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INTERNATIONALISM AND LAW-MAKING

1996 may see the summoning of an international diplomatic conference to give the final touch to the statute for an international criminal court - the first of its kind in the world. Its task is to punish grave crimes against the law of international humanitarian law.

The courts on ex-Yugoslavia and Rwanda are already in existence, though public procedures against individuals remain to be seen. The first court was set up two years ago, the second is only half a year old. The new efforts to construct a court for the whole world are far more ambitious than for the other two.

The world has certainly not lost its impetus, despite much recent disappointment concerning respect for international law principles. The peace accord on ex-Yugoslavia did not mention the two most wanted war criminals of that war: the Bosnian Serb political leader Radovan Karadzic and the military commander Ratko Mladic. Efforts failed to include words in the peace document on their delivery to the war tribunal in The Hague.

It is remarkable that the world continues to work on a permanent criminal court for the whole world, irrespective of the problems just to have the legal apparatus working with two countries on which international justice has been imposed. Nobody asked Croatia, Bosnia-Hercegovina, or Serbia whether they would accept the Hague Tribunal: the world at large demanded such a body, as it later agreed on the equivalent for Rwanda. But the jurisdiction for the coming world court will depend on its acceptance by each country of the world.

People of a certain age can remember the outcome of the Nuremberg judgements in 1946, when ten prominent Nazis were executed, others were condemned to prison, and a few were acquitted. Nuremberg could not easily be copied - the statute of the court was framed by the five victorious powers, which is in perfect line with commonly accepted international law. More than 80,000 Nazis were later convicted by allied, West German, or East German courts.

No dictatorship, after being replaced by a new political system, has experienced such a thorough legal battle as the one against the Germans. Despite much development in the humanitarian principles of international law since then, a host of ex-dictatorships have given higher priority to national reconciliation than to justice. The impunity for army and police officers as well as some medical doctors in, for instance, Argentina, Chile, and Uruguay, has been strongly criticized, particularly by medical NGOs.

Yet figures on atrocities committed in countries in all parts of the world since the Nuremberg process are frightening: according to Richard Goldstone, Chief Prosecutor at the Hague Tribunal, 160 million people are considered victims of war crimes (mostly in civil wars) since then. Many wars have 'invented' new forms of inhumanity: use of brain washing in the Korean war (1950-53), use of various biological weapons in the Vietnam war (1958-75), ethnic cleansing in the ex-Yugoslavia war ... It may be called paradoxical that the men of power, together with modern technology, brutalize war as such, whereas humanitarians and lawyers simultaneously do their utmost to create an international network of justice!

In 1949 the International Red Cross Conventions provided minimum rules for the treatment of civilians and prisoners of war which included the prohibition of torture, but the UN did not get its own convention against torture until 1984.

This convention, the cornerstone for all the work done by the IRCT, demands that each participating state make torture an offence under its criminal law. It allows for the persecution of the torturer wherever he is. The primary purpose of the convention was to define torture, something that had not been done before, though it was already prohibited in the European Convention of Human Rights of 1950 and the UN Human Rights Covenant on Civil and Political Rights of 1966. Since then, statements at many conferences, not least by medical doctors, have condemned the use of torture and appealed to governments not to grant impunity to torturers.

To the regret of the international community, the need for peace and reconciliation has made impunity the rule rather than the exception in newborn democracies. South Africa has appointed a Truth Commission, which began its hearings just after the new year 1996. The idea behind this body is to at least to reveal the evil of Apartheid to all South Africans as well as to the world - but not necessarily to bring justice, considering the tremendous obstacles in the way. Heavy political problems burdened the commission from the very start; former State President P.W. Botha refused to witness before the commission. He therefore risks up to two years imprisonment according to the new South African Constitution.

Amnesty International, as well as the Watch Committees and other NGOs, continues reminds us of gross human rights violations, not least the widespread use of torture. Smaller countries such as Denmark have not escaped the watchful eyes of the human rights fighters, and a few foreigners have been compensated by the Danish state after being maltreated by immigration authorities. Worldwide, a handful of countries have punished policemen and military officers for the same offence.

There is a need to distinguish between systematic use of torture and the occasional failures of countries that normally make an effort to maintain a clean human rights standard. Nowadays there is also a need to reconsider the effect of many campaigns against impunity. Apparently the results of them have been depressingly small.

The three proposed criminal courts express the patient search for justice - a message that, it is hoped, will be conveyed to the organizations and parliaments of all the members of the world organization, including those of Croatia, Serbia, Bosnia-Hercegovina, Somalia, Liberia, Angola, China, Iran, Iraq ... and others. In realizing the non-violent society, in which torture and killing is abandoned, the wish of the individual citizens as a continuous pressure on their governments is far more important than any international convention or organization.

H.D.
We begin with the basic assumption that every individual belongs in a social and cultural structure. It is impossible not to belong. This belonging expresses itself through different groups and institutions each individual joins along his life (including the primary group, the family), and each of them leaves an imprint by means of different identifications. Belonging may assume various forms. When a person's identity, or main aspects of his identity, depends strongly on one group of belonging, with little autonomy, we may say that his identity is basically an identity through group belonging and that it will be shaped by a number of traits common to that group. A mature expression of belonging, though, leaves open the possibility of joining or turning from the group of belonging. In this case the individual may shift because he has acquired a degree of personal autonomy as regards the group. Mature belonging allows for greater development of the subject's potential.

Certain periods of our life, such as adolescence, require in many societies a strong bond to groups of peers who will support personal identity in the difficult transition from childhood to adulthood. These groups usually wear the same type of clothes, and they share a common language and set of activities that all the members adopt unquestioningly.

Certain social situations, especially traumatic ones, may create or foster in some groups the need to promote belonging with an enhanced "esprit de corps", or to leave strong imprints on personal identities. Such is the case, for instance, of "war veterans", to whom that is a mark of identity, of their social origin that may become an essential feature of their personal identity.

People affected by different instances of political repression undergo a traumatic situation, i.e. a situation in which the degree of aggression/stimulation greatly exceeds the ability of the psyche to elaborate it. Different theoretical views, psychological and psychiatric, have coincidentally described and defined mental trauma. However, the issue has been heavily influenced by economic conditioning. Indeed, recognition of traumatic situations that heavily affect the psyche usually entails the subsequent demand for economic compensation from the part responsible for such situations.

We speak here of traumatic situations rather than trauma, because victims of political repression have undergone several traumatic situations, never a single trauma, as after an accident, for example. Moreover, intentionality of inflicted trauma as a strategy of power constitutes a qualitative difference in these situations. The traumatic situation as we see it is not only a concrete and material threat to physical integrity, or to life itself, but also the multiple and traumatic after-effects produced by the way in which repressive power tries to obtain consensus and the social processing of the situation. In most cases, one aggravating element of the traumatic situation is precisely its being prolonged in time.

On the other hand, affected people usually have to undergo a process of mourning and bereavement, the psychological elaboration of different types of loss. This process of bereavement presents special features when dealing with the loss of a missing person, as we have pointed out previously.

Elaborations of the traumatic situation and mourning are never individual processes, but both individual and social. It must be taken into account, however, that the amount of the loss or of the traumatic situation, or at least some of their aspects, may be virtually impossible to cope with. As a result, it may be necessary, in order to carry on with their physical and psychological lives, to come together in groups with others who have gone through the same kinds of experience. This grouping is based on an identity imprint similar to what we defined as identity through belonging.

This is also linked with the problem of memory and oblivion. The same powers that resorted to State terrorism are actively promoting collective oblivion, obliterating the historical and social inscription of the facts. Therefore, the victims have to undertake not only their personal elaboration of the traumatic situation and mourning, but also the social transmission of historical memory. The latter, as is the case with all historical inscriptions, imports more than just remembering, but a definite alignment regarding the present and the future.

In Latin American countries, the policy of impunity for the repressors demands that the State applies active measures to induce oblivion. And even, as occurred recently in Argentina, in the case of kidnapped twins misappropriated by a police officer, or when the Navy tried to promote some chiefs involved in torture, the Government produces an outright justification of State terrorism.
In the more than 15 years’ experience of our team, while the traumatic situation was in course, the preferred method of approach to psychological elaboration has been the organization of reflection groups in which the victims can discuss their plight. We do not consider that these people are sick, and nor do they, feeling affected by external circumstances. This type of intervention usually takes place in the natural meeting grounds of the group, i.e. where they meet to undertake the social steps necessary to confront their situation (Human Rights Organizations, etc.). These types of action play a preventive role, allowing a personal and social elaboration of the traumatic situation and mourning at an early stage. In previous works we have pointed out the role of the victims’ active participation.

In the particular case of children and youngsters, we believe that it is necessary to minimize the mark of identity (identity through belonging) left by the traumatic situation, and encourage them to open to the broadest possibilities of autonomous development. Thus, in these cases we consider that groups must be handled very carefully and be brief; otherwise we might risk strengthening the identity imprinted by the traumatic situation.

We would like to emphasize that we do not advocate not-remembering. On the contrary. As we see it, the core of the problem is the question of identity. From this prospective, it is inevitable that adults who have suffered irreparable losses should have relevant aspects of their identity imprinted by the traumatic situation. The stronger the social pressure to erase them from historical memory, the more reinforced the personal memory.

In those cases in which the traumatic situation has faded, or at least changed qualitatively in its form (from State terrorism to impunity), or when the psychological scar of catastrophe is very crystallized, we believe that the best approach is individual therapy. Including, naturally, the use of the appropriate prescribed medication when necessary.

Social isolation of survivors of persecution in a post-totalitarian society: the therapist's dilemma

Christian Pross*


After the fall of the totalitarian regime in East Germany, the dissidents who had organized the mass movement that caused the fall of the Berlin Wall in 1989 acquired for a short period a degree of power, social respect, and honour. Five years later they have fallen into oblivion and social isolation. They see their former oppressors making fast careers in politics and business, while they have lost their jobs and live on social security. Therapists are confronted with overwhelming disappointment and bitterness in the clients, who feel that all their sacrifices were in vain. Therapists cannot make up for the social isolation of the client, for the indifference and hostility of the “silent majority”, nor do they have political power to change legislation regarding compensation.

I want to demonstrate this in a case example:

During the period of the East German regime
Mr. T spent two years in prison in the early 1960s as a high school student aged 16 for participating in a dissident student circle fighting for reunification. He was kept in solitary confinement for several months, where his psychological defences were broken and he was sexually abused by a female guard. In the decades after his release he led a fairly miserable life on the fringes of society, in constant fear because his interrogators had told him that he would be under permanent observation. Due to the sexual trauma, he was unable to relate to women. When the mass uprising against the regime started in the beginning of 1989, he was among the activists in the front line in the famous Leipzig “Monday-Rallies”.

* Center for the Treatment of Torture Victims
Haus 6
DRK-Klinikum Westend
Spandauer Damm 150
14050 Berlin
Germany
Mr. T's reaction after the collapse of the regime
After the collapse of the regime in December 1989, he co-founded a documentation and education centre on the crimes of the East German Secret Service “Stasi”. The centre was located right in the belly of the beast, in the former headquarters of the Stasi in East Berlin, a huge complex that had been tainted for years with fear and rumours. Now Mr. T felt an enormous triumph to reside as a former political prisoner and outcast in Kafka's castle like a “king”, as he recalls. It was the happiest period of his life. Former Stasi officers and party leaders encountered him with awe and servility. He gave lectures in schools and at public meetings.

But the euphoric period lasted for only two years. His documentation centre had to close for lack of funds and internal struggles that he believes were fabricated by the persisting Stasi network. He was attacked in the street by men who shouted at him: “Beware, we are still alive!”. Now five years later, the dissident movement having virtually disappeared, he feels isolated, bitter, depressed. He suffers from flashbacks, angry outbursts at family members and friends. Every time he is confronted with reports about impunity for the perpetrators, and the smooth integration of the old nomenclatura into the power structure, his condition deteriorates dramatically. He becomes paranoid and has hallucinations about being followed by Stasi agents to arrest him.

In the therapeutic sessions, all his thoughts repeatedly circle around the same topics: the end of the dissident movement, the return of the nomenclatura, and impunity. He cannot get away from it, he is obsessed by it, and it makes him unable to enjoy the simple things of life. He feels small, anxious, like someone who failed in life – he feels that all his sacrifices were in vain. He paints reality darker than it is, and he minimizes the lasting achievements of the dissident movement, such as the law that grants every victim access to his Stasi file.

It is in fact a historically unique but controversial achievement because on the one hand the files dismantle the frightening labyrinth of surveillance and intimidation, which can have a healing effect on the victim. On the other hand, the files can produce very painful discoveries, such as having been denounced and spied on by a close friend or family member, in some cases even a spouse. Mr. T himself discovered in his file that he was spied on by two very close friends with whom he shared intimate personal affairs.

His present situation
Mr. T isolates himself totally, and spends days without ever going out. He is afraid of going mad. Sometimes he becomes so desperate that he yearns for the good old days of the totalitarian regime, when he knew who his enemies were, when his hatred had a clear object, when he was able to differentiate between good and bad, and when he had an identity as a dissident. Now he feels empty, he feels he has lost his “centre”. He experiences the disappearance of a clear enemy in the new Western pluralistic society as a loss. From being a hero, he has descended to being an anonymous member of the large mass.

It seems as if he clings to his obsessive going round in circles to avoid touching on deeper and threatening affects such as fear and shame. Thus he remains the eternal victim, his therapist being the only person in the world who listens to him and takes him seriously. My counter-transference reactions sometimes change from sympathy and respect to feelings of helplessness, impatience, and anger. I feel as if he is drawing me into his fatalistic circle, with no way out.

My colleagues and I experience the same dynamics as with Mr. T at meetings of former political prisoners, who are looking for an ally in the doctor who can make up for the depressing political situation. We are constantly asked by patients' and victims' organizations to give expert testimony in compensation claims to the authorities and courts. Thus we become caught in the incompatible roles of therapist, politically allied, and independent professional expert – all at the same time.

Selected list of publications
received in the IRCT International Documentation Centre

Projet de thérapie pour réfugiés victimes de tortures : etude de faisabilité / Weiss, Regula. - [Switzerland] : Croix-Rouge Suisse, 19930200. - 59 p. - Also available in German

Spirit is stronger than force : how torture effects the individual and the community / Freer, Robert. - Victoria : Victorian Foundation for Survivors of Torture Inc ; VFST Inc., 19930000. - 24 p. : ill.


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The challenge of human rights and cultural diversity / Ayrón-Shenker, Diana. - New York : United Nations Department of Public Information, 19950300. - 6 p. - United Nations Background Note


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Remedies for torture survivors

The need for REDRESS

Why seek a remedy? - Reparation as rehabilitation

Keith Carmichael, Hon director*, Fiona McKay, Legal Officer* &
William Dishington, Information Officer*

"Systematic state torture is a horrifying aspect of the contemporary world, in some cases well within our power to arrest. Failure to exercise that decisive influence translates simply as direct complicity in the crime" - Professor Noam Chomsky.

The widespread use of torture as a method of repression has been well documented in this journal. It has been estimated that government sanctioned torture occurs in 77 countries throughout the world. Our own research, based on the analysis of the work of several NGOs, suggests that reports of torture or other cruel, inhuman or degrading treatment or punishment emanate from 132 countries.

The Human Rights community has responded in a number of ways. First, as exemplified by the exceptional work of Amnesty International, by publicising human rights abuses and pressurising repressive regimes for the release of prisoners of conscience. Second, and equally impressive, by setting up specialised centres for the physical and psychological rehabilitation of torture survivors. About 48,000 men, women and children were treated for the effects of torture in 1992. Third, though least well developed, by the use of international, regional and national legal mechanisms to provide reparation for survivors and, it is hoped, deter offending governments.

Although this third response might appear to be separate from the other two, REDRESS's experience with torture survivors has led us to believe that, for many, seeking reparation is an important part of the rehabilitation process both for the individual and for the society where the torture occurred. Torture may be perpetrated on individuals and families, but its effects are also felt by the whole social grouping to which they belong. As Dr. Derek Summerfield, a psychiatrist with the Medical Foundation in London, puts it "... Some torture victims seek psychological help but all of them want social justice ... Allied to this is the vital question of official reparation for human rights crimes. Victims may better become survivors if some part of the legacy of the past can be addressed ... Justice, even if long delayed, is reparative ... to assist both distressed individuals and distressed societies ... to endorse the link between psychological recovery and societal reparation and justice".

As the UN Rapporteur Theo Van Boven underlined in his study, reparation should be understood in the widest possible sense to include re-employment or the provision of a new position, pension rights, medical and educational services, social security, housing, restoration of reputation and the revelation of the truth. This last point is of particular importance as Naomi Roht-Arriaza has pointed out "... any victim-centred procedure must put a heavy emphasis on people being able to tell their story fully before a decision maker who is perceived as neutral, honest and attentive. Public airing of victims' stories seems to serve important psychological and therapeutic ends ... more formalized procedures, including the ability to have an advocate and confront and question their victimizers, may be more satisfying for victims than less formal, less adjudicative models ... the superiority of trial-type procedures, either civil or as an adjunct to criminal process, is preferable to more legislative or commission-type procedures from the point of view of victims".

The question of financial compensation needs to be handled carefully so that it is not seen as buying silence from the survivor, but it is nonetheless important in restoring a survivor's way of life and should include compensation for physical and psychological damage, imprisonment and lost working capacity and a punitive amount to deter the country involved from repeating the violation.

Neve Gordon has even argued that civil suits have a number of advantages over criminal proceedings. As the torture victim is the initiator of the lawsuit, there is an organic element in the rehabilitation process. Personal involvement in proceedings helps the individual to emerge from the status of victim to become a survivor. During proceedings, the two sides try to reach an agreement. The torture survivor takes part in the negotiations and decides whether to agree to a suggested compromise, which generally shortens the legal process and provides tangible results over a reasonable period of time. Success leaves the survivor with the feeling that to some degree justice has been done. This sentiment helps the survivor to regain some trust in others, some self-esteem and the hope to regain control over a shattered life. Furthermore, challenging a state can promote the political fight against torture; by becoming part of this struggle, the survivor transcends the sphere of personal responsibility and enters the public domain. This political responsibility is another major step in the process of rehabilitation.

While seeking reparation, it must not be forgotten that the problem of impunity can negate the positive aspects of this process. "It is a general opinion in our rehabilitation movement that although material compensation is of extreme importance, satisfactory rehabilitation can never be fulfilled in a society where impunity exists." 6

Why REDRESS was established

From 1984, Keith Carmichael, a torture survivor, consulted people with extensive experience in human rights, law and non-governmental organisations. Four in particular: the late
Peter Davies OBE, former Director of Anti-Slavery International, Rosalyn Higgins QC, Leah Levin, former Director of Justice, and Professor David Weissbrodt in the USA, shared the same interest in seeking ways to combat torture. Keith Carmichael had also met with over 90 torture survivors, many of whom, like him, wanted to seek redress but did not know how to go about it. While existing NGOs helped survivors of torture in other ways – by campaigning for their release, providing safe havens and medical care – none assisted them to obtain reparation.

In 1990, a concept paper for a new initiative, REDRESS – a programme to focus on the right of torture survivors to reparation and to assist them to seek a remedy – was circulated. The idea was discussed further at the IV International Symposium on Torture and the Medical Profession held in October 1991 in Budapest, and again at the Symposium on Human Rights and Development in December 1991 in Manila. Among others, Eric Sottas, Director of OMCT/SOS-Torture, Professor Bent Sorensen, and Dr. Inge Genefke, participated in the discussion. The conclusion was that there was a need for such a specialised organisation and an action programme should be developed. Keith Carmichael established REDRESS, which was registered as a charity in the UK in December 1992. Since then, REDRESS’s work has been supported by patrons, trustees and volunteers, who have been generous in giving their time and expertise.

Today REDRESS’s activities are a mixture of case work, law reform, research and information and advocacy and campaigning. REDRESS tries to maintain a balance between providing legal advice and assistance to individual torture survivors, and promoting effective remedies for torture at the international and national levels.

The need for reform of international and national law
The right to reparation – including restitution, compensation and rehabilitation – for victims of serious human rights violations such as torture, is recognised in the international law of human rights. The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of 1984 (The Convention) obliges parties (90 states have now ratified the Convention) to ensure that any victim of torture has a right to “fair and adequate compensation, including the means for as full rehabilitation as possible”. Other human rights treaties echo this right to a remedy.

The problem is how to translate this into fair and effective remedies for survivors of torture. Most states which practise torture either do not ratify the international human rights treaties or ratify but fail to implement their provisions. While a country’s laws might clearly prohibit torture and provide for the punishment of offenders, the gap between law and practice is often very wide. REDRESS is now collecting data on national legislation and case law in different states in order to identify not only where there is a remedy on the statute books, but the extent to which remedies are available in practice.

The obstacles in the way of legal challenges are not uniform. Where torture is practised as part of political repression, the obstacles will be primarily related to lack of democracy: absence of rule of law, fear of reprisals, etc. However, as pointed out in a recent article in TORTURE, there are other contexts in which torture takes place, including ill-treatment of ordinary criminal prisoners. Here the difficulties might include lack of will to halt torture and other ill-treatment on the part of the relevant authorities; lack of adequate procedures, training and other safeguards; corruption. The lack of remedies is likely to be linked with impunity; where perpetrators of human rights violations escape justice it will be very difficult to pursue legal proceedings aimed at obtaining reparation.

Where there is no national remedy
When the state fails to take action to deal with serious human rights violations fairly and effectively or at all, an alternative way of holding torturers accountable for their actions is by taking legal steps outside the country where the torture takes place. Historically, the principle of sovereignty of states was understood to mean that leaders could do more or less as they wished within their own borders and it was nobody else’s business. In today’s world, the extent to which leaders responsible for human rights violations are vulnerable to external adjudication is witnessed by the recent instigation of both criminal and private actions against Bosnian-Serb leader Radovan Karadzic. Both actions have been initiated externally: the criminal indictment in the International Criminal Tribunal for the Former Yugoslavia, and the private legal action in the USA.

Nevertheless the international mechanisms for prosecuting torturers remain weak. While a number of states, complying with the Convention, have introduced laws which allow prosecution of foreign torturers, national courts have proved unwilling to implement them. The UK, for instance, made torture a criminal offence under s.134 Criminal Justice Act 1988, but to our knowledge this has not yet been invoked in any case. Moves towards the establishment of a permanent International Criminal Court are proceeding, but it will be dependent on states consenting to its jurisdiction.

One advantage of civil actions over criminal prosecutions is that they can be initiated by private individuals, thereby overcoming the problem of persuading reluctant state authorities to prosecute. Typically, however, the principle that other states and their agents are immune from the jurisdiction of a country’s courts, together with the internationally recognised principles of diplomatic and head of state immunity, block such actions.

Interesting developments have recently taken place in the US, which has permitted its courts to be a forum for suits
against perpetrators of torture in countries where there is no possibility of obtaining redress. Basing their claims on an obscure law passed in 1789, the Alien Tort Claims Act, tens of non-US citizens have sued perpetrators of serious human rights abuses in the US courts since 1980. Since the enactment of the Torture Victim Protection Act in 1992, US citizens have also been able to sue in such cases. The list of torturers who have been sued in the US courts includes: Argentine General Suarez-Mason, Philippines dictator Ferdinand Marcos, Haitian head of military Prosper Avril, Ethiopian official Kelbessa, Guatemalan General Gramajo and Bosnian-Serb leader Radovan Karadzic. In most of these cases, substantial awards of damages were made. The stream of cases was unleashed by the landmark decision of Filartiga, in which a US Court of Appeals in 1980 stated that “official torture is now prohibited by the law of nations” and that the federal courts should be open to adjudicate rights recognised under international law.

Such cases have limited capacity for putting a stop to human rights violations while they are occurring. This is not only because they impose a monetary obligation and not a criminal sanction but also because all those listed above were sued after the event, not while in office. Like many existing remedies for serious human rights violations, the flaw is that they only come into play once the violating regime has fallen. Nevertheless they surely have some importance in making those individuals who carry out human rights violations believe that they will one day be called to account for their actions and that they will not be welcomed in many parts of the world. They also, as we have emphasised, have considerable importance for the individual and collective healing of torture survivors.

American law may soon change so as to allow torturing regimes – as well as individuals – to be sued for their actions for the first time. A new law expected to be passed by Congress soon will allow actions to be brought in the US courts against foreign states for torture and other serious human rights abuses where there is no effective remedy in the state where the violations took place. Although this law will apply only to US citizens, it represents a breakthrough in making states accountable for their violations of human rights.

REDRESS plans to propose similar legislation in the UK in 1996. The principle is already being asserted in the test case of Al Adsani v Government of Kuwait. Suleiman Al Adsani is a dual British Kuwaiti national, a Kuwaiti Air Force pilot. In May 1991 he was tortured in Kuwait. His ordeal included being forced into a pool full of cadavers and being put in a room where petrol soaked mattresses were set alight, as a result of which he was seriously burned. In its decision of January 1993, the Court of Appeal found a good arguable case in the submission that torture, unlawful under public international law, should not be accorded state immunity. This hint that the UK courts may be ready to follow the US example in recognising the principle of universal jurisdiction so far as grave human rights abuses contravening public international law are concerned is welcome.

The Trustees and staff of REDRESS would like to thank RCT/IRCT for their continuing support for our work.

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10. See, for example, the European Convention on State Immunity 1972 and the US Foreign Sovereign Immunities Act 1976
11. Dolly M.E. Filartiga and Joel Filartiga v Americo Norberto Pena­
ria, Court of Appeals Second Circuit 30 June 1980.
12. Lord Justice Evans, Suleiman Al-Adsani v Government of Ku­wait et al, FC3 93/6212/E.
Lessons from the South African struggle

A model of conflict transformation

Terence Dowdall, MA, Senior consultant*

This article is a modified version of the Opening Address at the VII International Symposium "Caring for Survivors of Torture: Challenges for the Medical and Health Professions", Cape Town, 15-17 November 1995.

The 20th century has simultaneously been one of the vilest periods of history and one of the most hopeful. It is the century of genocides - the Hereros, the Armenians, the kulaks, the Jews, the Tutsis, Muslims, "class enemies", and many others. It is the era in which torture has flared up in a wide range of previously democratic states under military regimes, and persisted as before in many autocracies.

But the 20th century is also the first era in history in which a growing international revulsion against human rights abuses, and torture in particular, has begun to surface, and a systematic international movement to outlaw torture and torturers has begun. This is as significant in this time as the movement against slavery in the last century, and is part of the hope of this century.

South Africa was one of the notorious nations which, over the last three decades, engaged seriously in torture in the implementation of state policy. In many ways the South African experience parallels the experiences of other countries plagued by the torture outbreaks of the late 20th century. In some ways it has reflected the specific circumstances and contradictions of the apartheid state. The following words are reflections on some of the lessons of the South African struggle, and the challenges which they set the health professions for the future.

The South African challenges

The first lesson is what we learned through the reactions of the established professional bodies for medicine and psychology, and that such bodies will tend to represent the class interests of the group from which they are drawn. The ethical codes of the professions will tend to be subordinated where these class interests are threatened. The people on these committees are who they are - which is political beings, especially in countries torn by civil conflict. Hence we had the fiasco over the Biko case, when the SA Medical and Dental Council and the Medical Association of South Africa fudged and prevaricated over the disgraceful conduct and dereliction of duty of the doctors whose collusion with security police torture led to Biko's death. With one single exception, the Psychological Association of South Africa maintained a deafening silence in the face of mounting evidence of torture and abuse by the State. The argument always raised was that these were not professional issues, they were political issues, and that professional bodies had a responsibility to remain neutral politically. But in an overtly repressive situation, neutral means acceptance of what is happening, and that is taking sides.

The response in South Africa, as in many countries under repression, was for socially concerned individual health workers to resign from the established bodies, form small alternative volunteer bodies, and work directly with liberation organisations to deliver services to survivors of torture and abuse. The challenge at this period after liberation, however, is to see that affiliation to the liberation struggle does not convert into party political affiliation. It is crucial for the future of the country that NGOs and health practitioners be principle bound and not party bound. Health organisations and NGOs have to be as ready to confront human rights abuses in the new order as in the old.

At the individual level, the district surgeons employed by the state were especially vulnerable to being co-opted to turn a blind eye in their relations with the security forces, and this facilitated much of the torture which went on. The challenge which arises from this lesson is that we have to find ways to make health practitioners sensible of the responsibilities they hold through their calling. The health professions need the most stringent training in their ethical duties in relation to torture and abuse, and medical students need to be rehearsed in the correct course of action when faced with torture.

Several papers at this conference document the encouraging beginning made in South Africa and other countries to fortify medical students against collusion with torture.

The professionals' adverse situation

I have mentioned the alternative volunteer organisations that developed in the health and mental health fields in the situation of widespread repression and torture in South Africa. I wonder if you can imagine the extraordinarily complex position in which these professionals found themselves as they attempted to play out their role of ministering medically and especially psychologically to tortured and traumatized members of the liberation movement.

The vast majority of South African anti-apartheid doctors and psychologists were inescapably and visibly members of the white ruling class, while the survivors and their families, with whom they worked, were for the most part members of the oppressed black working classes. On top of that, doctors and psychologists came with their professional trappings, status, and authority, obtained as their way had been smoothed before them by racial privilege. Within the broad community of health workers they occupied the top rungs of an occupational status pyramid, in a way that was uncomfortably linked to the South African racial pyramid of status and power. It is true that they were mostly members of the English liberal community, but it must be remembered that this community, for all its protests and protestations, was shielded and advantaged because of their whiteness, while the Afrikanders in power did the dirty work.

We were received with extraordinary generosity of spirit
and politeness by the liberation movement, which had real health and medical needs. The basis of acceptance was the political and anti-apartheid position of the health workers, understood through their membership of progressive health organisations which had links with liberation movement organisations.

Problem of competence
The anomalies were, however, still uncomfortably obvious. To add to this there was a further serious problem – that of competence. Of course the doctors could treat injuries, but, as we know, torture brings in its wake a host of psychological and interpersonal sequelae, and this was where further difficulties lay. White professionals – psychologists, psychiatrists, and social workers – had been trained in the Western middle-class tradition and suddenly found themselves in the position of the king with no clothes. The discounting of African languages by the regime meant that most could not speak to African survivors in their own language at all, let alone detect subtleties or nuances. The rigid separation of apartheid meant that health workers found themselves woefully ignorant of the daily realities of life in black townships, and also of the rich culture and cosmologies of the black members of the liberation movement. The minimalist social services made available to blacks meant that few had been exposed to psychotherapy services, and they were unfamiliar with its codes and conventions. People in the townships relied more heavily on a “natural helping network” of local clergy, san­gomas and other indigenous healers, extended family and political organisations for support – which was largely invisible to white mental health professionals for a long time. Psychological services tended to be associated with “insanity”, and people were prudently cautious of the association with its stigma. Over and above all these gaps, most mental health professionals’ training focused heavily on a “natural helping network” of local clergy, sangomas and other indigenous healers, extended family and political organisations for support – which was largely invisible to white mental health professionals for a long time. Psychological services tended to be associated with “insanity”, and people were prudently cautious of the association with its stigma. Over and above all these gaps, most mental health professionals’ training focused on the predictable relationship distresses of middle-class White life, and little was written on torture.

Towards democratisation
In the South African context, nothing could have been healthier than democratisation, and nothing less could have inspired the intensive rethink of psychological practice which began in the 1980s in the practical context of the progressive health organisations.

One of the important shifts was towards democratisation of organisations. The state-linked political and organisational structures were generally authoritarian and hierarchical. Faced with the perception that professional hierarchies looked uncomfortably like a replication of apartheid power structures, progressive health organisations distanced themselves from the status pyramids of the hospital structures and espoused democratic forms. This has been one of the valuable unplanned by-products of the time. Processes and traditions such as transparency, democratisation, and consultation that were developed in the period of oppositional struggle, particularly in NGOs, have been sustained after liberation, and act as a check against authoritarian systems in the future.
ongoing groups to deal with group dynamics which may arise, and to go into personal therapy for periods of time when necessary.

The South African conflict resolution model
South Africa has in many ways become a model of conflict resolution through its transformation. But important lessons have arisen in the aftermath of the liberation struggle.

The first is vigilance. In South Africa it quickly became clear that when there were no more political prisoners, torture was turned on criminals, who can be seen as more "acceptable" targets, in order to obtain confessions. Nonetheless, horrific though many of their crimes were, it has been vital that we oppose this abuse resolutely, and charge when necessary.

The second lesson is that there are no circumstances whatsoever in which torture is acceptable.

The issue which preoccupies us in South Africa at this time is one which has vexed the Latin-American states, and will be debated at some length in this conference. This is the issue of impunity arising out of the Truth and Reconciliation Commission. What we are grappling with is the question of whether such a commission without justice is a good or bad thing. There seems to be no doubt that many survivors will experience the whole process as psychologically corrosive and retraumatising. At the same time, for the sake of the country, even a limited process that reveals the truth about human rights violations, rather than brushing them under the carpet, is of importance. This issue is of the greatest seriousness in the international campaign against torture, since credible deterrents are needed to start to make the point that the world will no longer tolerate this kind of obscenity. Even if prison is not politically an option, perhaps international pariah status and prohibition on travel outside country borders may help. Our challenge here is not only to provide useful support structures to survivors giving testimony, but also to understand that what happens here affects other parts of the world in the fight against torture.

The ongoing process
Finally, is there a way to work on prevention in the future? The lesson from our neighbours is that countries can throw off a tyrannical regime only to rapidly replicate all of the repressive structures. We have been exceptionally fortunate in our President, and this has set the country off on a good footing. But if we are to sustain a human rights culture, I feel that the effective channel will have to be through the education system. We need to entrench human rights in the school curriculum in an ongoing series of creative and participative exercises and debates. Children need to be taught the horrors and futility of genocide and human rights abuse. They need to be shown what we know of the strategies of propagandists and persuasion of tyrannical regimes and their modus operandi, and given exercises which help them to detect the race-hate, dehumanisation, and vilification methods used. They need to be able to spot these things in their own countries – the hate-slogans, the destructive agendas – and recognise them for what they are. Communication skills which teach people to talk out rather than act out their differences are also important. We need in every way to promote the concept and acceptance of multiculturalism and tolerance of heterogeneity. Education of professionals in law, health, policing, and all the occupations which may come in contact with torture is essential. All these initiatives are under way in this country, and in many others.

The fight against torture is one of the key struggles that lie before us. The case of South Africa has shown that it can be won. We have learned that over the years the cumulative work of principled individuals does make a difference, and that when states act together with a single purpose the renegades can be reined in. If our population can be inculcated through knowledge against the hate-merchants, and credible deterrents can be put in place internationally to punish the abusers, we have a chance of winning the war.

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Egyptian doctors arrest sparks protest / Kandela, Peter. - In: British medical journal; vol. 310. - 19950211. - p. 347-348

It is widely known that torture is practised by repressive governments to extract information and to break down personality. It is also expected by society that the doctor's sacred duty is to preserve life. But are doctors, under certain circumstances, capable of inflicting harm on their patients or on people in general? Are they capable of participating in or otherwise facilitating an assault on human dignity such as torture? Involvement of doctors in torture violates the four principles of modern medical ethics. The first states that doctors are prohibited from causing unwarranted harm to patients, the second obligates doctors actively to benefit their patients, the third pertains to patient autonomy wherein doctors provide treatment only in accordance with patients' wishes, and the fourth prohibits doctors from discriminating against patients on the basis of political belief, religion, social class, or any other characteristic that is not considered medically relevant.

In response to the widespread practice of torture, the World Medical Association (WMA), in the Tokyo Declaration of 1975, initiated an unprecedented effort to condemn involvement of medical practitioners in torture or "other forms of cruel, inhuman or degrading procedures". In 1983 the United Nations adopted a set of principles on torture that forcefully denounced the involvement of health personnel in torture, where it is considered a gross violation of medical ethics and an offence under applicable international instruments for health personnel, particularly doctors, to engage actively or passively in acts involving participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.

In the Philippines, reports of torture and other forms of abuse, which supposedly peaked during the Marcos dictatorship, have continued even during subsequent regimes. Eleazar, Obillo, and Lopez reported that 9 out of 10 political prisoners captured under the Marcos regime were tortured. In 1994, the US Department of State reported to the US Congress that human rights violations, including arbitrary arrests and detention, summary executions, and torture were still being committed in the Philippines.

Despite international efforts, reports of continued doctor participation have been published: Pross (Germany), Mehdi (Pakistan), Lopez (Philippines), and Vesti (Denmark). Testimonies by torture survivors have been documented by Clavel et al., Amnesty International, and Rasmussen et al.

Medical doctors are not the only health professionals who have inadvertently or inadvertently facilitated the practice of torture. There have been reports of nurses, dentists, psychologists, and other paramedical personnel who have participated in torture. A study by Eleazar, Obillo, and Lopez (The psychiatric morbidity patterns of Filipino prisoners (1991)) has revealed an alarmingly frequent involvement of health professionals, including medical doctors, psychiatrists, surgeons, nurses, and other paramedical personnel before, during, and immediately after torture procedures.

**Forms of health professionals' involvement in torture**

In what ways can doctors facilitate torture? Whether the manner of involvement is direct, active or passive, intentional or unintentional, this involvement can be in the form of examination of a detainee prior to interrogation to ensure that he can survive torture, and to find sensitive spots for exploitation during torture. In the torture process itself, the doctor monitors the process to stop the torture if the detainee is in danger of dying, or to resuscitate the victim if necessary. Another manner of involvement occurs after torture when the doctor "patches up" the victim to enable the latter to undergo further investigation or to conceal evidence of torture.

Moreover, the doctor involves himself in torture when he provides the authorities with certificates falsely stating that the prisoner is in good health or that death was due to natural causes or self-inflicted injury. Involvement can also come in the form of advising torturers or being directly involved in the employment of medical or psychological torture techniques, and lastly, when he fails to document or report cases of suspected torture. All these different ways of doctor involvement in torture are gross violations of professional responsibility and merit the strongest possible condemnation.

**Factors that contribute to the widespread tolerance of and participation in torture by health professionals**

Why does the practice of torture persist, and why does the participation of doctors in torture continue unabated? A look into the current systems of Philippine medical education, prison health care, and the intersection and cooperation of the two, will shed light on the question of widespread tolerance of torture in the country.

**A. Medical Education**

President Aquino in 1986 issued presidential memorandum No. 27, which required the teaching of human rights at all levels of education. The constitutional commission also emphasized "the teaching of human rights ... in non-formal training to persons and institutions tasked to enforce and guarantee the observance and protection of human rights", i.e. military and police personnel. Despite these measures, health professionals receive little, if any, educational instruction about their ethical and legal obligations, so far as national and international human rights standards are concerned. Medical educators tend to neglect the more fundamental percepts that should guide the quality and kind of care that doctors and health workers should provide for their patients.

Health professionals and the public alike have advocated various standards for the care of the dying and the handi-
capped, and medical participation in the prison health system. However, these issues, in addition to relevant human rights standards pertaining to medical ethics, are rarely discussed in courses in medical ethics at medical schools. As a result, doctors vary in their views about what constitutes torture, and they have different attitudes to the prevention and practice of torture.

Another possible reason for involvement of medical personnel in torture is the perception that medicine is merely a technical process requiring professional skills but devoid of a moral framework. This is reinforced by inadequate understanding of medical ethics, due largely to the low priority given by medical schools to this subject.

B. Medicolegal system
In the Philippines, medicolegal investigations are conducted by the medicolegal division of the National Bureau of Investigation (NBI). The Philippines follows the medicolegal officer system in which the medicolegal officer need not travel to the scene of a crime to examine the body; valuable evidence may be destroyed or overlooked when using this system.

The system is unlike that of the medical examiner or coroner system in other countries. In this other system, the coroner goes to the scene of the crime, examines the body there, and later conducts an autopsy at the morgue. On the other hand, under the Philippine system, local officials are authorized to appoint doctors from hospitals, clinics, asylums, and prisons to act as ex-officio medicolegal officers, who most often possess limited knowledge of forensic pathology. This is further aggravated by the negative attitudes of most members of the medical profession concerning medicolegal matters. Doctors regarded these matters with abhorrence, an additional burden to their duties and a waste of their time when they are summoned to the courts. These, aside from fear of reprisals.

C. Prison Health Care
The Medical Action Group (MAG), a non-governmental organization, reported in 1993 that the health and living conditions of several detention centres and military stockages throughout the country were characterized by overcrowding, common criminals and political detainees sharing the same cell; meagre food rations; insufficient medicines for a variety of ailments; and irregular visits by prison health personnel. These conditions were worsened by the fact that many detainees had been held for a year under such circumstances, and continue to live under such conditions today.

Some improvements in the area of prison health care had been noted by the mid-1980s when civilian doctors were granted access to prisons. This new development meant that detainees, particularly in areas where official health care was non-existent, could finally receive urgently needed medical attention. However, by allowing doctors access to prisoners, the government continues to wash its hands of its responsibility to provide medical care for prisoners. Since the doctors can examine the detainees in prisons, they are now in a better position to expose physical and mental abuse, and this fact has made them prone to reprisals from military officials who felt threatened by the situation.

"Study on the Knowledge, Attitudes and Practices of Physicians Regarding Torture"
It is within the above context that this study was conducted by June Pagaduan-Lopez, M.D., et al. in the Philippines in March 1995.

450 doctors attending the Medical Annual Convention of the Philippines Medical Association were respondents. The study aimed at obtaining basic information on the awareness, attitudes, and practices of professionals with regard to torture, doctor involvement in torture, and aspects of prison health care that facilitate torture. This information will be used to design a human rights education programme for medical students and doctors.

Objectives
It was the intention of this study to provide the investigators with an idea of current awareness, attitudes, and practices of doctors regarding torture. An attempt was made to determine whether factors such as age, years of practice, or gender affect awareness or attitudes, so that the programme can be tailored to fit the needs of different groups. It tried to identify differences in levels of awareness and practices between subpopulations of doctors. Other objectives focused on the provision of baseline data against which the success of the human rights programme could be measured; to develop strategies to end involvement of doctors in torture, and to serve as a model for further research that includes health professionals other than doctors from other countries. This can eventually lead to the development of an international data bank on the involvement of health professionals in torture.

Methods
The study used a questionnaire divided into four sections, which were self-administered by 450 doctors attending the Annual Convention of the Philippine Medical Association. The data were subjected to foxbase and SPSS computer programs for analysis.

Ethical considerations
It is of utmost importance for confidentiality to be given priority in this kind of study, because grave harm could come to the respondents from breaches of confidentiality. Without an absolute guarantee of such, it is extremely unlikely that correspondents would admit to attitudes that they perceive as unacceptable to their colleagues, their employers, the researchers, or society in general. This study, therefore, ensured maximum confidentiality for its respondents, and they were made aware that its results will not be used for persecution of doctors, but instead will be used to advocate policies that will provide better protection for doctors and other health professions who refuse to participate in torture.

Significant findings of the study
General profile
Of the 450 questionnaires that were given out to the doctors, 383 (85.1%) were returned. Most of the respondents belonged to the 30-39 year age bracket, and 65% of them were married. The participating doctors were mostly government hospital general practitioners, the rest having private clinics but being affiliated to private or university hospitals. Only a few respondents practised in city-based military hospitals and in medical facilities within military camps.

Some 68 respondents (17.8%) admitted that they had treated a detainee, while others had seen detained individuals in municipal jails and had treated detainees in camps and national prisons. One respondent reported that he treated a detainee in a "safe-house" (an unofficial clandestine facility for conducting intensive investigations, usually employing torture). Most of these doctors were acting on orders of a medical authority or their superiors. Furthermore, some respondents reported that medical personnel such as doctors and other health workers had access to medical records of detainees.

Awareness and practice of torture
The majority of respondents (55%) were aware of the occurrence of torture, and most did not agree with the statement that "torture is an extremely rare practice in the Philippines."
81% were aware that “most manhandling occurs during and immediately after arrest”. Only 11% were uncertain, and less than 10% disagreed.

It is interesting to note that the majority of the respondents agreed that most forms of maltreatment can be detected through physical examination, which reveals their lack of awareness of more sophisticated forms of torture that leave no trace of physical injury on the person. However, they believed that roughing up of suspects during interrogation resulted in lasting harm or in long-term effects, and that this may lead to psychotic symptoms in individuals who underwent torture.

**Perceived adequacy of protection for doctors**

When it comes to risks to doctors who report cases of torture or who testify that a prisoner has been tortured, most respondents decreed the fact that there was no adequate protection for them. Aware of this, one respondent hoped that “the Philippines Medical Association ... would be given protection by the state in cases of human rights violations when doctors have to testify or certify evidence”. Another respondent said that he was “sad to see doctors refusing to treat torture victims because of the medicolegal implications”.

The study revealed that most respondents (93%) were not aware of or were uncertain about prohibition of doctor involvement in torture by the WMA, as embodied in the Declaration of Tokyo of 1975. Awareness was greater with respect to the UN standards for the treatment of prisoners than for the WMA standards of medical ethics.

**Attitudes to torture**

Most of the respondents believed that solitary confinement was a form of torture. They also acknowledged that tying or hand-cuffing suspects can also be considered a form of torture. Those who agreed with this were older, predominantly females, specialists, non-military, and those who had treated detainees or prisoners. Most also agreed that coercion may sometimes be necessary “to extract information from suspects”. The use of sodium pentothal by health professionals on suspects or detainees who refuse to disclose “important information” was deemed unacceptable by most respondents. And when the safety of the doctors or his/her family is threatened, most readily agreed that they “would not blame a colleague for falsifying a medical certificate” although this becomes unacceptable when only the doctor’s career is put at risk. They would also like doctors to challenge authorities who bring badly beaten suspects for medical treatment.

**Experiences with Victims of Torture**

Personal testimonies from doctors who participated in the study showed that they had treated patients whom they suspected of having been tortured. One doctor said: “We issued medicolegal certificates for prisoners before they were brought to jail. Some of them had face injuries from being hit by rifle butts.”

Five doctors revealed that they knew of a colleague who had directly tortured a detainee. The perceived factors that made it easier for doctors to participate in torture were fear, death threats, harassment, prejudice, partisan politics, and being in the military service.

What could have prevented those doctors from participation in torture? The respondents mentioned factors such as medical ethics, moral conscience, Christian affiliation, protection, and awareness of human rights/human dignity. Support from medical colleagues and medical societies could also have helped them to refuse participation in torture.

**Conclusions and Recommendations**

The study made it clear that most doctors were not aware of prisoners’ rights. They expressed uncertainty about these, as on provisions that govern doctors’ participation in torture and other forms of degrading and inhuman treatment. More so, they were not familiar with the standards set by international bodies such as the United Nations and the WMA regarding such practices.

Large gaps have been noted in the doctors’ knowledge of what constitutes torture, its incidence, and its sequelae. There was also a significant tolerance for violent and coercive behaviour against detainees. And when it came to protection of doctors against death threats and harassment, most respondents felt that they were not given enough protection, should they refuse to participate in torture. Risks to doctors’ lives and their families and careers were the overriding concern of most respondents; hence, they hesitated to report cases of torture about which they were aware.

One comforting insight, though, that emerged from this study is the fact that the doctors were aware of their rights as medical professionals to minister to their patients; they believed in immediate access to the patient and affirmed the patient’s inalienable rights to health. However, they believed in reporting only to their medical superior.

Striking differences were observed in knowledge and attitudes among the various subgroups of respondents. Foremost, the faculty doctors were the most knowledgeable, and they most consistently displayed favourable attitudes to the practice of torture. This signifies that they will not accept maltreatment or acts of torture on prisoners under any circumstances. Such a stand means only that these doctors were sympathetic to the cause of human rights even before their exposure to torture.

It is safe to say that, despite the gaps in knowledge and attitudes of doctors on torture, most of them are highly motivated and are willing to contribute towards the prevention of torture. It is just a matter of providing them with proper education on human rights and medical ethics.

It is towards this goal that the following measures are recommended:

1. **DEVELOPMENT OF APPROPRIATE CURRICULUM**

The study showed that doctors’ knowledge of torture and prisoners’ rights are significantly lacking in the following areas: occurrence and current practice of torture, the sequelae of torture and their detection, the availability of protection for doctors who report cases of torture and the resources open to them, where to report suspected cases of torture, the existence of international declarations and standards on doctor involvement in torture and humane treatment of prisoners. To bridge this gap, there is a need to provide training and education for doctors in these identified problem areas.

In addition, a properly developed curriculum could also correct the persistence of less than ideal attitudes regarding the definition of humane and inhumane treatment (what is or is not acceptable), the role of a doctor who is present during interrogation/investigation, and doctors’ duties in handling patients.
2. CONTINUING COLLABORATIVE NATIONAL HUMAN RIGHTS PROGRAMME FOR DOCTORS
Courses of instruction about human rights should be held all over the country, and, to ensure their success, their conduct demands the cooperation of agencies*.

3. IMPROVEMENT OF PRISON HEALTH CARE POLICIES
Our study identified possible areas for improvement of current prison health care policies, such as concern the line of authority, accessibility of a detainee’s medical records, protection of patients’ rights to privacy and choice of doctor, and protection of doctors’ autonomy.

It is hoped that the above recommendations will make Filipino doctors more knowledgeable regarding torture, and prevent them from involvement in it or any form of degrading, inhumane treatment. The recommendations should also show them how to help to put an end to the use of torture on prisoners and detainees, and make them more responsive to the cause of the protection of human rights.

Note
* These agencies are the following: the Department of Health (DOH), the Commission on Human Rights (CHR), the Philippine Medical Association (PMA), the Association of Philippine Medical Colleges (APMC), the Department of Education, Culture and Sports (DECS), the Armed Forces of the Philippines (AFP), and the Philippine National Police (PNP).

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This article is based on results from phase one of a study on the knowledge, attitudes and practices of Filipino physicians regarding torture.

Long-term effects of torture of victims during the period of dictatorship in Greece

Study design and preliminary data

Dimocritos Sarantidis, Psychiatrist*, Maria Piniou-Kalli, Dermatologist, Medical Director, MRCT*;
Dimitris Pantazis, Psychologist*, Georgia Sotiropoulou, Psychologist*, George Haritakis, Psychiatrist*;
Domna Tsaklakidou, Psychiatrist*, Teodora Douroukou, Social Worker* & Metin Başoğlu, Psychiatrist*


There have been several reports in the literature concerning the chronic and delayed emotional reactions to traumatization. These reports prompted some changes in the stress-related diagnoses in the DSM-IV. Thus, the latest edition includes a new category, the acute stress disorder (table 1). This new diagnostic category requires fewer criteria than the post-traumatic stress disorder. The time-related criterion requires a minimum course of three days and a maximum of four weeks, while the onset of the disorder should be not more than four weeks after the traumatic event. As for the PTSD, two new sub-categories were included, acute and chronic. The acute requires that the symptomatology should last less than three months, and the chronic more than three months. The delayed PTSD, which also existed in DSM-III-R, requires the onset to be not less than six months after the event.

It is now generally accepted that PTSD may have a chronic course. As you can see (table 2), it is estimated that
Table 1. Introduction.

DSM-IV trauma-related disorders
- Acute stress disorder: Min 2 days, max 4 weeks and within 4 weeks of the event
- Acute PTSD: Symptoms less than 3 months
- Chronic PTSD: Symptoms more than 3 months
- Delayed PTSD: Onset not less than 6 months after the event

Table 2. Course of PTSD1.
- 30% recover completely
- 40% with mild symptoms
- 20% with moderate symptoms
- 10% unchanged/worse

30% of PTSD cases recover completely, 40% continue to have mild symptoms and 20% moderate symptoms, and in 10% the disorder remains unchanged or becomes worse. Strong social support and good premorbid functioning are two key factors for quick and complete recovery. For torture victims, commitment to the cause is also a good prognostic factor.

In our study we investigated the long-term effects of persons who were tortured during the dictatorship in Greece. This regime, which was the result of a military coup, lasted from April 1967 until July 1974, when it virtually collapsed following Turkey's invasion of Cyprus. After the restoration of democracy, the leaders of the military coup were sentenced to life imprisonment, which they are still serving. Torturers were also sent to court and sentenced to various terms. We believe that this very brief account will help you to understand the historical context and particularly the catharsis that had in many ways affected the victims of the military junta.

Going back to our study, the specific aims (table 3) are:

1. to investigate the prevalence of current and lifetime PTSD and other disorders, taking into account other life events.
2. to relate the degree of the sense of commitment to psychopathology.
3. to relate the severity of torture to psychopathology.
4. to investigate the effect of social support.

We used several sources to compile the list of potential participants (table 4):
1. Newspaper reports at the time of the trial
2. Relevant organizations and associations
3. Names obtained from the participants’ own accounts
4. Personal accounts from the research team.

The flow of the participants can be seen in figure 1. We have so far contacted 23 persons. During the initial contact 8 refused and 15 accepted. However, three did not keep two consecutive appointments and did not try to make any contact with us. Since the issue is sensitive, we consider that their reluctance meant refusal, and we did not insist further. Until now we have completed ten cases, while two more are in progress. Those who refused gave several reasons (table 5). Two said that they did not have time, one felt that he may become upset, two said that they were not interested, one said that the matter was too personal, and two expressed reservations about confidentiality.

The tools that we use are shown in table 6. The first interviewee was contacted by the psychiatric social worker of our team, who was also responsible for the flow of participants in the rest of the team. The team required approximately five hours to complete the assessment of every participant.

I will now present some of the data. Because the numbers are very small, I will not attempt any comparison. The sample (table 7) so far consists of 7 males and 3 females, mean age 50 years.

The number of arrests and imprisonments is shown in table 8. Two were arrested once, 4 twice, 2 three times, and 2 four times. Six persons were not sent to court and did not serve prison terms. Three went to prison once, and one went to prison twice. The mean period of detention without trial (table 9) was 69 months (range less than one month to 236 months). The mean period of imprisonment was 45 months (30–60 months).

The SCID (table 10) indicated that half of our subjects were healthy; one had a brief reactive psychosis during the torture event, with no psychopathology now. One was given the diagnosis of multiple drug use, one has panic disorders, one obsessive-compulsive disorder, and one had a previous episode of major depressive disorder.

In concluding these preliminary results, I would like to share with you some of the issues that we have thought about and discussed concerning this research. You are perhaps aware of some opposing arguments regarding the involvement of health professionals in the care of torture victims. Some of these arguments are shown in table 11.

1. Torture varies in many aspects from other types of trauma such as natural disasters, rape, accidents, etc.
2. Torture is only a political issue and it is an obligation of international organizations to prevent it.
3. Involvement of health professionals would only lead to passive acceptance of the practice of torture.
4. The involvement of mental health professionals in particular will only label the victims as psychiatric patients, while the fact is that they suffer from "normal reactions to an abnormal situation".
5. Publicizing the methods of evaluation and rehabilitation of the victims could result in more refined, more sophisticated, and "traceless" methods of torture.

I am sure that you are also aware of the counter-arguments, which I do not intend to list. I do not think that anybody can argue that health professionals should not become involved if they are confronted with physical or psychological suffering.

Table 6. Tools.

<table>
<thead>
<tr>
<th>Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic and personal data</td>
</tr>
<tr>
<td>Semi-structured Interview for Torture Survivors (SIST)</td>
</tr>
<tr>
<td>Semi-structured Clinical Interview and Diagnosis (SCID)</td>
</tr>
<tr>
<td>Hamilton (Anxiety &amp; Depression)</td>
</tr>
<tr>
<td>MMPI</td>
</tr>
<tr>
<td>PERI life events scale</td>
</tr>
<tr>
<td>Clinician Administered PTSD Scale (CAPS)</td>
</tr>
<tr>
<td>Physical examination form</td>
</tr>
</tbody>
</table>

Table 7. Demographic characteristics.

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>7</td>
<td>70</td>
</tr>
<tr>
<td>Female</td>
<td>3</td>
<td>30</td>
</tr>
</tbody>
</table>

Table 8. Number of detentions and imprisonments.

<table>
<thead>
<tr>
<th>Persons</th>
<th>Arrests</th>
<th>Persons</th>
<th>Prison</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>1</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 9. Duration of detentions and imprisonments (months).

<table>
<thead>
<tr>
<th>Detentions</th>
<th>Prison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>69</td>
</tr>
<tr>
<td>Min</td>
<td>1</td>
</tr>
<tr>
<td>Max</td>
<td>235</td>
</tr>
</tbody>
</table>

Table 10. Psychiatric diagnoses.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy/No diagnosis</td>
<td>5</td>
</tr>
<tr>
<td>Acute psych. (previous)</td>
<td>1</td>
</tr>
<tr>
<td>Drug use</td>
<td>1</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>1</td>
</tr>
<tr>
<td>OCD</td>
<td>1</td>
</tr>
<tr>
<td>MDE (previous)</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 11. Involvement of health professionals.

<table>
<thead>
<tr>
<th>Involvement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Torture</td>
<td>Varies in many aspects from other types of trauma.</td>
</tr>
<tr>
<td>Political</td>
<td>Issue. It is for international organizations to prevent it.</td>
</tr>
<tr>
<td>Health</td>
<td>Professionals would only lead to passive acceptance of the practice of torture.</td>
</tr>
<tr>
<td>Mental</td>
<td>Health professionals will label the victims as psychiatric patients, while the fact is that they suffer from &quot;normal reactions to an abnormal situation&quot;.</td>
</tr>
<tr>
<td>Publicizing</td>
<td>The methods of evaluation and rehabilitation of the victims could result in more refined, more sophisticated, and &quot;traceless&quot; methods of torture.</td>
</tr>
</tbody>
</table>

regardless of what has caused it. Besides, the fact that we can now document the torture cases is one of the best ways of putting a stop to torture. Research of course is one of the most powerful tools for documentation.

As for the study itself, there are some innate problems. To begin with there are practical difficulties. The time required for the assessment, the fact that more than 20 years have elapsed, the very personal event, and finally the resistance to psychological assessment would be enough to make people reluctant to participate. Thus, as you saw, we have many refusals. Even the persons who agreed to participate either miss appointments or they come late for the assessment. But there are more fundamental problems than the practical difficulties. Can we make general assumptions with our results, when we finish? One question for example is whether the people we usually treat can be compared with the participants in our study. The great majority of the torture victims that we all treat are refugees working without any privileges and usually in jobs that are far more menial than the ones for which they are qualified. By contrast, the participants in our study are not refugees. In fact, most of them are well known and have successful careers. Our list includes businessmen, politicians, members in the high hierarchy of political parties, union leaders, and writers. Perhaps more important is the fact that they witnessed both perpetrators and instigators being punished, which I would say is not the common situation. In any case, we intend to continue this research, bearing in mind the practical difficulties, the reservations about wider applicability of the results, and the ethical dilemmas.

References
Mental disorders in persecuted and tortured victims of the totalitarian system in Poland

Janusz Heitman* & Krzysztof Rutkowski*

This article presents the results of a study on the current state of mental health of victims of political persecution in Poland from 1944-1955. One hundred persons were examined; they were sentenced during the Stalin period for acts against the communist system and the country. The sentences were passed mainly by courts-martial on the basis of the 13 June 1946 Decree, also called the May Penal Codex, a document that introduced new kinds of offences and more restrictive penalties. The examined persons were found guilty of violent attempts aimed at changing the political system in Poland. They were sentenced for crimes such as removing red flags, painting graffiti on walls, printing and distributing leaflets, possessing arms, and membership of counter-revolutionary organizations and conspiracy groups that were meeting to learn the true history of Poland. Among the sentenced were many young boys, pupils at secondary schools.

Another group of sentenced were former soldiers of the underground movements Armia Krajowa, Narodowe Siły Zbrojne, and Batallony Chłopskie, who fought against the Germans and Soviets during World War II and continued their fight when the war was over, and who attacked institutions of the totalitarian state such as the militia, the security police, the communist party, state posts, and banks in order to obtain arms, documents, and money. These soldiers sporadically passed sentences themselves on militia men, security policemen, party functionaries, and persons suspected of collaboration with the secret service, or engaged in persecution. There were a few counter-espionage Armia Krajowa officers among the sentenced.

The studies varied from a few months to the death penalty, deprivation of citizen and public rights, and forfeit of property. All the 100 examined subjects were exiled from the charges (mainly in 1989 and during the system changes in Poland), and the sentences were abolished. The process is not yet finished, and some rehabilitative retrials are under way. From 1950-1955, approximately 40,000 people were arrested for political reasons; almost 28,000 were sentenced, some 1,000 to death.1

The studies on the earlier period, 1944-1950, are so inaccurate that it is impossible to give an exact number of the persons who were persecuted and sentenced then. The sentenced people were mainly put in prison or sent to labour camps. Approximately 200,000 were sent to the camps. Another sentence was to send the conscripts whose loyalty to the communist system was uncertain, or who had a "bad" social origin, to military service in mine battalions (obligatory work in mines).

Description of the sample
Of the 100 previous political prisoners who were examined, most had been in prison or labour camps, but some had been soldier-miners. 63 of them were kept in prison. According to forensic practice at that time, the remaining group were punished in a so-called "progressive prison" in the town of Jaworzno. 17 worked there in a mine or in industry, while 11 worked in other mines and 5 in a quarry. 4 were conscripted into the army and also worked in a mine (soldier-miners). Irrespective of being imprisoned, each of them was interrogated by security police, and only a few avoided arrest. Quite often, part of the punishment was later spent in prison, the remainder in a "progressive prison". All the prisoners were persecuted and tortured. Different forms of torture were used, including humiliation, extortion, or being threatened, and being put in the bunker cell (lower in height than a standing man), and different kinds of physical torture. It is difficult to link the kinds of torture with the psychological sequelae. There is no indication that the type of torture used resulted in any particular consequence.

To be examined, the ex-prisoners were directed to apply to the Department of Social Pathology in the Jagellonian University, Collegium Medicum, by the following social organizations: the Stalin Political Prisoners’ Association, the Retaliated Soldier-Miners’ Association, the International Armia Krajowa Association. Some were brought by friends. All the examinations took place between 1990 and 1995. The shortest interval between the repression and the examination was 34 years, the longest 40 years. Of course prisoners could be persecuted after release from prison.

The examined persons were not selected in a particular way. They had all applied to the unit and went through the so-called "verification", confirming that they really had been persecuted because of political reasons, and their sentences were overruled. 92% were men (figure 1). Their ages ranged from 60 to 83 years (average 66). 29% had had primary education, 44% secondary, and 27% higher (figure 2). The majority (72%) were pensioners and disabled. 82% were married, 6% widowers (2 re-married), 10% divorced (5 remarried), 2% bachelors (figure 3). 18% had had previous psychiatric therapy (figure 4). Nine had been sentenced to death, and there were three life-sentences. 19 were given more than 10 years, 28 were given 6-10 years in prison, and 27 less than 5 years. 10 were arrested and detained without sentence, while 4 were persecuted without being arrested (figure 5). Some of the examined did not know the direct reason for their arrest; if it was due to betrayal, they did not know the name of the betrayer. The majority were beaten and humili-

* Jagellonian University
Collegium Medicum
Chair of Psychiatry
Department of Social Pathology
ul. Kopernika 21
31-501 Krakow
Poland

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iated from the moment of arrest. During the interrogation, sophisticated methods of torture were applied, such as driving thumb tacks under the nails, beating with hard instruments, electrical torture, keeping the prisoner naked in a cold cell, suspension by the legs, beating to unconsciousness (even several times during one interrogation), threatening with death, threatening that their relatives would be persecuted in the same way.

They were isolated in so-called “bunkers” – cold cells, concrete, and very low, the floor covered by a few centimetres of water. The interrogations aimed to get information for use in later interrogations. The feeling of complete dependence on the interrogator was forced on all the examined persons. Stressors, connected with psychological and physical interrogation and imprisonment traumas, were present in the whole group. To a great extent, they threatened integrative and regulational psychological human functions. They influenced the examinees for a long time, and the traumatic situation, which ended only in 1989 with the change in the political system, made them continue even after release from prison or labour camp.

The psychological trauma, to which the examinees were permanently exposed, can be generalized to the following situations:

- threat of death from torture, exposure to pain, cold, hunger, somatic illness (tuberculosis)
- fear for safety of relatives due to one’s activities
- feeling of injustice because of the conviction of the opposition, which was continuing the wartime fight for freedom that was patriotic and right
- humiliation by militia, secret police, judiciary, prison administration functionaries (being the same nationality as the persecuted)
- helplessness with respect to the lying propaganda campaign - accused of criminal crimes, exposed to social condemnation when forced to change into Nazi uniforms and run along the streets
- not allowed an honest trial, false accusations, permanently at risk of being condemned to death
- feeling of being betrayed, and forced to betray others
- isolation and limited contacts with relatives
- feeling of endless persecution (retrial during imprisonment – so-called special interrogation, revigilation, and militia control when released from prison).

Physical traumas sustained by the examinees were important because of injuries to the central nervous system and multi-organ traumas (parenchymatous organs, fractures, dislocations, breaking of teeth, ear injuries, injuries to the anus, etc.). Physical injuries were usually the result of beating with fists, truncheons, chair legs, rifle butts, kicks, or injuries from falling on losing consciousness. The permanent starvation, deprivation of sleep, living in overcrowded unventilated cells, and particularly torture such as suspension by the legs might have induced central nervous system injuries.

The examinees often reported that interrogations lasted many hours, during which they were forced to sit on the tip of the leg of an upside down chair which drove into one’s anus. Many mentioned long-lasting standing-up roll calls, so-called “stojka”.

For many, release from prison did not mean the end of persecution. The majority could not continue their education or find employment. Some were watched by the security police even in the 1980s, and they were occasionally arrested for short periods. The period of Stalin persecution meant the total breakdown of the life line for almost everyone. It impacted disadvantageously on their lives. If they found jobs, these were below their capabilities and expectations – they would for instance never find a managerial position. They quite often found themselves isolated socially, labelled as criminals and surrounded by distrust. Their family lives suffered disintegration of loving relationships, resulting in late marriages and fear of having children.

On release from prison, many were afraid when they saw someone in a militia, military, and even railway uniform. The fear they had during the period of interrogation and imprisonment was still present later. Sometimes it settled into a threat from the surroundings, as shown by hypersensitive and obsessive attitudes.

As stated, the analysed group comprised 100 persons. The total number examined was in fact 102, but in order to maintain group homogeneity, two were excluded because, despite persecution, they did not show any mental disturbance and enjoyed comparatively good health.

Methods

The examinations were all carried out in the Department of Social Pathology of the Jagellonian University, Collegium Medicum, Section of Psychiatry. Each person was interviewed and examined individually, at least twice. The following psychological test methods were used: State-Trait Anxiety Inventory (STA) (Spielberger, Gorsuch, and Lushene), Scales of Depression (Beck, and later Hamilton), the Graham-Kendal test, and the Bender test.

Other techniques were used in some diagnostically difficult cases: the Wartegg Projection Method, the Unfinished Sentences Test, and the Eysenck Test (EPI).

A second psychiatric examination was carried out one week later. The specificity of the aetiology of the disturbances made us consider new diagnostic criteria of psychopathologi-
The depression-anxiety syndrome (F 41.2 in ICD-10) dominated in 78% (in this diagnostic category symptoms of anxiety and depression were proportional). The chronic depression syndrome, recurring (F 33.1 in ICD-10) and reactive in character, in which moderately lowered mood dominated markedly over fear, was present in 7%. Symptoms of neurotic depression were present in only 4% (F 48.0 in ICD-10), and anxiety disorder with anxiety attacks also in 4% (F 41.0 in ICD-10).

Somatic disorders were present in 2% (F 45.0 in ICD-10), and the psycho-organic characteropatho-dementive syndrome with strongly exposed dementive symptoms in 5% (F 03 in ICD-10).

It was impossible to differentiate symptoms of the depressive-anxiety syndrome from psycho-organic characteropathology described as organic mood disorder and organic anxiety disorder (F 06.3, F 06.4). The psycho-organic syndrome in a picture of depressive anxiety was confirmed in 78%.

Because of the advanced ages of the examined persons, it was difficult to know if their depressive and CNS-damage resulted directly from traumas experienced during interrogation and imprisonment. The indicator in cases of depressive syndrome was the time of onset of symptoms.

Stressful events before the start of symptoms were mostly caused by traumas to the head, often confirmed by scars, and particularly when accompanied by loss of consciousness, were recognized as being essential in the diagnosis of organic changes. These traumas might precipitate organic disturbances and increase symptoms.

In applying the diagnostic criteria of the Post Traumatic Stress Disorder (PTSD according to DSM-II-R), the diagnosis was made in 71%. For the remaining 29%, we cannot say whether there was any connection between the present state of mental health and the psycho-physical traumas that were suffered. There is no doubt that this group was influenced by the stressors.

The results may suggest that the diagnostic PTSD criteria are not precise and not entirely adaptable to this victimized group. It is also possible that we applied the wrong method. Among our results, it is worth singling out 6 cases.

- Post-traumatic epilepsy was diagnosed in 2 cases (a doubtful diagnosis of petit mal in a 3rd case was not included). They had lost consciousness many times from being beaten, and one of them had been tortured by having electrodes connected to his ears.
- Two cases, diagnosed as having somatic disorders (ICD-10-fpz 45.0), require a more detailed and wider psychological diagnosis. They both complained of feeling unwell and reported various and varying somatic ailments. It was difficult for them to describe their emotions, both past and present. Asthma occurred in one case, the first attacks during the final period of imprisonment and recurring a few years before our examination. Arterial hypertension was present in this case. The other case suffered a myocardial infarct 4 times. The domination and focus on somatic ailments made the psychological analysis difficult.
- Two men suffered from psychotic decompensation in the form of the delusional-hallucinatory syndrome. Both were arrested as young men. One was only 15 and had felt the separation from his family as very traumatic. He was kept isolated for one month in a low cell with standing water. Spontaneous losses of consciousness occurred during his imprisonment. These symptoms ceased on release from prison, but he suffered sporadic visual and auditory hallucinations. The second man experienced psychotic symptoms one week after the funeral of his father, who had been murdered during interrogation. The examined was the only person, apart from security police personnel, who was allowed to take part in the funeral; he was arrested soon after the ceremony.

Conclusions

1. Symptoms of mental disorder were present in almost all of a group of 100 persons who were persecuted for political reasons in Poland during the period 1944-55.
2. The disorders were in substance consistent with chronic PTSD, despite the necessity to widen the diagnosis to include depressive-anxiety and psycho-organic syndromes.
3. Depressive anxiety and psycho-organic characteropathic and dementive disorders, despite the influence of the age...
of the examined persons on the development of the symptoms, were directly related to psycho-physical traumas experienced during the period of persecution.

4. The exposure to stress had undoubtedly precipitated the processes of involution.

5. The study of victims of the totalitarian system in Poland has four dimensions: documentary, historical (as a moral justification), diagnostic-therapeutic, and scientific (symptomatology and physiology of the chronic PTSD).

6. The diagnostic criteria of PTSD are influenced by the age of the sufferers. The biological aspects of PTSD remain in close relationship with psycho-physical traumas, even if the traumas were experienced many years before the symptoms occurred.

Summary
A very large number of mental disorders were found in victims of the Stalin period of persecution. Only two in 100 were free from mental symptoms, a staggering figure considering the number of victims. It should be remembered that many have not yet disclosed their experiences from that period.

The examination aimed at revealing a causal relationship between present mental symptoms and psycho-physical trauma experienced during interrogation and imprisonment.

It is the basis for evaluating the degree of disability in relation to disability payments. It is important, not only because of the state of health of the previous victims, but also as a kind of justification. It is significant that few of the examined were claiming compensation. The majority expressed intimidation, abashment, and a tendency to withdraw. In many cases the examination was their first contact with psychiatry. Psychiatric treatment seemed necessary for most of them, and this made us set up an out-patient unit within Social Psychiatry for victims of the totalitarian system.

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22
The Red Cross Center for Tortured Refugees began as a test project in autumn 1985. There was a need for specialized resources for this project, which was also to function as part of the Swedish Red Cross's international work against torture. A rehabilitation Center that had opened a few years before in Copenhagen served as a model.

The Center began as a cooperative project between the Red Cross, the Stockholm County Council, the Municipality of Stockholm, and other organizations.

The Center became a permanent foundation under the Red Cross in 1989. An agreement was signed with the County Council for the period 1990 - 1995 for the care and treatment of tortured refugees, and for provision of information and education for the staff working within the health service. This means that the council covers the main part of the budget.

General goals of the Center's activities
- to decrease suffering from torture through treatment of the physical and psychological wounds
- to strengthen self-confidence, restore dignity to the torture victim, and re-establish a changed identity
- to give the refugee and his family the possibility of living a normal life – physically, psychologically, and socially – with relations and work.

To be admitted to the Center, three criteria should be fulfilled
- to have been subjected to torture
- to have a residence permit in Sweden
- to live in the Stockholm County Council area (about 1.5 million inhabitants).

Statistics
The Center received over 1200 applications/referrals since opening (autumn 1985) to the end of 1990. Of cases closed during the same time, 55% had earlier sought help elsewhere for the same problems, but had obviously not felt satisfied.
75% were men and 75% were less than 40 years old.
20% were working; the remainder were on sick leave, unemployed, studying Swedish, or were students.
The largest groups came from Iran, Chile, and Turkey.
Approximately 30% had found the Center on their own, the rest through relatives, friends, social-service employees, medical personnel, or the refugee resettlement service.
About 50% were treated for less than 12 months, and about 30% for 1-2 years.

In about half of the closed cases, there were children in the family.

Applications and referrals
When an application or referral is received, the person in question is called for one or several reception/assessment meetings. A decision is then made as to whether the patient will be treated or not at the Center or somewhere else. Individual treatment is planned, based on the needs of the refugee. This may mean medical examination and medical treatment, physical therapy, counselling psychotherapy, family therapy, crisis therapy, group therapy, etc.

The Center has been given funding to develop methods for working with children and families in which a member has been subjected to torture. Family therapists and paediatricians are involved.

Child and family work
Within the Center there is a team working with families and children. Professional social workers, specially trained as family therapists, are attached to it. A paediatrician and a psychotherapist/psychologist are consultants.
The project is included in the regular work of the Center and cooperates with the rest of the Center. It is obvious that not only the victim but also his/her family might have been
exposed to torture or trauma; the whole family can be affected by the consequences of extreme oppression.

**Length of treatment**
- from a few sessions to several years
- short-term crisis-, group-, and/or family-therapy
- it may mean close contact during one period, less contact during another
- one or several therapists may be involved simultaneously or consecutively.

The personnel are given continual therapeutic supervision.

**Center personnel**
The Center has 11 positions; however, since several employees are working part-time, this amounts to about 15 persons. Two treatment teams of a number of professions work from a holistic viewpoint. One team is more family oriented, the other is more oriented toward pain and psychosomatics.

The personnel group contains the following professions
- Doctors, psychologists, nurse/midwife, physical therapist, social workers, family therapists, and secretaries.
- We work closely with specialized consultants.

The voluntary group for asylum seekers
Within the foundation there is a special group of about 30 persons who give voluntary psychosocial support to torture survivors who are waiting for permission to stay in Sweden (about 60 per year). One social worker and a secretary administer this activity.

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**In Torture Journal vol. 5, nr. 2, 1994, the opening of the Honduras Centre and its forthcoming activities were mentioned. A proper presentation is now given.**

**CPTRT against torture in Honduras**

*Juan Almendares B., Director*  

CPTRT against torture in Honduras

Torture is a historic practice of the abuse of existing power; it has been used frequently in almost all societies. It is an act of violence that tears a person apart and makes him vulnerable in all phases of his individual and communal life. It is a trauma that leaves profound sequels, producing horrible and unforgettable memories of terrible suffering that remains marked on his body and imprinted in his mind for ever. The methods used to practice torture vary from the most primitive to the most sophisticated, carried out by empiric or experienced personnel. It is practised in several ways – openly, hidden, affecting the individual, a family, even an entire community. Torture has its roots in the culture of hate and aggression, racism, machismo, in institutionalized violence, in war culture, and every form of political oppression, and human rights violations.

Throughout the International Classification of Diseases, there is no explicit definition of torture itself, as an act of repression by a government or national security entities. A few researchers have tried to categorize the effects of torture as post-traumatic stress following a psychological event that has a traumatic basis, originating in an abnormal situation. Nevertheless, there is no specific category that corresponds to torture itself. This is so, not because torture is an uncommon phenomenon or hard to study with all the modern technology. It is so because it has political implications.

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* CPTRT  
Apartado 1796  
Tegucigalpa  
Honduras

CPTRT against torture in Honduras

CPTRT against torture in Honduras  

CPTRT The "Centre for the Prevention, Treatment, and Rehabilitation of the Victims of Torture and their Families" (CPTRT in Spanish) was founded in January 1995. It was a transcendental event in the history of Honduras, a country in which this act of violence has always been practised, carried out in a covert way, camouflaged or evident. The purpose of this institution is to focus all rehabilitation efforts in an integral, scientific, technical, and humanitarian way. Rehabilitation services for the victims of torture and their families encompass academic and alternative methods to ensure the patients' well-being. They are carried out by psychological, psychiatric, social, and medical professional personnel.

CPTRT constitutes a solid step towards helping women, children, young and old people who have been victimized in this way because of political repression, and have survived this cruel and degrading practice. This service sprang up as a historic necessity to alleviate the suffering of those affected by torture. It is our answer – to fight violence with non-violence. Without political, religious, cultural, or racial discrimination. Its intent is to serve those who could not survive. To alleviate the profound pain of the families which lost their loved ones as a consequence of the physical and psychological trauma generated by torture.

It took approximately two years of continuous work to develop this project, with the participation of sectors of Honduran society and organizations that have fought in a noble manner for help to the victims of torture and their families, and with help from institutions such as PRODECA [Pro-
The work
This centre was born from the national initiative through the combined efforts of different social sectors that have consolidated into a well-functioning service project. Work has centred in an interdisciplinary team, of which the essence is to concentrate the ideas and develop therapies, scientific techniques, and alternatives that respect the culture, the identity, the individual ethics, and the family. And the team can accomplish the optimum attention that victims of torture and their families require. The Centre has helped 34 survivors and 19 relatives between January and October 1995.

On the basis of this process, the Direction of CPTRT decided to give a great amount of merit to a professional who has given a constant amount of work, dedication, and above all love to the medical attention, particularly in Central America. He has been a constant support during the development and final realization of this project, which is unique in Honduras, and indeed in Central America. He is Dr. Ole Vedel Rasmussen. This institution wishes to honour him. Its inauguration was led by Dr. Rasmussen, who spoke about his strong belief in continuing to serve this cause.

We are sure that CPTRT will develop an integrated approach, whose foundations will always be those of humanitarian ideas.

The content of the UN Convention referring to torture, on which this Institution's labour is founded, is a decisive and relevant step towards the abolition of torture. It is important that these human rights violations stop and that all countries in the world make a substantial agreement so that torture will disappear, once and for all, from the face of the earth.
Palestinians in transition – a challenge to the medical profession

The "Gaza Community Mental Health Programme", a centre in Gaza whose work includes rehabilitation of victims of violence, held an international conference "Palestinians in Transition – Rehabilitation and Community Development" from 13-15 September 1995. The conference was attended by 250 doctors, psychiatrists, and psychologists from Gaza, Israel, Europe, USA, and Canada. The situation of the Palestinians is a challenge to the medical profession.

The populations in Gaza and the West Bank have suffered from Israeli occupation for more than 40 years, and people are especially marked by the things that happened during the Intifada, the revolutionary and political revolt that lasted from 1987 to 1993. The Intifada specifically affected the youth, who were often the direct target of aggression and violence. The young people were frequently involved in traumatic events such as shootings, beatings, tear gas attacks, imprisonment, detention, home raids and demolitions, deportations of fathers, etc.

Such circumstances not only lead to suffering of the directly involved individuals; the whole community will be affected.

Among the adults, both men and women have actively participated in resisting the occupation, but in most cases the woman's self-sacrificing role has been disregarded or even ignored. The explanation for this is that Palestinian women are brought up and expected to be mothers, daughters, and sisters, but never women with an independent status and recognizable human rights. Arab tradition prescribes explicit gender differentiation, the girls being raised as above, the boys to become independent "providers".

Both men and women are suffering, but Arab men do not want to be regarded as weak; it is therefore difficult for them to ask for help. By contrast, the Arab woman finds social backing when she needs it, and even if she is busy at home she finds time to visit mental health service centres.

Among the many grave violations of human rights is torture. Many Palestinians have been tortured by the Israelis, but torture also takes place among the Palestinians themselves, i.e. Palestinians torturing Palestinians. Torture must be brought to an end if democracy is to have a chance.

Some of the torture survivors are still in prison, some of the released have emigrated to other countries, but most of the Palestinian survivors live in Gaza or the West Bank with their families and are in need of rehabilitation. Rehabilitation is currently offered by two local organizations, the Gaza Community Mental Health Programme in Gaza, and the YMCA Rehabilitation Programme in the West Bank. Their therapeutic model entails an integrated approach involving the individual, the family, and the community in a therapeutic process that takes into account the cultural dimensions and impact on the client's mental well-being.

The growing international awareness of the psychosocial impacts of the traumatic experience is welcomed, but the use of Western ideological constructions has to be sensitive to local culture and requires explicit integration of clinical and indigenous understandings of trauma.
Seminar on torture in Albania

A two-day seminar organized by the Albanian Rehabilitation Center for Torture Victims called “Torture – Victims – Rehabilitation” took place in the Salon of the Albanian Writers League, Tirana, the capital of Albania, December 7-8, 1995.

It was the second seminar organized by the Albanian Rehabilitation Centre for Torture Victims (ARCT) after the establishment of the centre. The seminar was attended by approximately 100 participants, who were law students, professors, torture victims, members of the Albanian Association of ex-political prisoners, members of the Albanian Parliament, the Minister of Labour, Immigration and Ex-political prisoners.

The seminar was opened by Mrs. Kozara Kati, executive director of ARCT who asked the participants to stand up and honour all the victims who died or were killed during the 50 year long dictatorship of Enver Hoxha.

The seminar was chaired by Mr. Nufri Lekaj of Norway, board member of the ARCT.

Mr. Pjeter Pepa, MP, lectured on the documentation of the torture that took place during Albania the first five years of dictatorship. His presentation was based on his recent book “Open Dossier” with material from the archives of the Ministry of Interior. It was apparent from his presentation that the torture was approved and systematized by the Ministry of Interior at the highest level. It was documented that twenty-seven different torture methods could be applied.

Mr. Uran Butka, MP, referred to three hundred cases where the torture victims had been hospitalized together with mentally ill persons in mental hospitals in Albania. The purpose of this had been to destroy the personality of dissidents using psychopharmacological drugs.

The seminar heard testimonies from 10 torture victims. One of these was 75-year-old Drita Kosturi who was first arrested in 1940 by the Italian Occupation forces for her anti-fascist work. In 1946 she was arrested by the Albanian regime and put into the infamous prison, Burrel, where she was submitted to electroshock and lost her hair, teeth and one eye as a result. She was imprisoned for 15 years followed by 30 years internal exile. The worst torture was not the electroshock but the fact that she was put in an overcrowded cell with male prisoners and knowing that her fiancé was in the cell next door, she told the audience.

The audience also heard about the rehabilitation work of ARCT by three of the doctors connected to the centre. The lectures dealt with the physical examination, the physiotherapy and psychotherapy offered to the clients of the centre.

Facts about ex-political prisoners 1945-1990

- 5,037 men and 450 women killed with or without trial
- 26,768 men and 7,367 women imprisoned for political reasons
- 988 men and 7 women died in prison
- 48,217 men and 10,792 women were sent in internal exile
- 7,022 persons died in internal exile

During the seminar it was reported that around three hundred victims of the dictatorship had received physical and psychological rehabilitation in ARCT, the only centre in Albania to offer this kind of assistance to the former political prisoners.

Rehabilitation of torture survivors in Albania is made difficult by the severe social and economic conditions in the country and the poor medical facilities.

Professor of Social Science, Ledio Bjanku, lectured about the international conventions against torture and their implications for the domestic law.

Professor of Social Science, Gjergj Sinani, lectured about the ideological depersonalization of the individual and the dignity of the citizens confronting the State.

Furthermore the seminar had interventions by Dr. Søren Bojholm and Mr. Svend Bitsch Christensen of the IRCT in Denmark.

Translations into Albanian of the most important conventions and texts on medical ethics, as well as the textbook “Torture survivors – a new group of patients”, were made available to all participants in the seminar.

Adrian Kati, Coordinator and social worker
Albanian Rehabilitation Center
for Torture Victims, ARCT
Tirana
Albania
BOOK REVIEWS

Torture of Guatemalan street children


Casa Alianza, a branch of the New York based Covenant House, is an NGO working with the rehabilitation and protection of street children in Guatemala, Honduras, and Mexico. With the aim of calling attention to the problem of torture of Guatemalan street children, Casa Alianza submitted a report to the UN Committee against Torture. The book is in the form of an illustrated book with the text in both English and Spanish.

The UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment came into force in Guatemala in February 1990. Taking the point of departure as that date, the book presents a series of cases in which torture against street children has been carried out by the National Police, and in some cases by the Private Police (who are registered by the Ministry of the Interior, which is responsible for their actions).

Although the 33 cases presented are just part of a larger number of incidents, the book serves as a strong document that indicates widespread use of torture against street children by the Guatemalan State.

Many of the incidents involve maltreatment and torture of the children, some ending with brutal murder. Every incident has been presented to the Court in Guatemala. In only a few cases has it led to legal action against the accused police officers.

The force of the book is the descriptive presentation of each case, giving the court number, names of victims, persons accused, date and description of incident, and outcome of the case. The book’s usefulness goes further than its immediate objective of reporting to the Committee against Torture. It can be used in Guatemala as an instrument in the fight against torture of street children, and it can be used internationally whenever torture and other human right violations against street children are discussed.

Finn Rasmussen, MA
Information officer
IRCT
Copenhagen
Denmark

The Trauma of War


This book is based on the papers from a conference in Zagreb in April 1994, The European Community Task Force Conference on Psycho-Social Care of Traumatized Women and Children. Need for New Methods and Aims?

The book clearly shows how paramount the task has been, and will be for a long time, to establish a relevant and effective psycho-social outreach to a large traumatized population. It contains papers on a wide range of topics concerning psycho-social care for the traumatized population of the worst post-World War II trauma in Europe. The topics include theoretical overviews about the psychological effects of war, and useful and pragmatic papers about organizing psycho-social intervention.

The editor has contributed with a clear and very good introduction to the field of traumatic stress and the concept of post-traumatic therapy. The book also clearly shows the enormous problems that soon occur in this kind of post-traumatic work, mainly problems with coordinating the many efforts to help, and identifying those in most need of help and providing them with the needed help.

It seems to be a general learning point, also in the countries that have been receiving many Bosnian refugees, that traditional psychological post-traumatic intervention can often be offered too early, and a lot of other needs have a higher priority for the refugees.

In the book I miss more focus on the demanding role of the therapist and helper in this sort of work, and the psychological effect on the helper. We now know a lot about the psychodynamics between victim and helper. Work with war victims and victims of torture is among the most stressful therapeutic work you can enter.

The contributions in the book are of varied quality, making it rather inhomogeneous, but nevertheless it is a valuable and thought-provoking book about an area of psychology that, on a very tragic background, will teach us new frontiers and aspects of psycho-traumatology.

Anders Korsgaard Christensen
Centre of Crisis and Disaster Psychiatry
Rigshospitalet
Copenhagen
Denmark
NEWS IN BRIEF

A new guideline:

The Zürich Declaration

A declaration denouncing ethical implications of trauma, torture and flight for psychotherapy

Presentation and comments by
Thomas Wenzel, MD*

Though the importance of psychotherapy for refugees in general has sometimes been questioned, there has not been much discussion in regard to the necessity of an offer of therapy to torture survivors. The necessity of getting support after an isolation caused by fear, shame, and other sequels of persecution and torture has been sufficiently documented.

This holds true for the majority of survivors, if we take into account the often high prevalence in some groups of clinical post-traumatic disorders such as PTSD. In addition, untreated sequels can lead to lifelong suffering with more serious consequences than from most disorders commonly treated in "everyday" psychotherapeutic practice. The increasingly professionalized field of psychotherapy is therefore challenged by a special obligation to use its methods for the rehabilitation of torture survivors.

The inclusion of diagnosis and treatment of sequels of extreme trauma and human rights violations is a rarity in the training curricula of health workers. Also, general social and political conditions do not favour support and treatment for refugees in "fortress Europe". Therefore we have to expect a relatively low detection and treatment rate of even characteristic post-traumatic sequels in torture survivors, a development that is probably accentuated by the still widespread use of older diagnostic systems. It should be added that trans- and intercultural strategies for understanding and treatment are still a relative novelty in many countries.

For a necessary change in focus, a recent paper of the European Association for Psychotherapy (the Zurich Declaration), should be quoted. It was accepted by the General Assembly of the European Association for Psychotherapy (EAP) in Zürich, 25 June 1995, as part of the principle guidelines of EAP:

Humans who are forced to leave their homes because of urgent need or political persecution constitute a group of special importance for psychotherapy and psychotherapists because of the frequency and degree of traumatic experiences encountered. In addition, the access of refugees to social, economic, medical and psychotherapeutic resources is very often highly restricted.

Work with refugees, displaced persons and migrants will be of increasing importance because of growing social pressures and migration in and to Europe. The psychotherapeutic treatment or counselling of many refugees requires special transcultural and professional skills. Resource-orientation, continuity, active outreach to community, the avoidance of any stigmatization and the close observance of the mutual dynamic of physical and psychological needs during recovery and adaptation phases is, in our opinion, central to prevention and therapy.

Professional psychotherapy is also a setting where special knowledge is acquired in regard to the personal situation and traumatic experiences, which is usually not the case in most other social situations. Because of this there is a special obligation for psychotherapists to speak in support of refugees and migrants in a general climate of intolerance and fear of dealing with culturally and socially "different" groups.

1. The EAP will take steps to increase the quality and availability of psychotherapy for refugees and displaced persons.
2. Ethnic, cultural and social openness should be a basic principle in all psychotherapy, especially with refugees and displaced persons.
3. The special skills, especially for transcultural therapy and the needs of seriously traumatised patients, should be made a part of all training curricula in the European psychotherapeutic organizations. The EAP will also help to organize qualified advanced training programmes for health professionals working with refugees.
4. To further this co-operation and facilitate the everyday work of psychotherapists in all European countries measures will be taken by the EAP to help exchange information about cultures and ongoing events such as training programmes in all countries, especially also for countries with lower economic capacity and in war areas. This aim will also be supported by the setting up of a data base including information on these subjects with contributions by all member organizations.
5. The EAP will be active in all international organizations, especially the countries and organizations of the European Community, to work against the increasing marginalization and persecution of humans seeking asylum from situations of violence. Most European countries do seriously neglect the needs of people who have survived extremely traumatizing situations such as continuous persecution, torture and war.
6. In this aspect we want to confirm the importance of the final document of the World Conference on Human Rights in Vienna, 1993, which stresses the need to support and rehabilitate survivors of torture and other violent human rights violations.

The EAP Work Group on "Psychotherapy for Refugees and Displaced Persons" will set up sub-work groups to develop programmes to realize the issues mentioned above.

Comment

Many, but not all the important issues have been mentioned in the Declaration. Some issues could be stated more clearly – such as prevention, research or the support and integration of health professionals who are refugees or from minorities in treatment programmes.

Nevertheless, the statement of the European Association for Psychotherapy is a clear declaration of intent, but also a statement of solidarity. Its unequivocal acceptance by all psychotherapists should also have an impact in reaching more outspoken positions against the use of torture. Torture is to be seen not as a normal phenomenon but as an issue society must be held responsible for.

* Blumbergasse 4
A-1160 Vienna
Austria
References

Amendment to WMA resolution on human rights

A proposal by the British Medical Association to amend the World Medical Association resolution on human rights was adopted at the 47th WMA General Assembly in Bali, Indonesia, September 1995. The amendment calls upon member associations to support individual physicians who draw attention to human rights violations in their own countries.

With the amendment the World Medical Association resolution on human rights reads as follows:

Having regard to the fact that:

1. The World Medical Association and its member associations have always sought to advance the cause of human rights for all people, and have frequently taken actions endeavouring to alleviate violations of human rights.
2. Members of the medical profession are often amongst the first to become aware of violations of human rights.
3. Medical associations have an essential role to play in calling attention to such violations in their countries.

The World Medical Association again calls upon its member associations

1. To review the situation in their own countries so as to ensure that violations are not concealed as a result of fear of reprisals from the responsible authorities and to request strict observance of civil and human rights when violations are discovered.
2. To provide clear ethical advice to doctors working in the prison system.
3. To provide effective machinery for investigating unethical practices by physicians in the field of human rights.
4. To use their best endeavours to ensure that adequate health care is available to all human beings without distinction.
5. To protest alleged human rights violations through communications that urge the humane treatment of prisoners, and that seek the immediate release of those who are imprisoned without just cause.
6. To support individual physicians who call attention to human rights violations in their own countries.

Art exhibition in the Council of Europe

From 4 December 1995 to 5 January 1996 RCT’s resident artist, Néstor Guerrero, exhibited some of his ceramics and paintings in the main building of the Council of Europe.

The exhibition was organized in cooperation with the Club des Arts – Amincle du Personale of the Council of Europe. At the opening all the members of the European Committee for the Prevention of Torture (CPT) were present.

In his opening speech Professor Bent Sørensen, member of CPT, mentioned that Néstor Guerrero was an outstanding example of a torture victim who has become a survivor by means of rehabilitation. He also said that Néstor proved that refugees are not necessarily a burden to the country who receives them – on the contrary – Néstor Guerrero had contributed to post-modern art in Denmark by bringing ideas from his native country, Uruguay, which are so vividly represented in his art.

There was an overwhelming interest in the exhibition which was seen by a couple of thousand people.
IPA adopts resolution against torture

At the International Police Association's (IPA) International Executive Council meeting in Vienna October 1995, a resolution was adopted recognizing that any form of torture is absolutely inconsistent with the principles of the organization. The Danish Section proposed the topic *IPA against torture* for discussion at the XIV International Police Association World Congress in Luxembourg 1994. This led to the elaboration of a proposal for a resolution that it was decided to present for adoption at IPA's International Executive Council meeting in Vienna October 1995.

The proposal for the resolution was well received at the council meeting and subsequently adopted. The resolution will be part of IPA's future work; among other things, it will be presented as a topic on IPA posters that will be displayed at police stations in member countries worldwide.

The resolution is as follows:

**Adoption of a resolution by the 26th IEC conference in Vienna 1995 recognising that any form of torture is absolutely inconsistent with the principles of IPA**

This meeting acknowledges the proposal of the Section Denmark (set down at the IPA World Congress in Luxembourg 1994) and agrees to re-enforce the Association's continued commitment to the principles set out in the Universal Declaration of Human Rights as adopted by the United Nations in 1948, by recognising that any form of torture is absolutely inconsistent with these Principles.

Leo Eitinger honoured by veterans

On Sunday 12 November 1995 Professor Leo Eitinger was given the prestigious WISMIC-Prize for 1995 of the World Veterans Federation (WVF).

The prize was presented by the President of the veteran federation, Major General Bjørn Egge. In his speech Major General Bjørn Egge said that the prize was given on behalf of 27 mio. war veterans in 72 countries.

Professor Eitinger has been given the prize in recognition of his research on persons who have been imprisoned in concentration camps and for his epoch-making work in establishing the KZ syndrome.

(Source: Aftenposten)

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**MARTIN ENNALS AWARD**

Martin Ennals Human Rights Award (MEA)

**Objectives**

The Award is presented to an individual (or exceptionally to an organisation) that has made an exceptional, courageous and innovative contribution in his/her combat against human rights violations. Martin Ennals was the first Secretary General of Amnesty International and (co-)founder of several other NGOs, such as International Alert and HURIDOCS.

**Past Recipients**

1994: Harry Wu (China)
1995: Asma Jahangir (Pakistan)

**Restrictions**

Individuals or organisations may not nominate themselves.

**Deadline**

30th September 1996

**Mailing Address**

Martin Ennals Foundation

c/o HURIDOCS

2, rue Jean-Jaquet

CH-1201 Geneva

Switzerland

Tlf.: +41 22 741 17 67

Fax: +41 22 741 17 68

Application forms can be requested from the Martin Ennals Foundation at the above address.
FORTHCOMING CONFERENCES AND SEMINARS

Louisville, Kentucky, USA
30 May-4 June 1996

**Third Annual Postgraduate Clinical Forensic Medicine Conference**
Announcement and Call for Papers

*Further information:*
William Smock, MD or
Dwayne Briscoe
Department of Emergency Medicine
University of Louisville School of Medicine
Louisville, Kentucky 40292
USA
Tel: +1 502 852 5689
Fax: +1 502 852 0066

Sheffield, England
17-20 March 1996

**Traumatic Stress in Emergency Services, Peacekeeping Operations & Humanitarian Organisations**

*Further information:*
European Society for Traumatic Stress Studies
Emergency Planning Department
Trent Regional Health Authority
Fulwood House
Sheffield
S10 3TH
England
Tel: +44 114 263 0300
Fax: +44 114 230 6956

Hong Kong
29 July-3 August, 1996
27th International Conference on Social Welfare

**Societies in Transition: Development in a Political, Economic and Social Context**
Second Announcement

Hong Kong
28 July, 1996
Joint Symposium organized by the International Conference on Social Welfare, the International Federation of Social Workers and the International Association of Schools of Social Work on

**Social Development for Justice, Equality and Peace**

*Further information:*
International Council on Social Welfare
General Secretariat
380, Rue Saint-Antoine Ouest
Montréal
Québec
Canada H2Y 3X7
Tel: +1 514 287 3280
Fax: +1 514 987 1567

**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.