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This editorial will be devoted to discussing the Journal itself. There is no special occasion—a fifth anniversary is no jubilee, and it does not help to include the period back to the start of the predecessor of TORTURE, the International Newsletter on Treatment and Rehabilitation of Torture Victims. But the occasion will be used for some practical information.

The step from Newsletter to the Quarterly Journal, TORTURE, in 1990 was necessary because of a relatively long production time that did not go well with the term “newsletter”. Furthermore, the growth of IRCT gave a correspondingly increasing number of international contacts and thus a source of material on documentation of the concept of torture, a natural basis for a quarterly journal from IRCT.

This concept has been developed, and TORTURE now occupies a field of its own, surrounded by important information from newsletters and newspapers from human rights organizations, and monographs, reports, and background material, also from human rights organizations, e.g. Amnesty International, Physicians for Human Rights, human watch organizations and the UN. TORTURE has thus found a niche for information and background material, allowing us to an increasing extent to bring articles and contributions under headlines such as “Investigation and research” and “Documentation and background”. But the editorial board wants it to be known that we are still interested in original articles, particularly on new knowledge about torture, and not least on documentation of ongoing torture, in order to increase the safety of the torture survivors, their acceptance, and correct treatment as refugees, and in order to take up the fight against their torturers.

This issue of TORTURE contains a cumulative index for 1995. In the future a similar index will be printed at the end of each year. We are also planning an index to cover all the volumes of TORTURE.

It has been remarked that the similar appearance of the front covers of all the issues of TORTURE makes it difficult to distinguish them between and within years. This will change in 1996 when the front cover will have a different colour each year.

It has always been, and still is, very important for IRCT to pay attention to the protection of the people with whom we cooperate. It is therefore quite normal for IRCT, during working visits, to omit statements and actions that might provoke the authorities of the host country to hinder or prohibit on-going rehabilitation work, or, even worse, to endanger IRCT’s cooperation partners in that country. However, this does not mean that we are compromising in our condemnation of government-sanctioned torture anywhere. We also agree that such a critical attitude should be clearly expressed in TORTURE. It is IRCT’s objective to assist in the organisation of rehabilitation of torture victims where it is necessary, and at the same time to reduce and prevent the incidence of torture. When TORTURE publishes articles about the violation of human rights in a country, its objective is to bring the readers knowledge of torture and its global effect. Furthermore, articles about torture and accounts of the people who work with torture victims, at great risk of becoming victims of torture themselves, are a form of protection for these people. It has been stated that the existence of TORTURE is regarded as a protection for people working under pressure.

In the same context, we now try to include statements and conclusions from the reports published by the UN Committee Against Torture. Although these reports are official statements from a UN body, they will no doubt contain many allegations about torture.

H.M.
Torture and its consequences

An ICRC viewpoint

Hernán Reyes, MD*

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During the Seminar on Torture and Organized Violence held in Moscow by COMPASSION in September 1994, the International Committee of the Red Cross (ICRC) gave an outline of its main activities in the field of visits to prisoners, stressing the work being done in connection with the Nagorno-Karabakh conflict. Since then the conflict in Chechnya has taken on a new dimension. The principles stated at that time for visits to prisoners from all sides hold just as true in the more recent conflict as they do for all areas in which the ICRC works.

In writing this summary, the author has deliberately decided to specify certain general principles concerning torture and its consequences, as they are relevant to the work performed by ICRC delegates and physicians in the field.

ICRC visits to prisoners

The many activities of the International Committee of the Red Cross in areas of conflict include visits to prisoners all over the world. In 1994, over 99,000 prisoners were visited by its delegates and physicians. The purpose of these visits is to ascertain that people in custody are kept in adequate conditions of detention, and that they are not subjected to any forms of ill-treatment, i.e. that their physical and moral integrity is respected.

ICRC visits and the necessary conditions for them to take place have to be negotiated beforehand with the detaining authorities. There are several sine qua non conditions that have to be accepted by the authorities before the ICRC begins visits. These conditions and what ICRC visits are meant to accomplish have been described in a previous paper published in the International Rehabilitation Council for Torture Victims (IRCT) TORTURE journal. All health aspects unrelated to the problem of torture are detailed therein and will not be mentioned here.

In situations where prisoners are subjected to cruel, inhuman or degrading forms of treatment, ICRC delegates document the use of torture so as to submit a detailed account of the situation to the authorities, calling on them to put a stop to such practices. ICRC physicians have the additional task of seeing and examining these prisoners so as to assess their state of health.

The physician’s role

ICRC doctors receive specific training and specialized documentation to enable them to give the most effective help possible to victims of torture whom they see during the visits. The role of the physician in this specific field of work is obviously quite different from that of a doctor “outside” the detention environment. There can be no question of the ICRC doctor “treating” these persons, in the generally accepted sense of the term, whilst they are still held in captivity. Once they are released, moreover, the question of treatment is likewise beyond the scope of the ICRC doctors, but at least those persons in need of treatment can be referred to any readily accessible centre.

What can be achieved within the short period of time allotted to the doctor during the ICRC visit is to give the individual prisoner the opportunity to consult a medical professional who sympathizes with his or her plight. (A medical visit to a prisoner may take between 15 and, rarely, 40 minutes, sometimes even more: ICRC doctors have to explain that there has to be sufficient time for all those who need to see the physician to be able to do so.) The ICRC doctor can offer counsel and guidance after performing an independent medical examination, if the latter is warranted. The prisoner can then count on a medical advocate for any necessary therapy that is in fact available while he or she is still in detention. ICRC physicians endeavour to do all of this: one of their tasks that is often difficult is trying to obtain an outside medical examination (X-ray, laboratory, etc.) for the prisoners they see, or to have someone taken for specific treatment to a referral hospital, where the patient will be followed up by the ICRC doctor.

The importance of an independent – in this case an ICRC – doctor being able to perform a medical examination should not be minimized. Seeing an independent physician who shows genuine concern for the prisoners’ health is all the

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more important, since in many (or most?) countries where ill-treatment or torture is practised, prisoners have to rely on the services of institutional doctors – outside physicians are not allowed to attend to prisoners. Most often in such situations, prisoners do not trust the “inside” medical personnel. This may be for legitimate reasons in countries where doctors have, for example, actually participated in interrogations. It may also be an understandable feeling of mistrust that any prisoner might have while in detention.

If there is any question of torture, the importance of the doctor being independent is manifest. However genuinely professional a prison doctor is, it is only too understandable that prisoners who have undergone torture will not place their trust in a doctor seen as being part of the custodial – or repressive – system.

So apart from the obvious interest in establishing firsthand documentation of torture, ICRC doctors are thus also in a unique position to bring some medical assistance and comfort to these persons who have been denied comfort and relief during their ordeal.

On the one hand, a professional assessment of the torture situation leads to a report – which, in accordance with the ICRC’s proven working methods, is confidential – to the higher authorities, demanding that all such practices cease. On the other hand, at the “field” level (i.e. in the prison), and with immediate and practical benefit for the victims themselves, the ICRC doctor can advise, explain to and reassure persons suffering from the multifarious complaints and after-effects of torture.

Even though what may obviously be the main problem for prisoners – their being deprived of freedom – is an issue which ICRC cannot and usually does not tackle (apart from exceptional medical cases: requests for releases on medical or humanitarian grounds can then be presented), this unique contact while still in custody can be helpful. Being able to explain symptoms and give advice on what can possibly be done while still in prison, or what is to be expected in the long term, is already a form of therapy in many cases. It can be explained to someone, even behind bars, that the symptoms of torture are the “normal reaction by a normal person to an abnormal situation” (quoted from ICRT’s Dr. Inge Geneffke). This is, in our view, a service that can help prisoners much more than may seem apparent to the outsider at first sight. (To give just one example, it can be of immense relief for a prisoner to learn from an independent doctor that his body has been battered and abused, but that apparently – after examination – there is no permanent damage to the reproductive system. It must be remembered that the threat of future sterility is often brandished by torturers as part of the ordeal.)

Much of the knowledge acquired from the vast experience of the many rehabilitation centres for torture victims around the world, information that has been duly published, can be used by ICRC doctors in their attempts to bring all possible relief to these prisoners whilst they are still in custody, sometimes serving long sentences and with little hope of release in any foreseeable future.

On definitions of torture
The reasons for torture are many. They have been discussed at length in countless publications and papers, and particularly in medical studies and documents by the IRCT in Copenhagen and other such rehabilitation centres. While it is not the purpose of this paper to reopen this issue, a number of comments based on the author’s experience with the ICRC would seem necessary and useful.

“State torture”, as a designated government policy intended to break any or all political opposition and, as such, applied to anyone suspected of being an “enemy” of those in power, is unfortunately still a very real occurrence. Torture of “political prisoners”, and particularly of their leaders, is clearly still going on in various countries. (The term “political prisoner” is used here for the sake of convenience to designate opponents, real or seen as such by the government. Few if any governments admit to having “political prisoners”.) It is this use of torture that best fits the description of “the most efficient weapon against democracy” as used by the Danish IRCT (quoted from Dr. Inge Geneffke). Unfortunately, this rather restrictive definition tends to make people forget that torture can be and is used in many other contexts.

There are indeed many other aspects to this issue. The ICRC does not have its own definition of torture and uses, when necessary, those already established – or none at all – as it sees fit in a given situation. Definitions of torture have become more complex, and not necessarily clearer, over the years. (See the Amnesty International and World Medical Association definitions, both formulated in 1975, and the 1984 definition by the United Nations in its Convention against Torture.) The one generally accepted today is that of the UN, which defines torture as being an aggravated form of cruel, inhuman and degrading treatment.

It is interesting to note that definitions of torture have tried to set out the possible intents of those who practise torture. (Earlier definitions, as for example the definition by Professor Chet Scrignar of Tulane University, New Orleans, do not attempt to define the purpose of the torturer, but only describe the effect of torture on the victim. Prof. Scrignar defines torture as “An intentional trauma deliberately conceived by vile men to systematically cause pain and suffering to a selected individual, and ultimately ending with the physical and psychological collapse of the victim.”) The old notion that the main purpose of torture was to make people “talk” (and give information) was rightly countered in the 1970s by the opposite notion, namely that the intent of torture was, in fact, to make the general population keep silent … It is this targeted type of torture that indeed attempts to curb democracy.

Without getting into a detailed analysis of torture as it stands in the mid-1990s, it must be said, however, that the purpose of torture is not as clear-cut as it was, for instance, in the mid-1970s or early 1980s. In those years, the “torture versus democracy” formula was, if not the rule, arguably the most visible and widespread form of systematic state torture. This was the kind of torture that had been applied to the victims (or “survivors”, as they are called today) who managed to reach the various centres in Europe and North America, where they were received and tended by concerned health professionals and human rights workers. These people were the sources of information for many of the publications on torture.

But as it did even then, the true purpose of torture spans a much broader spectrum of reasons today in the mid-1990s than “merely” the dissuasion of political dissidents. Torture has always been, and still is, used for many other reasons. One of the most perverse forms of torture is its use to elicit compliance and collaboration from people not actually involved in a given conflict, but who are tortured and blackmailed so that they will infiltrate or testify against suspected “enemies” of the government.

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Forced collaboration, with all its implications, is arguably one of the most tragic aspects of the use of torture. The victims who have been forced to collaborate are shunned and rejected by all, and are at immense risk of being killed or tortured by their own people.

Torture and other forms of violence perpetrated to induce what is now called "ethnic cleansing" are another case in point. Innocent civilians without any political stance or ideology have been brutally tortured — and many massacred — only to force them to leave their lands. These people are victims of a policy that has little to do with repressing democracy.

A third example of torture that does not fit the "anti-democracy" definition could also be mentioned, namely the incredibly cruel and inhuman beatings and other forms of violence — that cannot be called anything else but torture — inflicted on prisoners in some countries. Those people are common law prisoners, and not dissidents or opponents of any kind, and they are tortured so as to dissuade them from escaping. Prison guards, when told that their already miserable wages will be slashed by 50% if a prisoner escapes, do not hesitate to use incredibly violent forms of repression.

The list could go on. The point being made here is that the fight against torture has to be seen to encompass all these forms of torture, and not just the torture of real or imagined political dissidents. It is in this light that the 1984 UN Convention's definition of torture very rightly states as the bottom line, when defining the possible intents of torture: "... or for any other purpose".

The term organized violence itself is perhaps rightly championed by many human rights groups. Such violence has been and is used for the same purposes as torture, and in some cases there has been a government policy to implement it. In other cases the motive behind the use of organized violence may be less clear ... The term certainly includes the notion of torture, whatever the definition, and its use may in many cases be preferable to the always controversial term "torture". (What is meant here by "controversial" is that the purpose of intervening against torture is to have it cease, not to beat around the bush by dissecting definitions. This is one of the reasons why the ICRC does not use any specific definition, but prefers instead to describe what is going on.)

The effects on the victims of torture or organized violence (and what about "unorganized" violence?) are obviously very different depending on the group that is targeted. When subjected to state torture, political activists, who are arguably "prepared" for torture — in some cases even "trained" to expect it — have coping mechanisms that men, women and children who are tortured because they happen to be in the wrong place or belong to the wrong ethnic group, or both, but who are not militants in any particular cause, obviously do not have. Civilians caught up in the various forms of "ethnic cleansing" in various countries are examples of persons who are in no way "prepared" for the frightful violence perpetrated against them.

It is certainly not the objective here either to comment on the diverging parameters of those professional medical groups who favour what can be summarized as the "torture syndrome" approach, and of those other professionals who believe that the effects of one and the same form of torture will vary immensely according to the inner strength, personality and coping mechanisms of those to whom it is applied.

Suffice it to say that there is still an immense amount of work to be done in this field. The main point to be stressed here would be that torture must not only be seen as a form of repression of potential political prisoners, but as a far more extensive evil.

On the documentation of torture
The ICRC can be said to have a significant amount of experience in this field, because it has been visiting political prisoners continuously since 1918. Torture has unfortunately very often been an issue during these visits.

Documentation of torture is compiled by ICRC delegates and physicians during their visits to prisoners in their places of detention. (Only rarely are prisoners seen by ICRC physicians after their release.) They do so during the essential stage of the visit which involves direct dialogue and contact with prisoners. These interviews in private are one of the non-negotiable conditions for ICRC visits to take place at all. Only through this personal and direct contact with the prisoner can the ICRC expect to get firsthand information on the various topics it is interested in covering.

The subject of torture and its consequences is obviously one of the main concerns of the ICRC. By interviewing prisoners individually and allowing them to talk about their problems and preoccupations, ICRC delegates and physicians get a general picture of what the situation is. Once the ICRC has a clear idea of it, the main objective is to raise the issue officially with the relevant authorities, calling on them to end such practices.

The doctor's additional specific role has been mentioned above. In some cases, ICRC nurses also assist the delegates and doctors in these tasks.

The actual reports submitted to the authorities have to give a complete and accurate picture of the prisoners' situation. By working in a professional way, with trained delegates and physicians, and by carefully cross-checking all information received — from authorities as well as from prisoners — the ICRC can determine what has actually happened. It is stressed to physicians in particular, who actually examine victims of torture and obtain most key information through their privileged doctor-patient relationship, that torture has to be documented in a comprehensive way. The main objective is an assessment of the overall consequences of torture, and not just a listing of the methods used.

This is an important point, with at least two sub-headings. First, it must be emphasized that merely "listing methods", a practice all too often used in the documentation of torture, is not an efficient way of dealing with the issue. Such listings cannot convey the real horror of a situation, and tend to separate "physical methods" from "psychological methods".

Second, it has to be underlined that visible and apparent lesions are only part of the story, and may indeed not be the worst part at all. ICRC delegates are trained to see beyond the mere scars or marks of torture they may initially see or be shown. "The worst scars are in the mind" (quoted from Dr. Sten W. Jakobsson, Stockholm) and it is much easier for a torture victim to show the wounds on his back than to tell about the wounds on the soul. What could be called the "WYSIWYG" (term meaning "What You See Is What You Get") approach to documentation should be avoided at all costs. Sequelae of torture have been widely documented elsewhere. Unfortunately, many health professionals who work with asylum seekers, for example, have to produce "physical evidence" to prove that torture has taken place. Psychological evidence of torture has yet to be accepted in most countries as valid evidence.

Whatever the method of analysis used by professionals in
studies and reports on torture, it would seem necessary to say a word for the record on documentation in general. There is a tendency to use “check-lists” and other such tables in field work. The information received from torture victims is often quite varied, and with the ever more frequent use of computers and databased systems, inexperienced health professionals who have to manage this information often present it in tabular form, merely checking off what methods of torture are used and listing them. Worse, the figures and categories in these tables are often fed into a system that calculates “statistics”. These figures may in some cases make a report look professional, but they are often misleading and certainly reductive.

At the ICRC, delegates and physicians are told when in training to avoid this “tabular” mentality. Nothing can replace a professional written report, describing methods and observations in factual sentences, with as many examples as necessary. These examples can be given in a transcription of the victim’s own words, or in a summary, whichever is more convenient and practical. Many professional human rights organizations work in this way and do not rely on misleading tabular presentations.

The following intentionally simplistic table (table 1) illustrates the type of documentation that, in the author’s opinion, should be avoided. The shortcomings should be particularly obvious in the three-case example given below, but the principle applies to any such tabulation.

Table 1. Fictitious example of three prisoners who are victims of torture.

<table>
<thead>
<tr>
<th>Priso­ners</th>
<th>Methods</th>
<th>Threats and insults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sacha</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Alyosha</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Pavel</td>
<td>++</td>
<td>+</td>
</tr>
</tbody>
</table>

This table is the “graphic” result of a hypothetical visit to a given prison where three prisoners who have been subjected to torture have been interviewed. The resulting table is similar to many such tabular summaries used by well-intentioned persons working with torture victims in their attempt to organize and set down information.

In the case shown, Sacha has been beaten (badly: ++ is worse than +) and subjected to electric shocks. Alyosha has also been badly beaten and has likewise suffered from the application of electric current. He has been hooded, too. Pavel, according to the table, has been subjected to the same treatment as Alyosha, without electric shocks. All three have been subjected to what is euphemistically called “threats and insults”.

What is not specified in the said table, but very well could be in an additional column, are the “statistics”: in this simplified case, there would be 100% beatings, 66% electric shocks, 66% hooding, and all (100%) prisoners subjected to threats and insults while being tortured. (The observation that statistics should never be drawn up on the basis of such a small number of cases is obviously relevant: however, this has been done all too often.)

It is precisely this type of “methodological table” that warrants further scrutiny:

The first prisoner, Sacha, who was subjected to beatings and electric shocks, should seem a straightforward enough case. An apparently “severe beating” was given. But what does this mean? Is the qualifying double “++” sign based on the description given by the prisoner? Or is it perhaps because of the physical state in which he was found at the time of the interview? Does “++” take into account the differences between receiving a beating when the subject it a strapping, athletic, strong-willed militant, or a peasant farmer’s wife who happens to belong to the wrong ethnic group or religion and has not the faintest notion of why she is being mistreated?

Electricity was used. But a mere + in the appropriate box gives no idea of the effect electric shocks may actually have had on the person. The + sign reduces the information here to the presence or absence of their use.

“Threats and insults” are all too often dismissed as an inevitable part of torture by inexperienced workers in their summation. As entered in such a table, they might be considered by the intended reader as something of a common side-effect, as nausea and vomiting are considered frequent side-effects induced by many medicines. This is obviously not the case, as anyone who has dealt with torture victims will know.

The second prisoner, Alyosha, has been subjected to the same ill-treatment. For argument’s sake, let us suppose that the circumstances were outwardly the same (same torturer, same duration, same place ...). Threats and insults were also a reality of torture for Alyosha.

The fact that he was hooded during the “session” can be most important, a feature that a mere table cannot convey. The additional anguish and pain induced by not knowing from which angle the next kick or bludgeon will come changes the situation entirely. The “same” beating will have a considerably different effect on these two prisoners. Many studies have shown that this apparently superficial detail is a major factor in making torture even more unbearable.

Apart from the mental anguish induced by the inability to see where the next blow will strike, there is an actual physical component as well. The uncertainty makes the body’s muscles contract in anticipation, and this makes the blow all the more painful – and an electric shock even more so. Muscular spasms induced by electric current in this situation are described as being much worse than when the shocks can be anticipated, and have been known to cause additional lesions.

Is it necessary to repeat that hoooding is part and parcel of torture, and not, as always alleged by the torturers, “merely a security precaution”? Included in a torture session of beatings and electric shocks, it compounds the effects of this torture. This fact can hardly be transcribed in a mere additional column in a table!

In the third case, Pavel, (this example – one of so many – is taken from a real case, that of a person interviewed by the author in 1994) the treatment would seem to have been the same as for Alyosha, with the difference that electricity was not used. How can any such table, however, convey what may actually have been the worst part of the ordeal for Pavel. In this case, the prisoner Pavel was arrested at the same time as his 14-year-old son. While being subjected to the same beatings as the preceding case (beatings while hooded), the worst of all in Pavel’s case was not knowing whether “they” were going to inflict the same treatment on his son and to be threatened with the use of electricity on him. Torture of his son may have been implied directly (and set down dutifully in the table’s aseptic column “threats and insults”), or merely imagined by the father. The threat to the son may have been
real, or it may have been merely used by the torturers as yet another form of torment. The result is that for this third prisoner, the fear he felt for his son completely screened off all physical suffering. (In the real-life case, the prisoner said he hardly remembered the pain caused by the (brutal) beating, he was worried for his son.) The mental anguish, however, continued well beyond the actual “session”, until he was finally able to find out what had happened to his son.

This psychological factor (“the worst scars are in the mind”) is impossible to incorporate into such a table! The point here is that the psychological effect torture has on people is impossible to translate into tabular form. A proper description of the effects the different methods of torture have on people, in a properly drafted text, cannot be replaced. It should be obvious from this intentionally simplistic example that describing torture situations is a complex matter, and that the real picture cannot be conveyed by tables and charts. The false sense of “scientific evaluation” given by drawing up such tables and their “statistics” can in fact be counter-productive. This is one of the main pitfalls drawn to the attention of ICRC delegates and doctors who are sent into the field to visit prisoners.

What is needed to convey the real situation to an authority responsible for such matters, with any hope of convincing it that torture has to stop, is a comprehensive report with an indisputable description not only of the methods used, but also of the after-effects of the torture on the victims. Medical descriptions, if warranted, should give the overall picture and not merely a forensic description of scars or other sequelae. The psychological aspects should be integrated into the physical aspects, so that there is no false dichotomy in what is in fact a single, indivisible entity.

Another consideration that is all too often overlooked or minimized, namely the degrading and humiliating aspects that play such a fundamental part in the world of torture, should also be spelt out and underlined. These aspects were omitted in the example above (table) so as to simplify the message, but likewise clearly cannot be transcribed in any additional column.

To summarize, an actual “clinical picture” of the situation should leave no doubt in anyone’s mind that the victims were indeed subjected to something that can only be called torture. In this way one can begin to discuss how to stop the procedure, instead of haggling over definitions, methods, or percentages.

Conclusions
To draw definitive conclusions on such a difficult topic as the one formulated in the heading would be presumptuous. Let it simply be said here that the ICRC endeavours in its work to bring relief and assistance to all prisoners it visits in a conflict situation, and to ensure their physical and moral integrity. This applies to all parties and to all sides.

Emphasis has been placed on the necessity of having neutral, and particularly medical, intermediaries. This necessity is particularly great when torture is involved. By obtaining its information directly from all sources and through firsthand assessments by its own personnel, including medical staff, the ICRC is able to draw up comprehensive reports which it transmits to all authorities concerned. By ensuring that all reports are as professional as possible, appropriate requests can be made at all levels for a stop to all use of torture.

To this effect, ICRC delegates and physicians must constantly strive to maintain a professional approach in making their assessment. In reporting cases of torture to the authorities, they must avoid the pitfalls inherent in categorizations and database simplifications. Use of tabulations and statistics is better left to physicians and medical groups who do research in adequate settings, using proper scientific methodology. The two approaches are complementary but most often not interchangeable.

References
Psoriasis as one of the possible sequelae of torture

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It is now widely accepted that the severity of a number of skin conditions can be influenced by stress: psoriasis is one of these conditions. The most obvious starting point is to define stress. The term stress may refer to different aspects of environment. Torture is extreme, deliberate, systemic, and continuous physical and mental stress on the human soul and body. The experience of torture, regardless of period, is an extreme form of stress, and the skin is the first barrier on the body, which is a first-hand defence against external stimuli. So, the skin is an end-organ for the stress response in that the electrical conductivity of the skin surface changes and the temperature of the skin, which is a function of the vascular tone of small blood vessels, changes during stress. Thus psychophysiological arousal is thought to be one of the mediating factors in flare-ups of eczema and other skin disorders (including acne, psoriasis, and urticaria).

Psoriasis is a common but heterogeneous disease. Its severity ranges from symptomatic to crippling, and occasionally it may be life threatening1. Psoriasis is reported to be prevalent in almost 2% of the general population2. However, as one of the possible sequelae of torture, it is being documented for the first time. Nevertheless, a generalized account of skin changes after torture was documented by Danielsen3, who also reported that physically provoked skin diseases might include the development of psoriasis or lichen planus in the traumatized areas, as a "Köhner-reaction".

Appreciating torture as a highly stressful factor, one might expect dermatological reactions such as rashes4 and urticarial eruptions5, alopecia7 and torture6. Although one might like to dismiss stress (in this case due to torture) as a factor in psoriasis, it is such a common antecedent for relapses that it must be important. Unfortunately it is difficult to produce statistical evidence that this is so, and there is also little evidence that removing the stress helps psoriasis. However, the work of Seville over a period of years showed, encouragingly, that patients in whom psoriasis was precipitated by stress did considerably better than those in whom the disorder was not stress-related. It can sometimes be hard to sort out whether it is anxiety or stress that is causing the relapse of a patient’s psoriasis or, alternatively, the psoriasis that is causing stress and anxiety8.

While managing psoriasis – as a sequela of torture – one should realize that the stress, in this case due to torture, for an individual is a product of actual stressful events and the internal perception or appraisal of them9. Thus the patient’s perception of the disease is paramount when deciding whether treatment is needed. Moreover, psoriasis varies greatly in severity and in the way it is perceived by patients. Both are important factors when planning treatment. Faraz7, in the same issue of RAHAT’s Medical Journal, also reported a case history of a Kurdish refugee who developed psoriasis.
Examined and treated at RAHAT.

Topical preparations remain the mainstay of therapy, although more potent systematic treatments are available. Another important consideration while instituting treatment for psoriasis is that chronic, and particularly visible skin conditions, such as the one under discussion, often precipitate a range of psychological reactions, e.g. lack of control, avoidance and loss of confidence, physical and emotional pain, loss and problems of adjustment. A chain of events is often established leading to clinical anxiety and/or depression. In addition, of course stress and depression also contribute to, and exacerbate, the physical disorder. Any ingredients constituting the problems require detailed analysis, and it is at this stage that the clinical psychologist can be approached for assessment.

The aim of assessment will be to identify the emotions, the patterns of behaviour that have evolved as a way of maladaptive coping, and the person’s belief about his/her condition. Stress management may then be offered to the individual to reduce to a minimum those factors that can be influenced. Stress is generally accepted to realizing that exacerbate psoriasis and this certainly appears to be a major factor in some individuals.

The typical psoriatic plaque occurs on extensor sites, i.e. knees, elbows, and over the lower back. The surface is glazed and erythematous, and fissuring is often present at the apex of the skin fold. Flexural psoriasis may occur de novo or in association with infective intertriginous conditions, and the choice of treatment should reflect this frequent association. More severe cases of psoriasis may present with, or progress to, a widespread pustular or erythrodermic form.

When treating psoriasis it is important to consider, not only the extent of the eruption and the specialist sites involved, but also the social situation of the patient. The main topical methods of treatment are coal tar extracts, topical steroids, anthralin derivatives, and synthetic vitamin D analog, calcipotriol, etc.

Stress management may not remove the physical problem but it may help to alleviate unnecessary exacerbating factors and allow the individual to cope better with the skin disorders. RAHAT has established a specialized department of Stress Tension Reduction Therapy (STRT) exclusively to alleviate stress secondary to torture, and torture survivors receive sessions of STRT weekly. We have had good results in stress management in the rehabilitation of torture survivors.

Patient X, a torture survivor of the last military dictatorship, remained in the solitary detention centre of Shadi-Qila, Lahore, Pakistan, for seven years. He developed extensive psoriasis following torture, received specialized dermatological treatment from RAHAT, and is still receiving treatment for this stress-induced psoriasis. Psoriasis is said to be elicited by trauma to previously uninvolved skin, which was found true in this case. This post-trauma psoriatic development is defined as the Köbner Phenomenon, as discussed above. In the management of this case, the aforementioned line of treatment and practice was followed.

References
Occupational health therapy

A description of the practice and the experiences from CINTRAS

Alejandro Guajardo, Professor*

Mental health is not the absence of symptoms, or even the absence of human conflicts; it can rather be defined mainly in terms of the healthy development of a well-integrated person, a development that we conceive of as the progressive growth of personal capabilities; the ability to learn and reflect on what one is learning; the ability to feel and to love; the ability to act, in the sense of possessing skills, capabilities. These potentialities must occur in harmony with the body, with nature, and with other people.

An individual who is distanced from his or her immediate reality, who does not experience a fundamental link with the processes of social transformation in a society at a given moment in its history, does not enjoy good mental health. An integrated vision of mental health is to be found in the dialectic relationship with what we could call “a healthy human environment” (a socially constructed environment) that involves other elements such as freedom, mutual assistance and support, justice and participation, all elements central to a society based on respect for human rights.

In a society where violence has become part of state policy, spilling over into all social relationships, it is impossible to think of a healthy environment for the development of mental health. Such is the case of Chile where, starting with the processes of historic change that began at the end of 1973, a dynamic of enormous economic, social and political transformations begins, all occurring within a context of political violence and grave violations of human rights, without which these changes would not have been possible.

Victims of human rights violations as a goal group for occupational therapy

It has been said that the damage from political repression is to be found at different levels, and that therefore therapeutic processes must be equally multiple; from the treatment of intrapsychic and somatic processes, to the rebuilding of a life project. From this perspective, the recovery of important aspects of skills and social and work abilities, an improvement in self-image and personal knowledge, as well as integration into social support networks, each constitute a specific dimension that takes in the totality.

Leaving aside more serious pathologies, the damage experienced by those who consult us is expressed in uncertainty, marginalization, fearfulness, frustration, mistrust, loss of roles in the family sphere, little social involvement, no work involvement, the lack of a clearly defined life project. That is, the conflict occurs not only at the private level or in terms of the internal psychological structure, but also in the subject’s daily practice and relationships with others.

The occupational therapist tries to carry out a therapy that transforms daily practice, making it rewarding, an aid to recovery, orientating and facilitating personal development, reestablishing a healthy balance in the process of mental health that coherently connects internal processes to the set of personal skills that allow individuals to experience daily life as satisfying.

To achieve this goal, occupational therapy uses human activity as a basic therapeutic instrument, understanding this in a broad and global sense. Thus, people’s style of living on a daily basis, as expressed through work, the family, the community, friends, etc., becomes our sphere of action. We are concerned with the daily structure of activities such as personal hygiene, taking the bus or train, integration into social networks, the search for work, etc., and, on a more internal level, the improvement of self-esteem, of the personal image, a reduction in feelings of anguish.

The practical activities carried out by people during occupational therapy reflect the objective reality of their way of living and impressions. It allows them to recognize that they are capable of absorbing objective experiences in order to make a positive change and, through those changes, also to influence the activities they will carry out in the future. This is a long and ongoing process. There is nothing automatic about it and it is fraught with difficulties, but when planned and structured by an occupational therapist to move from the simple to the complex, taking into consideration the patient’s needs and motives, as Leontiev says, it can lead to a situation where the permanent transformation of the subject through practice leads to a broadening of conscience and a greater differentiation of personality. That is, a growth in activity determines the growth in consciousness. Thus, the subject will be able to review personal history and, eventually, transform the diverse factors that have been determining it.

On this basis, therapeutic activity is oriented to more specific levels and stimulates the patient through the following aspects: skills for planning and carrying out a task; ability to interact well within a group; ability to identify and satisfy needs; ability satisfactorily to express emotions; ability to carry out the activities required for daily life; ability to develop a job-related activity; ability to enjoy recreational activities; ability to face crises and difficulties; ability to interact comfortably in the family, between couples, and in friendly relationships.

On consciously reflecting upon these results, internalizing

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the objective and subjective elements in them, the patient achieves a more integrated relationship with the world, not as a spectator but rather as an active subject, capable of transforming reality.

**Therapeutic approach**

The work of occupational therapy is individual by nature, since each patient has specific objective therapeutic goals, but the type of work may be individual, in groups, or with families.

The first step is the initial interview, which has several goals: to define the reasons for the consultation, to listen to the patient’s needs, to define strategies and work together, to establish the beginning of a therapeutic link, to outline an initial diagnosis of the occupational therapy, to agree upon working techniques to be used, to personalize the treatment.

Individual attention is the backbone of treatment in occupational therapy. This is why, throughout treatment, periodic individual sessions take place during which the patient’s needs, goals, and tasks are evaluated and defined; progress, or lack of it, is noted, strategies and goals are reworked. Also, during these personal sessions, it is possible to deal on a private level with anything that cannot be dealt with collectively.

Within this therapeutic framework, different working techniques are structured, that can be summarized as follows:

a. individual attention
b. therapeutic workshops, ergotherapy, work
c. group therapy: dynamics, recreation, physical work, social skills workshop
d. family involvement: psycho-education, manoeuvres for basic reframing
e. socio-therapy: collective breakfasts, assemblies, outings, visits to the cinema and museums, camping, celebrations, etc.

The treatment takes place in an atmosphere of therapeutic community, of daily functioning, where all members of the group participate in their own and others' recovery, committed to the roles that have been taken on, in an atmosphere of democratic relationships that stimulate individual and collective responsibility for planned activities.

As already said, the therapeutic techniques are related to the patient’s needs. We often face the following problems:

- patients in crisis
- getting back to work
- social integration
- deficiencies in social skills and support networks
- inadequate family management.

Patients may be referred for one or several reasons. The process of rehabilitation must always be considered as ongoing, where each work area is interconnected with the rest, with the flexibility and agility necessary to modify therapeutic situations at opportune moments.

For reasons of space, I will enlarge on only three of the aspects mentioned above.

a. **Patients in crisis**

A significant number of our patients show an emotional response when faced with painful experiences or conflicts that they cannot overcome. The description of symptoms is very varied; depression, anxiety, phobias, psychoses, etc.

In these cases, the function of occupational therapy is basically to support the patient, to act as a model for the resolution of conflicts, to reinforce and develop personal capabilities for the improvement of self-esteem and confidence, to channel the symptoms, to give information about the objective world.

In these kinds of situations, because the patient feels totally involved, we must use a wide range of therapeutic techniques centred fundamentally on individual attention, therapeutic workshops (ergotherapy), socio-therapy, group dynamics, and family involvement.

Through individual work, we structure the day-to-day functioning on an intra- and extra-institutional basis, and in family sessions we carry out basic, necessary instruction, for example on how to confront psychotic episodes.

Group integration, basically through the workshop, acts as a cushion for creating emotional relationships. The goal is to receive and accept, as well as to experience, alternative ways of solving problems, using the experiences of other members of the group as a starting point.

The central aspect of treatment is the ergotherapy workshop, a creative/expressive situation that promotes basic psycho-therapeutic aspects. By transforming a basic material into an object, we try to make this a mediating agent between the internal and external worlds, triggering a reduction in...
anguish and anxiety, but also recreating skills that strengthen the person’s psyche. The development of creativity is an essential element of this, since through it we can achieve resolution of conflicts, realization of desires, etc. in a symbolic manner. By applying skills we also reinforce the “ego” and relieve anxiety through the representation of the object of conflict. The materials used in the ergotheraphy workshop are various: drawing, painting, leather, copper, wool, clay, wood, music, etc.

b. Getting back to work
This goal can become the second step, once the initial crisis has been overcome, or it can be an independent element.

The problems of getting back to work are of genuine importance, since the fundamental human activity is work. The socially adapted being finds himself or herself in this practical activity, which forms the basis for any personal project. Thus, the loss or absence of work provokes severe psychological damage, since it involves the rupture of a vital project.

Through occupational therapy we try to put social practice and the individual’s work experience back together, by developing skills and knowledge that will make it easier to return to a life project that is both more dynamic and more hopeful.

The goals of the different work-oriented, therapeutic workshops (carpentry, bookbinding, printing, sewing, photography, multiple handicrafts) are fundamentally to permit the development of healthy capabilities, to contribute to integration into both society and the workforce, and to provide the patient with resources. To do this we use a multiple approach: vocational and occupational analysis; analysis of the workplace; evaluation of vocation and the workforce; occupational profile; training; preparation for the workforce; location; follow-up.

The workshop is complemented by group techniques (role playing, group modelling, dramatization) and a diagnosis of the existing job market.

c. Social integration
This may also be an individual goal or the continuation of other goals. To achieve it, we direct therapeutic activity through the development of social skills, and through work with other social networks.

We use specific group work, socio-therapeutic activities, and therapeutic workshops. Through these we create a group situation where people can generate a feeling of belonging; they accompany each other through painful experiences, express their conflicts, exchange messages, and rebuild their damaged network of emotional connections, overcoming isolation and self-absorption.

The techniques we use vary, as mentioned above, but nevertheless we focus on three:

- social skills workshop: group dynamics (communication, forms of relationship, etc.)
- creative techniques: work with expressive techniques, using the body, paper, drawing, photography, collage, theatre, puppets, etc.
- socio-therapy, with integration into the community.

Through these techniques we try to open channels of communication, to release inhibitions in contacts with others, improve self-image, manage affectivity, promote empathy, etc.

We know well that one of the most traumatizing effects of repression is the abrupt shattering of social ties due to torture and imprisonment or to situations of great risk that lead the person to leave the country, to live underground, or to break every link with his or her past life. The destruction of the social network is one factor that leads to self-absorption and the resulting lack of an emotional support system.

Through our work with social networks we try to reestablish, rebuild, or re-order those significant relationships that a person creates on a day-to-day basis throughout life and that contribute to maintaining psychological integrity and social identity.

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The UN Committee against Torture concluded its fourteenth session in May 1995, having reviewed the steps being taken by the Netherlands, Mauritius, Italy, and Jordan to implement the rights enshrined in the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

The Committee expressed its concern about allegations of maltreatment in police stations or in prisons of the first three countries and called on the government of the Netherlands Antilles to shorten the period of 10 days of police custody allowed under the law in Aruba.

With respect to Mauritius, the Committee called on the State to establish a system of surveillance in police stations and to undertake proceedings to punish the perpetrators of any maltreatment.

In examining the report of Italy, the Committee called on that country to consider the concept of torture in its legislation as required by the Convention. Italy was also called upon to ensure that an arrested suspect has access to a doctor and a lawyer during preventive detention.

Regarding Jordan, concern was expressed about the continued application of the death penalty, as well as corporal punishment, which could, in itself, constitute a violation of the Convention. It called on the Government to make torture a specific offence, to strengthen the rights of detainees, to investigate allegations of mistreatment, and to punish the perpetrators.

In addition to the considerations of those reports, the expert body examined, in closed meetings, information appearing to contain well-founded indications that torture was being systematically practised in a State party to the Convention. They also considered communications from individuals claiming to be victims of a violation by a State party of the provisions of the Convention.

The Convention, to which there are now 88 State parties, requires signatories to outlaw torture. They are explicitly prohibited from using "higher orders" or "exceptional circumstances" as excuses for acts of torture.

The Committee voiced deep concern over a number of allegations of torture in Jordan since the country acceded to the Convention and noted that such allegations were rarely subject to full investigation. Moreover, during 1993 and 1994, political detainees had been sentenced to death and imprisonment on the basis of confessions allegedly extracted by force.

The Committee regretted that the headquarters of the Jordanian General Intelligence Department were recognized as an official prison and that the officers were allowed to act as prosecutors who could subject civilians and army personnel alike to incommunicado detention. Detention could last up to six months, during which detainees were deprived of access to judges, lawyers, and doctors. Even worse is the continued application of the death penalty, as well as corporal punishment, which could, as stated, constitute a violation of the Convention. The allegations that individuals had been expelled to countries where, it was believed, they could be subject to torture are also worrying. (UN Information Service).

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Greece is at the cross-roads to the north. For years now it has been a transit country. The need for a “first-aid” Service for Refugees is therefore obvious. Our centre was founded in 1989. It is a non-profit NGO which serves a double purpose: prevention and abolition of torture, as well as medical rehabilitation of torture survivors.

**Organization**
In its present form it is organized as follows: the general assembly elects a 9-member Board of Directors, the mandate lasting three years. The director and founder of the centre is a doctor, the rest of the personnel are employees. With the exception of the legal counsellor and the research group, they can be divided into two groups:
- An organizing group, comprising an administrative director, a secretary, an accountant, and a person responsible for public relations (a volunteer worker).
- The therapeutic group, comprising a physician, a psychiatrist, a psychologist, a social worker, and a physiotherapist (a volunteer).

Both groups cooperate and inform each other about current issues at weekly meetings. There are also two volunteer groups. One helps with social services, its members being whoever might be interested in the Centre’s activities and goals. The other is a totally independent network of volunteer doctors consisting of private practitioners or working in the public health service; it functions outside the Centre wherever the doctors may work.

**Premises**
The Centre is located in a small place in the centre of Athens, easily accessible for everyone who might want to get in touch with us. Special attention has been paid to making the place welcoming and friendly. The work calls for sensitivity and special knowledge, because the employees are burdened by the problems and adversities their clients have had to face.

**Where the cases come from**
Our Centre receives people from certain areas with increasing frequency, which is of course the result of the political and social turmoil on our planet. Today, most of our cases come from the wider area of the Middle East, mainly Kurdistan, Iran, Iraq, and Turkey.

During the last year we dealt with approximately 50 cases.

A few of them needed one session only, when their history was taken down and the fact that they had been submitted to torture, under given circumstances, was verified. This verification makes them eligible for emigration as special cases. Most of the cases, however, are still under medical and social care.

Most of the cases are referred to our Centre by UNHCR and other social services for refugees. Others have heard about us from friends who have already been clients here. We do not examine their legal status in order to undertake their therapy. The diversity of legal statuses causes us problems and creates the need for various ways of confronting them, because the services given are different for each group. We could call those who are under no protection of any organization, a high risk group, either because they are still seeking refugee status or because their application has been rejected. The result is that they are medically covered for emergencies only, and not for pharmaceutical needs, as opposed to the others who enjoy these benefits.

**Torture survivors as clients – general approach**
Everyone who is being cared for has a double identity – that of the torture survivor and that of the refugee.

As refugees they have been forced to leave their country, a fact that is physically and psychologically painful and hard. They are obliged to live in another country with different values, customs, habits, and language, cut off from relatives and friends, with the feeling that their lives and personal traditions are cruelly interrupted.

As torture victims they have survived the most humiliating treatment and have been deprived of human dignity. Health problems are added to their need for personal reorganization and to feelings of injustice.

The psychological sequelae of torture that we frequently encounter are: revival of the traumatic event asleep or awake, disturbance of attention and memory, difficulties with concentration, sleep disturbances, depression, and other emotional disorders.

On the somatic level, the most usual symptoms are stomach disorders from bad nutrition during imprisonment or inadequate food generally; damage to teeth because of electroshock, beatings and other forms of torture; orthopaedic problems because of falanga, suspension and beating; oto-laryngological problems because of telephone torture; skin problems, e.g. alopecia, as a consequence of electric shocks on the head.

All these lead to psychosomatic symptoms that we always have to bear in mind in order to be able to respond quickly and efficiently. A few representative examples are: headaches, sexual disorders, and pain all over the body.

It is natural that these sequelae also find expression in their...
The Medical Rehabilitation Center for Torture Victims, MRCT, is situated in Athens.
and optimism, as well as the conviction that solutions can always be found.

Physiotherapy (irrespective of the doctor’s order) plays an important part in completing the rehabilitation task. Only when we believe that this is a part of a holistic approach to care can we meet the demands of this work.

I would like to conclude the picture of our Centre by drawing attention to the fact that all our services, by whoever they are offered, close in a circle that starts and ends at the same point of view – that our client is a highly complex human being with needs at many levels.

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**CENTRE PRESENTATIONS**

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**TORTURE WORLDWIDE**

**Cases reported from MRCT, Athens**

**Case I**

The couple came to Greece via Turkey in November 1991, without passports. They presented themselves to the Greek authorities in order to seek political asylum. At the same time they were taken under the care of a responsible organization for refugees that provided financial support, food, and meal coupons. They lived in a small house in the centre of Athens. The husband worked occasionally.

The social worker in charge referred them to our Centre with two requests. First, to be medically examined. Also the eventual issue of verification, i.e. that they were torture survivors, would let her propose them as special cases for emigration to another country, since the Greek authorities had previously rejected their application.

Second, that we take care of their health problems, including mental health, which were the following:

1) During detention the husband had been subjected to falanga, la barra, and electric shocks to the genitals, resulting in a lesion of the right ankle, pain in the lumbar spine, frozen shoulders, and occasional pain in the genitals.
2) The wife had been burnt with a hot rod on the soles and all along her legs; she had been subjected to electric shocks on the head, and sexual abuse; the result was scattering in the lower limbs, partial baldness, and depression.

They underwent a thorough orthopaedic examination; the medical director of our Centre, a dermatologist, attempted to cure the wife's baldness; scrupulous gynaecological and microbiological tests followed.

We suggested a series of physiotherapy sessions for the husband and a programme of sessions with our psychologists for both of them.

So we had to face a number of health problems that needed time to show amelioration. At the same time the husband refused to accept reality and to adapt to it. Refusal in cooperating was for him a way of resisting provisional half solutions. He insisted either on being fully recognized or on being helped to emigrate. Only under these conditions would he cooperate. He gave up physiotherapy after the first appointments, leaving it for "some other time".

The wife, a young woman, faced reality through her own sadness and loneliness. I have to admit that she struggled from another perspective for the same goals and with much love and care for her husband as well as their relationship. In this vein of thought, common psychotherapy was rejected by him from the beginning, and the wife came to almost all the appointments alone.

When the two social workers met, they came to the conclusion that, once the immediate medical needs had been provided for, all the attention should be focused either on finding some work, preferably for both of them, because their subsidy would run out soon, or on their being accepted by another country.

At this point, one member of our volunteer group acted quickly, and, with the help of our Centre's social worker, we obtained from the city council of Attiki the disposition of a little apartment that could cover the immediate need of shelter and which was given to the Centre. This happened just at the time when their landlord asked them to leave the house.

We judged the situation impartially and decided to give them the flat. At a meeting of the social worker with the couple, it was explained to them how the flat was found, how the decision was taken to give it to them, which were the obligations, and what we expected from both of them in the future. They had to promise that primarily they would try to find work so that they could meet their expenses. Also that they should try to promote the issue of their emigration through other organizations. Until all the necessary steps with the city council were taken, the couple had to stay in a hotel. The cost was shared by two organizations.

We had to go through various phases until they were finally settled in the apartment. First, the city council had to be informed. Next, the other tenants had to accept them. We met serious resistance. The meeting was so difficult and painful that we had to keep the couple away from the dispute between the social worker and the tenants. The furniture was provided by a coordinated effort of the social worker and the volunteers so that all necessary items could be supplied quickly. After this, a volunteer who had been by their side from the beginning, and had been present throughout the whole procedure became the link between the couple, the city council, and our Centre.

Some time after their settlement the social worker visited them at their place. It has to be pointed out that the husband took no part in the whole procedure of setting up house. He was present during the visit though. The news was remarkable. With restrained joy they informed us that – I cite literally – “their relationship with the other tenants was desperately good”. Neighbours were assisting them to get established, they offered sweets and items for the household, they
introduced them to possible employers, and generally declared that they were available for every need.

I have to admit that, even if this sounds non-professional, this was very touching and unexpected. Their progress met no difficulties from then on. Information passed on through the volunteer helper, who had established a close and permanent relationship with them by then.

Quite some time later, the husband called at the office, something which had never happened before. In very good Greek he asked us to visit them and at the same time informed us that he was working in his own profession permanently. So our prime goal, to secure them a social life, was achieved. Our secondary goal, to obtain political asylum, or to be resettled, is still to be attained.

Case II
This Iraqi couple came to the island of Samos in January 1993 in a little boat, via Turkey by the usual way. They had no passports. As they had been informed by other Iraqis, they turned to the competent UN office for recognition as political refugees. They came to our Centre in March 1993. She was already in her 7th month of pregnancy with intense signs of anxiety and neglected state of health. He had severe symptoms of depression.

We considered that the case was urgent and that it had to be dealt with on many levels, irrespective of recognition by the UN or Greek authorities. This made our task more difficult since we could not easily offer the services we wanted to and should provide.

He met the psychiatrist of our Centre, who prescribed a pharmaceutical back-up which would enable him to attain the tranquillity needed in order to give us the information necessary for further cooperation. During his detention he had suffered electric shocks, burning with steam, tearing off of nails, and injuries from a pointed instrument.

At the same time we had to take care of appropriate nutrition, and check-ups for her and the fetus. Friendly doctors undertook the necessary pre-natal examinations in a public hospital, without the normal formalities.

Simultaneously, the case was referred to another organization with the request for food supply at regular intervals. This was achieved.

While the sessions with the psychologist continued, the suspicion arose that she suffered from epileptic fits. We had to take her to a public hospital in order to be able to justify the necessary medical care and to have all the necessary tests for her epileptic fits. Drug therapy was prescribed, but we had to confront the major problem of purchasing medicines. We had to search everywhere for sources in order to cover this permanent expense. Since we failed to obtain social service funding, we had to solve the problems within the limits of our Centre's capacity. At the same time the husband underwent a total check-up, the results being that he was not in need of major treatment, just physiotherapy.

As time went by we got a more complete picture of the couple. Medical problems had been dealt with, the social worker had visited their home repeatedly, psychotherapy was continuing, and medicine and essential food were provided. But their relationship and the picture each of them presented did not improve. At times the couple were in deep conflict, at times they simply managed to co-exist.

The social worker and the psychologist decided that it was best for all concerned if the wife could be removed from the household for a short while. There were 3 reasons for this: to relieve the tension between the couple, for better nutrition and health control, and to be certain that she would be taken to the maternity clinic in good time.

After the necessary contacts and correspondence were completed, she was accepted by a special centre, although she did not fulfil the requirements. The social worker there and the doctor took on the responsibility until the day she would give birth, but then she would come back in the care of our Centre. There was constant cooperation between the foundation, our Centre, and her throughout the whole procedure.

At the same time work was found for him. The psychologist was in charge of preparing him for this because it involved treating metals and sharp objects, something that could revive memories of the abuse he had suffered.

The period prior to the delivery of the wife was the quietest and most controlled time for all of us. She gave birth to a boy on 31 May 1993 in a public maternity hospital under the best conditions. Before she was discharged she had been instructed by the nurses in the fundamentals of caring for the baby and herself.

Her return home opened up a new cycle of troubles. Worrying about real adversities, the presence of a third person, i.e. her new-born child, rejection of their application by the UN, and the loss of the husband's work contributed to the instability. Sessions with the psychologist started again on a weekly basis.

The baby's nutrition and health are now primary concerns. A volunteer organization offered to provide nappies and baby food, a private paediatrician took over the supervision of the baby's health, and a gynaecologist, also private, the mother's health. Clothes for the whole family were found by the Centre's volunteer group, and one member offered a subsidy for the little boy's needs for as long as necessary.

We got in touch with the municipality where they live and requested housing to improve their living conditions and relieve them from having to pay rent. We have not yet succeeded with this. Not long ago the baby was baptized according to their wishes in their parish church – a small celebration was organized. At that time, and after we had considered all the immediate needs that were covered, we took steps to come into direct contact with UNHCR about a re-examination of the case. The whole file was sent to them and a new date was set.

Our present experience is that this multi-levelled and many-sided way of dealing with a case usually brings about a change in the people for whose benefit it is meant. This is expressed in an improved ability to concentrate, and increase in the ability to organize their needs on a steady basis, and in better relationships. In the present case, this change did not occur, at least to the extent we expected.

The man's best moments were when his son was born, at the baptism, or when he occasionally found work. For the rest of the time he hardly contributed to the rehabilitative efforts in a positive way. He retreated deeply into himself and from the things that were happening to him. The wife was unable to organize herself and expected too much from her husband. She asked for his cooperation when he was unable to cope, or she demanded services and benefits from outside the family. Their disputes became so intense very often that
she felt obliged to leave the house – but now there was also the baby.

After the last and most serious fight we sent her with the baby, after thorough consideration, to the shelter for abused women, where she stayed for a few days until she decided to return home. At that time we got the answer from the UN that they had been accepted as political refugees. The file we

had sent played an important role in that decision. It means that the family now gets a monthly subsidy, and medical pharmaceutical care is secured.

Our Centre now keeps the social worker informed; from now on she is in charge of the couple. Future responsibilities and services are distributed and coordinated between the two organizations.

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**PERSONAL COMMUNICATION**

**A report from death row**

*Pierre Duterte*

Even though I am a fierce opponent of the death penalty, it is not my purpose to write an article against this barbarism. I would rather try to explain how a democratic country can torture its own citizens confined to the death row, even if its Constitution, in its Eighth Amendment, forbids cruel and unusual forms of punishment.

We must not forget that this torture lasts about 9 years, the average interval from sentence to execution. Some inmates who for various reasons drop their appeals, to reach the end quicker, endure it for at least 3 or 4 years. Most of them fight and hope until the end, and this end may occur after 17 or more years of “surviving” in this hell.

In the Texas death row, the daily torture consists of humiliations, the most common of which, and the most frequent, is the strip-searching. In fact for those who are not in the work programme (to make uniforms for the guards who will drive them to their death), every time they have to go out of their cells, for any reason, they have to go through the complete strip-searching (sometimes by women!).

There is a total lack of privacy in death row. One side of the cell (1.50 by 2.75 m) consists only of 14 bars covered with wire-mesh; they live in this space, as wide as an average bathroom, 24 hours a day on Saturday and Sunday, 23 hours a day from Monday to Friday. Even the little amount of “own property” is regularly “visited”, broken, destroyed during “major shakedowns”. In summer the heat in these cells is often over 30°C or 35°C, and, by contrast, it might be freezing in winter.

To live in such a row is to be in permanent contact with noise. One of my correspondents told me that what he missed most was silence, peace.

Lack of medical care and treatment is also torture. There will be a lot to say about this subject, and about the so-called doctors practising in death row. The “quality” of the food is also very special; one of my correspondents wrote to me that he would not give it to his dog, and that some guards spit in the tray before slipping it under the door.

To enter death row makes it impossible to have any physical contact with anyone except the guards and the other inmates. You are never allowed to shake hands, embrace, or give a kiss to your wife, children, or friends, even on the day of your execution. I have seen death row inmates in the visiting room “kissing” their wives by putting their lips on each side of the narrow little window, made of bulletproof glass. I have personally “shaken” the hands of my correspondent by striking my hand on this same glass in front of his hand on the other side.

What, except mental torture, can justify the fact that the inmates in Texas death row are not now allowed to buy cigarettes? So now they are smoking what they can: cotton, tea leaves, etc. And that they might not soon be allowed to watch TV!

The sexual abuse that you can be exposed to if you don’t give a “strong” image is obviously one part of the everyday fear you have to live with while surviving in this place.

Don’t you think that to be walking with an escort and hearing these men shouting “dead man walking” can be compared with torture? And how is it possible to justify the practice of sending death warrants to the death row inmates, letting them know two or three months before the execution that a date for it has been set?

Isn’t it torture to have to go through the appeals process, expecting every time a new trial, a re-hearing; to see the inmates next “door” to you going to be executed, “leaving” for the death-watch cell, then being taken for their last drive to the execution chamber, and coming back, until the day he will not come back.

Isn’t it torture to have them deduct the shortening time, day by day, hour by hour; to start the execution protocol two or three days before the time of your end; to have guards living with you, next to you, every minute of your last 2 days; to have them asking you mandatory questions: Do you understand what is going to happen to you? – What would you like for your last meal? – Would you like to make a last statement? – What would you like to be done with your dead body? – To whom shall we give your properties? – To whom shall we give your money? – Who will assist at your execution? – Do you know what we are awaiting from you? – Do you feel at ease? – If not, what can we do? – If you don’t get a stay of execution, to whom would

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you like to phone? – What will be your last meal? – What is the colour of the clothes in which you will die? Isn't all that torture?

Can you imagine what it can be for a man to be driven to the prison where the executions take place, and see the trees, the sky for the last time, and then to wait there for a few hours? The first of my correspondents to be executed wrote to me how he lived in the death-watch cell the second time: 70 men spent their last hours in this cell. While I was in death row, 44 men were executed. I knew that they had used the same sink, the same toilet, had slept or stayed awake on the same bench where I was. Pierre, I could “smell” their presence. I could smell one odour, one constant odour that never left me. Strange as it may be, I think this was the smell of fear that was staying, left there by so many condemned men. You know I don’t feel courageous, because my odour is now melted into the smell of those who didn’t come back.

To be carried into the execution chamber, to have 2 IV tubes inserted in your arms, or in your groin if no veins are found, to have an anal plug and a penis catheter inserted to keep the place clean! To be strapped to a gurney, waiting for the legal time of hearing the warden reading the execution order, waiting all the time, until the last second, for a so-wanted stay, and if it comes, to have all that removed, to be brought back to your cell, just to be waiting for the next execution date. Isn’t all that torture?

Recently one inmate got a stay, went back to his cell, and the stay was lifted a few hours later, so he was brought back again to the death chamber and in fact executed. He had two executions separated by only a few hours. Isn’t that torture? I knew an inmate who was executed after his seventh date! And after 17 years of such treatment.

What can we say about a justice system in which two judges from the Supreme Court declare that to execute an innocent is not against the Constitution, providing they have had a fair trial?

If, as is my opinion, there is no use for legalized murder, it is obvious that there is no justification for such mental and physical torture; there is no way to understand the purpose of such torture, unless you admit that you have to kill “the head” before you kill the body.

I don’t forget the victims of some of these men. I have been the doctor of the mother and family of one of the last men to be guillotined in France, and I am still the doctor of the mother and family of the girl he raped and killed. I have known these two women for more than 10 years, I have been in front of two mothers facing the same pain, enduring the same horror. I have seen one family, not guilty of anything, destroyed socially and morally. Enduring the torture of infamy!

Physician participation in capital punishment


1. An individual’s opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in an execution. Physician participation in execution is defined generally as actions that would fall into one or more of the following categories: (1) an action that would directly cause the death of the condemned; (2) an action that would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; and (3) an action that could automatically cause an execution to be carried out on a condemned prisoner.

2. Physician participation in an execution includes, but is not limited to, the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution.

3. In the case where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; consulting with or supervising lethal injection personnel.

4. The following actions do not constitute physician participation in execution: (1) testifying as to competence to stand trial, testifying as to relevant medical evidence during trial, or testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case; (2) certifying death, provided that the condemned has been declared dead by another person; (3) witnessing an execution in a totally nonprofessional capacity; (4) witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a nonphysician capacity and takes no action that would constitute physician participation in an execution, and (5) relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.
Health Professionals Network

An AI initiative:

A meeting of representatives from Amnesty International’s Medical Network was held in London 19-21 May 1995 on the 21st anniversary of the formation of the first Medical Groups. Thirty countries were represented, and some of the action points from the meeting are described in the following.

One significant outcome was the unanimous decision for the Medical Network to carry out a medical campaign addressing certain specified medical issues. This campaign, to start in May next year, will be the first of its kind in AI’s history.

An Examination Network dealing with examination procedures of torture survivors was established, with the Dutch medical group as coordinator. This network will exchange views and information, and it is hoped that in the future it will be able to offer participation in seminars and other teaching sessions dealing with medical aspects of torture.

There was in general a strong wish among the delegates for the communication lines in the Medical Network to be strengthened in order to increase the quality and quantity of work. Many aspects of the work in AI contain elements of medical relevance, and the Medical Network has therefore called upon the International Secretariat to ensure an upgrading of the medical office.

Many other aspects of medical human rights work were discussed, e.g. medical actions, education in medical ethics, the death penalty, organ transplantations and doctors at risk. Dr Ata Soyer, the President of the Turkish Medical Association, spoke about the grave human rights violations in south-east Turkey, and he also referred to the obvious problem that some Turkish doctors are educated by and working for the army.

At the end of the meeting the “London Declaration” was agreed upon specifying the role and objectives of health professionals within AI.

Morten Ekstrom, MD Delegate from the Danish medical group

Health Professionals Network

London Declaration

On the occasion of the 21st anniversary of the establishment of the first Amnesty International Medical group, this meeting of representatives of the Amnesty International Health Professionals Network, which consists of physicians, nurses, psychologists, dentists, students in the health professions and others with a special commitment to health and Human Rights throughout the world:

Believing that health professionals should defend and promote Human Rights as an inherent part of their activities to promote health and well-being;

Reaffirms its commitment to the application of health care skills, knowledge and ethics for the defence and promotion of Human Rights around the world, in particular to:

- Free all prisoners of conscience;
- Ensure fair and prompt trials for political prisoners;
- Abolish the death penalty, torture, and other cruel, inhuman degrading treatments or punishments;
- End the denial of medical care as a form of ill-treatment;
- End extra-judicial executions and “disappearances”;

Calls on all health professionals to apply their clinical skills and professional ethics to the prevention of Human Rights violations and the defence of human values;

Urges professional associations and societies to undertake systematic activities to defend those under threat of Human Rights violations and to investigate and act upon all reports of Human Rights abuses by health professionals;

Invites all health professionals to join with the Network, either as members of Amnesty International or independently, to work to achieve these objectives.

London, 21 May 1995
BOOK REVIEWS

Co-dealing, co-sharing, co-learning


When one is requested to review a book, one is obliged to read it carefully, and then... sometimes one is pleasantly surprised.

The book Torture Survivors and Caregivers has the knack of attracting the reader's interest and of holding it undiminished to the end. This is not only because of the importance of the issues that it deals with, but also because of its vivid style - first person singular. This adds directness, and transmits to us the taste of the International Workshop on Therapy and Research Issues (9-13 March 1994, Tagaytay City), the proceedings of which this book consists.

As far as the content is concerned, many important questions emerge in connection with the theoretical part and the practice of dealing with torture survivors. Among the major issues that the book deals with are the global and national aspects of Human Rights work, the concept of psychosocial trauma, the Western biomedical model versus traditional healing practices, the effects on the caregivers of interaction with the torture survivors, and research and ethical considerations. Many other minor problems are also overviewed in its pages, but the most important thing is that all this happens in a very sensitive, human way.

One could comment that such a rich spectrum of issues cannot fit within the narrow limits of a 360-page book. Nevertheless, this does not constitute the main goal of the editorial committee. This book must be viewed as a reflection of the vivid debates developed about the end of the 20th century regarding these significant matters.

Maria Piniou-Kalli
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The horror of the dirty war as seen by the therapist


I am honoured that RCT's Documentation Centre in Denmark has trusted me with commenting on a publication which shakes and appeals to the consciences of professionals working within the field of psychiatry, especially to us who find that psychiatry and the social aspect are closely connected. La impunidad: una perspectiva psicosocial y clinica was written by a group of doctors, psychiatrists, psychoanalysts, and psychotherapists who combine solid and technical preparation with an integral vision of the social context of the personality, and with great respect and dedication for the victims of this scourge of the 1970s, especially in the southern part of the American continent. Government-supported terrorism with its aftermath of disappearances, murders justified by "order", torture, violations, and separation of minors. From an initial and strictly clinical perspective, and from the cases who received therapy, the authors develop their reflections, especially on the significance of the process and even more on Impunity, this untouchable barrier which the torturers and the murderers, as unlawful holders of the power, spread among themselves. This took place in spite of the fact that, officially, the period of dictatorship has ended, thus enabling the passing of laws which exonerate the perpetrators and transform them into representatives of law and order who merely obeyed their superiors to protect the higher social values.

The lack of sanctions against crimes prevents justice and legislation from fulfilling the functions of symbolic restoration, regulation, and social cohesion. As with a child, the omnipotence is brought to reality by accepting a symbolic order, by some rules and some delimitations. In society, legislation determines unacceptable behaviour and the sanctions against it, even though it does not restore life nor the goods that were lost because of a crime; however, it contributes to the restoration of order. The processes of grief and restoration, which allow the survivors to put the traumatic events or the lost memory of being loved into the past, and which qualify them to reassume their positions in the social context, are possible if there is a reference to respect.

The authors are very careful and accurate in their exposure of the attempts of those in power to conceal their crimes. These attempts were initiated with a depersonalization of the information, with the intention that people would eventually get tired of the many unpleasant pieces of news, and later on with the intention of putting the blame on the victims - i.e. they must have done "something" to deserve this treatment - and the psychological and psychiatric explanation of the behaviour of the persons who protest and claim their rights: las madres de la Plaza de Mayo are the crazy women from la Plaza de Mayo.

Furthermore, the authors analyse the consequences of this process of social irresponsibility and elimination of the law: the extreme feeling of fear, the total lack of social protection, lack of confidence in the judicial system, the increased aggressive behaviour, the tendency to take the law into your own hands, the tendency to ask for tougher penalties - among these the death penalty. All this emphasizes the fact that those who discredit the law by giving pardon to people who are responsible for the most horrible crimes are the same ones who propose capital punishment.

Marta, a 15-year-old girl, seeks treatment because of a crisis of paranoia; Juan, 17-year-old, son of a disappeared parent, with a new father, reaches crisis point when faced with possible military service; Maria, torture survivor, wife and mother of disappeared persons, with whom we share the horror of horrors; Oscar and Ana Maria, two families destroyed by the impunity; Susana, who represents the conflict.
Creating hope in times of disaster


The war in former Yugoslavia represents a serious threat to many of our ideals and visions for the future. The war that has been called a “blow to modernity” has proved what we thought would be impossible just a few years ago. And what was believed to be the great chance of uniting forces in Europe for peace and prosperity as the wall came down has developed into a scene of indeterminacy, disagreements between neighbours, powerlessness, and shame.

Our hope for a multicultural and multietnic society has also been severely hit by this war: it is a war that may make the word nationalism mean ethnic purity, and peace a process where the only option may lie in the separation of one-time brothers and sisters.

It is a war that has systematically taken into use the only gender-specific weapon that exists, namely organized and well-planned mass rape as part of an overriding strategy – ethnic cleansing. And by aiming systematically at women, and by attacking what may be seen as womanly values, a vital part of society is targeted. Through mothers, daughters, and wives, all aspects of society are “effectively” affected and potentially destroyed.

The international response to the atrocities from the international humanitarian aid organizations has been marked. Many of the projects initiated deal with the psychosocial effects of the war, aiming at interventions after trauma and loss, and at preventive actions of different kinds. In Europe the EU organizes and finances many of the existing projects in collaboration with NGOs and other relevant institutions. One project is BOSWOFAM, initiated by IRCT and implemented in both Bosnia-Herzegovina and Croatia, a project that is now well documented in this recently published book.

Facing the hopelessness, the massive traumas, and the extreme need, one may ask where to start and how, and whether it is psychology and psychosocial assistance that is needed. The book answers these questions well, both directly through references to research and the authors’ own observations, and indirectly by describing the core experiences of the refugees, the programme implemented, and the reflections of the helpers.

It is a multidisciplinary and multicultural team that developed the BOSWOFAM projects of psychosocial support for women and their families, and it is the many voices in the projects that are heard in the book.

The book contains an overview of the planning and the working objectives, underlining the point that formulating this is something very different from implementing the actual work. Central aspects of the refugee experience are described, as well as the contribution to the project from the different professional positions. We are here presented with some of the difficulties as well as some of the hopes the helpers had when entering the project. Vulnerable groups are described at more length, and we are brought close to the human traumas, as well as to the possibility of moving from despair to hope. Assessment of psychosocial status is discussed as a means for planning, selection, documentation, and evaluation, and the book contains “a collection of measuring instruments that we used in the diagnosis of psychological disturbances and assessment of therapy of the refugees and displaced persons” (p. 9). This collection, a relevant bibliography, together with the reflections on the helpers’ situation and the organization of a team, makes this book not only interesting from a professional point of view, but also useful in everyday work with survivors of war and trauma.

Its great strength is that it describes work that has been realized in an extraordinarily difficult context, and where more than 10,000 refugees have been assisted. We are told about how help was planned, given, and received; the authors share many insights and accounts from their professional experience with refugees under these circumstances.

As readers we have been well notified that it is not a textbook on traumas or a theoretical book on therapy. It is a
presentation of a project for psychosocial support under wartime conditions. But despite this I would have welcomed more discussion on the central issues of therapy and assessment/diagnosis since these represent the backbone of the project. The project clearly aims at empowering, social rehabilitation, and non-pathologizing, but heavy focus is given to therapies of different kinds and to psychiatric assessment. Working in the midst of crisis it seems relevant to raise the question regarding assessment of problems and pathology in relation to a resource-oriented approach drawing on narrative and new understanding. This may well have been part of the conversations with the active participants in the projects. But I had wished to take part in it. The experiences that are described are recent and vivid, which is what I like about the book. But perhaps a follow-up would be possible at some distance, where this discussion on the priority of assessment, diagnosis, and therapy could take place in relation to other ideas in the field.

The team has given us an important document both on needs and on ways of intervening. Their experiences inspire professionals, and show that it is possible.

Nora Sveaass, psychologist
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**Doctors’ dilemma in hunger strikes**


When doctors are involved in hunger strikes – and in particular when there is talk of forced feeding – they are confronted with a dilemma; on the one hand they have to save life as far as possible, while on the other they have to pay attention to three ethical principles – respect for the individual, man’s right to decide for himself (autonomy), and finally the well-known principle of the Hippocratic oath “above all do no harm”, since forced feeding in itself is fraught with serious, sometimes fatal, risks.

These dilemmas are dealt with soberly in the publication of the Johannes Wier Foundation for Health and Human Rights Assistance in Hunger Strikes; a manual for physicians and other health personnel dealing with hunger strikers. The booklet begins with the chapter on hunger strikes from the report *Medicine Betrayed* of the British Medical Association, published by Zed Books in 1992, dealing with the phenomenon during the last three decades, especially within the United Kingdom but also outside it.

The next chapter, written by Dr. Jeanne Smeeulers, deals with the practical description of what happens to the hunger striker from a medical point of view. It also emphasizes relevant guidelines for the doctor. At the beginning of the fast, the hunger striker should be given access to an independent doctor whom he trusts, to make a “statement of non-intervention”; this is in use in The Netherlands, where a “doctor of confidence” obtains information about the hunger striker’s wishes, including informed consent concerning what he wants the doctor to do should he become confused or unconscious. The information given is short, precise and valid, but even so it ends up with:

“... it can be stated that medical practice shows that the method [: artificial feeding], to put it euphemistically, cannot be considered a perfect treatment” (p. 20).

The third chapter, “Doctors and hunger strikes; a legal approach” by Sjef K.M. Gevers, Professor of Health Law at the University of Amsterdam, contributes with a discussion about forced feeding, incompetence resulting from the refusal of nourishment, and a personal, free decision on a background including the Declaration of Tokyo, accepted by the World Medical Association in 1975, and the Declaration of Malta on Hunger Strikers, adopted by the World Medical Assembly in 1991, revised in Mabella in 1992 – both can be found in this publication. This discussion will help doctors to solve the dilemma, but the involved doctors will still have to consult their own consciences and professional ethics.

Forced feeding is still practised, and the methods have not changed during this century. The publication is therefore valuable for all doctors. They may suddenly be put in a situation in which the authorities demand their professional skills to be used to “save” a hunger striker’s life.

The booklet’s guidelines are suited for countries in which the doctors are on the patient’s side. But not so much in countries where the doctors must first serve the system, and where the doctor, wanting to follow the principles of the Tokyo Declaration, for example, runs a great risk for himself and/or his family if he does not obey the system by refusing to participate in the forced feeding.

It is commendable that the booklet has worked out guidelines and given a model for a “statement of non-intervention”. The Malta Declaration is a step in the right direction. The next step must be, as in the Madrid Declaration, to get the medical associations of the member states to implement the guidelines in their respective countries, to establish an organization to which doctors can apply for protection if they are placed in a situation in which they have to participate in forced feeding of hunger strikers.

It would be desirable for this publication to reach all doctors and their organizations in order to continue the process. The publication contains a questionnaire, the answers to which will be of value for this work.

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**NEWS IN BRIEF**

**ISTSS elects 1995-96 directors, president-elect**

The International Society for Traumatic Stress Studies (ISTSS) has elected six new directors and a president-elect for its 1995-96 Board of Directors.

Terence Keane, PhD, president-elect, will serve as president for the 1996-97 Board. Dr. Keane serves as Chief, Psychology Service, Boston V A Medical Center; Director, National Center for PTSD; Professor of Psychiatry (Psychology), Tufts University School of Medicine, all in Boston.

The new ISTSS directors are: Susan Solomon, PhD, National Institutes of Health; Rachel Yehuda, PhD, Assistant Professor of Psychiatry, Mount Sinai School of Medicine, New York; John Fairbank, PhD, Senior Research Clinical Psychologist at Research Triangle Institute; and Jessica Wolfe, PhD, Director, Women's Health Sciences Division, National Center for PTSD.

Mary Beth Williams, PhD, LCSW, CTC, Trauma Recovery Education and Counseling Center; and Alexander McFarlane, MBBS, MD, Professor of Community and Rehabilitation Psychiatry, University of Adelaide, Australia, have each been elected to serve an additional term.

Continuing their ISTSS director terms in 1995-96 are: Sandra Bloom, MD; John Briere, PhD; Charles Figley, PhD; Edna Foa, PhD; David Foy, PhD; Ellen Frey-Wouters, PhD; Fred Gusman, MSW; Dean Kilpatrick, PhD; Robert Pynoos, PhD; Susan Roth, PhD; Bessel van der Kolk, MD; and William Yule, PhD.

Matthew Friedman, MD, begins his term as 1995-96 ISTSS President and Elizabeth Brett, PhD, becomes Past President.

The newly elected directors will serve three-year terms beginning November 4, 1995.

ISTSS directors leaving office are: Arthur Blank, Jr., MD; Arieh Shalev, MD; Tom Lundin, MD, PhD; Wybrand Op den Velde, MD; and Norman Milgram, PhD. Charles Mar­mar, MD, retires as Past President.

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**NEW PUBLICATIONS FROM IRCT**

**Physiotherapy for torture survivors**


After several years of experience in treating torture survivors, the physiotherapists at RCT are now the editors of a book based on presentations at international seminars on the treatment of this very specific group of clients.

There are introductory chapters on methods of physical torture and their sequelae, on the interdisciplinary treatment model at RCT, and on the physiotherapist’s ethical considerations. Other chapters deal with physiological pain mechanisms used in physiotherapy, the whiplash syndrome, and “falanga”, the very specific torture method of beating the soles of the feet and with its sequelae and treatment.

Since the WCPT in July 1995 in Washington D.C. adopted a declaration stating that “education regarding the prevention and prohibition of torture as well as the assessment and treatment of torture victims should be included in the curriculum for undergraduate and continuing physiotherapy programmes” (revised wording of the original London 1991 declaration), this book would be a natural choice to enter into the curricula of all schools of physiotherapy. But any physiotherapist in practice – as well as other health professionals – who might treat patients from countries in which torture is practised, should find valuable information in this publication.

As has been customary for several of IRCT’s publications, the cover is a very beautiful and bright design by RCT artist Mr. Néstor Guerrero. This creates a fine contrast to the often sombre aspects of IRCT publications.
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**RCT**  
The Rehabilitation and Research Centre for Torture Victims is an independent, humanitarian, non-political organization established in 1982 to help victims of torture and to contribute to the prevention of torture. Its main objectives are to rehabilitate persons who have been subjected to torture, to rehabilitate their families, to instruct Danish health professionals in the examination and treatment of persons who have been subjected to torture, and to carry on research into the nature, the extent and the consequences of torture.

**IRCT**  
The International Rehabilitation Council for Torture Victims is a private non-profit foundation, created in 1986 by the RCT. The objectives of the foundation are, on an international basis, to support research into all aspects of torture, to support education and training of health professionals and of other relevant personnel in the medical, social, legal and ethical aspects of torture, and to serve as an international clearing house for information about torture activities.