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The views and conclusions expressed by the authors herein do not necessarily represent those of the IRCT.

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THE MEDICAL PROFESSION AND TORTURE

The role of health professionals in relation to torture falls into three categories—in relation to rehabilitation and treatment of torture victims, in relation to prevention of torture and finally in relation to their participation in the practising of torture. In this edition of Torture all three role definitions will be represented. It is characteristic that the medical profession among health professionals, appear to have taken upon themselves the leader position both in the group for torture—and in the group against torture. Regarding the first group, Ole Vedel Rasmussen found in 1990 that 20% of 200 examined torture victims reported that medical personnel were involved in their torture. This included attention, treatment and resuscitation but just for the proper purpose of torture. Knud Smidt-Nielsen now reports that 34% of 80 torture victims, while imprisoned, gave information of doctor participation in torture. This sad fact that doctors are heavily involved in different aspects of torture, gives deep mistrust to a profession that is expected to relieve and help, especially in severe situations, but this is strongly counterbalanced by the two first mentioned roles. With regard to these, particular focus has been placed on the preventative aspect, by the initiative which the Indian Medical Association and Delhi Psychiatric Society in collaboration have taken by organizing a successful debate and subsequent essay competition on torture, where almost 300 prospective and younger doctors participated.

From a pragmatic point of view, torture may be seen as analogous to a disease concept and, as such, should be dealt with from a traditional medical way of thinking through the stages description and classification, as a prerequisite for later optimal treatment. Favourable results of such a treatment course could, meanwhile, inspire traditional methods of treatment towards bringing to perfection a visible success, as opposed to the interest in development of preventative measures, which could serve in minimizing, or—better here—eradicating the incitement of causing illness/suffering.

As known in relation to major worldwide diseases, e.g. malaria, diabetes and duodenal ulcer we have had to wait until the recent years for this work to be channelled towards hindering said diseases in breaking-out, instead of fighting them as soon as they appear. A parallel can here be drawn to torture. Torture is well described and enlightened. Treatment related initiatives are available—they are still developing and they help there where they are. Therefore, the time is ripe to use our energy and resources—and there is a need for both—and to use such immodestly to prevent this society induced disease—in other words, to prevent torture.

The Indian Medical Association (IMA) deserves to be congratulated for the courageous stand it has taken against torture. According to IMA, doctors serving in the military, police and prisons have the highest risk of either being involved in or asked to cover up cases of torture as all custodial torture victims or deaths are to be examined by this section of the medical profession. However, IMA’s essay competition addresses young doctors, dedicated to a prospective assignment closely connected to Hippocrates’ sentence:

*Wherever the art of medicine is loved, there also is love of humanity.*

But, with such a clear message as in this, as well as in earlier respects, and with such a basic—and controversial—topic for such a wide circle, encompassing doctors from a considerable subcontinent, IMA has placed itself in the forefront of the fight against one of the strongest scourges against mankind.

_H.M._

References
CAT and articles 20 and 22

Contribution to the Festschrift for Jacob Möller
Raoul Wallenberg Institute

Bent Sørensen, Professor, MD, DMSc*

The Convention

The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (hereinafter: the Convention) was adopted in consensus by the United Nations Assembly on 10 December 1984, and went into force on 26 June 1987. On 1 August 1998, 105 states had ratified the Convention.

Article 1 gives a definition of torture that is widely accepted. It has proved a useful tool over the years in the fight against torture.

Article 2 prohibits torture, and emphasizes strongly that there is no excuse whatsoever for torture.

Articles 4-16 and article 19 describe the duties of the States Parties. The main demands are: to prohibit torture, not to "refouler", to punish torturers, to educate, to rehabilitate the tortured, to control the system of interrogation and detention, and to report to the Committee.

The Committee

To make sure that the Convention's provisions are implemented in the domestic law of the States Parties and are kept in practice, a Committee against Torture (hereinafter: the Committee), (the Convention's article 17) has been established. The Committee consists of "10 experts of high moral standing and recognized competence in the field of human rights, who shall serve in their personal capacity ...". The Committee "shall establish its own rules of procedure ...". The Rules of Procedure can be found in references 2, 3, and 10.

Since the start of its work, the Committee has met twice yearly, each time in a two-week session.

The author, a member of the Committee from its start in 1988, is at present Vice-Chairman.

Thus, the Committee handles cases relevant to articles 20 and 22. The secretarial activities concerning article 20 cases are attended to by the administrative secretary of the Committee; this function, for article 22 cases is attended to by the Centre for Human Rights' Communication Branch, which was headed by Mr. Jacob Möller until his retirement in October 1996.

Article 20

As of 1 August 1998 this article is in force for 94 of the 105 States Parties that have ratified the Convention. Only 11 States Parties do not recognize article 20: Afghanistan, Bahrain, Bulgaria, Byelo-Russia, China, Cuba, Kuwait, Israel, Morocco, Saudi Arabia, and Ukraine. While a State Party may "at any time" declare in favour, or can withdraw from article 22, this does not hold for article 20: only when signing or ratifying can a State Party declare not to recognize the competence. This cannot be done later, nor can a request to have this reservation enter into force again be accepted later.

Article 20, par. 1 reads:

"If the Committee receives reliable information which appears to it to contain well-founded indications that torture is being systematically practised in the territory of a State Party, the Committee shall invite that State Party to cooperate in the examination of the information and to this end to submit observations with regard to the information concerned." (Italics by the author).

Furthermore, par. 5 reads "All the proceedings of the Committee referred to in paragraphs 1 to 4 of this article shall be confidential, and at all stages of the proceedings the co-operation of the State Party shall be sought."3

If the three points "reliable information", "well-founded indications", and "systematically practised" are answered in the affirmative, the Committee shall invite the State Party to cooperate in the examination of the information.

The secretariat collects the material, but it is the Committee that decides in each single case whether the above-mentioned criteria are met. In this connection, the Committee can seek "additional relevant information" before making a decision and inviting the State Party.

The negotiations with the State Party always take a long time: the procedure as such is slow, with wide time limits that are laid down in the Convention. Moreover, the Committee only convenes twice yearly. In order to advance the inquiry, the Committee can "designate one or more of its members to make a confidential inquiry and to report to it within a time limit ...".

The Committee, also when negotiations with a State Party are ongoing, may seek "additional information from governmental and non-governmental organisations as well as

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individual additional information or answers to questions...", but the State Party is involved in all negotiations and investigations. Finally, the investigations may result in a visit to the country.

When all the investigations have finished, the Committee can decide "after consultation with the State Party concerned, to include a summary account of the results of the proceedings in its Annual Report."

It is noteworthy that only two procedures concerning article 20 have been finalized, viz. Turkey and Egypt. However, consultations are still ongoing. NB There are still closed meetings with respect to article 201.

Who can present information requesting the Committee to initiate an article 20 procedure?

Everybody can in principle. However, it is important to be aware of the following points:

1. Only incidents that have taken place after the Convention went into force in the country concerned are of interest, i.e. 30 days after the date of ratification (the Convention's article 27, par. 2).
2. The mentioned basic criteria, "reliable information", "well-founded indications", and "systematically practised", should be clarified separately.

• Reliable information: the organization should give a description of itself; what are the reasons for the Committee to believe that the organization is telling the truth?

• Well-founded indications: precise information about the torture must be available: the names of the tortured persons, the place where the torture took place, name of the torturer (if this is not possible, the reason must be given), duration of the torture, frequency.

• Systematically practised: if singular incidents are presented (which is the case under "well-founded indications"), they must be seen in context, e.g. special police units, special army units, etc.

3. The described torture must comply with the definition of torture, as stated in the Convention's article 1: "severe pain or suffering, whether physical or mental", "inflicted intentionally", "for such purposes", "by a public official".

It should be noted that article 20 only concerns torture. It does not concern "cruel, inhuman or degrading treatment or punishment", or any other form of organized violence that is not defined as torture (disappearances, extrajudicial executions), nor does it concern capital punishment.

4. If the information contains personal data that could be dangerous for the person concerned, his family or friends, if the authorities had the data at hand, it must be noted especially. Anonymity might be the only possibility, but that should be weighed against "reliable information" and "well-founded indications". The Committee's professional secrecy towards the public is absolute. On the other hand, the Committee has to negotiate with the authorities of the State Party, who need to have certain information to be able to verify the cases. Therefore, the optimal information for the Committee is information that can be passed on to the State Party without hesitation.

Results
The Committee against Torture has published 10 Annual Reports22. Only two summary accounts on article 20 have been published, i.e. only two enquiries according to article 20 have been finalized since 1988.

The first summary account, on Turkey, was published in 1993. The conclusion after a visit to the country was that systematic torture was used at the police stations in Turkey. The other summary account was about Egypt16. The negotiations with Egypt continued for five years, from November 1991 to November 1996. A visit to the country was not possible. The Committee's conclusion was that torture was "systematically practised by the Security forces in Egypt, in particular by State Security Intelligence".

Article 22
Article 22 deals with the possibilities for individuals (regardless of nationality) to complain to the State Party in which they are staying about violations of the Convention's provisions by the country concerned.

Par. 1 of article 22 gives the States Parties a possibility specifically to ratify article 22, and likewise par. 8 gives the States Parties a possibility to withdraw from the provisions in article 22. To the best of my knowledge, no country has withdrawn to date. On 1 August 1998, 39 States Parties have ratified article 22; their names are listed in table 1.

Table 1. The state of play. (1)

<table>
<thead>
<tr>
<th>State</th>
<th>Total no. of cases</th>
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<tbody>
<tr>
<td>Algeria</td>
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<td>Argentina</td>
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<td>Australia</td>
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<td>Bulgaria</td>
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<td>Canada</td>
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<td>Croatia</td>
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<td>Ecuador</td>
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<td>Finland</td>
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<td>France</td>
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<td>Greece</td>
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<td>Netherlands</td>
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<td>New Zealand</td>
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<td>Sweden</td>
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<td>Tunisia</td>
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<td>Turkey</td>
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<td>Uruguay</td>
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<td>Venezuela</td>
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<td>Yugoslavia</td>
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What can you complain about?
In principle you can complain about violations of the provisions of the Convention. Here it is relevant to mention that all articles are relevant to torture, as defined in article 1 of the Convention. According to article 16 of the Convention, the concept of "torture" can be replaced with "other cruel, inhuman or degrading treatment" as far as the provisions of articles 10, 11, 12, and 13 are concerned. Only two communications have made use hereof (no. 8 and no. 46).

Conditions for receiving complaints
These are described in par. 2 and 5.

PARAGRAPHS

2
- The complaint may not be anonymous. Others can complain on behalf of an individual, but then it must be quite clear that the complainant has authorization to submit the complaint.
- The complaint may not be "an abuse of the right to submission of such communications".
- The complaint may not be "incompatible with the provisions of the Convention".

PARAGRAPH 5 reads
"The Committee shall not consider any communications from an individual under this article unless it has ascertained that: the same matter has not been, and is not being, examined under another procedure of international investigation or settlement; the individual has exhausted all available domestic remedies; this shall not be the rule where the application of the remedies is unreasonably prolonged or is unlikely to bring effective relief to the person who is the victim of the violation of this Convention."

What to do in practice?
The conditions for submission of complaints are in practice laid down in Rule of Procedure no. 99 and in Fact sheet no. 7, "Communication Procedure". Furthermore, Annex 5 in Fact sheet no. 17, Committee against Torture, contains a model communication.

Possible applicants may seek advice there, or they can obtain practical information by contacting the Communication Branch. The address of the Communication Branch appears at the end of the article.

Complaints should preferably be worded in English, French, or Spanish. They may also be lodged in Arabic, Chinese, or Russian, but this will automatically lead to a prolonged delay in handling the complaint. Annexes may be added in the language of origin, but their essential points should be translated into English, French, or Spanish so as to make them more easily read by the receivers of the complaint, and thus shorten the handling time.

It should be noted that the Communication Branch of the Centre for Human Rights forwards the complaint to the country in question for comments. The complaint should therefore be written in such a way that it can be read by the authorities in the country without putting the individual or a third person at risk of danger.

The Committee’s handling of complaints
When the Committee's Secretariat receives a complaint, the Secretariat at first decides on whether to reject the complaint immediately for formal reasons (please cf. the above-men- tioned conditions for lodging a complaint), or if there is such an evident lack of substance in the complaint that handling it would be meaningless. When the complaint is not rejected immediately, it is forwarded to the members of the Committee, who then first decide whether "the formal demands" have been met, and whether the complaint contains sufficient substance. If this is not the case, the complaint is rejected.

If, however, conditions have been met, the handling of the complaint as such starts. The complainant’s presentation, together with any questions raised by the Committee, is forwarded to the government in question for comments. The questions for the government to answer are: 1) Do they find that the case is admissible? 2) What is the government’s view? 3) What is their conclusion?

When the reply from the State is to hand, the Committee re-handles the case. There are then two possibilities. The Committee may find the complaint inadmissible, in which case the author of the complaint and the State are informed accordingly with a view to a later publication.

If, however, the Committee finds the complaint admissible, it is sent once more to the State and to the complainant, together with the Committee’s conclusions and with a request to comment on the substance of the complaint.

When these replies are to hand, the Committee handles the case once more, and, based on the comments by the State and the complainant, including comments by both parts to each other, the Committee decides whether the State, according to the Committee’s view, has violated the Convention, which paragraphs, and in which way. The conclusion may of course be that the Committee finds that the State has violated the Convention, as well as that the State has not violated the Convention. In both cases, the complaint is published in the Annual Report with a thorough account of the handling and conclusions. The name of the State Party is always published, whereas the name of the complainant is anonymous, unless the opposite is specifically requested.

Table 1 lists in alphabetical order all 39 states (out of 105 possible) that have ratified article 22, and the number of complaints received by the state concerned. At first glance, the table’s contents may seem surprising. It is important to know that most of the complaints relate to the Convention’s article 3 (please see below). Furthermore, the complaints are directed towards the country in which the person is staying, and not to the state to which he fears to be extradited.

Table 2 gives a survey of the 82 complaints that have been registered so far.

<table>
<thead>
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<th>Table 2. Decision on complaints in relation to article 22.</th>
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<td>Decisions taken</td>
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<td>Decisions pending</td>
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<td>Total</td>
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It will be seen that about half of the cases are pending, but only three of these are "in proceeding" – thus, the Com-
mittee is fairly up-to-date with its work. It is the number of complaints that is increasing rapidly.

It should also be noted that, as far as the decisions are concerned, only 13 express views on the substance, in eight cases it was a matter of violation of the Convention, and five cases were not found to have been in violation of the Convention.

Table 3 is a tabulated survey of the number of decisions year by year, and a splitting up of the decisions in two groups: communications related to article 3, and communications related to all others, mostly torture.

An analysis should be based on which countries have ratified article 22 (listed in table 1), and then one can ask: What can be expected from complaints?

Naturally, there were no complaints for the first two years. The Convention had only just entered into force, and of course it takes some time to spread the message that there is a possibility to complain to the Committee.

Since then, the number of complaints about torture or other cruel, inhuman or degrading treatment or punishment has been fairly constant, and there are only a very limited number of communications. This may give rise to astonishment. When dealing with the States Parties' reports delivered under article 19, the Committee rather often finds that torture is practised in the states. In this connection, please also compare the list of countries that have ratified article 22.

However, it is more important to point out that there are other international institutions which handle communications, and they have done so for a considerably longer period than the Committee against Torture – especially the Council of Europe’s Commission for Human Rights and the Court of Human Rights and the Inter-American complaint system concerning torture.

It should also be noted that only one of the decisions was about a case which could be characterized as gross torture. This case was found inadmissible, because the torture had occurred before the Convention entered into force in the country concerned (Argentina), Communication no. 1.

Of special interest regarding communications is article 3 of the Convention, which reads:

1. No State Party shall expel, return (refouler) or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture.

2. For the purpose of determining whether there are such grounds, the competent authorities shall take into account all relevant considerations including, where applicable, the existence in the State concerned of a consistent pattern of gross, flagrant or mass violations of human rights.”

It should be repeated here that article 3 only comprises torture, and not “cruel, inhuman or degrading treatment or punishment”; neither does it cover capital punishment. On the other hand, all individuals are included in article 3: refugees who are asylum seekers, the citizens of the country, citizens in other countries, sentenced persons charged with crimes, and persons who have served their sentences for crimes. In short: No one must be sent back to a country where there are “substantial grounds for believing that he will be subjected to torture”.

The demand in article 3 is an absolute one.

Problem of timing

The time problem is especially relevant when dealing with violations of article 3 (extradition). The Committee against Torture convenes twice a year (April/May and November). How then is a complaint to be dealt with in practice? An extradition of an individual is often done immediately after the last domestic court has spoken. According to the Committee’s Rules of Procedure, the Committee can elect a rapporteur (par. 3 of rule 106): “The Committee may designate special rapporteurs from among its members to

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of com.</th>
<th>Inadmissible</th>
<th>Other int. org.</th>
<th>Domestic</th>
<th>No sub. or abuse</th>
<th>Decisions/Views</th>
<th>Art. 3</th>
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<td>7</td>
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Other int. org. = Communications raised before another international organization
Domestic = Domestic remedies have not been exhausted
No sub. or abuse = No substance in the communication or an obvious abuse of the provisions of the Convention.

a = inadmissible
b = view: plus violation
c = view: minus violation

1 article 12
2 articles 10, 11, 12, 13, 16
assist in the handling of communications", and during sessions, the chairman may designate such a rapporteur (rule of procedure no. 17, par. 2)\(^2\). The rapporteur can immediately handle the case, ask for further information from the state, etc., and evaluate whether in his opinion there is a fair reason not to extradite the person, because in his opinion there would be "substantial grounds for believing that he would be in danger of being subjected to torture". In that case, the rapporteur can carry into effect par. 9 of rule 108: "In the course of the consideration of the question of the admissibility of a communication, the Committee or the working group or a special rapporteur designated under rule 106, par. 3, may request the State Party to take steps to avoid possible irreparable damage to the person or persons who claim to be victim(s) of the alleged violation. Such a request addressed to the State Party does not imply that any decision has been reached on the question of the admissibility of the communication."

The complaint is forwarded to the State via telefax, requesting comments on the problem of admissibility. In order to save time, the State authorities, if they find the case admissible, are usually also requested to comment on the substance of the complaint at the same time (the second part of the official procedure described above).

Until now, the States have in all such cases complied with the Committee's recommendations, and no individual has been extradited during the handling of the case.

Communications on article 3 must contain special information. Apart from meeting the above-mentioned demands (please cf. the subheading "Conditions for receiving complaints"), reasons must be given for assuming that there will be "substantial grounds for believing that the person will be subjected to torture". First, a description must be given of why the person fled, and whether he was tortured before he left the country. However, the most important aspect is whether he risks being tortured on return to the country. We are dealing with the future, not the past. In this connection it is useful to have a certain knowledge about torture, torture methods, the aim of torture, and the target group. A good description can be found in the book "Torture survivor - trauma and rehabilitation"\(^3\).

**Discussion**

There are 22 million refugees all over the world. Many of them (most of them?) flee their country because of violations of human rights, whether civil, socio-economic, or the right to development, as defined in the Final Document from the World Conference on Human Rights, Vienna, June 1993\(^4\). How many of the refugees have fled because of torture is a difficult question to answer. Only very few valid, scientific investigations have been made on the problem. The latest is from Denmark. It showed that, of the children from the Middle East who came as refugees to Denmark\(^5\), 51% had a father and/or mother who had been tortured. Thus, it constitutes a large problem.

The State authorities naturally express their astonishment at the fact that the Committee, based on papers only, can arrive at a conclusion other than that of the national authorities, who have seen the papers, and who have also interviewed the person. My own personal explanation is that the members of the Committee have considerable knowledge about torture, and the way torture victims often react, knowledge that is perhaps not sufficiently disseminated within the national boards.

The Committee has of course discussed in depth what are "substantial grounds for believing that he will be subjected to torture". The discussion was based on the Committee's knowledge about torture methods, about the aim of torture and its consequences, and the potential target objects for torture.

Furthermore, the Committee has discussed the contents of par. 2 of article 3: "... existence in the State concerned of a consistent pattern of gross, flagrant or mass violations of human rights." Here, too, the Committee sometimes reaches an opinion different from that of the State Party concerned. The State Party's opinion is to a large extent founded on reports from the embassies. However, the Committee evaluates, critically, information from UNCHR, ICRC, and other official organs and NGOs.

It is important to note that par. 2 of article 3 does not provide sufficient grounds to refrain from extraditing a person. The Committee has stated repeatedly: "... it follows that the existence of a consistent pattern of gross, flagrant or mass violations of human rights in a country does not as such constitute a sufficient ground for determining that a person would be in danger of being subjected to torture upon his return to that country; additional grounds must exist that indicate that the individual concerned would be personally at risk. Similarly, the absence of a consistent pattern of gross violations of human rights does not mean that a person cannot be considered to be in danger of being subjected to torture in its specific circumstances." (Communication no. 13/93, Mutombo versus Switzerland).

Thus, the important question is whether the person concerned (not a group of persons, but this particular person) is at a substantial risk of being subjected to torture.

In each single case the Committee designates a rapporteur who, usually together with the secretariat, will go over all the documents in a case. Such documents are usually fairly extensive and not always written in one of the official UN languages.

The Rapporteur then presents his view to the Committee, which is often a divided view: a view that advocates violation, and a view advocating no violation, because it is always the whole of the Committee which stands behind the views. The process leading to a decision on views is time-consuming and may be painful to both the rapporteur and to the Committee. The Committee considers torture as one of the most severe violations of human rights, and many of the members of the Committee consider torture as the most severe violation. Torture is such an abominable act, with so far-reaching and terrible consequences, that the thought of having made a "wrong" decision which could lead to torture of a person can give the Committee members nightmares.

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Notes
(1) As of 1 July 1997.
(2) As of 1 July 1997.

Acknowledgement
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TORTURE Volume 8, Number 3 1998
Non-verbal therapy of traumatized war victims

Lilla Hárdi, MD* & Éva Kalmár Erdős, Artist and Non-Verbal Group Therapist*

The Cordelia Foundation for the Rehabilitation of Torture Victims has been active in Hungary since 1996. The Foundation, within the frame of a “mobile centre”, deals with the rehabilitation of traumatized war victims in several refugee camps. The staff – a psychiatrist, a non-verbal therapist, a human rights activist, and interpreters – enter the space of the client in the psychological and physical meaning as well.

The therapies used at the Cordelia Foundation are adapted to the “special situation” of a refugee camp. We use verbal and non-verbal methods both individually and in groups. The patients originate from Europe, mostly former Yugoslavia, and from several non-European countries (about 30). The members of the working group elaborated a special non-verbal therapeutic method called “animation therapy” (to animate unanimated objects). The therapist has used this method at psychiatric departments for several years, and adapted it to the rehabilitation of trauma victims.

Treatment objectives and methods
The most important aspects of our therapy are the following:
- to give back the tortured scheme of the body using non-verbal methods
- to strengthen the broken, sometimes to a psychotic level, ego boundaries
- to reconstruct the clients’ trust towards each other, towards themselves, and towards their environment
- and, last but not least, to prepare them for individual verbal therapy.

The method is used to treat the symptoms of Post Traumatic Stress Disorder (PTSD), to increase the adaptive abilities, and to mobilize the coping abilities.

The result of our programme was indicated by the relatively quick change in the psychological condition of the clients. They were able to leave the refugee camp in order to return home or to go to a third country.

We applied the non-verbal “animation method” as follows:

The members of the therapeutic group are selected from the patients with PTSD, who comprise 25% of the clients. The groups, all male or all female, contain six to eight members. One session lasts for 90 minutes.

The process, which continues for six months, comprises the following elements:
- breathing exercises
- gesture therapeutic elements
- moving to music
- fix a gesture in plaster of Paris
- contact exercises
- communication exercises
- exercises with a rope
- grooping and painting the face
- re-acknowledgement of the person’s body, and that of others
- relaxation exercises
- Dynamic Examination of Drawings (according to Istvan Hárdi)
- “write a sentence about yourself” exercise.

The framework of the group session was an application of the Hungarian Dynamic Examination of Drawings. This is a serial-comparative method of drawings, following and expressing changes in the psychological state of the clients. The changes can be approached in formal categories, in content, in the personality levels, and in time.

The members of the groups, though keeping strictly to the frame of the therapy, regularly reacted in opposition to the request to make a drawing; they laughed at it. This behaviour could be estimated as positive or as the expression of spontaneous reaction, but on the other hand it could be interpreted as defensive behaviour precipitated by the anxiety generated by moving deeper into psychological material. It could also be the expression of lack or loss of contact.

Cases
We now give examples of drawings by three members of a group of male patients:

Case one (fig. 1)
Aged 42, he had spent six months in a Serbian concentration camp. He saw women and children burnt alive, was the survivor of several episodes of severe torture and humiliation.
His first drawing (A) shows uncertain lines around the body, a relatively well elaborated face, but the limbs are missing, unable to cling.

His second drawing (B) is a bit worse; the outlines are less certain, the face is empty and expressionless, looking into nothing. The body is tightly tied in both his drawings.

The uncertain lines express the uncertainty or the loss of ego boundaries, getting a bit worse as the result of regression in the non-verbal method. At the beginning of the group process, the clients leave themselves to regression, expressed very well by the drawings. The tied body refers to the fragmented ego, tied or kept in with tremendous energy.

The client left the group after the second session, being unable to tolerate anxiety, but he was able to undergo individual psychotherapy, from which he obtained the support he needed. After this he was able to learn English in order to leave the refugee camp. He now lives in the USA.

Case two (fig. 2)
Aged 38 from Bosnia, victim of several traumas. He was forced to leave his house with a gun in his mouth. He was experiencing somatoform symptoms, sinking sometimes into deep, nearly psychotic regression.

His first drawing (A) shows a well-elaborated, sad female face with an umbrella-like object around the head. The second drawing (B) reminds us of his self portrait with more direct lines; the umbrella-like object (or the wish to remain in safety, to be in a "frame") appears again.

His next drawings (C-G) mirror his fluctuating anxiety, with quick, uncertain lines expressing his ego weakness. His regression can be followed on the 8th (H) and 10th (J) drawings, a primitive profile with big, ridiculous nose and a double profile. The missing mouth symbolises the previously mentioned but repressed traumatic memory.

His last drawing (K) better delineates the face of a man. The expression of the face is depressed and anxious, waiting and looking far into nothingness.

Case three (fig. 3)
Aged 41, suffering borderline personality disorder. He spent three years in jail in an isolation cell. He survived repeated serious torture, including being beaten with sticks and chains, electric torture, testes tied and twisted with chains, permanent starvation, etc.

His drawings are stereotype, the figures moving the same way. Only the face is elaborated. The body is always covered with the same dress, only one of the arms is visible, but it is
transparent and the lines of the clothes can be seen as the expression of problematic attachment.

The boundaries of the body are uncertain in the first drawings, drawn with hairy lines, but the outlines of the following drawings are more direct, the shoes are better elaborated. The whole series is stereotype because the client was permanently imprisoned in his own aggressive behaviour. His last drawing shows a bit more energy, the smiling mouth ready for verbal psychotherapy.

These drawings are only snapshots of six months' therapeutic processes. We continue our research today.

**Treatment experiences**

The tools used in the therapy (chalk, paint, origami papers, pictures to montage technique, etc.) are of good, inviting quality. None of the clients reacted positively, though previously they used to build houses, work in their garden, etc. Objects have become negative, "bad" or "persecutive" as the result of several traumas. The clients feel that they are not allowed to touch, perhaps the objects can explode. Some members of the group therapy were forced to cross a minefield, where even mother earth got a hostile quality.

The clients put a gesture on their limbs in plaster of Paris in order to see, to grasp the "state" of the gesture like a split part of their ego. The client accepts the problem with the help of the paradox of objection, placing it at a certain distance (fig. 4).

Using a rope as the therapeutic asset symbolising and strengthening the group cohesion seemed to be a risky thing, because some of the members of the group had been previously tied by ropes or chains.
The result was astonishing as they used it to focus on the traumatized part of their body.

One of the clients tied the rope round his belly, and he began to move it around the injured part. The therapist knew how much the client dealt with his gunshot injury so the symbolic action was quite understandable: his attention was "fixed" on his belly – meaning tied to his belly.

Groping and painting the face resulted in interesting experiences. A client asked the therapist "to correct" the painting on his face, expressing the unconscious wish to regain his original handsomeness, lost when he was beaten with an iron stick.

Summary
The Hungarian non-verbal method approaches our clients through increased productivity and creativity, while treating PTSD symptoms. The patients reorganize themselves at a symptomatic level as the result of the therapeutic process. Their inside healthy reorganization is reflected in their adaptive, coping abilities, in their better quality of life.

The animation therapy can be summarized in three points:
- the clients recreate the lost self-respect and trust towards others
- they can mourn their lost objects
- they learn to love again, first of all themselves, then perhaps others.

The broken world is being reconstructed, new human relationships are born. The homeless find the fatherland or the mother earth, they find the way to return to their abandoned mother with the reconstruction of "trust and paradise lost".

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How to punish perpetrators of gross violations of international humanitarian law

The International Criminal Court (ICC) is now established, but unfortunately there are many states that have neither the ability nor the will to recognize their responsibility in this connection

Henrik Decker

In the 1990s we see an intensification of international efforts to put pressure on the states that seriously and frequently violate the basic principles of respect for man. But the violation has to be so serious as to be classified as relating to international humanitarian law. In July 1998, representatives of 120 states, meeting in Rome, agreed to establish the world's first general penal court for those responsible for war crimes and crimes against humanity.

It can be questioned whether this has changed international law: unfortunately two of the world's great powers, the US and China, could not approve the final document of the Rome conference. But Great Britain, France, and Russia were among the 120 states that now grant jurisdiction to the ICC, the first of its kind since the Nuremberg Tribunal of 1946, which sentenced the worst war criminals of Germany's Third Reich.

One may therefore have to accept that the US is and remains a half-hearted defender of the international law concerning human rights, i.e. a "system" for the states in which international fora are respected as setting the standards of the individual's inalienable rights, and as seeing that justice is done when national states and authorities fail. In this respect, few have many illusions about China.

The touchstone of internationalism is to be found at the cross-roads between legal endeavours to punish violators and protect victims versus great power policy, where some states tend to gloss over the vices of their friends. Here there is room for much wishful thinking.

The US frightened by international jurisdiction
Quoting the words of the German poet Goethe "all theory is grey", but "the golden tree of life is green", it should be borne in mind that the Soviet Union accepted even the UN International Covenant on Civil and Political Rights of 1966, while the US was considering it for years. It should also be remembered that the Soviet Union persecuted, imprisoned, and tortured its own citizens, while the US did not.

Nor should it be forgotten that the US was not a member of the League of Nations of 1920, the predecessor of the United Nations.
In the US, where there are thousands of lawyers and where even the President can be taken to court on matters concerning private affairs, one has thus always been sceptical about attempts to introduce international jurisdiction. It was also the US that in 1986 declared that they did not accept the International Court's decision that the placing of American mines in Nicaraguan harbours was a violation of international law - the mining was part of American support for the “Contras” who were fighting the left-wing regime in Nicaragua from neighbouring Honduras.

The mighty military power of the US is thus not necessarily always a support for the humanitarian internationalists of this world. The US is concerned that American soldiers on UN peace missions around the world may have to face the new International Criminal Court. While the mini-dictator Radovan Karadzic and his military monster, Radko Mladic, both wanted for war crimes according to the Dayton agreement, can move around freely in their Serb-dominated area of Bosnia-Hercegovina, the mighty US is frightened that the International Criminal Court may hit them like a boomerang!

**Sixty states must ratify before it comes into force**

But let us assume that international law after all has moved ahead by adopting general standards for punishing war crimes, genocide, and crimes against humanity. However, it is still in the minds of the realists of the world: Is this for any good at all? Will the ICC get any cases? It will surely take a long time before the first case comes to court, probably in the Hague, where the ICC may be based.

The reason is that no fewer than 60 states must ratify the Court's basic legal document, i.e. the half of the states that voted for it in Rome, a very high number with respect to international law. Yet, it is necessary for so many states to participate because it is expensive to set up a court that should also have the power to institute prosecution. We have not heard much about its budget, but this is difficult to estimate until there is an overall view of the number of states that are serious about having the ICC. The funding has to come partly from the ordinary budget of the UN, partly from the ratifying states.

If one imagines that the court will have two cases (or cases from two areas/states) on its first annual budget, experts estimate the cost at about 100 million US dollars, corresponding roughly to the total annual cost of the two ad hoc tribunals for ex-Yugoslavia and Rwanda.

It requires quite a lot of imagination to see how the ICC can really get to the stage of having a war criminal appear before it in flesh and blood. It is no use imagining an international court case against a Cambodian such as Pol Pot (who was hiding in the jungle for years), or a Serb such as Karadzic (who in reality is still inviolable in the Bosnian-Serb provincial town of Pale), or an Iraqi such as Saddam Hussein (who can play tricks on the whole world and humiliate even the Secretary-General of the UN).

**The new basis for international punishment**

None of these despot will ever dream of moving away from their safe domains (it is not necessary to say hiding places because they do not even have to hide). One has to rely on what might be called “the international humanitarian intelligence service”, i.e. human rights-oriented NGOs, and private organizations with their worldwide networks, such as IRCT, Amnesty International, Human Rights Watch, and others. But that is not enough.

To grasp the future work of the ICC, it is necessary to understand that bringing someone before this court is meant as a last resort. National courts should also be at liberty in the future to bring assumed war criminals or violators of international humanitarian law to court. In order to charge a suspect, an *international public prosecutor* will have to be appointed. This person will have to be rather independent in order to charge whoever he or she wants. Suggestions that the UN Security Council should have the right to interfere were rejected in Rome.

Let us take a closer look at the offences that were criminalized:

1) War crimes, the easiest to define because the Nuremberg statute listed them after the Second World War, and because the UN Security Council has further developed the list in connection with the ex-Yugoslavia and Rwanda tribunals. Ethnic cleansing and political mass rape have been added, as have the Red Cross Geneva Conventions of 1949 with supplementary protocols of 1977, including civil war, generally called internal conflicts.

2) Genocide is also well defined because one of the first UN conventions of 1948 dealt with it. The expression includes total or partial extermination of a national, ethnic, or religious population group, or cruel violations against it with the purpose of wiping it out, and furthermore forced sterilization of such special groups or assaults against their children.

3) Crimes against humanity, comprising systematic attacks on civilian populations (and thus not necessarily particular groups) with the purpose of killing, enslaving, deporting, torturing, or in other specified infamous ways, of subduing or imprisoning population groups contrary to international law.

**Not one word about human rights**

It is worth noting that the phrase “human rights” does not appear anywhere in the statute that was passed in Rome on 20 July 1998. Crimes against humanity, i.e. category 3, is the phrase that comes closest, but it is emphasized that the serious interventions must have been against a group of people. These violations belong in the category called humanitarian rights, which mainly comprise serious violations during wars or war-like situations, typically in countries where social conditions are so chaotic that ordinary court cases concerning violations of human rights cannot take place in practice.

By contrast, the “ordinary” human rights treaties, usually called conventions, do not concern rights for groups. States have in general been hesitant in this respect, illustrated most obviously by the lack of legal protection for minorities. But the Rome statute is quite different. The prosecution, which has to be established in connection with the court, thus has the right to start a case against persons who have violated the statute in a state in which the statute has been ratified, or who come from that state. But what kinds of state would qualify? It is difficult to imagine, but perhaps Somalia, Liberia, or Afghanistan are sufficiently chaotic?

Various groups in Rome tried to win agreement for taking serious violations of human rights to the international criminal court. It has been a shortcoming of international law that punitive action cannot be taken anywhere. The European Human Rights Court in Strasbourg, for instance, can only grant compensation to a victim for a violation - and then try to enforce a change of legislation in the state concerned. But the states did not give in. With reference to political reality,
it is understandable why for instance torture in general did not achieve a majority for inclusion in the catalogue for punishment. Having the right to charge torturers could in certain circumstances be compared with political dynamite – releasing serious problems of interpretation.

Considering the state of the world today it is very difficult to foresee situations that would justify such a large international legal system. The people to be prosecuted can hardly be caught in their own countries. It has to be accepted that previous torturers from, for instance, Argentina, camp commanders from Bosnia-Herzegovina, or the killers of Kurds in Iraq would not take a trip abroad. On the other hand, it will be difficult to find real proof in many of these international court cases at the new International Criminal Court.

Even a national sense of responsibility is lacking
In the midst of the satisfaction over the creation of the ICC a sense of powerlessness may grasp any believer in modern humanitarianism. All can be reduced to reflections on human responsibility. The handful of Northern European states that feel that this concept should cross any state frontier without hindrance, and that are willing to fight not only for freedom and equality, but also for justice and welfare for all the nations of the world, have at the same time accepted that there will be disappointments.

Ask a Serb, a Croat, or a Muslim in Bosnia-Herzegovina about their sense of responsibility to somebody from the “other” population group, ask a Turk about his/her attitude to the Kurds, or ask the French government if it thinks that, for instance, the Bretons should be treated as a minority group! For that matter, ask a Latin-American if he/she would dream of prosecuting the government! But the palaces of justice are often huge and resplendent. One remembers Cicero: “Summum jus, summa injuria” – “The bigger the court, the greater the injustice”.

It is lucky for the world that there today are rich and justice-seeking nations (e.g. Denmark), but this exclusive club is deluding itself if it thinks that its congenial concept of the world has already taken root, for instance through the UN. Unfortunately there are still hordes of states that have neither the will nor the ability to practise tolerance, and in which the lucky ones and the few who are well off have no feeling of solidarity with the poor, and in which nobody would dream of furthering a court case. There are many (political) democracies, in which justice in the broader sense of the word is a pure torso!

**International responsibility requires new ways of thinking**
As a side theme, we can reflect on the few court cases in large parts of the world that lead to anything within a reasonable time – apart from fees to lawyers. In brief, power rules instead of justice. A terrifying example of constitutional lack of cross-national tolerance is ex-Yugoslavia, more precisely Bosnia-Herzegovina.

So far, few cases in the world have been taken to court concerning torturers or massacres of the kind that for instance Colombia and Guatemala have presented. It is dangerous and costly, and perhaps has only a small chance of leading to a sentence. Proof is difficult to obtain for the victims. In order to find cases for the new ICC, a large number of people must show a degree of courage not seen before. In practice, reasonable use of the new ICC requires many more countries to move at a speed more like that of Northern Europe, i.e. both the population and those with political power must show a societal moral aiming at justice.

In theory it is a question of law and justice, but in practice power structures and political constellations are decisive. During the preparations for the Rome conference, the demanding “humanitarians” tried to have the concept of “aggression” included – just as in the Nuremberg statute. To get those responsible sentenced is more difficult by far than anything else. Perhaps it was good to postpone something so political till later. It would seem correct to take heads of state to court, since the main responsibility for wars of aggression is theirs. But the old International Court of Justice in the Hague has not solved many conflicts between the great political powers. The new ICC is meant to solve conflicts between states and their citizens in a political minefield. There is unfortunately no reason to think that yet another international court will have an easier task.
IRCT video films

1997

Returning to life – about the fight against torture
Producer: Lars Feldballe Petersen
Duration: 19 min. Price: DKK 75/USD 15

Returning to life shows the gravity of torture and how rehabilitation can help victims of torture to re-establish a normal life. The film features Shamal, a torture victim from the Middle East, who was severely tortured during his two years in prison. Shamal talks openly about his horrible experiences, the difficulties in resuming a normal life, and how his treatment is progressing at the Danish Rehabilitation and Research Center for Torture Victims, RCT. Directors and health professionals from RCT are interviewed on general aspects of treatment, and the Secretary-General of International Rehabilitation Council for Torture Victims, IRCT, adds her comments on the global perspectives of torture and its ramifications.

The film has been produced by Lars Feldballe Petersen, FilmCompagniet, in cooperation with RCT, for IRCT, Copenhagen, and with financial support from the Danish Ministry of Foreign Affairs and the European Commission.

Available in English and Danish.

1995

The innocent victims
Director: Lars Feldballe Petersen
Duration: 50 min. Price: DKK 150/USD 30

The Innocent Victims is a documentary about torture and oppression against children. The film tells the stories of three children, a boy and a girl from Sri Lanka, and a Muslim boy from Bosnia. At the age of six the girl from Sri Lanka, Nadika, witnessed the killing of her family and only narrowly escaped being killed herself. The boy, Jayweera, was taken away by the military and spent one month in a military camp where he witnessed torture and killings of adults and other children. He was also tortured himself, and the military threatened to kill him. The boy from Bosnia, Nino, was twice used as a human shield during the war in Bosnia, was sent to a concentration camp and had to flee to Denmark with his family.

These three children are only a few examples of how children always suffer when adults fight each other. The lives of the children will never be the same, they have seen things which mean that they cannot live and think like other children. Witnessing torture is also torture.

Available in English and Danish.

1994

And after the torture
Director: Lars Feldballe Petersen
Duration: 40 min. Price: DKK 150/USD 30

And after the torture is a film about the consequences of repression. It takes place in Chile in 1993, four years after the fall of the Pinochet dictatorship. The time of the dictatorship was a period of violence, torture and disappearances. The torture rehabilitation centre CINTRAS estimates that 1/5 of the Chilean population was affected by the violence.

The present government tells the people to forgive and forget. However, this is very difficult when the torturers were never identified, found guilty or punished. After Pinochet’s fall, the torturers very often maintained their powerful positions. The torture victims and their relatives say that if the torturers would admit their guilt and say sorry, maybe they could forgive. Instead they have to live side by side with their former torturers, and this prevents rehabilitation. The knowledge that Pinochet is still head of the army creates uncertainty, and therefore the silence about what happened continues. The film very clearly shows the negative effects of impunity.

Available in English and Danish.

1990

Doctors and torture
Director: Phillip Wearde
Duration: 45 min. Price: DKK 600/USD 100

Doctors and Torture is a film about doctors’ participation in torture in South America. Military dictatorships used torture to stay in power, in their “fight against subversion”. The victims of torture in countries such as
Argentina, Brazil, Uruguay, and Chile all talk about involvement of doctors in the torture. The doctors participated with their knowledge, and their function was to keep the prisoners alive, to get them ready for more torture. Sometimes they even participated in torture sessions or developed new ways of torturing, for example by developing new drugs.

The above countries have now overthrown the military dictatorships, but only a minority of doctors have been identified as torturers. Very few have been prevented from practicing as doctors which means that the doctors who participated in their torture are still able to practice as doctors.

The film is followed by interviews with Inge Genefke, former Medical Director of RCT; now Secretary-General of IRCT; John Dawson of the British Medical Association; and Gregorio Martinez, former President of the Uruguay Medical Association.

Available in English.

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Clinical considerations concerning refugees in the Denver region

Debbie Kreisberg-Voss, ABD, MA*, Dennis Kennedy, LPC, NCC*, Peter Van Arsdale, PhD* & Karl Ferguson, MA*

Survivor populations in Colorado

Estimates of the number of survivors of torture and other human rights abuses currently residing within the United States vary around 400,000. The refugees in the greater Denver region have suffered severe trauma through war and political terror, torture, and other human rights abuses. Exact statistics on the percentage of torture survivors within the refugee population are not available, a fact which represents part of the unique difficulty of responding to this need. There are approximately 30,000 refugees in the state of Colorado, and our conservative estimate is that ca. 5,000 of them are survivors of human rights abuse and torture. That number increases when the broader Rockies region – Utah, Wyoming, New Mexico, Kansas and Nebraska – is taken into consideration.

The Bosnian refugees who have come to Colorado during the last two years represent a population of which a high proportion were very recently subjected to torture and other human rights abuses. Most had suffered significant trauma stemming directly from war abuses and/or imprisonment in concentration camps.

There are ca. 300 Arab Iraqi refugees in the Denver area. Most are refugees from the Desert Storm conflict, and have spent from one to six years in the Rafaha refugee camp in the Saudi Arabian desert before arriving in the US. Many have moved to Denver to be reunited with family and friends. The majority of these refugees are men, here without their wives and children who are still in Iraq. In March 1997, over 150 Kurdish Iraqis arrived from Guam following the conflict in Northern Iraq. Many came in family groups. All of these Iraqis, Arabs, and Kurds have suffered through war and ethnic persecution; and many are also victims of torture or imprisonment. For other ethnic groups, such as the large Vietnamese community in Denver, many of whom are survivors of re-education camps, the trauma might have occurred many years ago. However, the delayed response and lack of any appropriate treatment or rehabilitation often result in ongoing and intergenerational impact.

The types of torture that the Rocky Mountain Survivors Center (RMSC) clients and their families have suffered cover a wide range: physical beatings, rape, concentration camp imprisonment, execution of family members, death threats and harassment against family members remaining in their native country, and psychological torture in the camps. Four case study examples of survivors are given below.

Case studies

These case studies represent a subset of cases at RMSC, in an effort to show the diversity of the entire case load.

1. Male, 33, Bosnian – This man has epilepsy. He was imprisoned in a Croatian concentration camp where he was tortured psychologically and physically. He came to the United States, was arrested for a crime, and illegally deported back to Bosnia. He was returned to the United States without a visa, and held for ten months in an Immigration and Naturalisation Service detention centre. He is now living with a chronic alcoholic. He is unable to work and suffers from Post Traumatic Stress Disorder (PTSD). The programme initially co-ordinated hospitalization and psychological services and provided an interpreter for counselling services in his native language. He has received ongoing follow-up counselling in his native language.

2. Young woman from a Middle Eastern country – She was tortured in her native country, came to the US, applied for asylum, and is awaiting disposition of her case. She is a victim of domestic violence and spent some time living in a shelter for abused women. She suffers from PTSD. The programme obtained long-term, safe housing for her, and she is receiving psychological counselling.

3. Male, 60, Bosnian – Suffers from brain damage from being beaten in the head in Bosnia. He is disconnected with reality; does not remember who tortured him, and gives different life histories. He cannot work and is living alone on Supplemental Social Security Income. He is receiving counselling in his native language, and has been receiving volunteer assistance for the last two years.

4. Male, 27, Bosnian – Psychologically and physically tortured in a concentration camp in Croatia. A soldier killed his brother. He is living alone, but has problems because he is drinking alcohol. His mother, brother, and two sisters have received permission to come to the US. He is being assisted with finding medical services and help with medical insurance. During the past year he has had individual psychotherapy, and he is now receiving counselling in his native language.

For a presentation of the Rocky Mountain Survivors Center, please turn to p. 95.
The participation of health personnel in torture

Knud Smidt-Nielsen, MD*

Abstract
The purpose of the present study was to examine important aspects of the participation of health personnel in torture and furthermore, to find out whether doctors' participation in torture had left the torture survivors with suspicion and fear of the medical profession.

The study comprised 80 clients, 70 men and 10 women, who were treated at RCT, Copenhagen, after obtaining asylum in Denmark. The Middle East representation was 93%, and 40% of the clients were under 20 years of age.

The method of the study was prospective with semi-structured interviews. The first part of the questionnaire covered the general conditions during imprisonment. The second part dealt with personal experiences with doctors during imprisonment and what prisoners might have learned from other sources about participation of doctors in torture. The third part concerned the attitude to doctors after imprisonment.

The general prison conditions were described as very poor with regard to food, hygiene, washing and toilet facilities, overcrowding, and solitary confinement. Forty-one percent of the clients had been in contact with medical personnel in connection with their torture, most common was doctor contact after the torture. Mistrust to doctors, avoiding to seek doctors' help after imprisonment, and nightmares in which doctors were involved were often reported.

The conclusion from this study is that doctors are involved in torture situations to a considerable extent, nurses to a much smaller extent. When clients have had such experiences, they often mistrust doctors for several years after their release from prison.

Background
The purpose of the present study was to examine important aspects of the participation of health personnel in torture.

In the Declaration of Tokyo by the World Medical Association torture is defined as the "deliberate, systematic, or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason".

The medical work against torture began in the early 1970s by documenting torture. In the beginning of the 1980s systematic rehabilitation programmes for torture victims were developed at several places around the world, and this has increased the awareness of torture, including data and knowledge in general. It is now obvious that the "design" of effective torture methods is based on insight into the pathophysiology of torture from either a psychological or a medical background knowledge.

Even though torture has been practised for centuries by using violent and more refined methods, there has clearly been further development of these methods to make them more and more effective.

Furthermore, there are accounts by torture victims from several places in the world about the participation of doctors and other health personnel in torture, either in connection with the evaluation of the victim's fitness for torture, directly in the torture process, or by attending to the victims after the torture.

Methods
The study population comprised torture victims who were undergoing treatment at the Rehabilitation and Research Centre for Torture Victims, Copenhagen. They had all been granted asylum in Denmark and had been referred for treatment from institutions and general practitioners, or had come on their own initiative. All the clients undergoing treatment were invited to take part in the study; two declined from fear of having their identity revealed. All the data were treated confidentially.

The study was prospective in the form of a semi-structured interview from which the answers were registered on a standard questionnaire. All interviews took place under the same conditions, i.e. during the last phase of the rehabilitation. The study covered the period 1 January 1993 – 1 June 1996, with a break of six months in 1995. Eighty persons entered the study.

Based on the questionnaires, preliminary quantitative data collection and data-analysis took place with respect to further analysis.

The first part of the questionnaire covered the general conditions under which the prisoners lived during imprisonment, i.e. hygiene, food and water, overcrowding, isolation, etc. Since these conditions are known to exacerbate the health of prisoners, they should be of natural concern to the health personnel in prisons.

The second part dealt with the prisoners' personal experiences with doctors during detention, and what they might have learnt about from other sources about the participation of doctors in torture.

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Denmark
The questions focused on five points with respect to contact with medical personnel:
1. examined by doctor before torture
2. examined by doctor during torture
3. treated by doctor during torture
4. direct doctor participation in torture
5. inspected or treated by doctors after torture.

Information about possible doctor contact was excluded if the client's head had been covered up, making him/her unable to identify with absolute certainty the person as a doctor.

A great effort was made in the present study to find out whether doctors' participation in torture had left the torture survivors with suspicion and fear of the medical profession.

The third part therefore concerned the attitude to doctors after their imprisonment. Had they lost confidence in doctors in general? Had the fact that the doctors did not live up to their oaths with respect to prisoners resulted in avoidance of seeking doctors' help? Had their experiences with doctors left them with nightmares involving doctors?

Finally, the clients were also asked if they had heard about other inmates who had had experiences with doctors in connection with their torture.

**Material**

The study comprised 80 clients, 70 men and 10 women (87% and 13%), who were treated at the Rehabilitation and Research Centre for Torture Victims (RCT), Copenhagen.

Country of origin and sex are listed in table 1. The Middle East representation was 93%. Age and sex are listed in table 2. The age is recorded at time of first detention. Forty percent were under 20 years, the youngest being 11 years old.

All had been detained for a shorter or longer period. Thirty-eight persons (47%) had been detained once, 24 (30%) twice, and 18 (23%) three or more times. Although some had been imprisoned more than three times, these additional imprisonments have not been included. In total, 140 imprisonments have been recorded.

**Ethical aspects**

The choice of the study design was made with due respect to the Helsinki Declaration II.

**Results**

**General conditions during detention**

The food was stated to be generally insufficient by 98% of the interviewees. The food was said to be intentionally insufficient in order to weaken the prisoners' resistance. A weight loss of 10 to 20 kilos was not uncommon, and it was often difficult for the prisoners to regain the weight loss.

Overcrowding was reported to have taken place in 73% of the imprisonments, often with 30 to 40 prisoners in a small room, thus leading to the spread of germs and infectious diseases such as diarrhoea and pulmonary infections, as well as hepatitis, which further reduced the prisoners' resistance. The overcrowding meant that the prisoners could not all lie down and sleep at the same time, causing aggressiveness and violence among them. Informers were often placed among the prisoners, causing general suspicion among them and often leading to paranoia, a condition that often persisted even after they obtained asylum in Denmark.

When questioned about the possibility for open air walks in the prison yard, 95% of the prisoners said there was no such possibility.

Solitary confinement was common. Eighty-six percent of the prisoners were isolated for one to three weeks in connection with the preliminary interrogations, and later on often for months, even years, often in dark rooms or with the head covered. The length of the isolation periods was not recorded because the clients found it difficult to be precise, having lost their sense of time.

To obtain a true picture of the general conditions, it should not be forgotten that the detainees were poorly dressed in thin clothes, usually without shoes, and only some had a very thin blanket. Therefore, they had very little protection against considerable temperature changes, and they often felt very cold. The isolation cells were very small so that the prisoner could not stretch out completely when lying down or standing upright, and the floors of the cells were often under water. Hygienic conditions were described as poor. There were no washing and toilet facilities, perhaps a bucket, otherwise the floor had to be used. The clients have explained that they were sometimes allowed to go to the toilet outside the cell, once or twice in 24 hours, but that these visits were delayed deliberately and often interrupted after ½ to 1 minute.

**Doctor contact**

The prisoners' general impression of the doctors was that they were the regime's long arm, and that they were acting in close agreement with the directives from their superiors. The prisoners regarded these doctors with great mistrust and did not expect to get any help from them.

The frequency with which doctors appeared in connection with torture is listed in table 3. Thirty-three clients (41%) stated that they had been in contact with medical personnel in connection with their torture.

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**Table 1. Country of origin and sex. n=80.**

<table>
<thead>
<tr>
<th>Country</th>
<th>Sex</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
<th>%</th>
</tr>
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<td>0</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Bosnia and Hercegovina</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Chile</td>
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<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
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<td>0</td>
<td>2</td>
<td>20</td>
<td>22</td>
<td>28</td>
</tr>
<tr>
<td>Iraq</td>
<td></td>
<td>7</td>
<td>23</td>
<td>30</td>
<td>38</td>
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<tr>
<td>Israel</td>
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<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>China</td>
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<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Kirghizia</td>
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<td>3</td>
<td>3</td>
<td>4</td>
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<tr>
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<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Lebanon</td>
<td></td>
<td>0</td>
<td>10</td>
<td>10</td>
<td>13</td>
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<tr>
<td>Somalia</td>
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<td>2</td>
<td>2</td>
<td>3</td>
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<td>Syria</td>
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<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Turkey</td>
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<td>0</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Vietnam</td>
<td></td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10</td>
<td>70</td>
<td>80</td>
<td>100</td>
</tr>
</tbody>
</table>

**Table 2. Age and sex. n=80.**

<table>
<thead>
<tr>
<th>Age</th>
<th>Sex</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
<th>%</th>
</tr>
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<tbody>
<tr>
<td>11-19</td>
<td></td>
<td>4</td>
<td>28</td>
<td>32</td>
<td>40</td>
</tr>
<tr>
<td>20-29</td>
<td></td>
<td>2</td>
<td>30</td>
<td>32</td>
<td>40</td>
</tr>
<tr>
<td>30-39</td>
<td></td>
<td>4</td>
<td>10</td>
<td>14</td>
<td>17</td>
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<td>40</td>
<td></td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10</td>
<td>70</td>
<td>80</td>
<td>100</td>
</tr>
</tbody>
</table>
Table 3. Contact with medical personnel in connection with torture. n=33 (41%).

<table>
<thead>
<tr>
<th>Type of contact</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examined by doctor before torture</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Examined by doctor during torture</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>Treated by doctor during torture</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Direct doctor participation in torture</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Inspected or treated by doctor after torture</td>
<td>31</td>
<td>94</td>
</tr>
</tbody>
</table>

Contact before torture
Medical contact before torture was not particularly common. Only three prisoners (4%) had been in contact with a doctor before being tortured.

Doctor contact during torture
With respect to doctor attendance (monitoring) during torture, six persons stated that they had been examined during torture, while five said that they had been treated by a doctor during the torture. The doctor’s role was usually to prevent the prisoner from dying, or to revive the prisoner if he lost consciousness, in order that the torture could continue. In this way the so-called monitoring is borderline direct participation in torture. Two clients confirmed that a doctor had taken direct part in their torture.

There are accounts of doctors playing an active role in torture by giving injections of strong neuroleptics over a period of time to influence the mental state of the prisoners. Likewise, of prisoners being given injections of morphine before release, in order to make them addicted to such drugs, something which would reinforce the impression of the prisoners being irresponsible and amoral persons, an impression which the torturers wish to give. There are also accounts of doctors giving prisoners deadly injections. The present study also includes two statements about doctors in a Syrian prison who themselves injured the hands or feet of the prisoner with a roller fitted with knives or razor blades.

There are accounts of a well-known important doctor in Iran who went to the prison on his own initiative to take an active part in the torture. He was regarded as a torturer, but also as a friend of the prisoners, because on several occasions he had ordered the killing of some of the most severely tortured, which was considered a merciful deed.

Doctor contact after torture
By far the commonest doctor-prisoner contact was after the torture and before the next torture session. Thirty one persons (39%) reported this. The doctors usually attended to the prisoners in their cells, but also in a clinic or hospital department if necessary.

The doctor’s aim was to patch up the prisoner so much that torture could resume quickly. The examinations were described as very superficial, if carried out at all, just as pain relief was not given.

Nurses
The participation of nurses in torture seemed to play a much smaller role than that of doctors. It was usually a question of attention and treatment after torture, i.e. in only 16 cases of the 140 imprisonments. Other than that, only a further five cases were reported. The behaviour of the nurses was said to be not very professional. Since there are very few trained nurses in the countries concerned, it would not seem probable that the authorities would waste their skills on the treatment of imprisoned opponents of the regime. By contrast, the doctors were needed for the torture.

Suspicion and fear
Table 4 shows the consequences of detention and torture in relation to doctors.

Table 4. Consequences of previous experiences. n=14 (15%).

<table>
<thead>
<tr>
<th>Consequences</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mistrust to doctors</td>
<td>8</td>
<td>57</td>
</tr>
<tr>
<td>Avoidance of seeking doctor’s help</td>
<td>6</td>
<td>43</td>
</tr>
<tr>
<td>Nightmares involving doctors</td>
<td>12</td>
<td>86</td>
</tr>
</tbody>
</table>

It is particularly remarkable that 12 persons stated that doctors appeared in their nightmares after their imprisonment. Seven of the 14 persons had indicated doctor contact in connection with their torture.

A former prisoner said: “The greatest trauma for me was perhaps not even being tortured, but the feeling I had when a doctor entered my cell after my torture, and said that he had taken part in the torture, and that he just wanted to tell me that I would certainly be ready for interrogation soon and that my injuries were not that bad. Then he just left without even examining me or helping me. I have never been able to forget this behaviour.”

Indirect statements
The clients were also asked about what they had heard about the doctors’ activities in connection with torture. These statements confirm the direct statements, only accentuated at a higher level.

Discussion
Much information has been published during the last 10 to 15 years about how doctors have participated in various ways in torture”. However, only few systematic studies concerning this problem are available, and most of these studies have focused on showing the fact that doctors take part, only a few to what extent. The question to examine is no longer whether doctors participate in torture, but rather the extent to which they do so.

The present study has made a special effort to question the clients under the same conditions, i.e. just before the end of their rehabilitation, when they are well adapted in the treatment system. Furthermore, almost all had been through prolonged psychotherapy for relief of their torture experiences; their memory of possible doctor participation in their torture would therefore be clearer than if they had been questioned at the beginning of their rehabilitation. In order to avoid the risk of insecurity and misinterpretation, the same interpreter was used as the one the clients were used to from their therapy.

The participants were very similar with respect to cultural background since 93% of them came from the Middle East.

Sources of error
There are naturally many possibilities for sources of error in a project of this kind, apart from those connected with checking the collected data. Thus, the torture victims’ heads were often covered, sometimes for months. As they could not see, they were unable later to recognize their torturers or doctors. Information about possible doctor contact from cli-
ments with their heads covered was not included in this study, even when the victims were quite sure that they had been examined by a doctor. A person was recorded as being a doctor when the clients had made a visual identification of a person who was dressed in medical clothes, and they were not directed. This definition was necessary because 13 of the clients said that torturers and guards were dressed in white coats, a fact that might be another source of error. It was also reported that in Iran the worst torturers, who for instance applied corrosives to the anus or burnt the genitals, were called “doctors” – no doubt a nickname used by the prisoners and the prison guards. Other information reported that the Iraqi regime selected suitable persons for a very short course of medicine, then awarding them a diploma and the right to call themselves doctors in order to be used as prison doctors. Other sources of error might be the poor memory of the victims; that they had forgotten or suppressed their experiences.

The study revealed that 14 (18%) of the clients suffered nightmares including doctors and/or felt that their attitude to doctors had changed because of their torture and imprisonment. The feeling of being left alone by somebody from whom help is expected, has been described by many torture survivors and has no doubt added to the momentary hopelessness and the mistrust that often continued to follow them in their attitude towards other people, in particular to doctors. Studies on this phenomenon have not been found in the literature. Only 7 of the 14 clients had personally experienced contact with medical personnel during their torture. The attitude to doctors and the nightmares might also be explained by the generally insufficient medical care during imprisonment, or by the fact that clients had heard that others had experienced doctor involvement in torture.

Doctors at risk and international agreements

Many declarations and conventions prohibit doctor participation in torture, e.g. The Declaration of Tokyo and The UN Convention against Torture, which states in article 2, paragraph 2: “No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture.” And in paragraph 3: “An order from a superior officer or a public authority may not be invoked as a justification of torture.”

However, the picture is not just black and white, but rather grey. There is no doubt that there are doctors who, for various reasons, become “prison doctors” or “police doctors”. It may be from reasons of economy, career, or ideology. The Iranian state, for instance, offered a medical training to many family members of victims of the Shah’s regime and of the war against Iraq. It would be difficult for these doctors to turn down an offer of employment, e.g. as prison doctors. Doctors may be more or less forced to become prison doctors or military doctors, etc. because of threats of violence against their families, of taking away their medical authorization, or because they are themselves threatened with torture and execution. There are reports of several doctors being executed because they refused to participate in torture.

One may question whether the same yardstick can be applied to all doctors who in some way or other took part in torture. It might be said that just the fact that a doctor set foot in a prison where torture was used routinely puts him in the category of potential torturer. But it is difficult to put all the responsibility on the individual doctor in such a situation, when he is pressed to break the medical ethical rules because he is working in a hierarchical system that demands blind obedience. In such situations, international organizations must help by putting pressure on the government in question in order to have the conditions changed. It is very difficult for the individual doctor to stand up against the system in countries where torture is accepted or directly used as political pressure. In countries with local medical associations that are relatively independent of the regime, there is a chance that these can take action and support the individual doctor who is in danger of being pushed into situations such as those mentioned above (“Doctors at risk”).

Fortunately, it seems that the international medical organizations are becoming aware of their responsibility in this field. Thus, in September 1995, The World Medical Association (WMA) amended the WMA Resolution on Human Rights of 1990 by adding article 6, by which the member associations are encouraged to “support individual physicians who call attention to human rights violations in their own countries.”

It should also be mentioned that WMA at its annual meeting in Hamburg in 1997 passed a resolution dealing with torture which states that WMA finds it necessary to support and protect, and to call upon its NMAs to support and protect physicians who are resisting involvement in such inhuman procedures or who are working to treat and rehabilitate victims thereof, as well as to secure the right to uphold the highest ethical principles including medical confidentiality.

References


Acknowledgement

I wish to thank Dr. Ole Vede Rasmussen for his help in finalizing this article.
Rocky Mountain Survivors Center

History of the Center
The Refugee Mental Health Access Project (RMHAP) was created in February 1995. The development of this project grew out of the recognition that there existed no coordinated system of mental health care or other resources to provide culturally appropriate services to refugees in Colorado (other than to south-east Asians and Hispanics). The primary goal of RMHAP was to create better mental health services for refugees in Colorado. Today the programme is a free standing centre for the treatment of survivors of torture and human rights abuse.

The growing need
All too often refugee populations enter the US with limited screening, and as a result, survivors are often undetected by sponsor organizations. In many circumstances torture experiences have left refugees mentally confused, physically unhealthy, and unable to present a coherent account of the oppression they have suffered. This is problematic, because voluntary resettlement agencies (VOLAGs) are unprepared to deal with severely traumatized refugees. Deadlines and resource scarcity lead to a focus on the immediate survival aspects of resettlement, such as employment and housing. VOLAGs are unable to commit additional case-management time to mental health/survivor issues. This is compounded by the reality that family and community group sponsors who are even further disconnected from the mental health system are being increasingly relied upon to provide support for newly arrived refugees.

Since January 1997, the A.F. Williams Family Clinic of Denver has been performing refugee public health screening and health assessment. By January 1998, 868 refugees (91% of all arrivals) had received a health assessment in addition to the public health screening. A total of 519 abnormal health conditions were identified; one of the commonest was mental health problems. Among the refugees, 32 were identified as having mental health needs. These represent the first statistics from Colorado to include the number of refugees with mental health conditions (victims of torture/rape, depression, post-traumatic stress syndrome, etc.). The RMSC has assisted the Colorado Department of Health and A.F. Williams Clinic with this data collection and analysis, marking the beginning of potential cutting edge research. All these refugees were referred for counseling services. Efforts are underway to further refine the mental health element in the refugee health screening process.

The physical manifestations of a torture experience can be overlooked by doctors who are unfamiliar with the signs, and there is even less chance of the psychological manifestations being uncovered in this setting. It must be recognized that, even if all personnel working with newly arrived refugees were adequately trained to identify survivors of human rights abuse who need special services, the emotional problems of severely traumatized refugees are long term, and often have a delayed appearance after the initial resettlement process is complete.

In the past, mainstream human services in Colorado have proven unprepared to provide either culturally appropriate psychological assistance or coordinated access to other necessary support services. A number of critical factors, such as language, cost, timeliness, cultural awareness, professional training and experience, must be taken into account when attempting to address the service and resource needs of any individual survivor of human rights abuse. All too often resources are either not available or are not coordinated due to logistics. While some independent agencies offer culturally appropriate services to particular populations, such as the Asian Pacific Center for Human Development and Servicios De La Raza, both located in Denver, there has been no system for service coordination with other refugee populations. The Refugee Mental Health Access Project represented a successful effort to provide culturally appropriate and sen-
The Center
The Rocky Mountain Survivors Center (RMSC) is the only center for survivors of torture (there is currently a small residential center in Oregon) that exists in the US geographical area that extends from the Marjorie Kovler Center for the Survivors of Torture in Chicago, Illinois, to the Survivors International of Northern California. The Center is located on the main floor of a refurbished House in Capital Hill. It comprises three rooms for therapy and clinical offices, two administrative offices, a kitchen, and two bathrooms, as well as a lovely outdoor deck. Located near downtown Denver, Colorado, it is not far from two refugee resettlement agencies. This address means convenient and safe access for the survivors who are seeking treatment. One of the offices is used as a group therapy and counselling space. Art therapy, women’s support groups, and the children’s movement therapy group all take place here. Stuffed animals, toys, plants, and books add comfort to the already home-like environment.

Further information about RMSC

Information sharing and research
Monthly conference calls with other US survivor centres have been a helpful source of information. Direct clinical and non-clinical provision of services to the Bosnian populations in Colorado, literature research, and collaboration with other centres in the US and internationally have allowed the programme to begin building an information base about working with these survivors.

An invited paper, “Treating Refugee Victims of Torture: The Rocky Mountain Survivors Program” was presented on 7 March 1997 by Peter Van Arsdale, Chairman of the Board of the Center for Cultural Dynamics, at the annual meeting of the Society for Applied Anthropology in Seattle, Washington. This paper was published in the autumn issue of the Society’s journal Practicing Anthropology. An expanded version of the paper, co-authored with Dennis Kennedy, will be published in a special issue of the Journal of Immigrant Health. The paper focuses on the theoretical and conceptual foundations that helped in the formation of RMSC and its services to survivors. It also details the history, programme structure, and staffing and network connections that were created prior to, and helped to support, the development of the programme. Many people were cited and helped to contribute to this paper, including Program Coordinator, Debra Kreisberg, and Dr. Antonio Martinex, Director of the Institute for Survivors of Human Rights Abuse.

The Center personnel
Dennis Kennedy, the current Director, who has many years’ experience of specializing in cross-cultural counselling, psychology, and education.
Debra Kreisberg-Voss, Assistant Director and Program Coordinator, whose long-time focus has been on refugees and immigration policy.
Karl Ferguson, Development/Finance Coordinator.

The Center’s model
The RMSC is profoundly impressed by the dignity of survivors of torture and by the strength and resilience they manifest in continuing with their lives. The RMSC uses the word “survivors” to acknowledge their attempts and abilities to overcome victimization. The RMSC is committed to the idea that survivors need a relationship with a community – a healthy relationship incorporating psychological, physical, social, and spiritual elements – rather than only with a specific treatment. The separation of body and mind is especially not appropriate in the treatment of survivors of torture. The focus of rehabilitation is not to cure, but rather to free the survivor. Post-traumatic symptoms are often less a form of illness than a form of bondage. Within the torture experience, the body has to be used to gain access to the mind and soul; therefore treatment must be approached holistically, simultaneously healing body, mind, and soul.

The RMSC uses an eclectic-holistic model of treatment that assists the individual, both on-site at the Center, and at service locations within the community. It also recognizes social justice education, solidarity with survivors, and systemic change – locally, nationally, and internationally – as critical components. Based on this model, the RMSC has developed programme goals that will provide direct services.
to survivors, allowing them to access services for a range of needs: psychological, medical, social, and legal. A wide variety of mental health treatment and social service approaches are offered by on-site staff as well as volunteers giving pro-bono services, including psychotherapy, social rehabilitation therapy, art therapy, pastoral counselling, English as a Second Language tutoring, and friendship.

Programme components for the RMSC include: providing advanced training for mental health and other professionals in symptom and behaviour recognition, and treatment for survivors; training and ongoing support for pro-bono and volunteer service providers; referral and coordination of psychological, physical, social, and spiritual services for survivors; on-site culturally appropriate counselling; outreach in refugee communities to raise awareness of mental health issues and available resources; preventive mental health education; and community presentations on human rights abuse and work with survivors.

Achievements
Training
Since October 1996, 69 persons have been trained. Expansion of training to mental health and health professionals is ongoing and will continue into 1998-99.

Orientation
The following are estimates based on Colorado Refugee Services Program statistics of arrivals in 1996, 1997, and 1998. Total arrivals under the five categories for 1998 were 2585. An estimated 10-50% of this total are potential high-risk refugees who have suffered human rights abuses. This includes from 285 to 1427 new arrivals. This number should move towards the lower end of the scale as Russian refugees are counted within these totals, but they include few persons who meet the high-risk definition.

Netwok
Sixty-nine volunteers have been recruited and trained since October 1996.

Service provision
Provision of clinical mental health services occurs via the network, including referral of services, case consultation and coordination needs assessment, and mental health counseling. During the first six quarters of the grant period (October 1996-September 1999) a total of 150 clients received clinical services through RMSC. In addition, 269 clients received either direct or indirect non-clinical services through RMSC. These numbers reflect the need for these services in the Rocky Mountain region.

Community education
We were exactly on target during the first six quarters. RMSC is moving forward with a number of events in an effort further to establish links with high-risk refugee communities (Bosnian, Arab Iraqi, Kurdish, Ethiopian, Eritrean, Zairian, Haitian, and other, smaller communities) through "gatekeepers" in order to provide education on mental health, and with community organizations in an effort to raise awareness of refugees in general, human rights abuses, and mental health needs. Our continuing efforts to develop new channels with the refugee community organizations, educational institutions, and faith communities are coming along well.

Mission statement
The RMSC works alongside survivors of human rights abuse to provide specialized human services as a direct response to the traumatic effects of torture and other such abuses.

Please turn to page 90 for the article "Clinical considerations concerning refugees in the Denver region" by the RMSC.

Selected list of publications
received in the IRGT International Documentation Centre


Pathological brain stem evoked potentials in tortured prisoners of war/Wcra, Andelko; Malinar, Marta. - In: Croatian medical journal ; vol. 37, no. 1. - 19960000. - p. 35-37.


Torture and war trauma survivors in primary care practice / Weinstein, Harvey M.; Dansky, Laura; Jacopino, Vincent. - In: Western Journal of Medicine ; vol. 165, no. 3. - 19960000. - p. 112-118.

Indian essay competition on torture

The Indian Medical Association (IMA) has done an impressive, courageous, and good job by informing the Indian medical profession about the torture that is practised in India. Because it is kept secret, the victims, when they seek help, may best be identified by their general practitioners.

As part of the IMA's efforts, the Delhi Psychiatric Society has, together with the IMA, organized a debate on torture: "Torture and Human Rights' relevance to the medical profession", which took place in October 1997. At the same time, that debate led to an invitation for an essay competition on the subject "Torture and Human Rights, Indian Perspective'. This competition was open to all medical students and interns. There were five prizes, the first of 2,000 rupees. All the participants received a certificate, and a college shield was promised to the best participating college. The arrangement was a success, with many participants and much interest for the subject.

In collaboration with the organizers of the competition, the editorial board of TORTURE was asked to evaluate 25 essays with respect to quality, knowledge, and type of information, and give suggestions regarding similar activities. The evaluation committee found that the 25 selected essays were in general of a very high standard, six being exceptionally good. Two were placed joint first, another came in third, and three shared the fourth place. In our evaluation we paid special attention to whether the writers had tried to stick rigidly to the topic that had been defined very clearly: "Torture and Human Rights", in that order, and also whether the Indian perspectives had been highlighted. Also the originality of the essay was included in the evaluation.

The result was that Dr. Pradeep Agrawal, President of the Delhi Psychiatric Society, reported back that the selection of essays and their placing agreed with the evaluation that the Indian organizers had made.

This essay competition is an excellent idea, which cannot receive too much support. The editorial board of TORTURE is pleased to publish parts of the essays. We find this idea of the IMA and the Delhi Psychiatric Society excellent, and hope that the mention of it here will stimulate others to similar initiatives.

In the following we will bring one of our proposals for the first nomination in full, and later parts of three other essays.

H.M.

Tortures and Human Rights in Indian perspective

Vijay Kumar, 3rd year Medical Student, University College of Medical Science, Delhi

"All human beings are born free an equal in dignity and rights. They are endowed with person and conscience and should act toward one another in a spirit of brotherhood." These opening words of Universal declaration of human Rights express a concept of man which underpins the framework of human rights embodied in the universal declaration and the two International covenants of Human Rights. We may identify human rights as those moral rights which are owed to each man or woman by every man or woman solely by reason of being human. Without human rights an individual cannot maintain his or her existence as a being different from the rest of animal kingdom. The universally acclaimed human rights have been broadly divided into following categories. 1. Right to life 2. Right to liberty 3. Right to freedom of belief and expression 4. Right to freedom of Association and assembly. 5. Right to property and economic and social right.

Since ancient period India has been a supporter of human rights due to its liberal and humanistic approach. India was regularly attacked by the foreigners and remained slave. When got freedom from the slavery burden, the constitution guaranteed and secured fundamental Right as a human right in constitution part III to all the people of Indian.

There is no denying that in spite of all the constitution provisions and safeguards, there have been aberration and lapses with regard to the practice of human right in India. Our media records daily cases of abuse of authority by law enforcement authority, custodial deaths and rapes, excessive use of force and torture, terrorists' violence against innocent people, torture cases reported against women, child minorities and backward classes.

The human rights movement in India is just two decades old, started during the emergency in 1975. The peoples' union of Civil liberties was founded to defend the individual's freedom and people's right to liberty as an agitation against the draconian laws of detention without trial. Former justice Mr. V.M. Tarkunde is the initiator of the people's response to the brutalities committed by police. Jayprakash Narayan founded the Citizen For Democracy (CFD) to articulate the rights of the people. Wherever and whenever excesses were committed against Muslims, Dalits and helpless, CFD released it to the media and forced New Delhi to constitute the human right commission.

TADA ACT was enacted on 23 May, 1985 to deal with subversive activities in Punjab and Jammu & Kashmir. But it was misused. According to National Human Right commision Report from 1985 to 1994, more than 75,000 people were held in this act of which only 8% were real culprits. Gujarat which suffers from no problem of terrorism has the highest number of 19,263 TADA cases. Now TADA has been dropped, but even now scores of detainees languish in jail. The Prime Minister Mr. I.K. Gujral's instructions that their cases
should be reviewed have not accelerated the process of release.

There were a number of cases of death and rape reported in police custody, people were tortured inhumanely to confess their crime, like rape, third degree torture etc. CFD found both security forces and terrorists violating Human rights, but to kill terrorists in false encounter of police custody is to supplant the process of law.

Violence against women began to be practised, the door of educational, economic, social, political and Cultural opportunities were closed for them and they were tortured by being enslaved, by prostitution, child marriage, rape, bride burning etc. According to report of National Crime bureau, there is a massive increase in rape case at a rate of 29.8%, sexual abuse 21.8%, eve teasing 19.4%. In 1994 98,964 cases were reported, a quarter of the cases related to the torture of women. Even in Delhi, every 16 hours one rape case is registered. Besides these, who can forget the case of Amina Bai, Bharmwari Devi (Sathin) who was strapped in front of all villagers. On 20 October 1996 woman supporters of Utrakhand were tortured and sexually abused by police.

In Punjab in recent bizarre incident, a woman being stripped in front of her son in Bhatinda by the staff of CIA. In a similar case a 14 year old Dalit girl was paraded naked by three persons in Pakka Pind in Amritsar. Actually, women in their own right are threatened by rape if they dare to speak about against injustice. The activists who for instance stopped a child marriage in Rajasthan were gang raped.

Education and Employment are yet aliens to many people. Child labour and bounded labour exist in many parts of the country. According to the latest data of UNICEF in India, 1.5 crores out of 6 crores of child labour are bounded labour. The existence of child labour in India is a complex reality, a social torture, a torture against the community. Children are employed in Hazardous factories. Every 3rd household in India has a working child. Every 4th child in the age group of 5 to 15 is employed. Such children are physically, mentally and sexually tortured at various levels. Hard hours of labour kill their creativity and cause deteriorating effects on their physical and mental health.

At present, 14 major legislative enactment to provide legal protection to children like Article 39(e), children should not be abused, article 39(f) children should be given opportunities to develop in a healthy manner and Article 14 no child below age of 14 shall be employed. Besides these, factories act and mines act provided for the child labour. In 1987 a National Policy on child labour was formulated.

The reprehensible practice of untouchability has not disappeared. Transportation of human excreta by scavengers can be seen even today. The lower caste people are still tortured by higher caste people.

India has made great effort towards developing human rights. The status of the women of the depressed class has visibly improved with respect to education, employment, opportunities and many other social and economic rights. The Practice of untouchability though it is yet to disappear, is on the wane. Minorities and tribal groups have been given sufficient protection.

The Government set up a Human rights commission, and under the human rights protection act of 1993 article II, N.H.R.C. received 10,200 complaints from April 1995 to March 1996, including 444 deaths in custody, while it received 6,987 complaints in 1994-95 of which the majority was about violation of citizen rights, rape, deaths, torture in police custody. This year the commission received as many as 2,769 complaints from Uttar Pradesh, including 37 deaths, rapes and torture in police custody. Then comes Bihar with a total of 1,230 cases in which 75 were of torture, deaths and rapes in custody. In 1995-96 the commission investigated 170 cases against police torture and 22 police officials were charged case in court, 70 were suspended, and 26 were considered. 22 victims were given from 25,000 to 1 Lakh rupees as a compensation.

The report of N.H.R.C. in 1995-96 emphasized on consideration on Civil liberty and improved police system to prevent Human rights violations. According to these reports Local Magistrates or Police Officers should be informed of and included in the search programmes in terrorist affected areas. Human rights training is a must for both soldiers and officers. The Indian Jail act 1894 should be restructured.

Provisions to stop torture in police custody gave direction to the Government to implement 2nd Police development reports 15th lesson immediately. Isolated Police investigation from political administrative interception considered prisoners wounded in custody to have been tortured by the police. The Supreme court provided the right to prisoners to tell their whereabouts in custody to their relatives. Several issues were on the agenda, like Garbage carrier person, death due to starvation, the Right of tribal people to their land, child prostitution, the right to have a house (in Habitat II summit), child labour was considered a desperate problem. N.H.R.C. constructed a group of child development department, NGOs and combined Child fund to tackle these problems.

In the 50th human right commission of the UN, terrorism has been accepted as another main source of human rights violations. In last 10 years in Punjab, 10,000 innocent people and 1,700 police persons were killed by terrorists, in Jammu & Kashmir the number was 5,500 people.

Some terrorists have constituted human rights organisations themselves. It is as if a tiger donned the skin of a lamb.

For example United Liberation Front of Assam (ULFA) has floated the Manab Adhikar Sangram Samiti (MASS). Before the recent murder of Sanjoy Ghose the MASS invited Human Rights activists to visit Assam to denounce the joint operation by security forces. Their brutalities are no less galling than those by the Security forces. What is the difference? Similarly, Naxalites in Andhra Pradesh, after having waged a class war and Naga revolt, lost its motive and humanistic support because of indiscriminate killings, Kidnappings and extortion.

Recently India has become a target of attack from Human Right Diplomacy. Amnesty International and Asia Watch have been condemning the act of the police and paramilitary forces in Punjab and Kashmir as violations of human rights. India refused their entry into India to study the human rights situation, which increased criticism of India. John Mallot from the US recently commented upon the human rights situation in India in serious terms. Germany, Japan, France, Pakistan minced no words in accusing India of such violations at any international forum.

Generally, the evidence given by International Agencies of the Human Rights violations give total credence to data and facts supplied by some groups, without taking into account any of the justifications offered. They ignore what the terror-
ists, secessionists and other ultras are doing to innocent civilians.

On the objective of Indian diplomacy that terrorism should be included as a violation of human rights has been accepted by the 50th human rights commission of the UN. The Indian Government would like Amnesty International and other similar organisations to get in touch with H.R.C. India however rejects outside interventions on the issue of safeguarding human rights within its territory. Being a democracy, India has sufficient checks and balances with regard to violations of human rights.

An atmosphere of authoritarianism comes to prevail in the country, when a group of irresponsible people who decide what is right or wrong does not respect the law and order, just like ultras.

Human rights are not likely to be guaranteed in full measure to the Indian citizen unless the nation as a whole is determined to cure itself of its basic maladies. Law enforcing machinery must be trained and made sensitive to the issue. The state can and should, however, strive harder to minimise the violations of basic human rights by the authorities in power. Even publicly minded persons and the media must contribute to spreading a civilised attitude in society. People should be aware of their rights. Constitutional Safeguards are worth the paper they are written on if they are not actually implemented. And here it is political will and sincerity that matters, not empty words and hypocritical claims.

Torture and Human Rights – Indian perspective

Vimal Kumar, 3rd year Medical Student,
G.S.V.M. Medical College, Kanpur

(...) Today, as India celebrates its 50 years of Independence we still find the sorry state of her citizens in blatant violation of Human Rights. Let us now analyse systematically the Indian perspective of Human Rights and torture.

The police force in India enjoys a Colossal position as far as Human rights violation & torture by cruellest of all means are concerned. Never before the society was besieged by the problem where the very institutions entrusted with the responsibility of ensuring public order have perverted their role and, in order to carve out their own empire for their personal aggrandisment, have unleashed a reign of terror of brutalities, atrocities, physical and mental torture, or the very members of society, whom they are supposed to protect, assist and serve. Peace-loving citizens were never so helpless against dacoits, outrlaws, terrorists and antisocials, as they are today against the public guaradians of law and order.

During British period, they committed brutalities to uphold British rule, today the same is done to maintain the undemocratic, unpopular politicians and musclemen in saddle. Nexus between politicians, gangsters and police, who exchange their services with each other result in victimisation of moral fabrics of society and Human rights.

The use of third degree torture on arrested persons, deaths in fake encounters and unwanted and unprovoked firing deprives citizens of even the right to live.

Unwanted use of force on peaceful processionists completely defies right to freedom of speech and expression. Undertrials are detained in jails for years without trial, in subhuman conditions, depriving the person of the Right to Justice. Draconian laws like National Securities Act, TADA, Armed Forces Special Powers Act etc. further strengthen the hands of these forces, throwing Human rights in doldrums.

The political patronage to these law breakers results only in an official wink to torture, rape, massacre, prison-privations, registration of false cases, padding of evidence etc. by the police.

(...) Thus, India needs to strengthn its enforcement mechanism to provide basic Human rights to its citizens, educate the children, deal with police atrocities with heavy hand and curb militancy to a bare minimum.

Torture and Human Rights, Indian perspectives

Mukesh Kumar Joon, 3rd year Medical Student,
University College of Medical Sciences, Delhi

(...) Torture: A Big Slap in the Face of Human Rights

In the recent past, the people of Punjab were maltreated at the hands of both Police and the terrorists. The terrorists openly tortured the people to satiate their own animal like urges. They murdered people at their will. Punjab women were victimised and had to bear sexual and psychological torture. There was no one to come up and enlighten the souls of the Punjab people. To add to their misery, the Punjab Police was no less than the terrorists in performing this atrocious and barbaric act. Cases have been reported in which the police-person raped village-women, tortured innocent people to admit crimes which they had not committed or for the sake of getting money, and sometimes even murdered innocent people. In such a case, question of who tortures more: the terrorists or the police, finds no answer.

The Kashmir people are increasingly made victims of the physical torture of the terrorists as well as the mental stress imposed by the military. The lobbyists have created a hell of the peaceful Kashmir by impelling the United States senators to implement laws which directly/indirectly are responsible for harassment of the people. Terrorists are also financed by them. Terrorists are receiving formal training in Pakistan and enter our Kashmir to create an aura of fear among people. The Human Rights Organisations raise alarm and question the Indian Government when the military try seek the co-operation of the people by asking for hide-outs of terrorists or other means. Are these organisations really taking care of interests of human rights?

(...) Despite medical ethics, medical personnel are involved in torture to a surprisingly large extent. Doctors are vulnerable to pressure to misuse their scientific knowledge. Physicians who are highest on the list of becoming involved in the practice of torture are military doctors, police doctors, prison doctors and forensic medicine experts called upon to cover up the case of torture with a certificate of death from natural causes. Doctors in service for their respective authorities
issuing false fitness and indulge in injecting drugs to extract information. Even post-mortem reports may to tailored to meet the demands of the authorities.

(...) The time has arrived when all social organisations, Human Rights Associations like Amnesty International, Human Rights Watch Organisations of various countries, Human Rights Committees and Worldwide Medical personnel should join hands in uprooting this evil from society. To maintain the utmost respect for human life, every individual should make a serious attempt to nip this evil in the bud. To respect and maintain the dignity of other persons' rights is the duty of each and every individual. Torture, like war, is a curse which must be removed.

Torture and Human Rights – Indian Perspective

Nasreen Qureshi, 3rd year Medical Student, Maulana Azad Medical College

(...) The causes of torture can be classified into political or governmental, wartime torture, police torture, organised crime or others. Government generally applies the torture techniques to anyone suspected of being an “enemy” of the state, to force compliance or to leave their lands.

(...) In India, the constitution specifies the fundamental rights of the citizens and the relevant provisions relating to torture are article 20, clause (3) and article 21. Article 20 (3) lays down that “No person shall be compelled to be a witness against himself”. While article 21 states that “No person shall be deprived of his life and personal liberty except according to the procedure established by law”. The supreme court has repeatedly held that the right to life is not the right to mere animal existence, but the right to live with human dignity, and it is this inalienable right that furnishes the jurisprudential basis for holding torture to be unconstitutional.

Two categories of people can be said to be deeply involved and closely related to this issue of torture – Officials of Law and Medical professionals. The UN has drafted a Code of Conduct for Law Enforcement Officers. Besides, orders by a senior official is no excuse for incurring torture and is punishable by law. For medical ethics, the importance of the subject of torture lies in its vital connection with human sufferings. Declarations have been made by UN, and by the General Assembly of the World Medical Association regarding medical professionals and torture.

(...) Though there are laws, conventions, good will, yet there are cases of torture seen very often in India today. Thus if the torture does get inflicted after all, there is treatment for the victim of torture.

(...) The need of the hour is to devise an antitorture campaign among the medical community. Doctors should document evidence of torture and conduct the autopsy in a fair manner. It is an ethical obligation on the part of the doctor to report all torture cases. The medical association should issue an official directive condemning and banning these practices. They should prescribe strict ethical rules and guidelines. Provision of Sections 330 and 331 IPC for causing hurt and grievous hurt to extort confession must be known to doctors. Awareness should also be created about Section 376 IPC which describes punishments for rape and Section 498A for dowry deaths.

Effective measures against torture require a scientific analysis of the factors which generate and sustain the problem. Social, behavioural and political sciences can contribute much to the understanding of the factors that are associated with a high prevalence of torture in various parts of the world. The studies should be directed at determining, for example, why governments and institutions and/or individuals torture and what can be done to prevent it, or for determining what factors can be introduced, manipulated and/or transformed in order to change the social, physical and psychological outcome of torture.

The overall process of rooting out the problem of torture is a difficult one because it entails the process of “making the obvious obvious”, i.e., rendering torture visible and subjecting it to reflection and study. This process of clarifying the obvious unfairness of torture and its unjustified infliction of suffering on others, forces citizens and their communities to reject their past acceptance of cruel and inhuman behaviour, especially when it is officially sanctioned. Only in this way do we have any real hope of influencing the real world around us.
Sometimes the way to overcome pain goes through the pain itself


Most of the articles in this book are elaborated versions of contributions to an international conference held in Zagreb during 1993, at which delegates of different nationalities and countries connected with the psychosocial assistance programme of IRCT, Boswofam ("Bosnian Women and their Families"), presented their work and co-work.

The book presents the results of research on a field experience with survivors of ethnic cleansing from the war in the former Yugoslavia, and conclusions about the organization of assistance on several levels.

The first two parts cover the issues that refer to the general setting of the situation, e.g., the nature of the war and ethnic cleansing, and the definition of war torture. Aspects of adaptation in refugees are discussed, together with the influence of the war on individuals and the community, and coping with trauma.

An article in part II gives a general presentation of the population that was the subject matter in all the articles in this volume about Boswofam's work.

Part III focuses on the methods of refugee care and their availability and suitability for the targeted population. Some significant aspects are covered, e.g., the unrecognized need for psychosocial help and the importance of comprehensive solutions in refugee care in third countries.

The following three parts mainly focus on the different therapeutic methods used in the work with torture victims. The way the different authors present the methods vary from the highly concrete to the more generalized.

I would like to emphasize the importance of the basic principles of refugee care, pointed out by the head of the Centre for Psychosocial Help to Refugees, Anica Mikuš-Kos, as the use of the inner resources of the refugees themselves as partners and collaborators in psychosocial or mental health programmes, with emphasis on the reality and primary needs in refugees' lives. Application of the idea about refugees as potential active subjects is reflected in part VII of this book, where refugee counsellors present their experiences of psychosocial help given to other refugees.

Part IX describes and analyses the psychological problems of children in war, with the psycho-pathology and ways of treatment. One of the authors, Stanislav Matašić, summarized his article as follows: "... War breeds new war, when the generation of traumatised grows up. Untreated trauma remains written in the body, as well in the individual and collective memory." This is why I would expect more attention to be given to issues concerning children.

Many helping professionals and paraprofessionals are caring for traumatized people in the world. These carers are managing really well, but they do not have enough energy and initiative to reflect their valuable experiences. The publication of this book is an obvious sign of the efficacy of joint efforts in well-functioning projects. I thank the authors for their easily understandable language, an expression of respect towards the target group — international readers.

The book is of great importance mainly for helpers in the mental health area who are treating war victims and refugees, but also for workers in psychosocial assistance, whose functions include treatment and rehabilitation of victims of crime and/or violence under peacetime conditions.

The book's recorded results, which illustrate persuasively the needs of traumatized people, can serve as a supportive means for organizers of assistance, while presenting suggestions to policy makers. The book's value may be maximal in countries where psychosocial assistance and rehabilitation of refugees and victims of crime/violence are still not established.

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Hard times


Zakaria Fadoul Khidir was born in a small village in the northern part of Chad. He was one of the eight sons of a traditional leading family.

Now a teacher at the University of N'djamena (section of linguistic studies), he has had to experience hunger, war, premature death of his mother, and the death, under torture, of most members of his close family. He himself was imprisoned in 1986, for the mere reason that he is a Zaghawa, a tribe that suffered a sudden and cruel repression.

In his book he describes the place, people, and facts in what could be considered a "cold" report, so keen is he to keep a distance from his emotions in order to protect himself from being overwhelmed by painful memories. Zakaria has not been tortured physically. But what he has been confront-
BOOK REVIEWS

A new guidebook on the group of post traumatic mental conditions


In this comprehensive guidebook, O'Brien deals not only with the concept of Post Traumatic Stress Disorder (PTSD), but also with a wide range of Post Traumatic Illnesses (PTI), including acute stress reaction, adjustment disorders, and post traumatic personality changes. This critical evaluation is based on his personal, extensive experiences, and a detailed review of the literature.

The introduction, with a brief historical perspective, is followed by a discussion of the normal reactions to trauma. A major problem in this field seems to be the difficulties in establishing the border between normal and abnormal reactions to traumatization. Even in cases of severe PTSD there seems to be no consensus as to whether this symptom complex constitutes a normal reaction to an extreme life-threatening event or a pathological syndrome. O'Brien, in a review of the epidemiology of PTI, concludes that the best estimate of the lifetime risk of PTSD in the community today is 1%, and the prevalence about 0.5%. Comorbidity with affective and anxiety disorders has been established, but not with psychotic syndromes. Looking at aetiological and predisposing factors, O'Brien concludes that trauma is an essential element in the causation of PTSD, but does not explain it. A wide range of pre-traumatic characteristics such as personality, social network, and family history of mental illness seem to play a role in the development of PTI.

“What constitutes a stressor?” is the next question O'Brien tries to analyse. It is a fact that PTSD symptoms not only follow extreme stressors, and furthermore that PTSD is not the usual consequence of extreme stressors, except as a relatively transient phenomenon. He points out that the true relationship between trauma or stressor and PTSD will not be established until we have some independent means of assessment such as a blood test.

So far a multimodal approach, combining structured interviews, behavioural observations, psycho-physiological tests, self-reported symptom questionnaires, and other measures have proved the most appropriate and valid way to diagnose PTSD. Many books deal in much more detail with the management approaches of PTI, but, again in a concise way, O'Brien gives the reader an introduction to the field, based on numerous relevant references. Finally, possibilities for prevention and future research are taken into account.

This guidebook is relevant, not only for mental health professionals, but also for lawyers, counsellors, and others with an interest in the influence of traumatization on the human psyche. An interesting chapter deals with medicolegal aspects of PTI; it stresses the reliance that experts place on documented evidence, and their maintenance of an independent and sceptical stance.

From a human rights point of view, however, O'Brien's book falls somewhat short. Torture and other government-sanctioned human rights violations are scarcely mentioned, while the author chooses to focus on wars, and civil and natural catastrophes as potential traumatic events. The fact that some 15 million people around the world are living as refugees, and the way refugee status affects mental health and probably intensifies pre-existing PTI symptoms, is only sporadically touched upon. Likewise, one wonders why experts such as Leo Eitinger and Metin Başoğlu are not even mentioned in the otherwise extensive reference list, which contains more than 800 entries.

In conclusion, O'Brien presents us with a valuable overview and evaluation of one of the most debated psychiatric entities over the last two decades. This book must be of interest to everyone working in the field of mentally traumatized people. However, a human rights perspective is missing, unfortunately.

Morten Ekström, MD, PhD
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13-16 December 1998

6th International Research and Advisory Panel Conference on Forced Migration

Announcement and call for papers

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New Delhi, India  
6-8 February 1999

International Congress of Forensic Medicine and Toxicology & XX Annual Conference of the Indian Academy of Forensic Medicine

Early announcement

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

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

To further these goals the IRCT seeks on an international basis:

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