Information Request by PIOOM
The Interdisciplinary Research Programme on Root Causes of Human Rights Violations

Wanted by Pioom
Information on Torturers

The Dutch-based nonpartisan research organization PIOOM is currently preparing a project with the title:
The Politics of Pain: Torture Seen Through the Eyes of the Torturer and his Employer. Lessons for Victims’ Relief, Drawn from First-Hand Accounts by Torturers.

This project, which is supported by the United Nation's Voluntary Fund for Victims of Torture, is conducted by Prof. Ron Crelinsten (Department of Criminology, University of Ottawa) and by Dr. Alex P. Schmid (Center for the Study of Social Conflicts, Leiden University).

The principal researchers have collected ego-documents from several countries. They have also developed a detailed questionnaire with the help of which they interview torturers. Some of these interviews have been videotaped - the purpose being to give torture a face.

For both the identification of torturers and their employers and the location of ego-documents (confessions, court testimonies, letters, diaries, interviews to the press, etc.) PIOOM would welcome the cooperation of other researchers and people in a position to know.

If you have any relevant ego-documents or other information which might be of assistance to the completion of this project, please contact:

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Torture has many faces, all ugly. Just think of the difference between the dripping crane in Stefan Zweig’s *Chess novel* and Saddam Hussein’s electric torture bed. Or think of the many examples of rape by policemen compared with the refined misuse of psychotropic drugs.

Despite the now generally acknowledged definition of torture in the medical Tokyo Declaration of 1975 and in the UN anti-torture Convention of 1984, human imagination will always be incomplete compared to the general evil and inventiveness in a modern technological world, and to the new perspectives of misuse of force, be it physical or mental.

When Amnesty International reports that thousands of women all over the world are routinely raped at police stations or in prisons - this is also torture in the sense we deal with it within the world of human rights and medicine. Rape committed by a civilian without authority is not considered torture.

To be put in a cold - or very hot - prison cell, to be without proper medical treatment, or to be hungry every day or served inedible food, is also torture. It is just much more difficult to prove than, let us say, the more traditional forms of harming the body.

Generally speaking, the RCT and IRCT only deal with that kind of torture which is performed by governments and on a more permanent basis. Arbitrary and sporadic misuse of authority is not regarded as torture. And automatically some countries of the world practice kinds of legal punishment that other countries will call torture.

But one can also talk of “related” torture victims, i.e. relatives of torture survivors. The spouse (often the wife) and children of a person who has been exposed to various forms of torture, including perhaps long absence and fear of what was going to happen, go on suffering for many years after the release from prison of the victim.

The many characteristics of torture of our day were part of the agenda at the IV Symposium on Torture and the Medical Profession in Budapest last October. It is of special importance for doctors that it is possible today to prove that torture has been used on a patient, even when there are no visible scars.

Science has told us how to trace chemical changes in the structure of the tissue in order to prove torture. However, only few doctors have dealt with patients whose accounts of torture the doctors suspected of being false.

The problem is really more often that the torture survivors do not speak about the torture when, for instance, they are given a thorough medical examination several years after the torture took place. They tend to suppress the horrors in their memories.

There is one kind of torture victim for whom human rights activists and doctors can do nothing: the victims who are tortured to death. Documentation on this is naturally scarce, but examples from Turkey and India are mentioned in this issue of TORTURE. The best known single person who died in such a gruesome way was the South African Steve Biko.

That the fight for freedom and democracy can lead to such atrocities is a strong memento for everybody engaged in human rights, and a repetition of what has been said earlier in this magazine: Prevention is better than cure. Many dictatorships have no way of dealing with courageous opponents apart from torturing or even killing them. For fear of losing their power, they never enter into a dialogue with them.

The fight against torture thus implies a continuous fight for democracy and for general respect for human rights. Those of us who live in democratic societies should never forget to induce the spirit of respect for the individual, wherever he lives. This, however, is a product of a Western perception. In many civilizations, the group, be it the family or a defined circle of political friends, is more important than the individual - and respect for other different groups is rare.

Group solidarity has proved to be an insufficient weapon against repression, especially with respect to protection of the individual. This is the grim experience from various parts of the world. The development of a total dictatorship such as the many described in various reports, mentioned in this magazine should have been stopped years ago by all available means. The far-reaching consequences of the complete oppression are now further mistreatment of different ethnic groups.

The international community - the voluntary agencies, the non-government organizations (NGOs), and the handful of governments that are internationally concerned in this respect - only makes slow progress in fighting torture. Amnesty International in particular, but also specialized organizations such as SOS-Torture, keep track of torture all over the world and describe “the many ugly faces”.

They remind us, they try to influence governments - but in the last resort they cannot remove it - only the populations themselves of the countries concerned can do away with torture. The communist states did it. Several states in Latin America likewise. May they get many followers.
The ethical obligations of doctors - and some activities of Danish doctors

It is clear today that the Hippocratic oath is not sufficient to ensure that doctors follow the spirit of the oath in their ethical conduct. Therefore, many national medical associations have found it extremely important to develop ethical guidelines and rules for the ethical conduct of medical doctors.

In Denmark, free, democratic, non-governmental organizations, and the medical profession, have been very successful in developing ethical regulations, probably more successful than any governmental legislation would have been.

Since World War II, there has also been a growing understanding in organized medicine for the necessity of establishing ethical guidelines and rules for medical doctors to ensure an international ethical standard for physicians. Medical ethics was covered through intensive work in the Standing Committee of Doctors of the EC (CP, Comité Permanent), and in the World Medical Association (WMA).

The Declaration of Tokyo

Torture has played a significant role among the topics with which these international medical organizations have worked. The Danish Medical Association (DMA) played a significant role in the preparation of WMA's Declaration of Tokyo, adopted in 1975, and in CP's Statement of Madrid, adopted in 1989.

At the beginning of the 1970s, with the late doctor Jens Daugaard in the forefront, the DMA was one of the prime movers in having the Declaration of Tokyo accepted. Torture is defined therein as “the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.”

The Declaration of Tokyo contains an unconditional prohibition against a doctor's participation in torture in any form - including procedures connected in any way with the use of torture.

The Declaration concretely sets forth:
- Prohibition against permitting, approving, or participating in the practice of torture regardless of what the victim is suspected of. This prohibition applies during armed conflict.
- Prohibition against providing premises or facilities, medicines or knowledge which can assist the practice of torture.
- Prohibition against even being present in any situation where torture is taking place. In addition, it pronounces that a doctor must have complete professional independence in his decisions as to the care of a person for whom he is medically responsible.

The Declaration of Tokyo, further, requires doctors to respect the wish of mentally sound persons not to take nourishment. Thus, doctors may not cooperate in the forced feeding of persons who are undergoing a hunger strike for political reasons.

Finally, those medical associations which have adopted the Declaration are required to provide every form of support for a doctor and a doctor's family when the doctor is subjected to threats or reprisals as a consequence of his wish to live up to his obligations under the Declaration of Tokyo.

The Statement of Madrid

In August 1986, the DMA, in cooperation with the Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen, held an international conference in the DMA House on the basis of which principles for the work of further implementing the Declaration of Tokyo's principles were developed. One of the conditions that one sought to improve was the possibility for medical associations to enforce effective sanctions against any doctor who participates in torture and violates the principles of the Declaration of Tokyo.

The DMA, therefore, in November 1988, submitted a proposal to the Medical Ethics Subcommittee of the Standing Committee of Doctors of the EC (CP) which would supplement the Declaration of Tokyo with a European Declaration against the participation of doctors in torture. That initiative resulted in the adoption by the Plenary Assembly in November 1989 of the Statement of Madrid, which was founded on the principles developed by the DMA/RCT in August 1986.

As stipulated in that Statement the CP decided:
- to urge all national medical associations which have not yet...
done so to ratify, publicize, and implement the Declaration of Tokyo (Guidelines for Medical Doctors Concerning Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment in relation to Detention and Imprisonment) adopted by the World Medical Association in 1975 as the definitive statement of the position of the medical profession on this topic;

- to urge the inclusion and integration in the medical education curricula of information about the existence of this problem and instruction in the ethical responsibilities and regulations by which the doctor is bound and to which he may refer when subjected to pressure to act contrary to the best ethical principles of the medical profession;

- to urge all national governments which have not yet done so to ratify and implement the United Nations Declaration of 1982 and other relevant international declarations on this topic;

- to urge the establishment of an international reporting system regarding ethical infractions within the profession in this respect and to publicize information about the existence of torture and to urge that similar educational measures be taken for all health professions and police and military personnel, and to encourage and support research against torture and for treatment of the victims of torture, and

- to urge that international support be given by the profession to colleagues who take action to resist the involvement of doctors in such procedures and to mount an international protest against any efforts to hinder the profession in attempts to uphold the highest ethical principles of physicians.

The DMA was for several reasons outside the WMA for some years, together with the medical associations of the UK, Canada, Sweden, Norway, Finland, Iceland, the Netherlands, and others. The Danish and several others of these medical associations have now re-entered the WMA.

The work of the WMA could be correlated to the work done in the UN. A lot of declarations and goodwill have been expressed, but still many member associations and member states do not fulfil their obligations.

An important element in the Statement of Madrid is its calling for the establishment of an international reporting system which will make it possible effectively to register the doctors who have transgressed the international norms of medical ethics in this respect.

In this connection, the RCT has expressed the wish to involve the medical association in the work of establishing an international tribunal to investigate cases of doctors and lawyers who are responsible for torture.

The best means of supporting doctors who are seeking to resist involvement in torture, in the opinion of the DMA, is via collegial ethical review, education, and efforts within the international medical profession's democratically elected bodies.

The WMA should in my view establish an ethical body or committee to make sure that the members of the WMA and their members behave in all respects in accordance with the relevant declarations.

The time has come for organized medicine to demonstrate that international ethical guidelines for medical doctors, and maybe especially the Declaration of Tokyo, are more than just words. I can assure you that the DMA will do all we can to make WMA aware of its responsibility.

**Initiatives in Denmark**

In Denmark, the DMA has established formalized training of the group of doctors who have been called, internationally, *Doctors at Risk*. These include doctors working in developing countries, prison doctors, and military doctors.

This means that all doctors who are sent to developing countries have a one-day course with presentation of fundamental medico-ethical principles and international regulations on ethics and human rights. In the same way, formalized education in medical ethics for all doctors working in Danish prisons or drafted to serve in the military is being established this autumn.

Most recently, the DMA, in cooperation with Amnesty International’s medical group, the RCT, and the Danish Human Rights Centre, entered into a cooperation with the Danish Foreign Ministry and the Danish Ministry of Health to prepare a Danish proposal further to develop the UN’s principles on Medical Ethics from 1982, with an emphasis on the individual doctor’s right to refuse to participate in torture.

The DMA, in cooperation with the Danish Lawyers Association, has furthermore developed an inter-disciplinary course aimed at helping Romania, and possibly other Eastern European countries, with the reconstruction of their society in order to introduce democracy and to establish a constitutional state. It is an integrated course directed towards a target group which represents functions in society considered fundamental in a state based on the rule of law (judges, lawyers, administrators, and doctors).

The project was well received by the Danish government, which provided economic support of $50,000. On the whole, independent professional organizations in the Western World should in this way try to extend their international network to young democracies in Eastern Europe.

The DMA, therefore, welcomes the setting up of rehabilitation centres in other places, both in Denmark and elsewhere.

The DMA will also, in the future, hand in hand with its cooperation partners, work for the development of human rights and work against torture in all its forms. Thus the association considers that knowledge and information about the situation of torture continue to be among the most important weapons in this fight.

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The need for tribunals

Setting up national and international Tribunals to investigate the involvement of professionals in torture

By
Gregorio Martirena, MD*

The numbers of torture cases and killings from repressive governments may have decreased during the last years, but gross violations of human rights, sometimes leading to death, continues today with the complicity and participation of both doctors and lawyers.

Mock execution, murders, extra-judicial executions of criminals in so-called “accidental” circumstances, “prison suicides”, the electrical torture, the suspension, the beatings, the submarino (water torture) are all practices that are still in common use today during police interrogation and imprisonment.

Introducing democracy, as has happened in several states of Latin America the theory of national security and the fantasy of “civil war” against subversive activity have disappeared, but it has led to another type of theory of civil defence and a declaration of war against crime, which is centred in, and whose components derive from the deprived and extremely poor social stratum.

The trial of professionals who tortured and ordered killings with the following “moderate” or “conditional” fulfilment of their sentences, should not end there. They should be made morally responsible for not upholding the ethical principles that their university diplomas bestow on them.

University professionals, such as doctors and lawyers, have as a priority an ethical code to follow, in which responsibility is of major importance. Doctors should fulfil their medical duties in a self-sacrificing and altruistic manner, with a caring and unselfish attitude, and lawyers should do the same and in addition should fight for the enforcement of the law, especially for human rights.

Based on these thoughts, the statutory project would extend the power of the international tribunal in two ways:

First, it would not limit its action to the common worldwide view on torture, but would extend it to all crimes against humanity in which there was evidence that medical practitioners and lawyers had participated in enforced disappearances and cases of death.

Second, it would allow the tribunal to reproach, on an ethical level, those governments or state departments which are responsible for the violation of human rights.

To deny the inhibitory power of international public opinion and of university colleges around the world would be a real error of misjudgment.

During 1984, while Uruguay was still under military dictatorship, the national medical convention established the medical ethics tribunal of Uruguay, with the aim of judging the ethical conduct of police and military doctors assisting political prisoners. Eleven doctors were found guilty of ethical misconduct during an investigative period of five years.

In 1985, the college of physicians of Chile incorporated the ethical principles of the United Nations into their code of ethics, which enabled them to use legal resources to judge the conduct of doctors when assisting political prisoners.

In 1988, an ethical tribunal for the people of Argentina was set up to examine the conduct of doctors who were involved in human rights violations.

In 1990, after the Tromsø talks and the meeting of the Montevideo group in Copenhagen, it was decided to create a statutory basis for the establishment of an international ethical tribunal for medical practitioners and members of the bar. The statute of the tribunal was developed in a cooperation between Professor Ole Espersen and Dr Knud Smidt-Nielsen of Denmark, Professor Rodolfo Schurmann Pacheco of Uruguay, and myself and finally written by Dr S. Pacheco. We must now find financial resources and put the first tribunal to work.

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Frontpage of Les Echos No. 6, Togo, 1990. The text says: To fight torture and arbitrary detentions is to liberate the citizen from the fear of expressing himself.
New regime in Chad

A french mission has treated torture victims in the former French colony in Africa

By Hélène Jaffé, MD*

The large majority of torture victims remain in their country of origin. Taking this fact into account, AVRE1, from the very beginning, defined in its statutes the necessity of implanting short-term missions in countries where torture is practiced.

The new political situation in Chad made one such mission possible. The quasi dictatorial regime of Hissène Habré was toppled by Idriss Deby and his troops in December 1990. Habré himself managed to escape and obtain political asylum in Senegal.

AVRE was mandated by the newly appointed Commission of Investigation on the Crimes and Embezzlements of Hissène Habré and his Accomplices to provide medical aid to the victims of torture under the previous regime (1982-1990).

Chad was the last country to be colonized by France in Africa (1900-1913). Independent since 1960, the country has experienced instability, repeated border conflicts with Libya, civil war, ethnic strife, and massive repression.

An evaluation mission of one week was undertaken in July-August 1991. We discovered a country and its people, sad and destitute, still under the shock of atrocities that surpass imagination. All political prisoners were set free on the day (1 December 1990) Deby and his combatants marched into the capital, N'Djamena, giving rise to joy and hope. But the initial euphoria died down quickly. For one thing, many families had not been reunited with their relatives; the majority had not come out of prison; they had died following torture or had perished under the extremely harsh conditions of confinement.

Those who had survived were in a pitiful state. Reduced to skin and bone, a sizeable number of them had succumbed to their illnesses or, sadly enough, died from over-eating only days after their liberation. Stripped of all their belongings at the time of arrest (a common practice under Hissène Habré), most ex-detainees still have literally no means of living.

Despite significant improvements on the path to democratization - the appointment of the Commission of Investigation3, the existence of newspapers that openly criticize the present government, the creation of a Chadian Human Rights League4 - developments do not seem to be sufficiently fast or substantial.

Insecurity is still a major problem. The perpetrators, this time, are the very “combatants” who “liberated” N'Djamena. Unpaid but armed, they pillage civilians in the capital, sometimes executing those who dare to resist handing over their motorbikes or vehicles. These “uncontrollable elements” were ordered out of the city limits last November ... but they remain, unpaid and mostly armed.

Another factor of unease is the reconstitution of a political police unit that incorporates, moreover, known members of the infamous D.D.S. (Direction of Documentation and Security), the political police unit in Habré's time.

For ethical reasons, and to take advantage of Idris Deby's announced will to establish a state that respected Human Rights, we announced clearly that our consultations would be open to all victims of torture, past and present.

After our initial evaluation mission, we decided to carry out intermittent missions of 2 weeks or more - up to 4 or 5 per year - to receive and treat the victims of torture registered by the Commission of Investigation or, for the more recent cases, sent to us by the Chadian Human Rights League, for example. By the end of our third mission in N'Djamena (July-August 1991, October-November 1991, January 1992), we had established 245 patient files in all. We rented two rooms in a Catholic mission situated in a popular district, which we used for consultations in general medicine, psychology, rheumatology, and orthopaedics. In the quiet, closed-off courtyard, tree stumps for sitting under a thatched roof served as the "waiting room".

Categories of patients seen (torture victims):

Civilians (66%), of whom
- 8% were high school or university students
- Soldiers (22%)
- Prisoners of war (12%)
- 3 women consulted

Of the 245 patients:
- 45% have been reintegrated into their previous occupation (this is the case mainly for the military corps)
- 15% have found work other than their previous occupation
- 40% are either physically incapacitated to take up their previous activities, or they lack the material means to recycle themselves into another profession.
The complaints:
The most frequent complaints were:
- aches and pains (headache and joint pain were the commonest)
- sleeping problems: insomnia, nightmares, nocturnal frights
- change of mood and concentration
- reduced hearing and visual acuteness

These complaints were directly connected with torture and the conditions of detention. They were not, in 99% of the cases, related to any previous medical condition: the patients we receive are young men whose health has been prematurely altered.

Medical aid:
In prison:
Medical assistance was almost non-existent. For the few who were taken to hospital for urgent treatment, how many died in prison? A few tablets of paracetamol were occasionally distributed. For many, the leaves and fruit of the nimier tree were the all-encompassing remedy (when obliging guards brought them). Treatment used before arrest was interrupted (insulin for diabetics, for example)

On liberation and before the mission was set up:
The most serious cases were given hospital or medical care. The others “managed” as best they could, depending on their chances.

Many prescribed treatments were never started, or they were not continued, for lack of financial resources, meeting the same difficulties as the general population with respect to access to medication.

At the mission:
We give each patient the necessary time to express what they feel about their experiences. It is often the first chance they have had to speak about what they have gone through to somebody who is politically and emotionally neutral, sensitive, and open.

The list of complaints established during this first meeting serves as a guideline for the clinical examination, which is carried out by either a general doctor or a specialist. Medicine is brought over from France or bought on the spot and given in sufficient quantities for a complete treatment, the results being assessed from mission to mission.

Disability:
Already we can list 46% of cases of permanent partial disability, ranging from premature presbyopia to serious disablement of neurological origin.

Among our patients, seven had been incarcerated under Hissène Habré and yet again under Idris Deby. The second arrest caused great anxiety. However, all but one, who still bore traces of recent torture (institutional), said that they had not been ill-treated.

Finally, we saw a young man, recently severely tortured in a private setting, who showed courage in coming to the mission for treatment.

All our patients have our address and are free to write to us if they wish.
Prospects

Our initial idea was to work hand in hand with Chadian doctors, sensitive to the problems of their compatriots having lived through torture. We attempted to include such willing doctors, in the hope that they would continue the consultations in our absence. Our procedure proved to be a little hasty, though. This kind of work was considered risky by some, and in addition the patients were distrustful of them.

We hope that eventually we will be able to go to certain provinces that were massively affected by the repression. Such trips, and even those to N'Djamena, depend largely on future political developments in Chad.

Notes

1) AVRE (Association for Victims of Repression in Exile) was founded in 1985. Situated in Paris, our care centre has so far received 1000 patients. Missions have already been carried out in Guinea Conakry (1985), Marocco, and Turkey.

2) The Commission of Investigation should be filing a comprehensive report of its findings at the end of February 1992. We hope that it will be distributed widely.

3) Just as we were writing this article, we learnt that the Vice President of the Human Rights League, Joseph Behidi, was assassinated in the streets of N'Djamena.

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A Dutch think tank on torture

A new way of analysing reasons for torture and its prevention

By Alex P. Schmid*

Think Tanks in the field of foreign policy and national security have a tradition that dates back to the immediate post-war period. Such bodies, often linked to universities, serve contending foreign policy elites and/or bureaucracies by elaborating various policy options and assessing their relative costs and benefits. Sometimes they are associated with political parties, which might be in or out of office, depending in part on the attractiveness of the policy options suggested by Think Tanks to the parties and through them to the electorate.

What is useful for governmental organizations - parties and bureaucracies - might also be good for non-governmental organizations (NGOs) such as Amnesty International, or for public international organizations such as the United Nations. In fact, both Amnesty and the United Nations have their in-house research departments, the latter in the form of the General Secretary's Office for Research and the Collection of Information (ORCI), established in 1987.

The problem with in-house research units, however, is that
they easily become entangled in policy fights and get bogged down by day-to-day emergencies. Generally speaking, the quality of a Think Tank's advice is greater, the more independent it is from the party it advises. A certain detachment from daily policy pressures is likely to increase both creativity and objectivity.

PIOOM is a non-partisan, Dutch-based, non-profit Think Tank, promoting, supporting, and conducting research. The acronym stands for Interdisciplinary Research Programme on Root Causes of Human Rights Violations. It was established as a foundation in 1988 and is the brainchild of Rear Admiral (rtld) J.D. Backer, the former chairman of Amnesty International in The Netherlands. Dismayed by the limited success of Amnesty International, Admiral Backer searched for new ways to make the strategy of human rights organizations more effective.

His idea was to mobilize the academic world to utilize its broad expertise in the social sciences, but also in the medical and legal disciplines, to develop new instruments for the struggle against gross human rights violations.

Admiral Backer toured all the Dutch Universities to find somebody willing to listen to him. With seed money from Amnesty International, he found somebody prepared to write a research programme. This set of project proposals was presented to the public in October 1988 during the first PIOOM symposium in the form of the publication Research on Gross Human Rights Violations: A Programme, by A.P. Schmid (Leiden, COMT, 1988, 2nd enl.ed. 1989 (245 pp.)).

These proposals were subsequently submitted in various forms to grant-giving bodies: They managed to attract funds from universities, the Dutch Ministry of Education and Science Policy, the Ministry of Foreign Affairs, the Netherlands Scientific Organization (NWO), the European Commission, the United Nations Voluntary Fund for Victims of Torture, as well as others. In Leiden, at the Centre for the Study of Social Conflicts (COMT), a coordination office was established where new projects are initiated and supervised. At the time of writing, 9 funded projects and more than a dozen unfunded or external PIOOM projects are being conducted by both local and foreign researchers in and on Latin America, Asia, and Africa. In addition, PIOOM staff act as consultants to human rights organizations and various United Nations offices.

The research strategy of PIOOM focuses on identifying and isolating those social, political, economic, and cultural factors which, on the one hand, facilitate human rights violations and those which, on the other hand, are likely to inhibit such violations. A second distinction made by PIOOM focuses on the ease with which enabling and disabling factors can both be influenced by human rights organizations: there are relatively "inert factors" that affect a society's human rights performance (e.g. ethnic heterogeneity), and there are "manipulable factors" that lend themselves more readily to social and humanitarian intervention. Such factors are isolated at macro, meso, and micro levels:

I. The level of the state and the international order;
II. The level of institutions such as the police, the military, and security services; and
III. The level of the small group and the individual.

Through comparisons between times and places with high levels of gross human rights violations and low levels of torture, political murder, and disappearances, certain patterns emerge which can be translated into hypotheses about the circumstances conducive to or obstructive to human rights abuses. It is expected that from the various investigations into the decision-making (and lack thereof) behind human rights violations, certain policy recommendations can be formulated for those eager to combat such violations more effectively than was hitherto possible due to the near-absence of scientifically-tested assumptions.

In its micro-level research, PIOOM focuses, for instance, on the torturers and their superiors. Much of what we know about torture is based on victims' testimonies. While this sort of knowledge is valuable, it is by its very nature neither an objective, nor a complete basis for understanding the processes that initiate, maintain, and perpetuate the institution of torture in no less than 100 societies.

PIOOM has therefore begun identifying, locating, and interviewing ex-torturers and their superiors. This is a difficult enterprise. In order to enlarge the sample, use is also made of written testimonies of torturers (confessions, court testimonies, interviews, memoirs, letters, etc.). The basic idea is to assemble a body of information on torture from the side of the perpetrators, analyse the information, identify vulnerabilities in systems of torture, and then make recommendations about how to improve the strategy of those who combat torture at the political level, or try to heal the wounds inflicted by torture at the individual level.

The purpose of this particular project is multiple: on the one hand we deem it important to give torturers a face, linking them to their victims; the provision of visibility to torturers is also likely to increase inhibitions against torture. On the other hand, it is expected that new insights on systems of torture will also provide instruments for doctors and psychologists that improve the chances of rehabilitation of former victims.

References


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Scarcity among plenty

How to treat victims of torture in the USA without government assistance

Health care in the United States is not for everybody; in fact an appalling number of Americans have no health insurance, public assistance, or other source of payment for medical care. It is currently estimated that 15% of Americans have no health care coverage. In public hospital emergency rooms, some of the uninsured, and others seeking care, leave because of long waiting times.

Needless to say, the situation for victims of torture in the United States is often even more desperate than for other uninsured Americans. The immigration lawyers often discourage survivors from applying even for Medical Assistance, for fear that it might prejudice the asylum process and their long-term safety. Even when a client does apply for assistance, the process is confusing and cumbersome. The rules are continually subject to change and the bureaucracy can be intimidating.

At the Center for Victims of Torture in Minneapolis, most of our clients, who come from all parts of the world, but mainly from Africa, are poor and unemployed when they enter our program. They often have no financial coverage at all for medical care. Only about 37% may qualify for state and federally-funded Medical Assistance. A very small percentage of clients have private insurance or belong to a health maintenance organization that is obtained through their employers.

The services of The Center for Victims of Torture are especially important for those who have no medical coverage. The routine medical assessment, which includes the medical history, the medical examination, and basic laboratory screening tests for infectious and metabolic diseases, represents the only health care that the client has had or is likely to get. Unfortunately, these medical procedures are quite costly for the Center. For example, in 1990 the Center's budget included $1,200 for laboratory testing at public and private laboratories. It also included $9,417 for medications, which the Center bought for its uninsured clients.

We continuously seek all avenues to obtain medical consultations, diagnostic procedures, surgical procedures, medications and other treatment for uninsured clients. For the most part, the Center's budget absorbs the tests and treatments which can not be delayed. One individual donor provided a small fund for use by particularly needy clients, which was quickly exhausted. Certainly there are medical personnel, especially surgeons, who have provided services for clients, but it is a challenge to find the number of providers needed to serve our clients' needs adequately.

At present, the Center is hoping that the overall system of payment for health care in the United States, or within the state of Minnesota, will change in the near future. Until then, our strategy is to continue to provide urgent care to our clients in spite of the cost. The Center is also vigorously pursuing the capability of billing the Medical Assistance program for care rendered to clients who are qualified or enrolled in that program. Finally, we are examining the possibility of recruiting volunteer physicians, possibly retirees, in certain specialties, who might come to the Center and provide consultations and examinations in such fields as cardiology, neurology, otolaryngology, or ophthalmology. One major difficulty with such an arrangement is coverage of professional liability for volunteers at the Center. At present the Center must insist that contract and volunteer physicians and other health care providers carry their own professional liability policies.

In closing, we must say that the difficulty in obtaining basic medical care for our clients is a time-consuming, frustrating, and complicated process which detracts from the efficiency of our staff. Small needs which ought to be routine become insurmountable obstacles. Clients find it confusing and difficult to negotiate the circuitous arrangements in obtaining needed care.

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Torture is endemic in Pakistan
The political and legal history of torture

By
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Torture is interwoven in the socio-economic matrix of Pakistan, and is used as an essential instrument for the survival of the system. Change in Government may bring a palliative change in torture, but the institutions of torture remain intact. The laws which allow torture remain. There are still torture cells, and torturers retain their posts. Thus, the death of General Zia-ul-Haq in a plane crash in August 1988 did not mark the end of torture in Pakistan.

The civilian governments which came to power after the general election could not stop the vast scale of torture conducted in the police stations, prisons, and interrogation centres of Pakistan. Torture is endemic in Pakistan, but it reaches epidemic proportions from time to time.

Many methods
Different methods of torture in Pakistan can be classified broadly into physical and psychological types. Commonly used physical methods include beating, which may be unsystematic, such as punching, kicking, and indiscriminate beating with different objects, or systematic, such as falanga, teléfono, and whipping. In falanga, the soles of the feet are beaten with a rod; in teléfono, the torturer gives a blow with the flat of his hand to the victim's ear. Whipping is done with a piece of leather or cane on the individual's back. Daang Pherna is a method of torture in which the victim is stripped naked and forced to lie upwards on his back. A bamboo is pressed firmly by two persons on the thighs of the victim and slowly rolled over the whole length of the lower limbs. Other forms of physical torture include suspending the individual in different ways, such as straight or upside down or parrot's perch style, forcing the individual to stand for prolonged periods or remain in awkward positions, burning with cigarettes and heated metallic rods, strangulation, dental torture, rape and sexual assaults, insertion of foreign bodies into the vagina or rectum, and electrical torture.

Submarino, the submersion of the victim's head in water contaminated with excreta, etc., until the victim nearly suffocates, is also used, as is dry submarino, in which the victim's head is covered with a bag containing foul-smelling material, again almost to the point of suffocation. Exposure to cold, such as submersion in ice-cold water or forcing the individual to lie naked on a block of ice, is also used as a torture method.

Commonly used psychological methods of torture include verbal abuse and humiliation, false accusation, witnessing others being tortured, threats of torture to self or relatives, and sham executions. Deprivation of food, water, or sleep and continuous exposure to powerful light or constant noise are also common, as are the use of solitary confinement or overcrowded cells, and pharmacological forms of torture. In most cases, the detainee is subjected to both physical and psychological methods of torture.

Whipping
Whipping as a method of torture and cruel punishment has been internationally identified with Pakistan. It was introduced into the modern judicial punishments of the subcontinent by the British colonialists when they framed the notorious Whipping Act of 1909. This act was incorporated into the system of punishments in Pakistan after the division of the subcontinent. The Whipping Act has since been amended at various times according to the needs of the new rulers. Thus, during the rule of General Ayub Khan, the act was amended by "The West Pakistan Ordinance VI of 1962" and "The West Pakistan Ordinance XLII of 1963", and under General Yahya Khan, by "The Whipping (West Pakistan Amendment) Ordinance of 1969".

General Zia-ul-Haq updated it by enacting "The Execution of the Punishment of Whipping Ordinance 1979". This ordinance, promulgated by General Zia, completely transformed the law of whipping in Pakistan. Under the provisions of the new law, which does not specify the crimes for which whipping should be carried out, the conditions for and the method of the punishment of whipping are set out.

One important aspect of these provisions is the highly increased role which the doctor is asked to perform during the process of whipping. Before the punishment commences, the authorised medical officer is asked to examine the convicted person, to ensure that the carrying out of the punishment will not cause the individual's death. If the person is ill, the punishment should be postponed until he or she is certified by the authorised medical officers as physically fit to undergo the punishment. The punishment is carried out in the presence of the authorised medical officer at any public place of the provincial government's choosing.

If, after punishment has commenced, the authorised medical
The doctor’s role
At first glance, it may seem that the doctor’s role in this whole process of whipping is protective and in the interest of the convicted person. But a careful analysis of the situation would show that quite the reverse is true. The doctor’s role in the process of whipping in Pakistan is in contravention of the accepted international standards of medical ethics set out by the World Medical Association in its Tokyo Declaration of 1975.

During the period of the third martial law, whipping was extensively used in Pakistan to demoralise and terrorise the people who were opposing the military dictatorship. The Karachi branch of the Pakistan Medical Association, in its resolution of 8 September 1983, stated: “Whipping is not only inhuman and against the dignity of man, but can cause serious physical damage and irreversible psychological trauma, especially in young people.

It is known that this punishment may activate latent diseases like tuberculosis and precipitate cardiovascular accidents, besides permanently damaging the personality of the victim”.

The participation of doctors in the procedure of whipping was discussed at a seminar organised by Voice Against Torture (VAT) in Islamabad on 26 September 1988, when it was declared that no one is medically fit for whipping and that doctors should refuse to participate in the procedure of whipping whenever they are asked to do so.

The health profession and torture
There are two aspects of this issue in Pakistan: the involvement of health professionals in the process of torture and their role in health care for torture survivors.

Voice Against Torture (VAT) represents the first organised and systematic effort to combat the serious problem of torture in Pakistan. Founded at the beginning of 1988, it is an interdisciplinary forum for the struggle against all forms of torture and for the treatment and rehabilitation of torture survivors, which links together doctors, nurses, psychologists, physiotherapists, scientists, sociologists, lawyers, journalists, intellectuals, and social workers.

The experience of VAT has shown that, though countries with a “High Torture Rate” can be individually marked on a map, torture itself is essentially a global phenomenon. Certain governments may claim to be against torture, but they share the responsibility when they support another government which practices torture. The brutal military dictatorship of General Zia-ul-Haq was indeed supported by western governments. Torturers, irrespective of faith and ideology, are internationally united, cooperating with each other, teaching each other and learning from each other, exchanging experience and technology, and even handing over people on the so-called “wanted list” to the respective governments. In such a situation, those who are struggling against torture are in danger of becoming torture victims themselves. It is therefore very important that they too should unite internationally, irrespective of faith and ideology.

Lack of specialised care for torture survivors in ordinary hospitals has led VAT to establish the Rehabilitation and Health Aid Centre for Torture Victims (RAHAT) in Islamabad (see TORTURE no. 2, 1991).

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A Turkish physician’s experiences of torture in Istanbul

By Dr Bülent Tarakcioğlu

During the night of 31 October 1981, I was forced from my home in Istanbul by approximately 10 heavily armed men, who had no warrant for my arrest, and driven to the Chief of police. The hearing began in the car. At the central police station I was blindfolded and led through a long, dark tunnel to the part of the building where the single cells are. There my blindfold was removed and I was pushed into Cell No. 34. This cement cell at the end of the corridor had a small, barred opening through which the neon light of the corridor shone. After my first step into the cell I stood still, as I had the distinct feeling that there was no more room than that in the cell.

What I then saw in front of me in the dim light from the corridor reminded me of pictures by Picasso: several naked feet, swollen and bloody, and a nose and an ear. The spatial distribution of the body parts seemed extremely strange to me. Shortly thereafter everything moved; ear, nose, and feet dissolved, disappeared from the picture. Except for the sound of breathing, all was silent. It was roughly 3.00 a.m. in my first night in the torture centre.

In the cell, of approximately 2.5 to 3 square meters, our number varied between 6 and 10; there was a lot of coming and going. Among us there were almost always two newly tortured; in order to leave them more space, the rest of us had to stand.

During the first hours of my imprisonment, I was intent on adapting to my new surroundings as quickly as possible. I was aware that thousands of thoughts were going through my head simultaneously, on different tracks and extremely fast. My thoughts were logical, but I often lost control of them. Fragments of memories, irrelevant to the situation, came into my mind, e.g. thoughts about my childhood, my family, etc.

I felt no need to sleep, although I had had a strenuous day; I was aware of being extremely alert and inwardly restless, and of the beginnings of an undefinable, growing fear. Physically I did not feel at all tired. My pulse was fast, my face warm, my hands cold and clammy; my mouth dry. When a few hours had elapsed, I felt a lump in my throat and pressure in my head.

I carefully made the acquaintance of my cellmates, who had probably already been tortured several times. My first breakfast in my cell consisted of bread, yogurt, and halvah. I was neither hungry nor thirsty.

When my cellmates learned that I was a physician, there were timid questions as to the effects of torture on one’s health. I was also asked repeatedly if I was really a proper physician.

During the following days, the distance and mistrust among us lessened steadily. Thus I was able to learn how my cellmates had been tortured.

It wasn’t until the third day that I felt exhausted. I had not yet been interrogated or tortured in the literal sense. At this time I became aware of a growing existential fear, brought on, I assume, by the descriptions of torture I had heard.

I also observed the immediate effects of torture. One of my cellmates was tortured for an entire day. He returned to the cell wounded, wet, and frozen; his whole body shook and his mouth foamed continuously. He only managed to say, “This time it was very bad”, before he lost consciousness.

Towards evening of the same day, my name was called loudly. I had been ordered to answer loudly, “I am here”, which I did. I was taken out of the cell and led into the guards’ room at the entrance to the cell block. Three civilians were drinking tea there; they asked me if I was a doctor, and if so, what kind. I answered accordingly. One of the guards said, “You know, doctor, dogs’ wounds heal best when they are licked by other dogs, so you’re the one best suited to heal these ‘dogs’ wounds’”. In this manner I was ordered to treat the wounds, or rather the torture wounds, of my fellow prisoners. By means of this task I later had contact with victims immediately following torture.

On the 4th day I was taken out of my cell early in the morning and blindfolded, and then taken upstairs to the “waiting room” next to the torture chamber. After a while I noticed a pleasant sensation of warmth. There was a lot of activity; many people were walking to and fro. I was taken into another room and made to stand against the wall. When I was certain that there was no policeman in the room, I loosened my blindfold and looked about me.

The scene in which I found myself was terrible. More than ten newly tortured persons lay or sat on the floor, completely immobile. Two of them were tied to radiators. In the course of the day several prisoners were tortured in the adjacent rooms. Their screams are unforgettable to me. I was filled with anger and hate, but remained calm and brave. Some of the torture victims, when they were brought into the room, were thrown on top of me and then lost consciousness.
Hours passed. My turn had not come yet. Towards noon, after a long, strenuous wait, I reached a state of exhaustion and fright caused by what I had experienced.

On each of the 5th, 6th, and 7th days I was interrogated for 8-10 hours without let-up. My eyes remained blindfolded the entire time; a policeman stood on either side of me, whispering into my ears and hitting my thighs or shoulders in order to distract me. Then a pistol was shoved into my mouth and a mock execution was carried out. The climax of these events took place in the actual torture chamber. There my blindfold was removed, I was shown the torture instruments, and threatened with being thrown out of the window.

After each of these hearings I was extremely exhausted, frightened, and nervous. But I also gained confidence from day to day because I realized in the course of this battle that the torturers also suffered from fear and that I, or rather, we had an advantage over them. My fear of death had almost completely subsided. I might also mention that during the first ten days I had no allergic reaction to the lice although I normally have strong allergic reactions to every kind of verminous insect. All of this was accompanied by a slight feeling of euphoria.

From the 10th day on I suffered from a severe form of exhaustion and became apathetic. I was aware that this was a bad sign. For a few days I felt cut off from reality and did my best to counter this feeling. I slept as much as possible during the day when the cell was relatively quiet and empty, i.e. when 2/3 of my cellmates were upstairs being “heard”. I wasn’t always conscious of fear, and when I was, the feeling was not particularly strong. My mood was depressed but I felt stable. My levels of concentration and alertness varied. I experienced slight loss of memory due to the intensity of the events. I had no significant bodily ailments except for strong allergic skin reactions to the lice.

In the course of my incomunicado imprisonment, from the 3rd day on, I was outside my cell for 2 to 3 hours nearly every day in order to give my fellow prisoners medical assistance. I was thus able to observe roughly 100 newly tortured persons, including approximately 20 girls and women between the ages of 15 and 60.

5. Extreme shivering of the whole body, hysterical crying, especially among women, extreme fear in the form of fear for one’s physical existence, were all observed. The question often arose as to “whether he/she had to fear being killed”.

6. In 2 cases stong stupefaction, vomiting, disturbances of the equilibrium, uncontrolled movements of the extremities, and anisometropia were observed, indicating brain torture. Indeed, one of these victims soon had an attack of grand mal and was taken away. Two days later it was recognized that the other was not a malingerer, and he too was taken away.

Newly tortured persons lived in constant fear of being tortured again. This state was usually succeeded by one of apathy, i.e. withdrawal, lack of interest, emotional numbness. In some cases these reactions did not ensue, and in their place was a kind of euphoria with slight to moderate aggressive tendencies.

To summarize, it can be said that a distinction must be made between two phases of incomunicado imprisonment, when one takes into consideration the fact that all prisoners are tortured shortly after their arrest. In the condition of acute stress following torture one might differentiate between these two phases:

*Phase A*, comprising the first psychological reactions to torture, during which time all further psychological reactions are forming, is not definable in standard terminology. It is a phase of total psychological confusion.

*Phase B* is one of the victim’s slowly becoming conscious of, and trying to come to terms with the torture and the acute danger of death, processes which result in states of depression/apathy or (less severe) depression/agitation.

A summary of the results of these observations:

1. Every new arrival was tortured without exception.
2. Almost every torture victim had considerable difficulty in walking because of *falanga* (the practice of beating the soles of the feet with a stick).
3. Skin abrasions on various parts of the body, flesh wounds, and small skin burns resulting from electric shocks were observed in many cases.
4. Facial expressions were distorted, seeking help. The pupils were often dilated, and dryness of the mouth was extreme.

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SERSOC

Uruguay organizes a rehabilitation centre

By
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Servicio de Rehabilitacion Social (the Social Rehabilitation Service) began its activities in 1984, shortly before the end of the dictatorship that had devastated Uruguay since 1975. From the very beginning its aim was to assist the victims of the State Terrorism. Thus its clients are ex-political prisoners and their relatives, as well as the relatives of the exiled people and the exiled people themselves once they return to the country.

From the beginning, the Service was aware of the fact that the arrest and ensuing torture were supposed to be an all-out aggression against those who suffered it, and there was no aspect of the human being that was not affected or damaged.

The kind of approach and assistance that the Service offered, and still offers, to its clients derived from the following premise: comprehensive assistance, since it takes care of the whole needs of the patient. The functioning structure of the Service was geared to this principle, since it gave assistance with medical, psychiatric, psychological, legal, and social problems.

As time went by, the fields of investigation and publications were added to the former activities, in order to systematize the knowledge and practice gathered during these 6 years.

Since 1990, SERSOC has embarked on a new field, direct work in the community, and the Primary Health Assistance was created for this reason. Its aim was to spread information about Human Rights in the population.

During the last decade (1973-1984), the Uruguayan society suffered one of the most ominous periods in its history, with serious consequences to its economic, institutional, social, and family life. During the dictatorship, terrorism was introduced by the State for the sake of “national security”, so that an “internal war” was imposed on any resistance to dictatorial authority.

A powerful repressive set-up was structured to spread terror in the population and to silence the different expressions of popular discontent. Society itself was the victim; every sort of freedom was suppressed, as well as individual warranties (legal rights), and the legal process and recourse to habeas corpus were eliminated.

Thousands of people were arrested and taken to military headquarters, where refined and systematic torture was applied. The aim of this practice, particularly in Uruguay, was the psychological destruction of the individual.

The prisoners were taken to “penitentiary institutions” - in reality concentration camps. This repression aimed at imposing an unpopular economic plan, the first consequence of which was to produce a poverty-stricken population.

The health professional’s collaboration

Some physicians, psychiatrists, and psychologists offered their expertise, not to improve the health of the human being, but to collaborate in the imposition of grief and destruction on these people. They were thus agents of the State Terrorism.

Health personnel were confronted with and ethical problem, since they were subordinated to a double line of authority: the technical line on the other hand, subordinated to the military unit to which it was assigned, with its vertical chain of command.

In fact, all health personnel who worked for the army were subordinated to superior military command, and the military officer’s opinion prevailed over all others, including medical and technical aspects. This double line of dependence gave many doctors an excuse that soothed their consciences.

From the work among ex-prisoners, there is evidence of many violations of the Medical Ethical Code on the part of the health personnel. There was evidence, for instance, for the following:
1) The presence of doctors during torture, their clinical examination of the victims, and giving the results to the torturers so that the torture process would either continue or be discontinued. It was shown that a medical doctor or a paramedic was present during or after 70% of the torture sessions; their presence was doubtful in 14%; it was definitely absent in 15%.
2) Medical cover-up of the torture. Reports, including autopsy reports, tended to conceal evidence of torture. In fact, autopsies were not performed in most of the cases, despite their being reported.
3) Omission of medical care in many cases of death due to illness.
4) Medical “assistance” was given despite the abnormal psychological conditions (the patient saw the doctor as an enemy) and the terrible physical conditions (-place, diet, etc.).

The effects of impunity on our patients

From the very beginning our assis-
tance was given to people directly affected by the State Terrorism, including the second generation. Thus, children, adolescents, and close relatives of victims were classed as “people at risk”; they were given preventive health care.

Our assistance, which began in 1984, suffered a setback with the introduction of the “law of impunity”, under which the repressors were pardoned. At first our clients came with symptoms caused by the horrors they had been through; now, the impunity of the repressors has caused a new traumatic situation, leading to relapses in many cases.

At present we have about 40 clients who have not yet achieved, and might never achieve, social reintegration. They go from health resort to psychiatric hospitals. Suicides are frequent, despite our interventions. The lack of possibilities for identifying their torturers leaves the victims helpless with respect to legal rights.

The victims are not recognized as people who have suffered an injustice. The lack of justice has led to a new traumatic situation in which our clients have become “social creditors”.

Inspired by the account by the Norwegian doctor, Leo Eitinger, of the favorable legislation in Norway with respect to former Nazi-concentration camp prisoners, SER-SOC has proposed a similar legislation in Uruguay whereby the State would compensate with a pension those people who have suffered various disabilities as a direct or indirect consequence of long confinement.

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Torture and repression in Estonia

I was tortured myself

By
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Most of the high-ranking officers, politicians, and cultural leaders were shot or arrested and sent to the GULAG when the Soviet Army occupied Estonia in 1941. Later, in the course of two deportations, nearly 40,000 Estonians were sent to Siberia. During the two Soviet occupations, 64,000 inhabitants of Estonia died from genocide. The following reflections and memories are based on my personal experience in the Soviet concentration camp of Unz, which was situated on the cost of the river Unz in the Gorky region. I was kept there without trial for 10 years.

I cannot say that medical personnel consciously tortured prisoners, but the medical organization was extremely primitive. I am inclined to think that there were instructions to organize inadequate medical treatment for political prisoners. It was the daily life of hunger, exhaustive forced labour, psychological terror, and humiliation that tortured prisoners. Solitary confinement was used very often.

High death rate among prisoners

Medical work was done by two kinds of physician: first, by those who were sent by the KGB to work in the camp, and, second, by those who were prisoners themselves. The first ones, as a rule, had not much medical knowledge, and did not care much for their patients. The others were well educated and experienced and did the ir best (for example, Nicolai Zubov 2) and Bronislav Jazburskis), but they were under constant pressure from the administration.

The medical reception room was very small and always crowded. It was often impossible to get sick leave before going to work in the forests. Those who had no permission, but still refused to go, were always heavily beaten. In 1953 orders were given to shoot them. I remember, for instance, that two 12-year-old boys were shot. Prisoners were forced to work in the forests during the winter even when they had a fever of more than 40 degrees C from spotted fever.

During the war all the prisoners suffered from pellagra, scurvy, alimentary dystrophy, and night blindness. Their elbows were white from dermatitis, all had constant diarrhoea, and most were apathetic. Their bodies were spotted with scurvy, and they had very little flesh on their bones. Every day a number of prisoners died, sometimes sitting at the table and eating their daily food.

Those who survived were too weak to be forced to work in the forests. They were sent to special camps (OP) where the food was better and the labour relatively easy. After some time the KGB doctors examined these prisoners, and those who had gained weight were sent back to work in the forests.

How to deal with hunger strikers

There were also hospitals where a prisoner did not have to go to work at all. Those hospitals were for prisoners who had tuberculosis and spat blood. They were kept in hospital only while the test for the presence of the tubercle bacillus in the sputum was positive. Tests were taken every week. Prisoners who began to recover were afraid of being sent away. Sometimes they begged their fellow prisoners, whom they knew to be positive, to spit into their mouths, where they held the sputum until the test was
taken. The conditions in the forests were so awful that on occasions prisoners mutilated their hands to get out of working there.

After the war many Estonian freedom fighters were arrested and sent to concentration camps in the Perm region, some of them repeatedly. For instance, Mart Niklus spent 16 years there in all, while Enn Tarto was sentenced 4 times. Largle Parek, leader of the Estonian National Independence Party (ERSP), who was sent to a concentration camp for women because she suggested that Estonia should become a nuclear free zone, told me that there was no real hunger, and they were not forced to work, but psychological terror was organized and they were tortured when they declared a hunger strike. The administration classified hunger strikes as acts of hooliganism against the administration of the camp.

Hunger strikers were sometimes force fed with rough food through a rubber tube, but sometimes they were not fed at all. The procedure, which was arranged by the medical staff, was very painful. A young scientist, Jüri Kukk, who was detained because he wanted to emigrate to France, died after such treatment in a Vologda prison in 1981. Nowadays hunger strikers in Soviet prisons are not fed against their will, but their clothes are taken away and instead they are given a sack with a hole for the head and placed in a cold room for solitary confinement.

**Psychiatric torture against dissidents**

Some dissidents, mostly those who intended to cross the border, were placed in special closed psychiatric KGB hospitals (there was a doctrine among the Soviet psychiatrists that those who criticized the Soviet system and wanted to emigrate must be mentally ill). They were treated with strong psychiatric drugs for long periods and were not released for many years. For example a youngster, Roland Kaschan, spent 6 years in such a hospital because he refused to serve in the Soviet army and wanted to cross the Iranian border. When he was set free in 1990, Estonian psychiatrists examined him. They did not find any symptoms of mental disease. Now he lives in the USA. Even now nearly 30 persons who have to be brought back to Estonia are held in Soviet psychiatric hospitals.

During the 3 occupations in Estonia (two Soviet, one German), half the Estonian people were repressed and most of them were tortured in some way 3). Hundreds of GULAG survivors who suffer from psychological disorders (insomnia, depression, neurosis, etc.) live in Tartu. Most of them also have somatic diseases. We have no complete list of them, but hope to find them all.

Our rehabilitation centre is in its organizational phase. The centre will cooperate with ERS, with the Tartu Poly clinic, and with the Tartu psychiatric hospital. We hope that RCT will help with the organization.

**References and Notes**

2) Nikolai Zubov was a highly intelligent physician. In his youth he worked for some time in Denmark. He was arrested because he did not say where the person was hidden whom KGB workers wanted to arrest.
3) Leo Talve. [Half the inhabitants of Estonia suffered under the repressions]. Rahva Hääl, 19 October 1991.

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**Amnesty database goes public**

The International Secretariat of Amnesty International has for the first time made its database of external materials available on a public electronic mail network.

The network used is GeoNet which is accessible to subscribers in 40 counties around the world. Amnesty International's database AIDOC, is available to GeoNet users through an organization called the Manchester Host.

To carry out searches on Amnesty International's database, GeoNet users log into the Host system using their personal computer and a telephone link, and then they have access to a full list of Amnesty International's external documents from 1988 onwards.

The AIDOC database includes the index number, title, keywords and, in many cases, short summaries of all documents published by the International Secretariat of Amnesty International. The documents listed are AI publications, circulars, news releases and urgent actions, along with articles from the Amnesty International News-letter and Amnesty International Annual Report entries. These can be searched through by country and topic.

Copies of the full text of all documents described on the AIDOC database can be obtained from the offices of the Amnesty International sections, and a current address list of all sections is included on the database.

Users accessing AI bibliographic information through will have to pay 25p per minute whilst connected to the database.

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**NEWS IN BRIEF**
The Philippine experience

Rehabilitation of survivors of torture and political violence under a continuing stress situation

By

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Since torture rehabilitation is relatively new in the Philippines, and given the economic and technical constraints of the existing rehabilitation centres amidst an environment of continuing political conflict, various research and other material necessary for a comprehensive discussion of torture and rehabilitation work are not yet available. Nevertheless, the limited information on rehabilitation work among torture survivors in developing countries and under conditions of continuing stress makes this exposition valuable.

Torture in the Philippines occurs within the context of state repression against internal dissent. Thus, while torture is also applied to individuals in regular prisons convicted or suspected of common crime violations, political torture, or the systematic use of force or violence to obtain information from opposition and dissident suspects, to destroy the individual’s personality and/or create terror in the hearts of opponents and disidents, or potential opponents and dissidents, came into force during the time of the late dictator, Ferdinand Marcos.

It was during this period, and particularly during the first few months after the declaration of martial law on 21 September 1972, that thousands were rounded up and thrown into prisons. In the process many were tortured while undergoing tactical interrogation by the military.

The February 1986 “People Power Revolution” did very little to alter the situation. In November 1988, the Philippine Alliance of Human Rights Advocates reported that during the first 1000 days of the Corazon Aquino government, 705 persons were executed, 480 died in massacres, 11911 were arrested and 1676 tortured, 204 were reported missing, while 37132 families became refugees in their own land. Highly militarized areas in the countryside have become virtual torture zones where victims are abused right in their own homes and communities. An atmosphere of fear continues to haunt the populace, including torture survivors, who continue to see those who violated their dignity not only roaming around freely but occupying higher positions of power.

The Medical Action Group (MAG) in 1989 reported the harassment, arrest, and detention and extrajudicial killing of 102 health workers, as well as disruption of 205 community health programmes by military, para-military, and vigilante forces during 1987-1989.

Rehabilitation programmes

It was in 1985, barely a year before Marcos was dislodged from power, that programmes for the medical and psychological rehabilitation of torture victims were set in motion. Before this, efforts to assist torture survivors in their health needs were unsystematic and erratic.

The Children’s Rehabilitation Centre (CRC) was established to give psychological and other related forms of assistance to child victims of political violence.

The MAG, established in 1982 as an organization of health professionals and students working for health and human rights, set up the Philippine Action Concerning Torture (PACT) for the rehabilitation of adult torture survivors, either in or outside detention.

BALAY was established specifically to assist ex-detainees.

There are various factors which profoundly affect rehabilitation work in the country. Foremost among these are political repression, economic factors, family and community, culture and subculture. These either serve as obstacles or positive factors for rehabilitation work or as important considerations for effective and appropriate intervention.

Governmental support for the aforementioned rehabilitation programmes was zero during the time of Marcos, and it is still totally absent under the present government. In fact, the current government’s “total war” policy, which is no different from Marcos’ counter-insurgency war, constitutes the single largest obstacle to rehabilitation.

Continuous maltreatment

Threats to the security of both the survivors and the health professionals severely limit rehabilitation work.

Survivors fear a repetition of the torture they went through while under the custody of the torturers, just as ex-detainees, although freed from detention, continue to suffer from stress symptoms, one of which is fear of recapture or reprisals from the agents of the state who were responsible for their torture.

In 1988, two torture survivors informed a doctor of the MAG that after their complaint of torture in a Supreme Court hearing for a writ of habeas corpus, and after their marks of torture were seen by health professionals, they again suffered maltreatment at the hands of their military custodians. In a survey of 100 ex-detainees in four areas in the Philippines in 1986, 49 respondents gave security reasons as the cause of their difficulties in adjusting to life after imprisonment.

Health professionals who are giving their services to torture survivors, and who are supposed to be protected by universal medical codes and covenants while they serve everyone, regardless of their
political beliefs, have themselves been the victims on many occasions of military abuse. While visiting detention centres, a number of health professionals were subjected to various kinds of harassment, including death threats, interrogations, and actual detention.

**Children's Rehabilitation Centre**

Intensified repression, launched by the Marcos regime, led to widespread abuse, not only of adults, but also of children. It was for this reason that the Centre for the Rehabilitation of Children (CRC) was set up in order systematically to meet the psychological and other needs of child victims of political violence, in the hope that they could grow up to be productive members of the society.

Child victims of political violence include those who are directly tortured, and those whose parents or families are forcibly arrested and detained, executed extrajudicially, punished, or dislocated. Children of human rights workers who are harassed threatened by rising political tension are classified as "potential victims".

Cases seen at CRC during a period of three years showed that most were suffering from emotional disorders and social maladjustments. Symptoms such as withdrawal behaviour, depression, irritability, sleep disturbances, extreme anxiety, and fear triggered by special stimuli such as armed men, loud noise, and sudden movements were very common. Difficulties in social behaviour led to problems at school, while poverty complicated the emotional problems.

The treatment procedure follows a general methodological flow, with specific objectives for the three stages - data collection and diagnosis, treatment, and monitoring and evaluation. The specific objectives aim at supporting the long-term objective of assisting the family to join the mainstream of society.

**Individual need and societal position**

Assessment and diagnosis of the children's problems is a continuing process throughout the entire relationship, but it is especially important at the beginning when the child care worker establishes rapport not only with the child but also with the family. The holistic view of the child demands that assessment is made of the non-verbal and verbal actions of the child at the emotive, cognitive, and behavioral levels. The cooperation of the family is a necessary ingredient in the identification of the child's problems, as well as for possible solutions for the problems.

Various therapeutic methods have been developed and refined by the CRC during the past years. In its treatment method, CRC has applied Sikolohiyang Filipino (Filipino psychology) in terms of looking at the children's problems at two levels. The first level focuses on the individual needs and problems of the child to ensure proper physical, emotional, intellectual, and social development. The second level is societal, focusing on the socio-economic and political roots of the children's problems and their consequences for the children's rights and welfare.

**The approaches**

In group therapies, the approaches include:

1. Intrafamily counselling. This is accomplished during home visits. Possible repercussions of certain behaviours of the child or the parents are analyzed and explained, to assist the family as a unit in responding to the problem. Family disintegration, which is a common consequence of war, is dealt with by the programme so that smooth family relations would pave the way for faster recovery of the families from the situation.
2. Interfamily counselling. Adults from different families get the chance of exchanging their views on handling problems which they may share in common.
3. Children's play activities. This method provides venues for the children to relate, express, and share their experiences with one another, so as to be able to cope with them. The activities provide the staff with venues for natural observation of each child, to monitor their progress and development.

**Skill-orientation**

Initially, in its one and a half years of operation, CRC adopted a topic-centred curriculum for group therapy where the children were passive recipients in the whole learning process. Very little feedback was elicited from the children. Later it was modified to become a skills-centred programme where the children engage in arts and sports activities. The skills-oriented approach enables the children to develop new skills, thus boosting their self-confidence and making them take a more positive image of themselves. Moreover, the activities allow for deeper and sustained interaction among the children, helping them to overcome withdrawal behaviour.

It also allows the CRC staff to interact with the children continuously and to observe them under various conditions. The meaningful relationships that are established with time among the children and between them and the staff members enhance the emotional support system of each child and facilitate the opening out of fears and apprehensions, thus leading to alternative sources of comfort and hopefulness.

Because of the children's stress and psychological trauma, the programme also conducts individual treatment of patients. This is done through home visits and constant observation and documentation of the progress of each child. A special programme is likewise designed for children with particular behaviour or socio-emotional problems, implemented either in their homes or at the centre.

**Family support**

The programme also gives other support services to the families of the victims in order to unburden them of economic problems and thus help them slowly to develop self-reliance through their income-generating projects. Although support services serve as an integral part of the individual therapy procedures, it can be taken as a separate programme activity because of its significant contribution to rehabilitation.

Several models regarding psychological events that follow a period of trauma, such as the death of a loved one, natural disasters, and accidents, generally postulate a clearcut period of stability for a discrete and short time after the traumatic event. A study on 25 Filipino children, however, showed that there is no discrete, peaceful pre- and post-traumatic period; the children had suffered stress long before the actual death or disappearance of a parent, and the stress situation continues for weeks,
months, or years afterwards. The continuing repressive situation, giving rise to continuing stressful situations, prevents us from using such models to label behavioral problems of the Filipino child victims of political violence.

One specific concern that is met in the rehabilitation of children is the withholding of information or truth regarding the fate of the lost parent. There were cases when the remaining parent or a surrogate parent withheld the truth for fear of not being able to explain the traumatic life situation in an understandable way to the child. This resulted in the denial of one important ingredient for a healthy and normal emotional growth of a child - the truth.

The truth shall be known

When half-truths about the parents are fed to a child, fragmented and distorted images of the parents are built up, even as the continued absence of the parents remains a mystery. Sooner or later the child may exhibit strange behaviour to attract attention. Unfortunately, it is the strange actions that the family members will notice, so that the child's real message does not get across.

Experience at the CRC has shown that, more often than not, information and knowledge of the truth help the children to cope with stressful life events. With cognitive mastery, the children are able to understand life situations at their own pace and level, and are thus able, with the help of this knowledge, to process and cope with whatever stressful life events they may meet.

When they start to confront problems, children can begin to grow, helped by the strength of support systems. Therapy and rehabilitation must therefore strike a balance between strengthening the child and revitalizing the existing support systems.

Coping in Nazi concentration camps

Based on research and interviews with survivors

By Leo Eitinger*

My task is to shed light on one specific aspect of the complex situation of extreme stress, that is on the problem of coping. It is not obvious that the coping mechanisms used in the concentration camps are the same as or similar to the coping mechanisms that are necessary under and after torture.

I shall describe here only a few of the most important coping strategies used by camp inmates, as later research has tried to formulate them. This presentation is based on interviews I had with 1500 - 2000 camp survivors, and on the study of the published literature. Therefore I do apologize for the fact that there are no new research results that I am going to summarize here.

During the interviews mentioned, one of the questions asked was why some people managed to survive the hell of the camps and others not, and after having established an adequate interpersonal contact, the question was very cautiously applied to the interviewed survivor himself.

First of all it is necessary to stress that a certain physical minimum of survival possibilities must have been present at all in order to differentiate the problems of coping mechanisms. The first theory of coping with aggression in concentration camps was set forth by Bettelheim. He was of the opinion that most of the long-term prisoners tried to cope with the violence and aggression which they met in the camps by identifying themselves with the aggressors. Bettelheim does not define coping in detail and I would like to do so tentatively.

A positive form of coping mech-
a rather fatal result for those involved. Both these experiences and my interviews proved that identification with the aggressor, as far as it occurred, was a negative coping mechanism, leading to the destruction of those involved and - in the few cases where they survived - to deep pathological changes of their personality.

In contrast to Bettelheim's viewpoint, we have Victor Frankl, who rightly stresses the fact that if you have something to live for, the amount of suffering you can endure is practically without limit. Frankl's description of a "contract with fate" - which presumes that every misfortune, every traumatization, etc. which the prisoners were subjected to, would spare his beloved in another camp from the same sort of misfortune - is of course very moving, naive, and deeply human, but according to the experiences I have gathered in my interviews, an extremely rare form of coping mechanism, or rather maybe self-deception. The fact that none of my interviewed survivors referred to this sort of coping mechanism would indicate that it was not among the most popular or positive ones.

**Stable Pairing**

On the other hand, the substantial mutual help that prisoners could be for each other should not be underestimated, even if one's expectations could not be too high, considering the facts of life and death for example in Auschwitz.

Here the studies of Luchterhand, an American sociologist, are of great interest.

He could show that what he called "stable pairing" was the most common type of interpersonal relationship pattern in successful copers. Most of them developed a sharing and helping relationship with another person; the pair was their basic unit of survival. Luchterhand was able to show that it was the cleavage between criminally-inclined and not criminally-inclined prisoners which most decisively influenced development of the prisoners' social system. Luchterhand's findings conform with my interviews to quite a large degree.

Even the results of interviews must be judged with the greatest caution when discussing an individual's "successful" coping mechanisms. We must never forget that if one survivor tells us that he survived "because" he used this or that psychological mechanism or "device", hundreds of others had in all probability done the same without surviving. The problem of coping can be approached objectively only with these reservations in mind.

During my interviews with survivors, the majority of those who felt relatively well after the war, who had been able to work and to reestablish good interhuman relationships, told me that the main reason for their survival was their ability to make decisions and to use their own efforts, that they wanted to survive and managed to do so.

The absolutely powerless prisoner was helped by the feeling that he had some power over himself. There was, however, a substantial difference in what the different survivors considered as "own efforts or decisions" - from trying to economize one's strength systematically, never giving up, helping others and getting help from them to dealing "correctly" with the daily ration of bread. ("Correctly" could be to eat every bit and crumb immediately after having received it, "not risking death with a crust of bread in the pocket", but "correctly" could also mean the absolute opposite, i.e. dividing the bit of bread into 2, 3, or 4 small or rather minute portions, and never eating more than planned at any time, in spite of one's ravenous hunger, "one had a reserve to fall back on, and this was just as important as feeling satisfied").

**Retaining personal values**

Those survivors who had been fortunate enough to get positions in a camp where they could retain their personal norms and values and continue their pre-arrest occupation in the same vein by working for and helping others, such as some doctors and nurses in the different camp "hospitals" - those were the people who had the best chances of surviving and of avoiding the ethically devastating atmosphere and influence of the camp. Only a tiny minority, however, had this good fortune. The greater part had to find other ways of coping. These are perhaps best illustrated by looking at those who were not able to cope.

Prisoners who were completely isolated from their family, bereft of all contact with groups to whom they were related before the war, people who very quickly abandoned themselves and their innermost values, people who were completely overwhelmed by the notion that they had nobody and nothing to struggle or to live for, who felt completely passive and had lost their ability to retain some sort of self-activity - these were the people who most easily succumbed. The symptoms of the feeling of hopelessness and giving-up could be seen by experienced observers rather early in the process of decline.

On the other hand, my interviews have shown that prisoners who had been able to stay together with some members of their family, to remain in contact with some of their pre-war peers, to help others and to get help, if not in a material way at least by mutual moral support, were those who resisted best. They were not deprived completely of all feelings of personal and human dignity and values in their own eyes or in the eyes of their close surroundings.

These findings are to a certain extent the same for ex-prisoners interviewed in Norway and in Israel. When asking the Norwegian ones what helped them most to survive, the answers were nearly stereotyped: "Being together with other Norwegians".

The answers of the Israelis were much more varied, because of the complex and group relations they had during imprisonment.

**To my body - not to me**

There were other coping mechanisms too. One was the attitude of a detached observer. There were a few who really managed to tell themselves that life in the camps was "actually" no concern of theirs. They were not the ones who slaved and were ill treated. They were just spectators of a terrible drama in which their own bodies "by chance" were also the actors. Or as Bettelheim put it: "This torture is happening to my body and not to me". Less than one per cent
of the interviewed, however, referred to this coping mechanism. This would mean that it is either very demanding or not very successful. From my own experience I am inclined to support the latter view.

A person who regarded his surroundings as unreal became unavoidably isolated and slowly lost contact with others and with reality. It seems to me that such contact was necessary in order to understand oneself and one's co-prisoners as fellow human beings.

Denial

From a psychological point of view, "denial" is a very interesting phenomenon. It could be disastrous when prisoners "denied" the grim realities of the daily duties, such as the necessity of the daily vermin control. But denial could to a certain extent be life-saving if it helped the prisoners to behave as though the most dangerous situations (and the most severe anxieties) did not exist, thus allowing some to survive. Otherwise acceptance of the "fatalistic logic" in the annihilation camps would have led to the "only possible consequence there", i.e. suicide.

The ongoing struggle to survive from day to day was a complicated one, dependent on a nearly infinite number of factors, but the poor prisoner had no influence whatsoever on most of them. There were, however, small fields where individual strategies - the allocation of defensive resources at one's disposal - could be of decisive importance. But again, we have only the tales of the survivors, while all those who succumbed - with or without the same strategies and resources - will never be able to tell their version of the story, though many ex-prisoners believe that they survived just because it was of vital importance to tell the story of their sufferings and survival.

On the other hand, there were quite a number of survivors who survived by mere chance or luck, according to their own view, without any personal influence whatsoever.

When comparing groups of survivors who mobilized such coping mechanisms more or less consciously and actively with those who ascribed their survival to mere luck or chance, it appeared, on a statistically significant level, that the former had fewer psychiatric complications than the latter.

In other words, coping mechanisms that enhanced the individual's contact with a group, that were based on intact and positive value systems, on retaining self-respect as a human being in the best and truest sense of the words, proved not only to be of importance in relation to the capacity of immediate survival. Such coping was also a way of survival without too many psychological disturbances and with one's personality intact - when camp experiences like those for instance in Auschwitz allowed it at all.

References:


Further suggestions for reading:


Medical ethics in the Czecho Slovakia

History and present state

By Helena Haškovcová

Ethics as a philosophical discipline, including medical ethics as a specific part, was systematically cultivated at high schools and universities during the First Republic (1918-1938). This trend was interrupted during World War II by forcible closure of universities. After the war, the tradition of education in ethics was resumed.

Soon after the coup in February 1948, compulsory lessons in Marxism-Leninism were introduced at all the universities. The Faculty of Arts at Charles University in Prague continued to teach ethics, though to a limited extent (J.Popelová-Otáhalová, M.Machovec, J.Cvekl, L.Svoboda, and later J.Pešková and J.Světlý), while the teaching of medical deontology by the Medical Faculty at Charles University was completely abolished in 1952.

Medical ethics was reduced to the so-called Marxist-Leninist ethics for 42 years.

Ethics and ideology

However, in spite of the adverse political conditions, the teaching of medical ethics was not completely stopped. There were many philosophically or psychologically orientated doctors, namely those who had been educated in former times in the field of ethics, who passed on their knowledge and experience to the younger generation. Later, the reality of everyday medical practice necessitated temporary solutions of urgent bioethical problems. The Community of Bohemian Physicians organized professional discussions, seminars, and conferences on ethical problems, but they were always associated with a topical, strictly concrete problem, e.g. the criterion of death in connection with the advancement of organ transplants.

The actual teaching was mainly individual, with a significant lack of foreign literature, but postgraduate courses (not free of political supervision) were organized later. Interest in medical ethics grew gradually in the mid-1970s, undoubtedly in connection with the absence of good quality education. Under the previous political system, some problems were taboo (e.g. thanatology), while others were treated only ideologically (e.g. euthanasia); proclamatory appellations were superior to morals. Despite that, it was possible to discuss certain ethical top-
ics among strictly professional circles.

The following specialists investigated selected topics of medical ethics: Josef Charvát (internal medicine), Prokop Máleč (transplantation), Antonín Rubin (pediatrics), and Vladimír Pacovský (geriatrics and the theory of treatment). They were joined later by Miloš Vojtechovsk (geriatric psychiatry and thanatology), Helena Haškovcová (haematology and geriatrics), Radim Brdička (genetics), Jan Petrášek (cardiology), Jarmila Drábková (emergency care), Olga Dostálová (oncology), and Pavel Čepíčky (gynaecology). Pavel Ričan, Tomáš Halík, and Jaro Křivohlávý published numerous papers on medical ethics. The Journal of Bohemian Physicians (edited by J. Petrášek), the oldest and most respected Czechoslovak medical journal, has been regularly publishing treatises on medical ethics.

The second largest Czech medical journal, The Practical Physician (edited by J. Strejček), has also regularly presented information in the field of medical ethics. In 1980, The Practical Physician published a proposal to establish a department of medical ethics (H. Haškovcová), but this idea has still not been realized. Medical law and its relationship to medical ethics has been studied by J. Štěpán and J. Stolinová.

Abolishing Marxism-Leninism

After the Velvet Revolution in 1989, the departments of Marxism-Leninism were immediately abolished in every university. It was stated that the standard of humanitarian education of university students was very low. The Rector of Charles University, Mr. Radim Palouš, instigated the establishment of humanitarian centres at all the universities. They were formed according to the needs and number of students at individual universities. Medical faculties have resumed the teaching of philosophy, sociology, and medical ethics. Simultaneously, courses in psychology have been expanded significantly. However, there is a lack of teachers of medical law. The Third Medical Faculty of Charles University in Prague, of which the Dean is Mr. Cyril Höschl, established the Institute of Medical Ethics in 1990, and in January 1991 medical ethics was acknowledged as an independent medical specialization.

In October 1990, the Minister of Health of the Czech Republic, Mr. Martin Bojar, launched the Central Ethics Commission at the Scientific Board of the Ministry of Health. It is chaired by Jaroslav Setka and includes representatives of various disciplines, such as a priest, a nurse, lawyer, etc. Since January 1991, ethics committees have been established in most major health institutions and research institutes.

During the past 42 years, medical ethics in the Czechoslovakia has developed without any rules, and under specific conditions of political control. The given information is therefore a mosaic and it gives no information about the situation in Slovakia. However, in April 1991, Bratislava (the capital of Slovakia) hosted an International Congress on Humanization of Medical Care. Major tasks for the near future include mapping the past and organization of scattered information.

Introduction to the Committee of Human Rights in Izmir, Turkey

At the Symposium in Budapest Professor Veli Löök presented the work done by the Committee of Human Rights in the Izmir branch of the Turkish Medical Association. This committee started to examine torture victims from December 1989. The same group of doctors continued their work in the Turkish Human Rights Foundation when it was formed in January 1991. Fałanga was the main type of torture among the victims, and the important findings by CAT scanning of the feet have been published previously in this journal (Volume 3, 1: 18-19, 1991). The findings report an extremely important device to follow up signs of physical torture, and Professor Löök was able to inform us that the incidence of falanga torture cases in Izmir had decreased since the publication of these findings.

Ole Veld Rasmussen
Editor of TORTURE

ABSTRACT SERVICE

Brown CJ, Lago AM. The Politics of Psychiatry in Revolutionary Cuba


This 220-page book documents and analyzes twenty-nine cases of psychiatric abuse of Cuban political dissidents. The dissidents were interned in Cuban psychiatric hospitals for a variety of political offences, such as attempts of illegal exit and distributing enemy propaganda and were subjected to electroshocks and/or psychotropic drug treatment.

Some dissidents were diagnosed as paranoid schizophrenic, others were diagnosed as apathetic to socialism and stille others were diagnosed as sane and yet were forcibly subjected to electroconvulsive and drug therapies. The book identifies the hospitals where the abuse took place, including the Havana Psychiatric Hospital, and the individual doctors responsible. It concludes that the evidence points to a patterns of systematic abuse of dissidents during the process of interrogation or as punishment for anti-government political behaviour while in prison. This political abuse of psychiatry was managed by the Cuban State Security agencies, which are in control of the forensic wards at the psychiatric hospitals. The book includes an introduction by Vladimír Bukovsky contrasting Soviet and Cuban misuse of psychiatry for political purposes.
Workshop reports

Four workshops were held on the last day of the meeting in Budapest. Here are the main statements from the workshops, and Dr. Inge Genefke’s concluding remarks.

I. Torture as a challenge to scientific research

This workshop dealt with the importance of scientific research, and focused on different research projects. It also looked at the function of clearing houses for the distribution of research projects and their results in this new field of multidisciplinary scientific work.

II. Torture as a challenge to organized medicine:

This workshop focused on the role of doctors' professional organizations in maintaining ethical standards of medical practice, and the preventing of abuses of human rights.

Suggestions arising from the workshop as to what should be done by the international professional community included:

i) The establishment of an international agreement among countries for the exchange of information concerning transgressions of ethical norms, and decisions to withdraw the licenses of particular practitioners. This would enable the international enforcement of disciplinary actions against doctors who were involved in torture.

ii) The establishment of a mechanism for international monitoring of the systems used within countries to maintain ethical standards with regard to human rights.

The procedures whereby these suggestions could be transformed into actions included:

i) Incorporation of international information exchange and international monitoring into the United Nations’ Convention against Torture.

ii) National governments should be pressed to sign the UN accords and conventions pertaining to torture. If they refuse, the national medical associations should then commit themselves to carrying out these conventions. In particular, they should commit themselves to the mutual exchange of information concerning member doctors who have been found guilty of involvement in torture and similar unethical behaviour.

iii) The current monitoring activity of the European Community, as embodied in the European Convention against Torture, should be expanded to all members of the Council of Europe, and similar Conventions should be developed by other transnational bodies, such as the Organization of American States, and the Organization of African Unity.

The Medical Professional Organizations should:

i) Adopt the Tokyo Declaration and other similar ethical statements, and ensure that these are put into effect by developing a clear plan of action, such as that contained in the Madrid Declaration for the EC countries.

ii) Put pressure on the national governments to accept the UN Convention against Torture, and to commit themselves to the mutual exchange of information programmes listed above, in order to ensure the international enforcement of disciplinary action against doctors found guilty of abusing human rights.

iii) Develop specific training for members, both undergraduate and postgraduate, in the concept of doctors at risk.

iv) Co-operate with non-governmental organizations, (such as trade unions, religious bodies, and other opinion-forming organizations), in putting pressure on relevant authorities to prevent torture and abuses of human rights.

III. Torture - a challenge to professional education

In this workshop the goal was:

i) To establish “the prevention of torture” as an entrenched ethical value for the behaviour of any person dealing with detainees.

ii) To establish torture as a clinical entity to be diagnosed and adequately managed.

The target populations for Professional education include:

i) Professionals, particularly those at risk, i.e. affiliated to prisons or the police.

ii) Officers in the armed forces, and other officers, who are involved in any aspect of detention, arrest, imprisonment, and interrogation.

Programmes of Professional education must:

i) Focus on practical goals which can be implemented immediately.

ii) Learn from countries where infrastructure is well developed and adapt this knowledge to prevailing conditions.

Activities should occur on four levels:

i) Bring training about torture into clinical disciplines, such as medicine and psychiatry.

ii) Provide a structural framework for medical training in forensic departments because, firstly, they work directly with issues of torture, and, secondly, they interact with officials who deal with detention.

iii) Provide guidelines for curriculum development and practical training. This would facilitate an interdisciplinary approach with important disciplines, such as psychology, social work, etc.

iv) It is important that many UN member countries endorse article 10 of the UN Convention against torture and other cruel,
inhuman, or degrading treatment or punishment from 1984.

This workshop suggested the following practical activities:

i) Creation of a package consisting of books and films already available.
   This package should include the UN Convention and the Declaration of Madrid, which calls for a national tribunal.

ii) Wide distribution of this package:
   - to all medical associations,
   - to all teaching institutions,
   - to all family practitioner associations,
   - to international conferences, particularly those involving family practitioners and forensic doctors.

iii) Reporting from international meetings and conferences, etc.

IV. Torture as a challenge to democracy

Statements from this workshop included:

i) Democratic constitutions are no guarantee against torture.

ii) Torture contradicts democracy.

iii) In the process analyzing the causes of torture and rehabilitating the torture survivors, a new democratic model is produced, i.e. finding causes and helping victims is building a new democratic system.

iv) Democracy exists only when torture and the death penalty are abolished.

v) The Ethics of Human Rights are the foundation of any democracy.

vi) International support is needed for systems to monitor violations of Human Rights, and also for systems to monitor military, health, and education budgets; law enforcement; assistance for fact-finding missions to different parts of the world, and finally financial support for the work of centres that assist victims of torture etc.

Dr. Inge Genefke

Dr. Inge Genefke recited Halfdan Rasmussen's poem in her concluding remarks:

Not the torturer will scare me,
or the body's final fall,

Not the barrels of death's rifles
or the shadow on the wall,
Not the night when to the ground
the last, dim star of pain is hurled,

But the blind indifference
of the merciless, unfeeling world

Many valuable contributions have been presented at the Fourth International Symposium on Torture and the Medical Profession here in Budapest, where professional health personnel have gathered for three days. I think that one of the most impressive was Dr. Lucille Edelmann's. Lucille mentioned la Silencia, the silence. The worst thing for those who have suffered torture, and for those who have suffered the disappearance of close relatives, is the silence around it in a society that does not care - as expressed in the poem: "The blind indifference of the merciless, unfeeling world".

Another very thought-provoking contribution was Professor Leo Eitinger's: "Coping mechanisms in the Nazi Concentration Camps". Leo Eitinger told us that the ability to maintain some decisions of your own, however small they may be, may help under such extreme and horrible situations. Another very important aspect is to be able to do something to help other persons, if not in a material way, at least by mutual moral support. In this way people are not deprived of all feelings of personal values and human dignity in their own eyes, or in the eyes of their close surroundings.

We made some decisions:

i) To establish tribunals to denounce doctor torturers.

ii) To put more emphasis on research. The IRCT has offered to function as a clearing house for research, and to distribute the different research projects and results among us.

iii) We have further decided that protection should be increased for doctors who are at real risk because they assist torture survivors. We would ask you to join the group of health professionals who have already formed a team which is ready to leave and help when one of these doctors is arrested and in danger of being subjected to torture.

iv) To stimulate professional education for health personnel. A package of educational material should be created for and distributed to all universities.

The importance of Gregorio Martirena's book concerning doctor torturers was emphasized.

An international group of journalists has been created to receive material concerning torture from the participants at this meeting. Their aim is to create general awareness of the fact that torture is the most efficient weapon against democracy.

When this Symposium started I expressed the hope that it would be creative and efficient, a hope which I think has been amply fulfilled.

I wish to end the meeting in the spirit of the great Hungarian poet, Sandor Petöfi, by quoting the following words:

"Freedom and love/charity is all I live for".

The poet states that he could live for this love/charity, but also that he could sacrifice even his love/charity for his freedom. Working for freedom, for democracy, against torture, that is our common task. If the world wanted it, governmental torture could be abolished by the turn of the millennium.

Note

1) Each State Party shall ensure that education and information regarding the prohibition against torture are fully included in the training of law enforcement personnel, civil or military, medical personnel, public officials and other persons who may be involved in the custody, interrogation or treatment of any individual subjected to any form of arrest, detention or imprisonment.

Each State Party shall include this prohibition in the rules or instructions issued in regard to the duties and functions of any such persons.
IN THE HANDS OF GUARDIA CIVIL IN SPAIN

"You cannot do to me just what you want"

By
Alfonso Sastre, writer*

It happened late one night - at midnight - that there was a knock on the door at the home of a woman friend of mine. She lives in a village near Hondarribia, where I live. The name of this friend was in the newspapers, and let us treat this case in the most appropriate way, if we can thus contribute to, not the casting of light on the facts (which are very clear), but the demand that somebody is held responsible for "the legal basis of the case".

Our friend had gone to bed. Her address was registered by agents of the Guardia Civil, and she was arrested. Thereafter they transferred her to Antiguo de San Sebasti-an, where there are barracks, sadly notorious from the Franco period. But apparently she was not taken to the barracks themselves, but to some strange nearby buildings on the other side of the street. However, she was forced forward by a Guardia Civil, who grasped her by the neck, and she did not know where she had been taken.

I shall not concentrate on the details of that night between Thursday and Friday. It was simply a night of sheer horror. Our friend was requested urgently "to talk", without being asked concrete questions (to tell what she already knew she would have to tell - Good Lord!), and as she did not know what she should say, she was beaten throughout the night, after being blindfolded by the torturers. Over and over again, among the most humiliating and threatening comments, she was exposed to forms of torture which we know all too well from the Franco era, as for instance dry submarino: a plastic bag was pulled over her head and fixed tightly around her neck until it provoked severe anxiety because of fear of suffocation. Of course, the "medical examination" was performed, as was beating of the victim's blue fingers.

I was much in doubt as to whether I should write this article, knowing full well that it would serve no purpose. In fact, I am tired of writing about these things ...for nothing. They continue to tell us that, perhaps, since the introduction of democracy, one or other from the Guardia or a policeman "piles it on", but that does not say anything about the system. I shall not tell about our friend's inferno of a journey to Madrid, nor about her second night. From what I have been told, she passed it in the headquarters of the Guardia Civil in Guzman el Bueno street in Madrid. It suffices to say that on the Saturday, 2 days after her arrest, she was acquitted by the judge of the Audiencia National (High Court) without having been accused of anything at all.

This infernal gallery, "They cannot do to me just what they want", the police commissioner José Amedo had said. What have they done to you? How much have you been beaten in a gloomy office? Were you blindfolded? Did they try to suffocate you with a plastic bag? Have you been punched by a fist on the back of your neck?

Must torture continue to be common practice at Spanish barracks and police stations? As for myself, I have sometimes said that I have always wanted to work with literature and nothing else, but also that I always saw that there was no way of getting to literature and theatre in a noble way without having to go through these infernal galleries - damn it!

LETTER TO THE EDITOR

How is it really in South Africa?

We have received a letter from S. R. Benatar, professor of medicine, University of Cape Town, and we print an extract from it below:

[...] I should like to comment on the report on South Africa in the International Newsletter on Treatment and Rehabilitation of Torture Victims (Volume 2 No. 3/4 1990).

In the section under, "Actions taken by professional organisations" on page 9 it is stated that "[...]
not all medical professionals are sympathetic to the cause of anti-apartheid groups. It is only the Psychological Association that has openly made a statement against apartheid".

This is incorrect and I am enclosing the following documents which may be of interest to you.

1. A statement published in the South African Journal in 1982 from the College of Medicine of South Africa "Medical treatment of Prisoners and Detainees".
2. The Credo of the College of Medicine of South Africa adopted by the College Council in October 1986.
3. A letter to the Cape Argus in September 1989 entitled, "The Cruel Limits of Repression in South Africa".
4. Some statements from the College of Medicine of South Africa in 1989.
5. An article entitled, "Detention without Trial, Hunger Strikes and Medical Ethics". May I also refer you to the reference section which lists some of the statements made by individuals and academic institutions in South Africa. This list is by no means complete.

I hope that you may be able to take some actions to correct the inadequate documentation in the RTC Newsletter. With very best wishes for 1992
Yours sincerely
S. R. Benatar, Professor of Medicine, University of Cape Town, South Africa

Answer

We want to state that articles in TORTURE do not necessarily express the opinions of the editorial board. The article referred to by professor Benatar was, as stated, an extract of the proceedings of the First International Seminar-Workshop on "Children in Crisis". These proceedings were published by Childrens Rehabilitation Center, 58 Escaler St., Loyola Heights, Quezon City, Philippines.

The Editor

*Excerpts from an article in the Spanish newspaper El Mundo from 20 June 1991.
Medical testimony on victims of torture


Physicians for Human Rights USA (PHR USA) have published an easily read and sober introduction to a very difficult subject.

The book's first chapter contains a description of the refugee's path through the USA immigration apparatus. The second chapter describes the medical doctor's role as a helper of torture victims asking for asylum (in USA). The book contains useful examples of how to write medical certificates for the immigration authorities. Furthermore, there is a description of, and diagnostic criteria for, relevant psychiatric sequelae, e.g. Post Traumatic Stress Disorder and Depressive Disorders. Finally, there are useful references for the interested reader.

It is praiseworthy that PHR USA has taken on the task of helping doctors with the evaluation of torture victims and with the writing of medical certificates. The need for information on torture and its psychological sequelae has been stressed on several occasions. It is also stressed that to a large extent the role of the doctor can be to explain to the authorities the background for a torture victim's mental state, general behaviour, and reactions, which may look contradictory seen from outside, and which can be interpreted as a direct expression of un-trustworthiness, when in fact they are mental sequelae of torture. Thus, it is not only the medical profession which is in need of information on torture victims' psychological difficulties - there is also a pressing need for the immigration system's decision makers to have a basic knowledge of these problems. Understanding for, and knowledge about torture and its sequelae are preconditions for doctors and authorities to handle torture victims fairly and decently.

No doubt the book will add to the quality of medical examinations of torture victims and of certificates based on such examinations. The book is short but it contains much useful information and advice to the doctor who wants to work with asylum seekers.

The legal part describes the conditions in USA which may be different from those in Scandinavia. It is stressed that, in his report, the doctor who issues the certificate should state his qualifications with respect to the examination of torture victims or other relevant experiences. This point of view is relevant - the subject is difficult, since this work is in practice a specialist task. As in all other medical work, one can become competent by studying the available literature and through clinical training, i.e. cooperation with a more experienced colleague. In Denmark, we think that this task should be allocated to interested groups of doctors who must feel obliged to keep up to date with the newest relevant literature, and who can obtain good enough working experience. Such groups of doctors must therefore also feel obliged to take on teaching tasks and thus help with the clinical training of colleagues who want to be involved in this kind of work.

Development moves fast. The next edition of PHR USA's book on the examination of torture victims can, it is hoped, be expected in a few years. The list of references will then no doubt be extended considerably.

PHR USA show a praiseworthy openness in their preface by inviting interested readers to comment on the book. Correspondence should be sent to: Asylum Project, Physicians for Human Rights, 100 Boylston Street, Suite 620, Boston, MA 02116, USA.

The book is recommended.

Hans Draminsky Petersen
Amnesty International,
Danish Section, Medical Groups

Hippocrates betrayed – in Latin America


Traicion a Hipocrates, together with Uruguay, torture and medical practitioners, are important documents that show the active or passive participation of doctors in torture in our modern world today, especially in Third World coun-
Based on Reports from Amnesty International (AI) and other sources.

INTERNATIONAL

Frequent rape by soldiers and policemen

According to AI, women in all parts of the world are exposed to sexual violation by soldiers, policemen, and prison guards. AI has documentation to prove that even pregnant women and girls under the age of 14 have been among the victims.

Many states around the world do not consider that rape is a serious violation of human rights. The rapists are therefore seldom punished, and if they are, the punishment is usually relatively mild, eg banning from work for a period. Most often, though, cases of rape are not reported. The fear of being exposed to even more violence, coupled with the social consequences of being raped, stop many women from reporting the violation.

In Uganda, threats of rape are part of the military's campaign of spreading fear among the women in areas of armed opposition, and there are other examples from the Philippines and Guatemala. In Greece, 12 women were ordered to undress at a police station after their arrest for putting up political posters. Dirty remarks were plenty, and some of the women are alleged to have been beaten. In Turkey, a 28-year-old woman, under arrest, was several times suspended naked by leather straps round her wrists and exposed to electrical torture to her breasts and private parts, coupled with other forms of sexual violation - with the sole purpose of forcing a confession.

Dr. Gregorio Martirena
Uruguay

TORTURE WORLDWIDE

Britain urged to stop export of torture instruments

The British Government has been asked by AI to ban the export of equipment which is used for torture and political killing in other countries. Thus, a British firm has installed an electronic "torture chamber" in Dubai. Nick-named the Hubbub-house, it was meant to frighten and confuse the prisoners without leaving any trace of physical harm. During the past decade, exported items include ankle chains, execution syringes, and other gruesome equipment suited for countries that practice suppression and torture, opposed by AI.

TURKEY

Still practicing torture

In its annual report on human rights, the US State Department has accused the Turkish authorities of using torture, even though the government in Ankara has repeatedly promised reforms.

The State Department quotes an independent human rights organization, which reports that 18 people were killed during 1991 year while they were in the custody of the Turkish police. The victims were either killed during torture, or by "falling out of a window" at the police station.

Detailed human rights report

The Human Rights Foundation of Turkey (HRFT) has published its first detailed human rights report (1991), of 168 pages; it has also been translated into English. Even though it is presented in diary form, documenting human rights violations almost every day, only a small number of the violations actually committed are mentioned. The truth is unobtainable.

According to HRFT, only 218 of 552 people who claimed to have
been tortured during 1991 could verify it by medical reports; 23 persons died under suspicious circumstances. Court decisions are often reached using statements extracted under torture, the report said.

**Police torture children**

Children in Turkey have been subjected to torture in police detention centres, according to a report from the International Helsinki Federation (IHF).

Three of the children interviewed were accused of ordinary crimes, and six of political offences. One 16-year-old girl was tortured and imprisoned for 75 days for hanging a "No to War" poster at school.

"None of the children's families were notified by the police of their whereabouts", the report said, adding that all of them were detained in prisons for adults.

The IHF, monitoring the observance of the 1975 Helsinki Final Act among the countries of Europe and North America, urged the Turkish government to investigate all allegations of child torture and to discipline anyone found responsible.

**SOUTH AFRICA**

**Violence against ANC**

South Africa's white regime still discriminates against the African National Congress (ANC), accepting the use of violence against ANC's members and sympathizers, states an AI report to UN.

"Punishment without trial, attempts at murder, and torture" are in common use against black members of ANC. Furthermore, several blacks have died shortly after being arrested. It seems that the white regime's "official policy" continues with persecution of ANC and its allies. The information is supported by the US State Department, which has reported several cases of discrimination against blacks, conditions similar to civil war in black townships, and torture.

**ISRAEL**

**Maltreatment in the occupied areas**

The Israeli authorities in the occupied areas are using systematic torture and maltreatment, according to a report from AI to the United Nations Human Rights Commission. It was reported at the Commission's winter assembly in Geneva that Israeli interrogators use methods such as flogging, beating with wet bags, and forced painful positioning for long periods.

**ALBANIA**

**Council of Europe to help torture victims**

The Strasbourg-based Council of Europe has set up a programme for alleviating the plight of many of the 500,000 former political prisoners in Albania.

The problems are immense; generations of Albanians suffered during the brutal communist regime of Enver Hoxha. Many ex-prisoners still live in the former camps, because they have nowhere else to go.

The Council of Europe is also to study the basic Albanian legal principles - of great importance, for instance, when compensation is to be decided for torture victims and their relatives. Albania needs assistance in establishing the legal framework based on respect for human rights which is a pre-condition for entering the Council of Europe.

**Gree k troops alleged of torture**

Albanian citizens who were expelled from Greece have been tortured by Greek troops in a systematic campaign to deter illegal immigration into Greece. The Albanians said that limbs were broken, eyes gouged, and severe burns inflicted by Greek border units before they sent the Albanians back over the frontier.

An example: "My clothes caught fire, but then I was dragged to a nearby pond", an Albanian, Guri Jemini, told Reuters in the Intensive Care Unit of the main burn hospital at Tirana, capital of Albania. Jemini's whole chest and left hand were covered with deep wounds. Groaning all the time, he could barely speak or move.

Athens has consistently denied Tirana's charges of torture and abuse of Albanians. But it makes no secret of the fact that illegal Albanian immigrants can expect arrest, detention, and summary expulsion. Thousands of migrants have poured south into Greece in the past few months, looking for work and food as Albania, Europe's poorest country, lurches towards economic collapse.

The European Community (EC) expressed grave concern to Albania over attacks on the Greek minority in Albania, and appealed to the Albanian authorities to re-establish order.

**MALAWI**

**Prisoners starved and beaten**

Prisoners in Malawi are beaten, chained naked to the floor of their cells, and starved, so that many of them die, and the government allows the prison staff to use these forms of punishment without risking any punishment themselves, says an AI report. In the prisons of Dzeleka and Nsanje, the inmates were forced to run the gauntlet between guards who were beating them with sticks, whips, and iron clubs. Those who survived were chained naked to the floor of their cells, and were only given small food rations.

The President of Malawi, Kamuzu Banda, has dismissed the report, and, speaking to diplomats, he called the described ill-treatment "quite repulsive". But AI reports that both political and
criminal prisoners are kept in hand and foot chains in dark cells, often without food, if, for instance, they commit the slightest offence against the prison rules. A political prisoner, Dylester Phiri, died in Mikyu prison in November 1991 while waiting for his sentence. Apparently the cause of death was tuberculosis, but according to Amnesty he had not been treated for his condition. A postmortem examination is seldom performed, and the bodies are not given back to the families, who have to be content with the clothes without any explanation.

CHINA/TIBET

Tibetan dissidents mistreated

AI reports that China keeps more than 100 Tibetans as prisoners, simply because they agitated peacefully for Tibet’s secession from China. Among them are Buddhist monks and nuns. China has sharpened her attitude towards those groups in Tibet which 4 years ago were behind demonstrations demanding the secession of Tibet from China. Other groups have also been imprisoned for political reasons without having had a fair trial in court. The common rule is “sentence first - trial later”. Information from previous prisoners suggests that the Chinese authorities systematically use torture and ill-treatment of political prisoners.

MYANMAR/(BURMA)

Muslim minority tortured and killed

Nearly 700 Burmese Muslims have died from suffocation in concentration camps near the border with Bangladesh. In January 1992, Burmese soldiers detained about 3000 young Muslims on the suspicion that they were members of an Islamic resistance movement. They were packed into 10 warehouses in Arakan province, according to the daily newspaper “Rupali”. Some 500-700 youngsters died from lack of oxygen within a few days. The Military Junta in Myanmar (Burma) has declared that the Muslims, a minority group in this Asian country, are illegal citizens; it has killed, tortured, raped, and persecuted them in many other ways.

According to the Bangladeshi daily Ittefaq, about 60,000 Burmese Muslims have fled to Bangladesh, and more are expected. Several have perished while trying to escape - victims of the bullets of the Burmese border guards.

INDIA

Torture, rape, and deaths frequent in prisons

Since 1985, AI has recorded the deaths of 415 people in custody in India. The victims, including women and children, were beaten brutally or tortured in other ways before they died. Many of them were arrested as suspects of criminal activity, unconnected to any political activity, and tortured with the purpose of extracting confessions.

Torture is also widespread in areas where the government faces armed opposition, such as Jammu and Kashmir, Punjab, Assam, and regions where the Naxalites are active; the most common methods are beating (sometimes with the victim hanging upside down) and electric shocks.

Of 415 deaths in custody, AI knows of only three cases when police officers were accused and later convicted of torturing prisoners to death. Falsification of medical records is common practice in non-fatal cases of torture.

The report stated that the long rule of the Congress Party (more than 30 years) has resulted in a symbiotic relationship between policemen and the civil services. AI’s survey of 415 cases shows that compensation to the relatives of people who were tortured to death was ordered in only 12 cases, and paid in 6 of them.

TREATMENT OF TORTURE

Readings and References

Ferne E. Atkinson, MSW, Editor

- comprehensive introductory guide to identify and treat refugees with psychic trauma due to torture
- collection of articles chosen from leaders in the field: Sonnier and Genetke, Horowitz, Kolb, Terr, Allodi, Mollica, Agger, Figley, Jensen, and others
- models and references for psychotherapy, family, group, art, and hypnotherapy
- sections relate to family, child, adolescents, with cross cultural applications
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The Netherlands
Tel: (+31) (0)30-369312
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July 19-23, 1992
The American Society of Law & Medicine: The Third International Conference on Health Law and Ethics

Further information:
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765 Commonwealth Avenue, 16th floor
Boston Massachusetts 02215. USA
Tel: (617) 262-4990
Istanbul, Turkey
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Further information:
ISPA '92 Istanbul Colloquium Office
ITS Büyükdere Cad
Kaya Aldoğan Sk. No. 12/1
Zincirlikuyu 80300
Istanbul
Turkey

Copenhagen, Denmark
August 17-20
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Myopain '92

Further information:
Congress Secretariat: The Danish Rheumatism Association
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DK-1825 Frb. C
Denmark
Tel.: (+45) 31 31 12 13
Fax: (+45) 31 31 06 14

Dresdens, Germany
September 16-21
XIIth World Congress of the International Federation of Physical Medicine and Rehabilitation

Further information:
Springer-Verlag
Mrs. Grossmann
Heidelberger Platz 3
Postfach
1000 Berlin 33
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Tel.: (+49) 30 8207-206
Fax: (+49) 30 8207-465

Borgå, Finland
September 25-27
6th Nordiska konferensen för psykoterapeuter som arbetar med traumatiserade flyktingar (6th Nordic Conference for Psychotherapists Working with Traumatized Refugees)

Further information:
Kerstin Sundman
Fortbildningscentralen vid Åbo Akademi
Domkyrktorget 3
SF-20500 Åbo
Finland
Tel.: 358-(9)21-654 658

Mmabatho, Bophuthatswana
August 23-28
Third Congress on Human Rights, Medicine and Law

Further information:
International Centre of Medicine and Law (ICML)
PO. Box 4182
Mmabatho 8681
Bophuthatswana
Southern Africa
Tel.: (+27) 140 842470 or 140 842471
Fax:(+27) 140 24894

Bucharest, Romania
October 2-4
International conference of the Romanian free psychiatrists association (APLR): Ethics and Psychiatry.

Further information:
Secretariat APLR Conference
Grupul Pentru Dialog Social
120 Calea Victoriei
sector 1 Bucharest
Romania
Fax: 0400 14 14 71

Vancouver, British Columbia, Canada
October 14-17, 1992
Western Social Policy Forum: Refugees in the 90's - National and International Perspectives: Integrating Policy, Practice and Research

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