, that breaks can be taken whenever desired, that he/she is under no obligation to answer questions, and by making it plain in every way that the nature of the evaluation is not adversarial. 12

In our experience, it is useful to commence the interview with a detailed psychosocial and family history that predates any political persecution and torture. This should be explained from the outset, so that the examinee, who may be primed to discuss the history of persecution, does not worry about whether the examiner is not taking him/her seriously or may be trying to trick him/her. While the pre-torture history may not be as crucial for medical examinations focusing on physical evidence of torture, it is important for collecting psychological evidence, because the examiner must gather data about the survivor's functioning prior to being exposed to torture to establish the nexus criterion. It is not necessary or useful to ask the examinee to describe his/her "inner life" in the way that some Western individuals might do in the presence of a mental health professional. An extensive inquiry into the day-to-day functioning in education, work, and family life can provide good clues to a person's past level of adjustment.

It is never sufficient for the examiner to rely solely on accounts of the torture history that were described by claimants or the referring attorneys prior to the evaluation. Whenever such documentation exists it must be made available to the examiner, who reviews the evidence and compares it to the history obtained during his/her own interview, duly noting and questioning any inconsistencies or additions, which is very important in assessing the issue of credibil-
evidence, rather than the treatment of the examinee. The examinee is not an object but a subject. The human encounter during the evaluation is inter-subjective.

(5) This is true also in a purely medical context. One of the authors (U J) recently reviewed a neurologist's deposition, who angrily replied to an attorney's question by saying: "This only concerns you guys. My job is to believe what the patient says when she comes to my office, complains of symptoms, and wants them treated." The record in its entirety suggested, however, that this patient was using the doctor as part of a plan to file a frivolous injury lawsuit. Since the doctor was not asked to be a forensic examiner, he could hardly be faulted for taking the clinical stance he took.

(6) It is worth remembering the words of the rebelliously ethical and old fashioned doctor Pappworth, as reported by Neil Belton in his biography of Helen Bamber: "Too many students, Pappworth said, grow up never to appreciate 'the true value of good history taking and never bother to practise and thereby acquire this difficult yet rewarding art'. The history is the individual's unique testimony. Pappworth advises his readers that to get a good history 'it is essential to be on good terms with the patient'. The doctor must be 'friendly, kind and sympathetic, not arrogant and blown out with the airs of feigned superiority or ultra-sophistication'. [...] It is only by adopting a friendly attitude that he will obtain the confidence of many patients and complete confidence is essential for good histories." Belton N. The good listener: Helen Bamber, a life against cruelty. New York: Pantheon Books, 1998:183.

(7) Credibility is a legal term and the ultimate finding of credibility rests with the court. The information provided by the examiner aids the court in making the final credibility determination.

(8) While most examinees are able to tolerate the interviewing process as described, there are torture survivors who become so upset during the interview that pressing on with the questioning of too many details would be unethical. However, in these cases there is typically less pressure on the examinee to gather all the facts and there are often significant others who can attest to the mental state of the examinee. In a recent case, a woman described the harrowing details of being interrogated, threatened and abused while being in labour, and having her baby taken away from her. She evinced signs of alternating flashbacks and dissociation and could not engage in a detailed narrative of events. However, her cousin was able to provide much collateral information about her current mental state and the demeanor evidence was very powerful.

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Selected list of publications

received in the IRCT International Documentation Centre


Torture and society / Centre for care of torture victims; CCTV. - Kolkata: CCTV, 20010206. - 47 p. - CCTV series nr. 3.


Traumatic experience and sleep disturbance in refugee children from the Middle East / Montgomery, Edith; Foldspang, Anders. - In: European journal of public health; vol. 11, no. 1. - 20010300. - p. 18-22.


The UN human rights treaty system: universality at the crossroads / Bayefsky, Anne F. - [s.l.]: [s.n.], 20010400. - 858 p. (in v.p.)


Danish support to Bangladesh to establish DNA laboratory

In Bangladesh society the number of crimes of violence against women is increasing, but due to the lack of scientific evidence and an effective medico-legal system most of the victims are being deprived of justice.

Recent statistics show that during the period of January to May 2001, 506 cases of alleged rape have been reported in the press. The number of rape incidents is sharply increasing, which is illustrated in table 1.

<table>
<thead>
<tr>
<th>Year</th>
<th>Incidents</th>
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<td>1996</td>
<td>1415</td>
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In recent days, the government is showing much concern to improve the situation. Steps are being taken to modernize the police investigation system and update the criminal investigation procedure and relevant laws.

It is therefore an important step that the Bangladesh government with the technical assistance and financial support of the Danish government through DANIDA (the Danish Agency for Development Assistance) has taken initiative to combat violence against women in Bangladesh. The initial phase consists of the launching of a two-year project, which involves the implementation of a multi-sectoral approach to violence against women. During the two-year period, the project intends to establish a management structure in order to launch various pilot activities and prepare a set of activities for the next five-year period. The main objective during the first phase is to establish two One Step Crisis Centres for victims of violence with facilities to provide medical, legal, and social services. To achieve this, support activities will be initiated in order to upgrade the Forensic Medicine Department facilities, including setting up a DNA lab in the Centre at Dhaka Medical College. Among other activities, training for police, lawyers, judiciary personnel, and of course the doctors is included.

The ultimate objective of the joint project is to improve the quality of services provided by the police, doctors, lawyers, and judges. Other objectives are to improve the existing conditions concerning women's difficult access to the criminal justice system, in particular that of poor women. Government officials, as well as people involved in the justice system, hope that project activities will also raise public awareness and thereby result in a general reduction in and condemnation of different forms of violence against women.

In May 2001, a team of consultants visited institutions in Bangladesh. The team included overseas consultants Karin Helweg-Larsen, senior researcher in forensic medicine, Professor Jørgen Dissing, genetician, and Dr. Zahidul Karim as a local team member. Besides meetings with the ministry and NGO officials working for women's rights, the team examined relevant materials, publications, guidelines, and policies related to the burning issue of violence against women. One of the main outputs expected of the consultancy is a report with detailed recommendations, including training of personnel and capacity building.

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Ministry of Health and Family Welfare
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Mohakhali
Dhaka 1212
Bangladesh
Another call for action to the IRCT network

In 1998, a diplomatic conference was held in Rome by the United Nations, at which 160 nations discussed the establishment of a permanent independent legal body - the International Criminal Court - with the aim of prosecuting individuals for serious human rights violations. This court must not be confused with the special war crimes tribunals for Rwanda, Sierra Leone, and the former Republic of Yugoslavia, nor with the United Nations International Court of Justice, which cannot prosecute individuals.

The statute was adopted by 120 state parties. There were seven votes against it, among these the United States of America, China, and Israel. Since then, the United States has signed the statute (as of December 2000). The United Nations usually makes decisions by consensus, not by a simple majority of votes. The Court will come into force when 60 state parties have ratified the statute. On 4 February this year, 139 state parties had signed the statute. The signing of a statute is a step towards the ratification itself. On 21 June, Denmark became the 35th state to ratify the statute, which will establish the first permanent International Criminal Court.

Situated in the Netherlands, the new court will not be limited by time or place, and will be able to react relatively quickly, as it is to be permanent. Hopefully, it will have a preventive effect on human rights violations. Moreover, it may encourage states to prosecute and convict criminals in their own country, and if they will not, or cannot, the new Court will exercise jurisdiction on their behalf.

The Court can prosecute individuals for criminal acts irrespective of their official status - for instance presidents and heads of governments. Military commanders can be held responsible for crimes committed by forces under their command, and there will be no impunity even for crimes that are committed by order of higher authorities.

Torture, which takes place in a large number of UN member states, has until now more or less been unpunished. This fact may not be changed at once, but chances are that the new court may become a preventive and effective weapon against torture.

Immunity does not any longer mean impunity.

When 60 state parties have ratified the statute, the Court can begin prosecuting those responsible for torture, whoever they are, and wherever they may be.

In this process of ratification, which may take some time before the countries have incorporated the statute into their national legislation, the IRCT network is urged to encourage its governments to ratify the statute.

Erik Bloch
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2791 Dragør
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Selected list of publications
received in the IRCT International Documentation Centre

Racism, violence and humiliation: findings, conclusions and recommendations of the Public Committee against Torture in Israel concerning the behavior of the security forces toward persons detained during the events of September-October 2000 / Ginbar, Yuval. - Jerusalem: PCATI, 20010400. - 37 p.


Torture in well-functioning democracies


"Tortura en Euskal Herria" deals with torture and ill-treatment in the Basque country in Spain. However, its identification of sources and actors, and particularly its proposals for preventing torture, reach much further than the Basque country or Spain.

The publication consists of a book in Spanish and a CD-ROM with the same information in Basque, English, and French, and is published by a Basque anti-torture organization, Torturaren Aurkako Taldea (TAT). The book begins with a description of the situation in the Basque country followed by testimonies from alleged victims of torture and ill-treatment, a summary of court cases, and an overview of the psychological effect of torture. It then identifies alleged perpetrators and the methods used, proceeds with statistics, references to criticism from international bodies, a discussion of the problem of impunity, and ends with constructive proposals for how to prevent torture in the Basque country and Spain in general.

When reading any book like this, its objectivity must be questioned. Bearing this in mind, the book is an excellent example of how to write a publication highlighting problems, and provoking discussions, which should be on the agenda in all of Europe. However, documentation or statements from independent, certified doctors would have made the ‘testimonies’ more useful as references. The book makes up for its shortcomings by proposing solutions to the problem of how to prevent torture from happening, and offers constructive and useful suggestions that could reach further than Spanish internal matters.

The major source of torture and ill-treatment, as identified in this report, is the Spanish anti-terror legislation, which provides the legal basis for the security forces to apply special treatment to alleged terrorists. TAT claims that this legislation is applied indiscriminately to all Basque persons who, for one reason or another, get into conflict with the police. Also, it leads to a practice which reverses the principle that a person is innocent until proven guilty, when the cases are tried before the special court, Audiencia Nacional. The judges in Audiencia Nacional, according to TAT, do not investigate alleged cases of torture. Thus, confessions and information obtained through torture and ill-treatment are accepted before this court – a practice that, if true, clearly undermines the rule of law.

Torture and ill-treatment are not methods necessarily applied to obtain information or confessions, but can be used as a means to keep an opposition quiet and to weaken democratic structures in parts of society or in society in general. Torture is, indeed, the most effective tool against true democracy and can never be allowed or excused. The absolute prohibition of torture in contemporary international law applies also to the fight against terrorism. However cruel and inhuman terrorism may be, it does not give any government or authority the right to use torture. The media have a big responsibility to focus on this conflict – a responsibility they, in the opinion of TAT, do not live up to in Spain.

When reading the suggestions for eliminating the alleged practice of torture in Spain, particularly the Basque country, one is provoked to also consider the torture problem in the context of traditionally well-functioning democracies, rather than always discussing the practice in ‘third-world countries’. Impunity for alleged torturers is a practice which is often criticised by European countries. The issue is discussed in the book in a Spanish context, and is mentioned as one of the major obstacles to the eradication of torture.

The book is an example of a way to describe alleged practices in a certain region and by certain state actors, and to raise awareness that organizations in democratic, well-functioning societies should sometimes look nearer home, instead of always directing their glance to dictatorships in other parts of the world.

Anders Buhelt, LLM, EMA Programme Coordinator IRCT Borgergade 13 P.O. Box 9049 DK-1022 Copenhagen K Denmark

Making standards work
– an international handbook on good prison practice


This excellent manual has now appeared in its second edition.

First published in 1995, it has now been translated into more than 15 languages and is also available on the internet. Making Standards Work is intended as a tool for reform and for the fight for decent prison conditions and is found to be an invaluable resource to governmental and non-governmental organizations worldwide.
Increasing sale of torture instruments

The international trade in electroshock batons and other torture instruments has steadily increased during the last decade, according to Amnesty International, which attacks the morality of the manufacturers.

Even though the fight against torture and other human rights violations has been a global agenda priority during the last decade, international trade in torture instruments has greatly increased during the 1990s. This is established by the human rights organization Amnesty International in connection with the launching of its annual report.

"International trade in high voltage electroshock batons, as well as stun guns and taser guns, has increased during the 1990s. During the last two years, more than 150 companies in 22 countries have manufactured or marketed electroshock equipment," says Amnesty International.

By way of comparison, only 30 companies worldwide were producing or supplying electroshock equipment in the 1980s.

According to Amnesty International's research, a number of these companies are French or German, as France and Germany, along with Poland, are the largest known European manufacturers of electroshock equipment.

None of these countries provide public export statistics for the sales of these products, but according to Amnesty International at least one French company has sold torture instruments to countries in North Africa and the Middle East, where torture prevails.

In the Scandinavian countries, Belgium, the Netherlands, Luxembourg, Switzerland, and the UK, electroshock weapons are considered prohibited weapons, "although the ban is not always fully comprehensive". The United States of America, along with China, Taiwan, and South Korea, is among the largest suppliers of electroshock equipment, which Amnesty International has tried in vain to have banned.

(Translated from the website of the Danish daily Berlingske Tidende at www.berlingske.dk, 29 May, 2001).

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The IRCT is an independent, international health professional organization, which promotes and supports the rehabilitation of torture victims and works for the prevention of torture worldwide. In working towards the vision of a world without torture, the IRCT promotes, values and accepts shared responsibility for the eradication of torture through:

- raising awareness of the need for torture rehabilitation and encouraging support for victims of torture
- promoting the establishment of treatment facilities around the world
- working for the prevention of torture
- documenting the problem of torture and collecting results of research related to torture
- working to increase funding for rehabilitation centres, programmes, and projects worldwide.