TORTURE
Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture
Published by the International Rehabilitation Council for Torture Victims (IRCT), Copenhagen, Denmark, with financial support from the Ministry of Foreign Affairs, Denmark, and the European Commission.
Volume 9, Number 4 1999
ISSN: 1018-8185

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EDITORIAL

JUST AN ORDINARY WEEK

Congratulations to Médecins Sans Frontières (MSF) with the Nobel Peace Prize. It was announced during week 41, which was also the deadline for the final editing of TORTURE 4/99, and this is why week 41 is the point of departure for this editorial. Others had of course been nominated for the Nobel Peace Prize, and among the favourites were the two Chinese dissidents and system critics, Wei Jingsheng and Wang Dan; this gave rise to speculation as to whether strong criticism from the official Chinese authorities had been taken into account. However, during the past years the prize has often been awarded alternately to individuals in their own capacity and to institutions. For MSF to receive the prize on 10 December is a completely correct and welcome choice that in a way hits back against the official China, whose concept of human rights is not in agreement with MSF's humanitarian ethics. This hard-working organization, which was created as one of the finest results following the 1968 youth rebellion's shake-up of traditional thinking, has ever since managed to keep its course as a critical voice against the misuse of power it sees during its work in war zones or in areas of civil war, where criminal misdeeds against human rights often follow. MSF calls a spade a spade, it interferes quickly when necessary, and it does not run away from its work in some of the most dangerous foci, wherever they may be in the world.

MSF's field of work, like that of IRCT, is deeply anchored in the medical profession and thus in several closely related health professions. For both organizations, the background for intervention is serious violations of human rights, and both have had to recognize more and more that the consequences of this work have clear political overtones. This recognition has been reached partly as non-silent witnesses of obvious violations of human rights, and partly as the indirect critics of heads of states' misuse of power or their impotent leadership that leads to violations of human rights by acceptance of violations and torture.

However, it is not only MSF that should be congratulated, but also the Nobel Peace Prize committee, which was one of the very first to focus on human rights around the world, and which continues to create interest in the fight against injustice, not least by this clear message in the recognition of MSF, which is unwanted by many nations because of its insufferable interference. But so much the better, to quote the leadership of MSF through Philippe Biberson at the announcement of the prize: "This prize recognizes the necessity of a humanitarian rebellion, totally independent of political and military influence, against all persecution and injustice."

In this same week 41, other news and messages were sent out concerning the temperature of the world's human rights situation. Thus:

- The finding of mass graves at the previous military headquarters in Guatemala as a sombre memory of the 36-year-long civil war that ended three years ago
- New information about killings and maltreatment in East Timor
- An official declaration from the Russian Minister of Justice about the overcrowded prisons being "places of torture"
- Accusations of systematic violations of human rights by the Vietnamese authorities.

It was, however, also announced that:

- Dr Basson, a South African military doctor during the apartheid regime, and known as "doctor Death", was taken to court, accused of 61 misdeeds
- General Pinochet was found fit by the Magistrates Court in London for handing over to Spain to face accusations of torture in Chile
- The report of the Committee for the Prevention of Torture (CPT) on a routine visit to Austria was presented.

This listing should in no way be taken as the statistical status of the present situation of human rights, but it shows that a single, rather typical week has examples of the continuous existence of violations of human rights, torture, and forced suffering. At the same time it has evidence of countermeasures by the world society, that the threshold of tolerance has been reached, and that a change of systems with respect to controlling measures has started. The Nobel committee's annual attack on the collective conscience has played an essential part in this development.

H.M.
The body in political violence: the phenomenology of torture

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Introduction: body physical and metaphysical

In classical times, i.e. in Greco-Roman thought, the body was the matter component of the person, and the soul was the form. This matter-form or hylomorphic conception lasted in the Christian West throughout the medieval period until modern times.

In ushering in modernity, Descartes, with his famous (or infamous) split, separated the body, as physical extension, from the mind, as an abstract domain. With this, the body became anatomy and physiology, and the spirit vanished from the bodily machine, and the alchemists ran for cover or, form. This matter-form or hylomorphic conception lasted from the mind, as an abstract domain. With this, the body in the Christian West throughout the medieval period until modern times.

In the 1940s, with the advent of post-modernity, the Cartesian or objective body began to lose its primacy of place and shared the stage with the body subject or lived body as social and personal experience or consciousness or, using the Latinate form, as corporeality. (In Spanish “corporeidad” or “corporalidad”, and in French as the sociological “corps”). Physicians had already used integrative schemes with holistic intentions (the psychosomatic concept) that, nevertheless, did not bridge the problem of the Cartesian dualism or, put in other terms, solve the problem of consciousness. The issue of the subjective or lived body (in German “Leib”, as flesh or body with sentiment, vs. “Körper” as object or anatomical body) appeared with the school of phenomenology of Husserl, Merleau-Ponty, Ortega y Gasset, and, prominently, Heidegger; in medicine and psychiatry with von Weizsäcker, as part of the existentialist analytical school, and in Spain with Lopez Ibor.

There is little doubt that the ghost of Hegel, visiting from the all-encompassing universe of consciousness, is behind the phenomenological conceptions of the body. The phenomenologists produced key ideas that helped to straddle the Cartesian dualism: consciousness, time, and intentionality. With them the body acquires a new dimension, one that is much more continuous with consciousness: the body as object and mere external reality transforms itself into a subject or, more accurately, a self-conscious and dynamic agent in the world and with others. The lived body is a non-dualistic body, and it does not live passively in the frame of time; it generates time, it lives as temporality. Finally, intentionality is the essence of consciousness; it is outcome of temporality, it is relatedness, openness, living in the world, being in the world. Ortega y Gasset writes of man being like an archer in tension seeking a target (telos) for his life.

In Freud, perhaps not a naive but certainly a reductionist Hegelian, the dynamic body appears as essentially an “Id”, from which is excluded the social dimension of the Id as “other”. This “other” is recovered for our theory of consciousness (as mind) and development of the self by the Chicago school of social psychology of G.H. Mead. Mead, influenced by Hegel, had a profound effect on Harry Stack Sullivan in his conception of the pathology of Ego in schizophrenia as incorporated “bad mother” into the self. In truth, psychoanalysis elaborated the development of the self into the personal environment with the term “object relationships”. However, it would be difficult to use in whole or directly the psychoanalytical ideas in this new analysis of the body, because its reductionism limits the concept of the body consciousness to the isolated or individual body conscious and unconscious Id. It regretfully ignores its extension to the “other”, as part of the social or political domain of our unconscious or repressed self, and thus perpetuates an individual-society dualism. This political “other” is not yet a fully conscious self, but is potentially available as conscious and complete self through the process of identification with the “other”, friend, neighbour, slave, or enemy. Admittedly, one cannot do justice to psychoanalysis in a brief paragraph. Nor is the intention here to engage in a critique of the philosophical validity of psychoanalysis, many times done elsewhere. Psychoanalysis, nonetheless, has inherited the body-mind dualism and has attempted to repair the rift with piecemeal non-philosophical solutions. Psychosomatics, self-psychology, interpersonal theory, and the British object relationships theory are attempts to build a bridge. In phenomenology there is no need of a bridge; being-in-the-world (“Dasein”) with the existentials (attributes) of temporality and intentionality announces the unity of self and the world. The old dualism comes closer to a solution with the phenomenological approach.

In summary and in consequence, the above ideas that link the body, the individual self, and the social context are assembled here as a philosophical instrument capable of explaining cohesively experiences of the body subjected to political violence. Those experiences, widely different as they...
may have been, have come to us in a variety of reports and personal narratives, coined under different ideologies and forms, altogether making them difficult to harmonize except through a composite of large universal categories, such as those proposed here. The key components or ideas of this model or instrument are:

1. **Body as fixed experience**, consciousness or subjectivity, besides the body as external or anatomical object.
2. **The temporality of the self** and of consciousness; i.e. the essential rooting of human experience in history. It assumes that self is consciousness, and consciousness is the experience of self in time.
3. **The intentionality of the self** or the projection in time of human existence.
4. **The self is always experienced in a current environment** or circumstance and in relation to others. (Ortega y Gasset stated this in his famous lemma: "I am I and my circumstance."11)

**Body as anatomy, body as experience**

Let us consider a double postulate: 1) the experienced or subjective body is the beginning of the consciousness of the I or self, and 2) the body experience is part of the unity of consciousness. The first postulate is accepted in self-theory, i.e. the body is the most elemental part of the Ego. (The Ego is the instrument of the individual and person; the self is the consciousness of the Ego, its reflective part. Therefore, self begins with the reflective experience of the body). On the second premise or postulate: the experienced body as part of the unity of consciousness refers to that property or tendency of consciousness to experience itself as a whole. There is much neurological evidence to support this. If one feels good in the body-objective, one also feels good in the body-subjective, and if one feels good in the body self, one also feels good in the experience of other parts of our self or in our whole self-experience or consciousness. Furthermore, we typify our body experience, file the experience in time, and keep it handy to support our self-experience in the future, like a spare experience in store for times of need.

In pathology, however, there is a breakdown in the latent ambiguity or duality of the body as objective or external body and the subjective or experienced body. The body object re-emerges, and consciousness ceases to act in unity and as a representation of both. Those states of ill-being are expressed in the dualism transmitted through the languages of the Western culture. Oscar Wilde refers to this unity and potential duality: "To cure the ills of the body with spiritual remedies and the ills of the spirit with remedies of the body." The same Oscar, in a pose as post-modernist philosopher, repeats it more cynically: "Protect me from the sufferings of the body that from the suffering of the spirit I can take care myself."

Psychiatrists, particularly those influenced by existential analysis, described the tendency to unity of consciousness when they spoke of the "vital sentiments" of patients, as in euphoria, in which well-being is experienced globally, encompassing body and spirit. In "vital anguish" ("angustia vital") the patient also experiences a total sentiment of anxiety. López Ibor quoted a Spanish poet saying "Me duele el corazón, el alma, y el sombrero", thus extending the sentiment of pain totally and including the hat as addition to the body scheme.10-20

The experience of the body is also selective and interactional; it is not an inert telegraphic machine receiving and sending orderly signals or messages. The body experience depends on other momentous and current experience or activities. We are our body as a unity of experience. In pathology, patients do not experience their bodies as unity (as in conversion disorders), or themselves in full consciousness (as in dissociative states), or themselves as a familiar experience (as in depersonalization). In hypochondriasis the objective body and the subjective experience are in disunity; one is healthy, the other is experienced as sick.

Finally and concretizing: in pathology or adversity the objective body has illness, the subjective body suffers, and pain experience is in between and in both.

**Body in culture and politics**

The body is in between nature and culture, as a stage, as a tool or medium for expression, coping, and social action. The body is also the first condition of individuality. The sociology of the body gives multiple examples of both the position of the body as object or matter, and as a tool of the culture and the individual for self-expression. There are examples in fashion, dressing, in the changing attitudes to nudity, and in the dissatisfaction and commercial manipulation of body experience and consciousness. All this provides a huge market for pleasure and profits in diets, pills, body-building, tourism, medical and psychiatric care, and plastic surgery.

In politics the body came under severe constraints with the secularization of cultures and the expectation of the kingdom of God on this earth. "The spirit is only in the body," says Merleau-Ponty. Man is body, totally body. Michel Foucault puts it more radically: "The soul is the prison of the body," a trick to take control of it. He goes on to describe in several of his books (Discipline and Punish and Madness and Civilization) how religion, school, the university, the army, the factory, the insane asylum, and prison are all institutions for control of the spirit.21-22 In Argentina after 1976, one of the participants in the conflict said: "The struggle is for a particular discourse", i.e. the articulation in the language of a particular spirit.

**The body in torture**

Torture is a failure of softer or more subtle mechanisms of control of the spirit. In torture the body becomes the key to the soul. Lytton Strachey writes on the case of a physician suspected of conspiring against Elizabeth I, Queen of England, and tortured: "An idea in the mind of the torturer becomes a word in the mouth of the victim." In torture the spirit of the agent is extended into the body and often the soul of the victim. The issue is violation, invasion, possession, power, and control. The Indians of the upper Amazon River in Peru had no ambition to work for money, or to harvest cauchu or chichile from the rubber tree for an English company. Torture was an instrument to force their bodies to work for a colonial economy. All colonial powers exercised some form of control over the body, very often including corporal punishment. Even in our own Western institutions (school, army, prison, mental hospital) many forms of control of the body were a prerequisite for socialization, often including punishment, a practice that has lasted until very recently. Foucault described how over the last 200 years there has been a major reduction of this treatment of the body in the Western World.21
The intention and effect of torture are based on the properties of the natural body, mostly its tendency to unity with the experienced body and thereafter with the spirit or consciousness. That is, torture is observed as physical violation and damage, and experienced as pain and suffering. What feels painful in the body is experienced as suffering and anguish in the soul; what disrupts the well-being of the body immerses the global experience and consciousness into a pit of darkness.

Here, in describing the effects of torture on consciousness, we begin to find the limits of words and the failure of all metaphors and other tropes of the language. Joseph Conrad, the author of the novel *Heart of Darkness*, in face of the history of the Congo people, who were reduced from 20 or 30 million in 1885 to 8 million in 1907 as result of the colonialist practices of the Societe Internationale of King Leopold of Belgium, can only say: “The horror, the horror ...”25-26 In fact, *Heart of Darkness* is not a novel, it is more like a mystic poem to the suffering of a people. He could have used the official language of the report of Sir Roger Casement, who was also in Congo shortly after Conrad,27 or a medical narrative or statistical tables and analyses so frequent in recent wars and conflicts. Whatever the language chosen to describe the suffering of torture victims, the results are always wanting.

**Interactional aspects of torture**

As the conquest of a body, the appropriation of a soul, and the stealing of a voice, torture is an interactional process, with one party, the victim, having indeed very limited options. Torture may involve, of course, an individual, a group, or a nation. I shall speak briefly of three main themes:

- The fears of the torturer, and guilt-free torture
- Pain and pleasure in torture
- Betrayal and resistance in torture.

The fears and guilt of the torturer

The goal of the torturer is the confirmation of his/her universe in the words of the victim. The torturer does not know for sure why he (generally it is a he) is torturing, and whether he is right to torture the victim. In torture the agent seeks the confirmation of his own ideological and moral universe and of his own actions. If the victim does not surrender his soul with his body, the agent is defeated and comes to fear every episode of torture. Many attempts at brainwashing victims or “recovery” schemes ended up in failure with much confusion and anger of the torturers.28

A guilt-free torture is the impossible disjunctive of the torturer. To maintain consistently his own political and moral universe, the agent has to justify his practice of torture. The techniques are simple enough: denial of the act or of the responsibility for it, dehumanization of the victims by denial of the essential subjectivity of the body or by a transformation of the body of the victim, expressed in the mendacity of language. Thus, the victim becomes a “dog”, a “foreigner”, a “two-legged monster”... All dehumanization techniques aim at reducing conflict in the torturer, by denying any potential identity with the victim as the essential “other”; not like me, not my brother, not my neighbour. Several reports on torturers have remarked on this fearful identity between agent and victim.29

**Pain and pleasure**

In the technique of “good and bad torturer”,26 the body of the victim is subjected to alternatives of pain and pleasure (pleasure as respite from pain or as minimal kindness). In it the body rises in a protoplasmic longing for comfort and love, or simply for a few more minutes or days of survival, carrying along with it experience and consciousness. This is most powerfully described in prisoners of the extermination camps of the Jewish Holocaust under the Nazi government. In those circumstances the demands of the body to survive are automatic and drive the soul, overwhelming all other responses; or, put in other words, the urge of the body to survive, in unity with its consciousness, drives the person to responses from which moral judgement should be suspended.30

Betrayal and resistance

The property of consciousness of revealing itself in unity is manifested in torture and its consequences. The instrumentation of the body produces an agony and a suffering that floods the consciousness and with it any historical rooting, projects, or commitments to the future (i.e. its intentionality.) These disruptions in the global sphere of consciousness imply contradiction in the self or betrayal. Consciousness pulled by its close identity with the body follows the body into the sorrows of betrayal. As the body is surrendered, the voice stolen and appropriated by the torturers, and the soul conquered or enslaved, if not surrendered, the consciousness of the self, linked to the surrender of the body, is profoundly troubled. In all cases of torture, if only for a few instants, the soul is tempted to betrayal. A Palestinian professor of history confessed to me that the worst moments of his life were not the physical beatings and torture, but the night he spent deciding whether to collaborate with the Israeli military intelligence and survive, or not to collaborate and die, thereby never seeing his one-year-old son again. That night he decided not to collaborate and accepted to die. The next day he was totally calm and at peace with himself. This man escaped with his body in pain, but with no loss of self.

On reading the lives of saints, heroes, and martyrs one becomes immediately aware that they spent a great deal of time facing the demands of the body on their road to sainthood, heroism, or martyrdom. It always fascinated me how they mastered those demands for comfort, rest, food, warmth, release, and sex. It seems clear that the anatomical and subjective body became subservient to another form of consciousness. I recall a patient of mine who told me that he had discovered that, by preparing himself mentally ahead of torture, he did not feel the pain of torture. He screamed and cried, “but not because I felt pain, but so they would not tear my skin or break my bones”. Jacobo Timmerman, in his Buenos Aires captivity, reported that to avoid pain he kept his consciousness at a vegetable level, so that with his “vegetable consciousness” he would reduce his pain.31 Clinically these phenomena are recognized as states of altered consciousness or dissociative experiences.

In the epidemic of torture of the 1970s and 1980s in the Southern Cone of Latin America (Chile, Argentina, and Uruguay) and in Central America (El Salvador, Honduras, Guatemala), the remarkable and overall conclusion that one has to reach after a continued observation of the stage for over 20 years is that torture of the body was useless to the military regimes, and that they failed to control the spirit, individually, in groups, or nationally. The bodies and the
communities that survived continue to remember the experience of anguish and loss. Now, with their own voices, they persist in their demands for history, continuity, justice, and reparation. The consequences of torture: post-traumatic stress disorder (PTSD)

Religion has always been the ideology of crisis for the human species. In times of adversity it provided explanations and rituals as cognitive and emotional schemata to master change and maintain continuity and meaning. When in Western society, with the arrival of modernity, religion was replaced by secularity, other schemes came into being; one such has been medicine with its technical know-how and humanitarian concern. Thus, PTSD is the technical and humanitarian response of the medical profession to a particular form of suffering.

The profession responded with its own voice to the suffering of the victims without voice. Dr Ruhama Marton, President of Physicians for Human Rights (Israel), said: "We must be the voices of those who have no voice to speak for themselves." The physicians speaking for the Vietnam veterans coined the term PTSD, which found its way into the official language of the medical and other health care professions, and later was used for victims of torture in the Chilean and other contexts. PTSD is, in a technical language, the expression of the inexpressible, i.e. of the pain of the body, the experience of suffering, and the loss of the wholeness of the self in adversity. In psychological dynamics it represents an attempt to master the loss of continuity of the self in time, in intention, and in relation to others. Of course, those symptoms or criteria with technical names, such as re-experiencing, hyper-arousal, and avoidance, are metaphorical expressions. All language ultimately consists of tropes, and in the case of a living body in torture, no language expression is truly adequate; only an approximate recreation of the experiences of the body in full consciousness is possible. Neither the experience nor an exact replica of the experience is possible in medical or social science, nor in literature or art.

Only empathy, as experiential or subjective understanding by the observer or reader of the victim, can put the suffering and meaning into the so-called symptoms. Aftermath and dawn

This heading evokes two primordial images referring to experiences of the human species from the beginning of memory: the cycle of violent human conflict or destruction and the renewal of time with the beginning of each new day. They remind us of war and of Cain, or anyone else, killing his own brother, whatever his name (Abel, Jesus, or Ismael), and of the fears and hopes of each new day. Aftermath and dawn as metaphors belong to a language equally acceptable to many cultures to refer to conflict situations in the world, be it Latin America, the Middle East, or the past European wars, including World War II and the Spanish Civil War. Those conflicts, as in Chile from 1973 to 1987, or in Argentina from 1976 to 1983, were moments of enormous human suffering and loss, social chaos, and historical disruption and darkness. National consensus was torn, and with it the common and universal rules of respect of the State and of citizens. Consciousness and the flow of national history was suspended in time, and the direction and tension required for further action for many and significant parts of the nation were lacking. Subsequent to 1973 in Chile, people spoke of the "loss of project", referring to this loss of temporality in human existence.

After the storm comes a period of crisis to reconsider and reorganize. What shall it be in the aftermath of a breakdown between State and citizen, as in the "dirty wars" and violent repression of the Southern Cone? Denial and impunity or reparation and reconciliation? These questions were prominent at the end of World War II and of Franco’s regime in Spain, and are voiced persistently in the Israeli-Palestinian conflict.

In Latin America, some of the proposals for repair of the damage done by a State torturing (or killing or “disappearing”) its citizens read like some liturgical requirements for confession and penance. There should be no surprise in this parallelism between religious and political procedures. The genealogy of human rights legislation, including the Universal Declaration of Human Rights of the United Nations in 1948, goes back to the revealed divine laws of the Judaic and Christian traditions, both of which possess language and rituals to repair the damage done to the man-God covenant by sin, as the contravention of divine law. An article by the editor of the English-language newspaper in Buenos Aires (David Cook, of The Herald) on the day after the official end of the Dirty War (26 April 1983) spelled out a proposal for reconciliation that reads very much like the requirements for a good old Catholic confession. Those requirements and rituals also exist in similar ways in other traditions, including Judaism and Islam. To defend their separate identities, some religious persons may argue that in fact the means and rituals are different. There is no doubt about it. The principles, however, are the same: how to repair the damaged relationship between man and God, and, in secular terms, between citizen and State. The procedure and ritual steps, in both profane and sacred language, are: 1) to examine in "conscience" and in public the unlawful event, 2) to express regret for the offence or the harm done, 3) to participate in a proposal for prevention or a "never again" plan, 4) to ensure penance or punishment of the guilty, and 5) to ensure reparation for the victims. This might be a maximalist proposal. Minimalist criteria were exercised by the Spanish parties after the end of Franco’s era, and proved quite successful in returning the country from totalitarianism to stable democracy. In between, there are other schemes and variations to carry out the process of reparation and healing of individuals and society.

Where does the individual fit into those schemes for national reconciliation? The self, which includes the consciousness of a violated body, is sustained by the reflection from the society in which it lives. The devastating effect of the Vietnam war on veterans was not so much due to the exposure to combat or to the witnessing of atrocities on both sides, but to the negative images that a whole country fed to their soldiers after they returned home. Thus, the healing and reparation of the damage done to individuals should not be left to each individual in isolation, but should be maximized by a national program of healing and reparation.

For some time a movement has been afoot and marching that involves medicine and other health and human rights professions. This health and human rights movement has been translated into specific educational and prevention projects in Haiti and Gaza, and they are in the planning stage in Argentina and Chile. Those projects are aimed at creat-
ing a consciousness of human rights in the civic society and governmental classes. These are slow, indirect, minimalist, non-political, consensual, and power-sharing approaches to the resolution of human conflict. They are aimed at developing a human rights culture within relevant civil and government structures and practices as a precondition of democracy. In the past, few of those schemes of reparation and reconciliation have been successful in reaching the perpetrators of torture and bringing them to trial, or at least to some kind of public forum, however named (inquiry, truth commission, ...) for discussion and perhaps consciousness of the violations. In few cases were the parties involved (State and citizen, oppressor and oppressed, aggressor and victim) capable of reaching a mutually validated consciousness of the events, as a base for reconciliation and projection to the future. Not in the Nuremberg trials at the end of World War II, where the victor tried the vanquished; nor in the trials of the Greek junta of 1968-1971, in which torturers faced their victims; nor in the Argentinian courageous trials of their two presidents responsible for the 1976-1983 violations. In some ways, the conclusion of Franco’s regime and the bringing about of democracy to Spain after 1975 has been hailed as a successful process of reparation and reconciliation.37

One of the dangers, implicit in this loss of temporality or meaning in national history, would be the disruption created by an aberrant search for reparation and meaning. There are multiple examples of those false solutions to crises of national consciousness or identity, in which a group follows false prophets or national leaders or engages in symbolic and costly acts of reparation.40 The Gulf War can be seen as an act of vicarious reparation for the damage done to the collective USA psyche by the Vietnam War. Equally, the Gulf War Syndrome itself has been diagnosed as a disturbance of body experience (somatoform or conversion disorder) and of the self consequent to an even more confusing national and personal experience.41 In the same vein, the religious fundamentalist reactions in some former colonial countries that suffered further defeats and disasters in the post-colonial periods, e.g. Egypt, Iran, and Palestine, have been interpreted as attempts to maintain some cultural continuity and cohesion in a badly battered national consciousness. The tragedy of these movements is that they overwhelmed or at least disrupted formal attempts by a considerable section of the intellectual and religious elite to modernize their cultures and governments in a process of continuity with traditional and latent elements of secularity, rationality, and democracy.42-43

In conclusion: in the past, physicians and health professionals have cared for the bodies of torture victims and helped them to heal and repair themselves, and have understood in empathy the suffering of those persons. In the future, physicians and health and human rights professionals, in solidarity of consciousness with a nation and people, must try to help to restore to those people their historical continuity and projection without which they cannot be.

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Acknowledgements
The author gratefully acknowledges the contribution to this paper made by Prof. A. Routstein and R.K. Baumanis with their critiques of the draft.
The Council of Europe’s Committee for the Prevention of Torture (CPT) 1989-99

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Work on the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment began in June 1984. The Convention was completed and ready for approval by 26 November 1987.

It came into force when seven of the then 23 member states of the Council of Europe had ratified it, in February 1989. The Convention Committee had its first meeting on 13 November 1989, i.e. 10 years ago. At that time 15 countries had already ratified it. In summer 1999 the Council of Europe had 41 member states with a total of 850 million inhabitants. Ratification has taken place in 40 of these countries, and no. 41 is about to ratify.

With respect to ratification, CPT is thus a 100% success. There are now efforts to extend the field of its activities: addendum no. 1 allows for non-member states to become full members of CPT on invitation from the Council of Ministers. All 40 member states must accept addendum no. 1 before it can come into force, and that has not yet happened in three countries: Andorra, Croatia, and Ukraine.

The ideas of the Convention are initiated by a committee as stated in Article 1, which ends with a job description: “The Committee shall, by means of visits, examine the treatment of persons deprived of their liberty with a view to strengthening, if necessary, the protection of such persons from torture and from inhuman or degrading treatment or punishment.”

The mandate of the Committee is remarkable, probably being one the most powerful in an international context. The mandate is described in detail in Article 8, and can be summarized as follows:

• The Committee shall have “unlimited access to any place where persons are deprived of their liberty, including the right to move inside such places without restriction”.

• The Committee may interview in private persons deprived of their liberty.

• It may see all buildings and installations – not only the cells.

• It may see all papers – not only the records of those detained.

• It may make unannounced visits and return for more visits.

It is important to emphasize that the whole work is based on Article 3: “In the application of this Convention, The Committee and the competent national authorities of the Party concerned shall co-operate with each other.” The key word is therefore: “Co-operation” – the first C.

The Committee comprises one member from each country, selected by the Council of Ministers from a list of three names suggested by the individual countries. The members sit for four years and they can be re-elected once. The Committee has also decided that it should not be led by one president, but by a troika: a Bureau consisting of a President, a First Vice-President, and a Second Vice-President – thus reflecting the different, necessary fields of competence.

With respect to the qualifications of the members, the requirements are high (Article 4). They must:

• have “high moral character”

• be “known for their competence in the field of human rights or having professional experience in the areas covered by this Convention”

• “serve in their individual capacity”

• “be independent”

• be “impartial”

• “be available to serve the Committee effectively”.

It is obvious that this type of person does not grow on trees. In general, however, the Committee consists of very high-quality individuals. Thus, the Bureau of the first four decisive years comprised three university professors, all internationally recognized for their various expertise:

• President: Professor Antonio Cassese, Professor of Human Rights and International Law at the European University at Florence (later President of the International War Crimes Court at the Hague.)

• First Vice-President: Bent Sørensen, Professor of surgery and expert in matters of torture.

• Second Vice-President: Jacques Bernheim, Professor of psychiatric forensic medicine and Head of the Medical Department at Geneva’s largest prison.
Together with the secretariat, and in particular with its leader, Trevor Stevens (UK), the first Bureau planned the work, worked out rules of procedure, arranged training of the members, and wrote down guidelines and standards for visits and reporting.

CPT works exclusively with prevention. Thus, it cannot take on single cases and it cannot pass sentence. The work is part of the work of the Council of Europe, and it supplements the legal initiatives, in particular those of the Court. In short, the Court deals retrospectively with violations of established rights, while CPT works prospectively with identification of situations or conditions that may lead to misuse, and thus for the change of future regulations.

In practice the work falls into two categories: periodic visits, and "such other visits as appear to be required in the circumstances" (Article 7).

**Periodic visits**

The first notification procedure: At a certain time during the year the Committee decides which countries should have a periodic visit the following calendar year. These countries are informed, and the list is published about one month later. The various NGOs will then know from which countries CPT wants to obtain information during the coming year. Two weeks before the planned visit the second notification is sent to the country's authorities, with the date of arrival of

**Expansion of the CPT’s field of operations: 1989-1999.**

![Figure 1. Situation as at 13 November 1989 (date of the CPT’s first meeting).](image1)

![Figure 2. Situation as at 1 August 1999.](image2)

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<th>States bound by the Convention: 15 States</th>
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<td>United Kingdom</td>
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Prison population: 292,250 prisoners

Prison population: 1,881,500 prisoners

(Source: http://www.cpt.coe.fr/en/general/rep-9.htm: It should be noted that the CPT’s mandate covers also all other categories of places where persons are deprived of their liberty by a public authority: police establishments, detention centres for juveniles, military detention facilities, holding centres for aliens, psychiatric hospitals, etc.

Note: This is an unofficial representation of States bound by the Convention. For technical reasons it has not been possible to show the entire territory of certain of the States concerned.)

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the delegation, the possible duration of the visit, and the composition of the delegation, all named:

- about five members of CPT
- 3-4 experts
- a certain number of interpreters, depending on the country to be visited
- 1-3 secretaries.

The country’s authorities can protest against the experts and the interpreters, but not against the visit of the CPT members or secretaries. In practice there are no more protests.

The third notification is sent 3-4 days before the expected day of arrival. It names the prisons, police stations, psychiatric departments, orphanages, etc. that the delegation wants to visit, and remarks that the delegation is free to visit any institution it may wish to, and to make the decision after its arrival. Furthermore, it is requested that information about the above-mentioned places should be available at the meeting with the authorities on the first day of the visit.

Visits required by circumstances

CPT has developed a practice in which such visits are part ad hoc, part follow-up, shorter or longer, often with a very specific agenda. The ad hoc visits are typically provoked by an acute situation following information that serious violations of the Convention might have taken place, such as mass arrests of so-called terrorists. Follow-up visits are typically arranged following a dialogue with the country, which may have refused to follow the recommendations of the Committee concerning a certain prison or police station, which the CPT will then revisit.

The visit

The visits in the various countries are the cornerstones of CPT’s work. A periodic visit to a large country often lasts two weeks, in smaller countries ten days, and in very small countries, such as San Marino or Andorra, 1-2 days. As a basis for the work, the delegation first aims to obtain a complete overview of the country’s penal codes, criminal laws, and statutory instruments.

Then always follow the visits to selected prisons and police stations, and other special institutions such as psychiatric departments, refugee camps, institutions for minors, etc.

In the following, the visits will be used as a model. It is CPT’s policy always to make a very detailed and thorough examination of the selected prisons, since it is much more valuable to examine one or more prisons thoroughly than to examine many superficially. A visit to a large prison may well last up to four days.

The delegation splits up into sub-groups during the visit. They inspect all the premises, examine procedures (the reception and release of prisoners, punishment measures, possibilities of complaining, etc.), and interview all the relevant people, from the prisoners to the prison director. The delegation always comprises doctors to examine the medical treatment of the detainees and other relevant health conditions in the prison.

Following the visit, the delegation should have a complete picture of how the prison functions, and how current laws and regulations are adhered to, as well as an overview of situations or physical conditions that might lead to poor treatment or even torture.

Another important institution is the police. In countries that practise torture, the police, as a rule, are responsible, while the prison conditions may be inhuman or disgraceful. Visits to police stations are therefore a very important part of CPT’s work against torture. As mentioned, individual police stations may have been informed about CPT’s intended visit, but most will not have been informed. The visits therefore almost always come as a surprise, especially since CPT prefers to arrive at times when the station is under pressure with many detainees, typically on Friday or Saturday nights after midnight. It is often difficult for the local head of police to understand that the CPT people can enter all the cells without hindrance, and can demand to speak privately with the detainees. However, CPT has never given up and has always succeeded in entering the institutions it had planned to visit. Sometimes it has taken a few hours; for instance, it was necessary one Saturday night to contact a ministerial secretary to make him explain that particular right. To make it easier, all members of a CPT delegation are always given credentials signed by e.g. the minister of justice, containing the rights of the delegation, written in the local language.

Before the delegation leaves the country, a meeting is always arranged with the relevant authorities. The head of the delegation will give a short briefing of its findings, which will later be written in the report. At this briefing, however, it is possible to state “immediate observations” (Article 8.5). These concern conditions that require immediate intervention from the authorities, i.e. conditions unacceptable to the delegation and therefore requiring immediate change. The experience is that the authorities always take this seriously and often inform the Committee in Strasbourg that action was taken immediately, and in all cases the authorities have responded within the given deadline of three months.

The report

Based on the delegates’ notes on their observations, the secretariat writes a report starting with the factual findings. Based on these, some questions may be asked, and comments and recommendations given. The report will be finalized in plenary meetings in CPT and sent confidentially to the government of the country in question.

This is the second C, “Confidentiality” (the first was “Co-operation”).

Perhaps because of the confidentiality, the government usually considers the criticism as positive. It is requested to give an answer to the questions posed by CPT before a certain deadline. A dialogue is started between the government and CPT about how to improve conditions for those deprived of their liberty. An important part in this continuous dialogue is of course the subsequent periodic visits.

It takes about half a year for CPT to make the report and to have it approved in plenary meetings. The government concerned is requested to answer the posed questions, reply to the Committee’s comments, and clarify how it has or intends to follow the recommendations. This first report is called the “Interim Report”; it is followed six months later, i.e. one year after receiving the CPT report, by a “Follow-up Report”, in which the government explains its latest initiatives.

The CPT report and the government’s reports are confidential. In practice, however, most countries have chosen to publish the CPT report and their own follow-up report. Thus, Denmark was the first country to publish its CPT re-
port in September 1991. At present it is almost customary to publish the report, but it should be stressed that it is up to the country concerned, not CPT, to decide whether the report should be published. However, in a few cases, when a country has published only parts of the report, CPT has published the whole report.

By August 1999 CPT had made 63 periodic visits and 27 ad hoc visits. A total of 59 reports have been published. Within the last years the reports have been available at the internet address http://www.cpt.coe.fr. This address also contains press announcements and more general information about CPT’s work and its members.

CPT’s forcible means

According to Article 10.2, if a country “fails to co-operate or refuses to improve the situation in the light of the Committee’s recommendations, the Committee may decide, after the Party has had an opportunity to make known its views, by a majority of two-thirds of its members to make a public statement on the matter”. These forcible means have only been used twice by CPT; in both cases concerning Turkey, in 1992 and 1996 respectively.

The results of CPT’s work, according to us, are positive and large. Most of the countries are grateful for CPT’s work and consider it a help in the work to improve conditions for people who have been deprived of their liberty. In this context it is important to stress that CPT should be, and is, a technical committee. It comprises people of vastly different competences. Among its members are lawyers, doctors (general practitioners and psychiatrists), experts in forensic medicine and torture, psychologists, prison experts, police experts, as well as priests. CPT’s criticism is therefore objective, not political, and it is exclusively directed towards the future, without condemning the past.

This is probably one of the reasons why CPT’s work has been so recognized and valued by all countries, as it is. Since the vast majority of the countries, as mentioned, in due course publish CPT’s reports in connection with their own responses, the public is able to follow the work of CPT and check that its recommendations are put into force for the benefit of the people who have been deprived of their liberty.

Selected list of publications

received in the IRCT International Documentation Centre


Toward a new paradigm in human rights thinking and democracy-building activities / Center for Victims of Torture ; CVT19981005. - 12 p. - Conference : IRCT Council meeting (19981005 : Minneapolis, MN).

The psychosocial effects of torture, mass human rights violations, and refugee trauma / Silove, Derrick. - In: The journal of nervous and mental disease; vol. 187, no. 4. - 19990000. - p. 200-207.


Political psychology as a lens for viewing traumatic events / Koepman, Cheryl. - In: Political psychology ; vol. 18, no. 4. - 19970000. - p. 831-847.
Traumatic experiences among female refugees in the Netherlands and the consequences to their mental health

Hanneke Bot, MSc, psychotherapist* &
Martien Kooyman, MD, PhD, psychiatrist*

Introduction
This article describes factors that influence the mental health of female refugees, the problems many of them face when admitted for psychiatric care, and the help that can be offered through in-patient treatment.

More men than women are admitted to the treatment centres for refugees in the Netherlands. This is partly because 65% of the total number of refugees in the Netherlands are male. (1) In addition, more male than female refugees receive psychiatric in-patient treatment. Approximately 80% of the patients admitted to the Phoenix Centre are men.

Many unmarried men enter the Netherlands as asylum seekers, while the women who arrive are usually married and accompanied by their children. If a woman and her children enter the country without the husband this is usually because he has already arrived. It is rarely the other way around.

Although the situation differs from country to country, women have usually suffered to the same extent as their husbands, but in a different way. While the men have often played an active role in a resistance movement or the army, women are more often the ‘innocent victims’. That is why, unlike resistance fighters and political activists, they are often ill-prepared for the risk of torture, imprisonment, and rape. Women seldom flee alone, and they are less frequently actively persecuted.

On arrival in a refugee camp in the Netherlands little is left of ordinary life. The refugees find themselves completely dependent upon others. Asylum seekers are not allowed to work or to begin an education, not even in the Dutch language. In many refugee camps people are not even allowed to cook for themselves. All the refugees can do is wait until their application for asylum is granted, a process which can take many years. According to Dutch law children under sixteen have to attend school, even children in refugee camps. So their lives bear at least some resemblance to ordinary reality. School brings structure to their day, gives them tasks to perform, brings them into contact with others, and helps them to learn the Dutch language. Although women lose their professional activities outside the home, they retain some of their normal activities such as caring for their family, especially their children. This means that they often have to push their own problems aside. This helps them to survive, but it also forces them to suppress their emotions.

Men often feel completely deprived of their normal lives. Their activities outside the home such as work or study have come to a standstill. Complete idleness has become their fate. Their status, which is based on work, political activities, and other contacts outside the family, is difficult to maintain. It is therefore not surprising that men are more often in need of psychiatric treatment than women. Women are more often treated as out-patients so that they can still care for their families. When women are admitted, their problems are usually more serious and complicated.

Background
There are two centres in the Netherlands for in-patient psychiatric treatment of refugees and asylum seekers. One is the Phoenix Centre, a 32-bed department of the psychiatric hospital of the Gelderse Roos Foundation in Wolfheze near Arnhem, the other is De Vonk, a unit with 24 beds of Centrum ’45 situated in the west of the country. Centrum ’45 was originally founded in 1972 for the treatment of victims of World War II. Phoenix was founded in 1982 for the psychiatric treatment of Vietnamese boat refugees. Since 1995 refugees from any country in the world are admitted in Phoenix.

Fifteen women have been admitted to the Phoenix Centre during the first two and a half years of its existence as a general treatment unit for asylum seekers and refugees. Of these, only four had to leave under-age children behind.

Concerning forced migration, two publications have to a large extent shaped our thinking: Psychoanalytic perspectives on migration and exile by Grinberg and Grinberg1 and Salman Akhtar’s article “A third individuation: immigration, identity and the psychoanalytic process”2. Grinberg and Grinberg point out that migration leads to regression: the immigrant feels...
helpless and has to learn how to behave, according to the
social rules of the new country, and even how to speak. This
is why Akhtar speaks of a 'third individuation', which can be
compared with the two individuation processes that we know
from development psychology, and which all immigrants
have to go through in order to integrate successfully in their
new country. Akhtar emphasizes that this process in itself is
not pathological; only when stagnation occurs can one speak
of a disturbance. Some of the problems that our patients are
faced with are problems that are inherent to this third
process of individuation, and can thus be put in a healthy
perspective. Akhtar also stresses the importance of 'emotional
refuelling': contact with family members and friends in one's
own country strengthens the immigrant and makes it easier
for him to let go of the old ties and to adapt to the new country.
This is an important problem especially in forced migration.
Often, either it is impossible to stay in touch with loved ones,
or one is afraid of bringing them into trouble by contacting
them. The development that Akhtar describes is a process
from 'splitting' to 'integration', i.e. life before and after the
flight has to come together in one life story.

Keilson's lessons are also important for us. He character-
izes the failure of family and friends to support the victim,
and the lack of a warm welcome in the country of asylum, as
a form of 'secondary traumatization', which enhances the
first traumatization. Exactly because these reactions do not
come from the 'enemy', and cannot be ideologically ex-
plained, they hit very hard. The attitude of the health pro-
vider can also, unintentionally, be traumatizing: a formal and
distant ('blank screen') attitude can quickly be felt as painful,
especially by patients who are not familiar with the rules of
Western (psycho)therapeutic treatment. In our clinic, we
therefore usually adhere to a clear and cognitive approach.
We refrain from using a psychoanalytic attitude.

In order to reduce regression, Dutch language lessons and
education in the rules and institutions of Dutch society are
given. These lessons are compulsory for all patients at the
Phoenix Centre. When the patients are able to use the Dutch
language, it is easier for them to feel safe. They are less likely
to develop paranoid thoughts based on mis- or half-under-
stood utterances by other people.

We not only ask our patients to learn about our society, but
we also regard it as important that our staff show an interest
in the countries of origin of our patients. We should have
some basic knowledge of the social, economic, and political
situation in their countries, and we should be aware of the
most important current political developments. Traumatized
refugees need to feel welcome and secure in order to heal.
The following two cases illustrate that female refugees
have to cope with specific problems.

Zohra

One of our female patients, let us call her Zohra, is a young
woman from former Yugoslavia. Long before the war began,
she entered into a 'mixed marriage'. She, a Roman Catholic,
marrried a Muslim man, an intellectual, interested in political
and cultural issues. For several years Zohra earned the fami-
ly income while her husband was a student. In that period
two children were born.

When the war began the couple started to encounter dif-
ficulties: their mixed marriage suddenly caught the public
eye, and they felt that people were watching them. Even so,
they did not decide to leave the country. However, the in-
security in their home town increased, and it became more
and more difficult not to take sides. When Zohra went to the
police to report the damage done to their house and garden,
they laughed at her. Then she was brutally beaten and raped
by several policemen and thrown into the street. When her
husband found out that she had been raped, he called her a
'whore, unworthy of motherhood'. He refused her further
entry to the home, and she was no longer allowed to see the
children. As she was raped, he had lost his honour. Her father
came to take her to his house in a nearby town. Zohra was
unable to bear the humiliation and loss, and decompensated.
A few short stays in a psychiatric hospital followed. Through
family and friends she stayed informed about the situation
of her children. She wanted to return to her home town to
search for her children, but she was afraid to do so because
of the presence of the policemen.

Zohra then met a man who was somewhat older than she
was, and who looked after her as a brother. He had had his
own problems because of the war, but this did not keep him
from further political activities. When the political situation
became even more tense, and they noticed that they were
being watched by the police, they decided to flee the country.

When they arrived in the Netherlands in 1993 it was still
relatively easy for asylum seekers from former Yugoslavia to
receive asylum. Within a few months they obtained a res-
idence permit and an apartment. However, Zohra decomp-
ensated again. Her phobic symptoms increased and psy-
chotic episodes followed. Ambulatory contacts with mental
health care were insufficient to stabilize her condition, and
after a few short clinical admissions, she was admitted to the
Phoenix clinic for a long period.

During the first few weeks after admission, she was so
afraid that she hardly dared to get out of bed. She showed
serious depressive features and suffered from panic attacks
with delusions. She deeply mistrusted all men, including our
male nurses. She felt that, with the loss of contact with her
children, her life had lost all its meaning.

The treatment started with symptom reduction. Her fears
were treated pharmaceutically and with behaviour therapy.
The first objective was to normalize her behaviour towards
men and to help her increase her radius of action. Zohra did
not want to talk and think about anything else except the loss
of her children. The treatment team focussed more on estab-
lishing a normal daily routine, and talking was limited to the
weekly hour with the psychotherapist. In addition, Zohra was
encouraged to learn the Dutch language. This served several
purposes: it kept her occupied and distracted, and, as she was
good at it, it strengthened her self-confidence and helped her
to express herself better. It also reduced regression.

Her psychotherapy focused initially on a behavioural ap-
proach to her phobic symptoms. Increasing Dutch language
skills helped her feel more secure when she went shopping or
walked down the street. She gradually started to speak about
her life in Yugoslavia. Her mother had left her and her father
soon after she was born. Her father remarried soon after. Zohra
felt ashamed that the new wife of her father was not her
biological mother, and she did not want to talk about this
with anybody. It struck Zohra that her own children were
now being brought up by a stepmother, though for very dif-
ferent reasons.

As Zohra slowly recovered, we began to talk about the
traumatic experiences that were the root of her problems,
particularly what happened in the police station. In the

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beginning, she only referred to these experiences indirectly, and she seemed to prefer to keep it this way. It took several months before she was able to talk about these traumatic events. She now felt stronger, and she was used to the clinic, the other patients, and the nurses and therapists. The sessions with the help of a female interpreter had become a routine part of the week and apparently she felt secure enough. Although the events in the police station were burned in her memory, she felt especially hurt by its sequelae: the humiliation by her husband and the separation of her children. However, a strengthening factor was the fact that it was increasingly easier to have contact with former Yugoslavia. The mail was delivered, and Zohra was even able to telephone some distant family members, through whom she received information about her children.

In the first few months after her admission, Zohra did not visit her home in the Netherlands. She did not even dare to leave her own bedroom at first. After some time she ventured out of the unit and attended occupational therapy elsewhere in the hospital. Her first unaccompanied outing outside the hospital grounds, to buy a postage stamp, was a memorable occasion. Although her radius of action increased, she did not even want to mention going on home leave. All men in uniform caused her to relive her traumatic experiences. She was also afraid of confronting children. In the hospital grounds there were few children, but in the residential areas she met many, which gave rise to panic reactions. Cognitive restructuring and behaviour therapy techniques were used to help her cope with her fears and enabled her to move about more freely.

Shortly before her discharge, some financial problems posed a serious threat to Zohra's well-being. It turned out to be difficult for her to cope with practical problems in a constructive way. She needed help from the social worker and a lot of support to solve the problem. When she was discharged from the clinic, Zohra could just cope with daily life. Her strong will to go 'home', and the fact that a therapist well known to her would provide ambulatory after-care, made her make this decision. We only saw her a few times after her discharge. Later we heard that, despite growing contact with her children, her phobic symptoms had partly returned.

When we look back on the treatment of Zohra, a few things are immediately apparent. Immediately after the first trauma that Zohra encountered (the abuse in the police station), she was traumatized again by the repudiation by her husband and denial of her motherhood. In the environment in which she could have best been taken care of, her own house, she was humiliated again. During the session it became clear that this second traumatization was the most painful for Zohra.

War and subsequent flight divide a person's life into two parts, a period before and a period after the flight. For a person's well-being it is important to experience life as an entirety. For refugees this means that the periods before and after the flight need to be integrated. Therapy should focus on repairing this breach in the life history. It is therefore important to look at the relationship between events before and after the flight, as this can help to repair this division. In the case of serious psychiatric morbidity, the treatment first needs to focus on symptom reduction and stabilization. When this is successfully achieved, we usually try to work towards integrating the trauma and the forced migration into the life story. Zohra was encouraged to learn Dutch: she happened to be good at it, and this strengthened her self-esteem. When she managed to express herself better, she felt more safe and independent, and regression decreased. The opportunity to receive news about her children was also an important factor to help her improve.

In the treatment of asylum seekers and refugees we also discuss practical problems in the therapy sessions. Matters of primary importance, such as housing and legal status, cannot be ignored. Although the psychotherapist is not actually involved in solving these practical issues, time is allocated to talk about them. In order to clarify feelings and to set priorities, we discuss the consequences of various choices. The confrontation with practical problems shows the patient's ability to face the problems of everyday life.

**Sabine**

The second case is that of a 20-year-old woman from Ethiopia. We shall call her Sabine. She is the eldest child in a family of six children, five girls and one boy. Her father was active in an anti-government party. As he was threatened, her parents left the country for the Netherlands, taking the four youngest daughters with them. Sabine and her brother, who were both in vocational training, stayed behind with an uncle (Sabine was training as a teacher).

Sabine's father died in the Netherlands, leaving her mother alone to look after the four girls. In Ethiopia, Sabine and her brother finished their training and went to Addis Ababa to look for work. Sabine found a job in a primary school. Her brother was politically active. Sabine accepted this but did not want to get involved. One day Sabine arrived home to find that the house had been raided: the house was in a mess and her brother was gone. Soon afterwards Sabine was visited by policemen, who hoped she knew more about the activities of her brother. The policemen raped her. Sabine did not dare to stay in the house by herself any longer. She decided to stay with family members again. As she also felt under pressure at work, she decided to leave the country to join her mother and sisters. It was a hard decision for her to make, as she had to leave without knowing where her brother was.

Sabine arrived in the Netherlands in the middle of a cold, wet winter. Once she arrived at a refugee camp, some people helped her to trace the whereabouts of her mother and sisters, and after a few weeks she received permission to stay with them while she awaited the decision on her asylum request. There was a happy reunion. Sabine started her new life in the Netherlands with much enthusiasm. Soon, however, Sabine started to develop strange symptoms. She had fits of rage in which she could not recognize anybody. She also had serious sleeping problems and suicidal thoughts. Having visited several psychotherapists and a neurologist who tried to understand her 'fits', she was referred to the Phoenix Centre.

On admission she was very shy, resembling a young girl. She seemed depressed, and was very insecure and afraid to go home for the weekends because she felt she might complicate. We tried to observe her fits, but they occurred only infrequently. They appeared to be classical hysterical reactions and were sometimes accompanied by hyperventilation. After consulting a neurologist, the fits were diagnosed as 'atypical panic attacks'. Examinations including an electroencephalogram showed no signs of epilepsy.

In the psychotherapy sessions we discussed the situation in Ethiopia and Sabine's worries about the members of her family who had been left behind. She was particularly concerned about the well-being of her brother. They had always
been very close, and, despite her sorrow about his disappear-
ance, Sabine was able to laugh heartily when she recalled the
things they used to do together. After several weeks she left
the clinic for a weekend for the first time. Although she said
that everything was 'fine' when she returned, it was clear that
this was not so. We decided to invite her mother and four
sisters for a family discussion. This turned out to be very clar-
ifying. Sabine's four younger sisters, who had been in the
Netherlands for several years already, spoke the Dutch
language fluently and without any accent. They were doing
very well in school, went to parties, rode bicycles, and swam.
They laughed at Sabine when she struggled with Dutch
words. Sabine could not swim and had never ridden a bicycle
before. As Sabine was the eldest, she tried to show her au-
thority by being strict and getting angry sometimes. In this
way she made even more mistakes, etc. It also became appar-
ent that Sabine's mother had hoped that her eldest daughter
would help her a lot because she suffered from ill health, and,
as she had no partner, she needed support.

When we mentioned these issues, there was a lot of recogni-
tion. It became clear that life had not been easy since the
reunion. Sabine had not been part of the family for several
years, and it would take a great deal of effort to become one
family again. They would have to tell each other about the
years in which they were separated, and let the others share
their memories.

After this meeting with the family, Sabine no longer had to
pretend when she went on weekend leave. She was now able
to talk about her difficulties in finding her position within the
family.

Before she was admitted to the hospital, Sabine had a
boyfriend. He kept in touch with her, and when she regained
her health, she also intensified her contact with him. He vis-
ited her in the hospital and appeared to be a kind and seri-
ous young man. In the individual therapy, sex is an important
topic of conversation. He gave her plenty of space to become
accustomed to sexual intercourse after her negative experi-
ences with being raped in her home country. Sabine seemed
able to enjoy it.

Sabine left the hospital nine months after admission. She
had changed a lot: she arrived as a shy, depressed young girl,
and left as a self-confident, mature woman. We had confi-
cence in her ability to cope with problems in the future
without substantial professional help. Since she lived far away
from the clinic, and the train fares were expensive, we did
not see her very often after discharge. There was occasional
contact by telephone. Six months after she left the hospital,
we heard that she had been granted a residence permit, and
that she was going to become engaged to her boyfriend.
Sabine was doing well at school and wanted to train as a
teacher, which seemed to be a realistic aim. At a follow-up
interview, she mentioned her strong wish to become a mother.
She stressed that in this strange country she would like to
have something she could really call her own.

Discussion
These two detailed case histories show two women who be-
came involved in a war without either of them choosing to do
so for ideological reasons. The situation forced them to make
choices that involved them in the war. In war situations, sex-
ual violence was very often used as a method of aggressive
intimidation. In former Yugoslavia it was even used as part of
the policy of 'ethnic cleansing'. For Zohra and Sabine, sex-
ual violence was also part of their traumatic experience.
Although they both suffered from a post-traumatic stress dis-
order, their clinical cases were very different, and the prog-
noses made at their discharge were also very different.

Despite the problems in her childhood, Zohra had become
a healthy adult who was successful at work and at home.
When all this was suddenly taken from her, and she was
betrayed by her own husband, she broke down. It seemed as
though the problems she had faced as a child, i.e. with the
acceptance of her stepmother, were intensifying her present
problems. The forced separation from her children gave her
the feeling that she had lost everything that she had built up
over the years. Her strong wish to give them a better child-
hood than her own could not be fulfilled.

Why was Zohra rejected by her husband after the rape? He
was an intellectual, who - judging by their marriage - must
have had modern ideas. In the Muslim community, it is not
uncommon that a man sees it as a loss of his honour when
his wife has been raped. He is seen as the most important vic-
tim, and the community sympathizes with the man while
holding the woman in contempt. It is the man who is seen as
the major victim when his wife has been sexually abused.

Many women do not dare to talk about their sexual abuse
with their husbands because of these consequences. Some of
them even ask for a divorce. A female refugee from the
Middle East was admitted to the Phoenix Centre after she
had succeeded in getting a divorce from her husband. As it
happened, she had been raped and tortured in prison by the
police, who had tried to discover her husband's whereabouts.
She was so afraid of her husband finding out that she had
been raped, that she had chosen to divorce him instead.

Several raped women who have been admitted to the spe-
cial centres for the psychiatric treatment of refugees in the
Netherlands requested the therapists not to tell this to their
husbands. They were all Muslim women from the Middle
East and other countries such as Yugoslavia, Algeria, and So-
malia.

Zohra's Catholicism may have played a role as well. A publi-
lcation by Withuis shows that the Catholic church is very
condemning towards victims of sexual violence. Withuis
describes a case of a young woman who wants to become a
nun, but in a war situation she is raped. After her confession,
the church considers her 'unclean', and she is refused
entrance to the convent. Although it was not expressed by
Zohra in her sessions, it was possible that the rape was seen
by Zohra herself as something that she had to feel guilty
about. This could be why she complied with her husband's
treatment instead of actively opposing it.

Sabine's traumatic experience took place much earlier in
her life, in a critical phase of her development: late puberty.
The development of her identity into an adult, the maturing
of her sexuality, and the confirmation of her position as
eldest child in the family were all cruelly disrupted. This may
possibly explain her breakdown when she arrived in the
Netherlands and realized that her position in the family was
threatened. However, Sabine was still young, and her focus
was on the future. Although Sabine certainly carried the
memory of her sexual assault as an unpleasant one, it was not
a predominant experience. The fact that she did not have to
keep it secret from her family members and her boyfriend,
and that they supported her, certainly played an important
role here. Also, for Sabine there was no taboo on sex before
marriage. She specifically told me ('You Dutch think diffe-
happy in the care of her extended family, she had apparently built up a stable psychological foundation. The fact that she had had a baby. Since her childhood seemed to have been happy in the care of her extended family, she had apparently built up a stable psychological foundation. The fact that she had had a baby.

Parents often decide to leave their children in the care of (distant) family members for economic reasons. She did not feel the fact that she and her brother were left behind in Ethiopia as 'abandonment'. Since her childhood seemed to have been happy in the care of her extended family, she had apparently built up a stable psychological foundation. The fact that she has several family members in the Netherlands, and could share their extended network of Ethiopian friends and acquaintances and their contacts with the social services, was also of help to her. The fact that her mother and sisters travelled to the Netherlands ahead of her may have caused some of her problems, but it also allowed her to make a quick start in the mixed Dutch-Ethiopian community.

It is often hard for asylum seekers to recover from their traumatic experiences if their request for asylum has not been dealt with. It is, however, remarkable that Sabine managed to recover, even though she did not know whether she would receive permission to stay.

Conclusion

The case histories in this article illustrate the exceptional position of women refugees. Both women were victims of political conflicts they had not chosen to become involved in. In both cases sexual violence had been part of the traumatic experience before the flight. In the first example, rape was the reason for being rejected by her husband and being separated from her children.

In sessions with a female psychotherapist, both women were able to share their traumatic experiences and express their emotions related to the traumatic events. Both women reacted differently, depending on their own life story and the norms and values that they and their environment cherished.

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Note

(1) Statistics from the Dutch Ministry of Justice.

This article was originally published in Dutch in the Maandblad Geeselijke volksgezondheid 1999;6:630-40.

Selected list of publications

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Guerra, genocidio, tortura : la reconciliacion, a que precio? / Munoz Valencia, Arcangel (ed.); Frausto Crotto, Salvador (ed.); FIACAT - Mexico : Desarrollo ; ACAT Mexico, 19970000. - 151 p. - also available in English, German and French. Conference: Seminario internacional de Acat sobre el tema de la reconciliacion, impunidad y justicia (19950607-19950611 ; Munster).


Entre sombras y silencio : la violencia intracarcelaria en el Centro de Detencion Provisional de Quito, CDP = Between shadows and silences : prison violence in the Provisional Detention Center, Quito [I] / Salgado, Maria Judith (ed.); Betancourt, Zaida (ed.); Chavez, Gardenia (ed.); Fundacion Regional de Asesoria en Derechos Humanos ; INREDH-CEAIV. - Quito : Fundacion Regional de Asesoria en Derechos Humanos ; INREDH-CEAIV, 19971200. - XIV, 176 p. : charts. - Series Investigagacion / Fundacion Regional de Asesoria en Derechos Humanos. INREDH-CEAIV ; no. 1.


Contents of psychotherapy with asylum seeking torture victims

Angelika Birck, MA, psychologist*

Abstract
The Behandlungszentrum für Folteropfer Berlin (BZFO, treatment centre for torture victims) treats persons with histories of persecution and torture. Most are refugees. A residence permit (granted asylum) is not a precondition for treatment. Instead, most of the patients live with an insecure residence status as asylum seekers. In a cross-case content analysis of 20 detailed psychotherapy protocols of former patients, different psychotherapy topics (course of symptoms, traumatic events, asylum seeking situation, social problems, country of origin, etc.) were assessed to describe the chronological relation between exile situation and psychotherapy contents. During psychotherapy sessions actual problems of the process of seeking asylum appeared to be a more frequent topic than the original traumatizations. Events in the context of seeking asylum frequently lead to aggravation of symptoms and to retraumatization.

Introduction
About 95% of the patients at Behandlungszentrum für Folteropfer Berlin (BZFO) are asylum seekers or refugees with only short-period residence permits in Germany. These patients are in a very insecure legal situation and live under a constant threat of deportation. Several negative aspects connected with seeking asylum are: work prohibition, a precarious financial and social situation, lack of privacy in refugee homes, and restricted possibility for making own decisions.

This precarious situation is the framework in which our therapy takes place. Our clinical experience is that in psychotherapy under these conditions the focus on past traumas is frequently interrupted by the necessity of handling the threatening problems of the present situation. It is not clear how the influence of this insecure situation on the course of treatment can be described, nor to what extent effects on the course of symptoms can be observed.

Therapy at the BZFO is carried out with a mainly psychodynamic background, though cognitive, systemic, Gestalt, and hypnotherapeutic elements are often included. A similar multimodal eclectic approach is also reported from other treatment centres for torture victims. Specific demands for this group of patients can hardly be answered by adopting one psychotherapy method. Sound recommendations regarding psychotherapeutic techniques specific for torture victims from non-Western cultures are not yet developed.

Currently the course of post-traumatic psychotherapy and recovery is usually described in different treatment phases. The definition of phases is founded on a theoretical model of post-traumatic coping, mainly influenced by Horowitz. He describes three phases: distress, working through, and assimilation of the traumatic experience. Post-traumatic therapy is often divided into similar treatment phases: establishment of trust and basic security, recollection and working through traumatic material, connection with actual problems, and carrying on with life.

The establishment of a basic feeling of security becomes a difficult task for traumatized patients under threatening life conditions, e.g. tortured refugees without a secure residence status. We assume that these conditions affect the contents of post-traumatic psychotherapy, as well as the improvement or aggravation of symptoms.

In the worst cases, actual threats can lead to retraumatization. To date there are only few empirical studies that focus on retraumatization caused by acute threats. These studies examined Holocaust survivors' and rape victims. There are no studies regarding torture victims and the frequency of retraumatization in exile. The present study focuses on the course of symptoms under specific exile situations, e.g. seeking asylum. We distinguish between aggravation of symptoms (worsening of already improved symptoms, often caused by reminders or stressful events) and retraumatization (aggravation of symptomatology caused by extremely stressful incidents that involve a threat to self or others, associated with feelings of helplessness and anxiety, often with an intrapsychic connection to the traumatic events of the past).

We tried to answer the following questions: Which are the actual contents in psychotherapy with torture survivors without granted asylum? How do these contents change during the course of psychotherapy? Can we observe an influence of the status of residence (granted asylum, insecure residence) on the contents of psychotherapy? To what extent can alterations in symptoms be noticed in response to changes of the status of residence, or to other influences of the insecure exile situation?

Methods
A sample of former BZFO patients was taken, based on theoretical formulations. The sample should be representative of the total of BZFO patients regarding gender, age, and ethnic distribution. The documentation of single psychotherapy sessions should be detailed enough to allow analysis. Random sampling was not possible because of incomplete documentation of treatment. The sample included 20 former patients treated by eight different psychotherapists.

The database for analysis was the patients' records, containing the medical history, protocols of therapeutic sessions, and information regarding the current legal and social situation (course of the application for asylum, situation in the refugee homes, decisions of social welfare offices, etc.). The analysis was based on the focus of therapists regarding con-
contents of the sessions. It is assumed that therapists’ protocols of single sessions are influenced not only by the importance the patient ascribes to specific contents, e.g. trauma history, but also by the significance the therapist attributes to them. Therapists make selections by writing down parts of what the patient actually said. When protocolling sessions, these biases are supposed to affect not so much the appearance of contents of psychotherapy sessions in protocols, but more the comprehensiveness and detailed nature of descriptions. In the analysis of contents, the comprehensiveness of single contents was not taken into consideration; instead each documented content of a session was counted in an unweighted way. The relative importance of single contents will be the result of a relative lack of other topics in the documentation of the session.

This information from patients’ files was chronologically ordered in displays according to the method of qualitative data analysis by Miles & Huberman. The first step of analysis was a single case matrix for each patient. Data input was made in rows for the categories: social and legal situation, housing, status of health, including medical care and distinct contents of psychotherapy sessions (exile situation, family and partner, country of origin, trauma history, activities and interests, politics and religion, symptoms, other); lines represented single weeks (sessions were held weekly in most cases). The categorization of contents is the result of a pilot-coding of two patients’ files, and of systematic modification and adaptation during the course of analysis.

A chronological analysis allows the observation and description of connected variables within a time frame, and this allows an interpretation of a possible causal direction of correlations. A sound single-case analysis deepens an understanding of observed changes in symptoms. The cross-case analysis is founded on the understanding of processes in single cases. Our analysis is concentrated on the course of symptoms, on the therapeutic work with the trauma history, and on corresponding information (coincidence in the time frame of one week) from the social and legal situation.

For the analysis of treatment phases, each single-case display was divided into three parts with the same frequency of therapy sessions in each phase. We assumed that contents regarding the social and exile situation are most frequent in the initial phase, but that they remain important (frequent) in the other two phases, and that psychotherapeutic work with traumatic contents takes place most frequently in the middle phase of treatment.

The statistical associations between subgroups regarding the frequency of contents (during treatment, in distinct phases of treatment), demographic variables, and the ending of treatment were tested statistically by Mann-Whitney tests (using SPSS for Windows 6.1).

**Description of the sample**

**Demographics**

The 20 former BZFO patients (14 men, six women) started treatment between 1992 and 1997, and ended between 1993 and 1998. Their mean age was 35.5 years (SD 5.4 years) at the beginning of treatment. Twelve patients were single, seven married or in a steady relationship, and one widowed. Six patients lived with their family in Germany, four had at least one relative in Germany, and ten had no relatives here.

Five persons were from Turkey, four from Bosnia-Herzegovina, two each from Algeria, Lebanon, and Sri Lanka, and one each from Angola, Bangladesh, Burma, Ghana, and Romania. Ethnically, there were five Kurds, three Muslims from Bosnia-Herzegovina, three Arabs, two Tamils, five Africans from different tribes, one Albanian, and one Romanian. The distribution of these demographic variables in the sample corresponds to the population of former BZFO patients, though the level of education of the sample was somewhat higher than in the whole patient population (one university degree, 11 completed professional training, six completed elementary school, one illiterate).

**Trauma history**

Nineteen persons had been imprisoned and tortured, one had been tortured during civil war without being imprisoned. The mean number of imprisonments was 1.7 (SD 1.3, range 1-6), and the median duration of detention was 4.5 months (mean 6.40 months, SD 12.29 months, range 2 days–11 years). Treatment at BZFO started three years after the last torture (median 3 years, mean 4.5 years, SD 5.7 years, range 5 months to 25 years).

**Symptoms**

All subjects were given the diagnosis Post-traumatic Stress Disorder (PTSD, ICD-10 F43.1) in unstructured clinical interviews by trained experts (psychologists and physicians). All had additional diagnoses, including a somatoform disorder (ICD-10 F45) in 16 patients. The frequency of diagnoses is listed in table 1. Detailed information of symptoms at the end of treatment was not available.

**Treatment**

The average duration of treatment was 59 sessions (SD = 32.3; range 24-138) within two years (months: M 23.1; SD 10.2; range 10-55). The background of treatment was psychodynamic, but cognitive and hypnotherapeutic elements were included. Fifteen patients completed treatment, and five patients broke off (four of them in agreement with the therapist).

**Situation of residence**

At the start of treatment only one patient had a secure residence status in Germany, 17 persons had a limited residence status, and two persons were illegal immigrants. At the end of treatment four persons were granted political asylum (one of them shortly after the beginning of treatment), and 16 persons had limited right to residence. For the analysis of treat-

<table>
<thead>
<tr>
<th>Table 1. Diagnoses of the sample, n=20.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
</tr>
<tr>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Post-traumatic stress disorder (ICD-10 F43.1)</td>
</tr>
<tr>
<td>Somatoform disorders (ICD-10 F45)</td>
</tr>
<tr>
<td>Depressive episodes (ICD-10 F32)</td>
</tr>
<tr>
<td>Postfàlanca syndrome</td>
</tr>
<tr>
<td>Ueli, colc</td>
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<tr>
<td>Psychogenic fainting</td>
</tr>
<tr>
<td>Eating disorders (ICD 10 F50.1 or F50.1)</td>
</tr>
<tr>
<td>Anemia</td>
</tr>
<tr>
<td>Also: alcoholism, HIV, menstrual disorder, morbus Bechhreus, paranoid-psyhotic reactions, partial blindness, psychosomatic itching, siliosis, tinnitus</td>
</tr>
</tbody>
</table>
ment protocols, the residence status during the course of treatment was taken into consideration, and therefore two patients with granted asylum were compared with 18 with limited residence status. The distribution of the security of residence status of the sample was similar to the distribution of the BZPFO patient population.

Results

Results of statistical thematic analysis
The rank order of topics in treatment protocols (frequencies) is listed in table 2. The most frequent topic was current symptomatology. Problems in exile and in seeking asylum were a more frequent topic in psychotherapy sessions than former traumatic experiences.

Rank of topics in treatment protocols

<table>
<thead>
<tr>
<th>Rank</th>
<th>Topic</th>
<th>% of sum of all topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Symptoms</td>
<td>33</td>
</tr>
<tr>
<td>2</td>
<td>Process of asylum-seeking, exile</td>
<td>23</td>
</tr>
<tr>
<td>3</td>
<td>Trauma history</td>
<td>15</td>
</tr>
<tr>
<td>4</td>
<td>Home country, losses</td>
<td>10</td>
</tr>
<tr>
<td>5</td>
<td>Problems with partner, children (in Germany)</td>
<td>9</td>
</tr>
<tr>
<td>6</td>
<td>Politics, religion</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>Other</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 2. Rank order of topics in treatment protocols, n = 20.

Distinct situations in the process of seeking asylum (hearings, dates at court, rejection of the application, etc.) were closely related to aggravation of symptoms or retraumatization. All of the 19 patients who had an insecure residence status at the beginning of treatment suffered aggravation of symptoms or retraumatizations caused by events during the process of seeking asylum. Events regarding the social situation (applications at social security offices, worsening financial situation, unemployment due to work prohibition) and the situation in refugee homes (lack of privacy, noise, inability to avoid traumatic memories because of constant confrontation with other traumatized refugees, etc.) were also related to aggravation of symptoms and retraumatization.

The analysis showed that the positive opposite of the above mentioned situations was connected with working through traumatic contents or with improvement of symptoms (table 4). Corresponding with previous results, an amelioration of the legal status (in the best case: a granted residence permit) or improvements in the social situation correlated with working through traumatic contents and with improvement of symptoms.

Discussion

Problems of asylum seeking play an important role in the course of treatment. Due to the small number of participants in the study, the possibility of generalizing the results is only limited. However, it appears that aggravating problems and burdens resulting from the insecure residence situation, the lack of private living space, and the work prohibition were a more prominent content of treatment sessions than previous traumatic situations (persecution and torture).

The frequency of aggravations of symptoms and retraumatization in the sample, caused by conditions related to the process of seeking asylum and conditions of exile, shows clearly that refugees seeking asylum who survived persecution and torture in their home country are deeply stressed by the legal situation in Germany. Present threats often have a retraumatizing effect. For traumatized refugees the process of seeking asylum becomes a further traumatizing sequence in a long series of traumatic situations.

Some events in seeking asylum strongly resemble former persecution in the home country, e.g. dependence on state authority, limited rights and incomprehensible conditions, hearings and interrogations, refusal of applications, long periods of waiting, lack of privacy, limited access to employment, etc. The results of our study comply with our clinical experience that the current process of obtaining asylum in Germany is highly stressful to traumatized refugees, and it has a deeply negative impact on their health.

The results of the analysis of therapy contents in different phases of treatment contradict our hypothesis that traumatic contents are of major importance during the middle phase of
Aggravation of symptoms | Retraumatization
---|---
Process of seeking asylum (hearings, court proceedings, worsening of legal situation) | 9 persons (45%) | 10 persons (50%)
Social events (applications at social security offices, financial trouble, unemployment) | 12 persons (60%) | 2 persons (10%)
Refugee housing | 1 person (5%) | 3 persons (15%)
(Political) situation in the home country, threats to family members at home | 4 persons (20%) | 3 persons (15%)
Confrontations with police in Germany (at demonstrations, raids to detect illicit work) | 1 person (5%) | 5 persons (25%)
Discrimination, racist attacks | 1 person (5%) | 1 person (5%)

Working through traumatic contents | Amelioration of symptoms | Other reactions
---|---|---
Improvement of the legal status in the process of seeking asylum (best status: unlimited residence permit) | 2 persons | 7 persons; improvement after granted residence permit led to termination of treatment in 3 cases

Improvement of social situation (reimbursement of costs, granted income support, granted limited right to stay in Berlin with access to treatment, etc.) | 3 persons | 4 persons | nil

Table 3. Situations leading to aggravation of symptoms and to retraumatization. n=20.

Table 4. Situations leading to working through traumatic contents or amelioration of symptoms. n=20.

References
New judgements in Strasbourg find Turkey guilty of human rights violations

_Breach of the right to life, of freedom of expression, and of the prohibition of torture_

_Henrik Döcker_

Several judgements by the European Human Rights Court in Strasbourg have confirmed that Turkey continues to violate the European Convention of Human Rights of 1950. In just one day in July the Court found Turkey guilty of violations in no fewer than 13 cases, one concerning torture. The heavy load of Turkey's serious violations had caused the Committee of Ministers of The Council of Europe to adopt a resolution in June expressing strong criticism of Turkey for not improving the standard of human rights.

The Committee is alarmed that, two years after the first convictions of Turkey, the Turkish Security Courts have not changed their practices, i.e. issuing harsh judgements and ignoring vital rules of legal procedure. The investigation in numerous cases concerning the Kurds have been inefficient. Important reforms of criminal procedure are required, the Committee observed. Acknowledging the necessity of combating terrorism, the means must respect Turkey's obligations under the Convention.

**Beatings and electric shock treatment**

About one month later, on 8 July 1999, the Court once more stated that Turkey had violated the Convention. In the Gäkcici case the European Court of Human Rights held that articles 2 (right to life), 3 (prohibition of torture), 5 (right to liberty), and 13 (right to effective remedy) had been violated. The applicant, Izzet Gäkcici, stated that his brother Ahmet had disappeared after being detained by the security forces.

Gendarmes were looking for evidence concerning the kidnapping and murder of teachers and an imam by the PKK (the Kurdish Labour Party), and they apprehended Ahmet Gäkcici in this connection.

He was then transferred to Diyarbakir provincial gendarmerie headquarters, where he was detained for 16 to 17 days in the same room as three other people. One of these three, Mustafa Engin, reported when he was released that Gäkcici had been beaten, a rib being broken and his head split open. He had also been taken out for interrogation and given to electric shock treatment.

The applicant and his family had received no further news about Ahmet Gäkcici until the government provided information during the proceedings before the European Commission of Human Rights. The public prosecutor in Hazro issued a decision of lack of jurisdiction concerning the allegations about Ahmet Gäkcici's disappearance, finding, among other things, that his identity card was found on the body of a dead terrorist.

**As often in Turkey: no effective response to relatives**

The Court noted that the Human Rights Commission's task of establishing the facts had been made more difficult since the Turkish government had failed to provide the Commission's delegates with the opportunity to inspect original custody records, to facilitate the attendance of the witness Hikmet Aksoy, and to secure the attendance before the delegates of two state officials.

The Court, considering that it was of the utmost importance for the effective operation of the system of individual petition that states provide all necessary facilities to make possible a proper and effective examination of applications, found that the Turkish government had fallen short of this duty.

The Court rejected the government's preliminary objection that the applicant had failed to exhaust domestic remedies. The Court found that the applicant and his father had made petitions and enquiries to the State Security Court prosecutor in relation to the disappearance of Ahmet Gäkcici, and that, though the authorities had been made aware of their concerns, no effective response was made.

No measures were taken by the various public prosecutors beyond enquiring about possible entries in custody records and taking two brief statements from the witness Mustafa Engin. No steps at all were taken by the public prosecutor to verify the report that Gäkcici's body had been found. In these circumstances, the applicant had done all that could reasonably be expected of him to exhaust domestic remedies.

**With no government explanation: presumption of death**

The Court found that the disappearance of Ahmet Gäkcici after he had been taken into custody led, in the circumstances of this case, to a presumption that he had died. No explanation having been provided by the government as to what happened to him during his detention, the government was liable for his death.

The Court held that his disappearance during an unacknowledged detention disclosed a particularly grave violation of the right to liberty and security of person, guaranteed by this provision. It referred in particular to the lack of accurate
DE JURE, DECLARATIONS, ETC.

and reliable records of the detention of persons taken into custody by gendarmes, and the lack of any prompt or meaningful enquiry into the circumstances of his disappearance.

Referring to its reasoning in, among other things, its judgment of 19 February 1998 in the case of Kaya v. Turkey, the Court considered that the national authorities had been under an obligation to carry out an effective investigation.

The Court, ruling on an equitable basis, awarded GBP 11,534.29 for pecuniary damage to the applicant's brother's spouse and children, GBP 25,000 for non-pecuniary damage to his brother's heirs, GBP 2,500 for non-pecuniary damage to the applicant himself, and GBP 20,000 for costs and expenses.

European Human Rights Court found France guilty of violating the torture prohibition – for the second time

*The Strasbourg Court awarded the torture victim FRF 500,000 in compensation*

Henrik Dæcker

The European Court of Human Rights in Strasbourg has once more found France guilty of violation of the prohibition of torture, as established in article 3 in the European Convention on Human Rights comprising almost all the 41 Council of Europe member countries.

In a judgement delivered at Strasbourg on 28 July 1999 in the case of Selmouni v. France, the Court held unanimously that article 3 as well as article 6 § 1 (right to a hearing within a reasonable time) was violated. The applicant made a complaint concerning his treatment in December 1992, and the proceedings are still pending before French courts.

Under article 41 (just satisfaction) of the Convention, the Court awarded the applicant FRF 500,000 for pecuniary and non-pecuniary damage, and FRF 113,364 for legal costs and expenses.

The applicant, 57-year-old Ahmed Selmouni, a Dutch and Moroccan national, is currently in prison in Montmedy (France). The European convention covers anyone who may be exposed to violation of his or her rights according to the convention, prisoners included, and it is no condition that you must be a citizen of one of the Council of Europe countries.

France was previously found guilty of violating the torture prohibition in 1992. A Corsican shopkeeper, Félix Tomasi, following a judgement by the European Court of Human Rights, was awarded one million French francs in compensation for being beaten for 40 hours and because it took more than five and a half years to deal with his complaint against the French government. He was suspected of involvement in a murder and an attempted murder in February 1982 by the ex-FLNC (Corsican National Liberation Front).

Four different doctors examined Tomasi in the days following the custody, and the many marks on his body indicated the numerous intense blows that had been inflicted on him. The Court, while recognizing the undeniable difficulties in fighting crime, not least terrorism (a reference to the well-known violent political movements on Corsica), held that the investigation must not remove the necessary protection of physical integrity of individuals.

The applicant sentenced for drug-trafficking Selmouni was held in police custody in Bobigny in France from 25-29 November 1991, while he was questioned by police officers from the Seine-Saint-Denis Criminal Investigation Department in connection with drug-trafficking proceedings. The maltreatment he suffered in police custody
resulted in six medical examinations, with accompanying certificates.

The Bobigny Criminal Court ultimately sentenced him to 15 years' imprisonment on 7 December 1992, but before that the judge ordered an expert medical report. One year earlier, in December 1991, an expert from the medical department of the Fleury-Merogis prison, appointed by the investigating judge, examined the prisoner and listed the visible injuries on his body, concluding that they had been sustained at a time that corresponded with the period in police custody.

On 1 December 1992 the applicant was questioned about the events for the first time by an officer of the National Police Inspectorate, and the record of the interview was sent to the Bobigny Public Prosecutor. In February 1993 the applicant lodged a criminal complaint, together with an application to join the proceedings as a civil party.

The reasons given were "assault occasioning actual bodily harm resulting in total unfitness for work for more than eight days; assault and wounding with a weapon (namely a baseball bat); indecent assault; assault occasioning permanent disability (namely the loss of an eye); and rape aided and abetted by two or more accomplices". All this, done by police officers, occurred between 25 and 29 November 1991.

**Several years' prison for the police torturers**

In February 1993 a judicial investigation into the complaint opened in the Bobigny tribunal de grande instance, lodged both by the applicant, Selmouni, and by another person who had been taken into police custody. An identity parade was organized on 10 February 1994. The applicant picked out four police officers (a fifth officer was identified by the other civil party on 7 March 1996).

In a judgement of 27 April 1994 the Court of Cassation decided to remove the case from the Bobigny investigating judge and transfer it to a judge attached to the Versailles tribunal de grande instance, in the interests of the proper administration of justice. The identified police officers were charged in January, February, and March 1997. On 21 October 1998 they were committed for trial at the Criminal Court on charges of assault occasioning unfitness for work for less than eight days and indecent assault committed collectively and with violence and coercion.

In a judgement of 25 March 1999 the Versailles Criminal Court sentenced the police officer who had been in charge to four years' imprisonment, issuing a warrant for his immediate arrest, and three years' imprisonment for the other officers. In a judgement of 1 July 1999 the Versailles Court of Appeal convicted the police officers of assault, in the course of their duty and without legitimate reason, with or under the threat of the use of a weapon, occasioning total unfitness for work for less than eight days in the case of Selmouni and for more than eight days in the case of the other victim. The police officers were given suspended prison sentences of twelve to fifteen months; the officer in charge was sentenced to eighteen months' imprisonment, of which fifteen months were suspended.

**Tortured to obtain confession**

The Court found that all the injuries recorded in the various medical certificates, and the applicant's statements regarding the ill-treatment to which he had been subjected while in police custody, established the existence of physical and un-
Amnesty International is vital in the international fight against torture

Henrik Döcker

Amnesty International Report 1999 (covering 1998) 371 pages + appendices

Amnesty International (AI) has now published an annual report for 38 years, and this is still the most respected and best-known annual survey of how the countries of the world behave with respect to human rights. Unfortunately, however, it is violation of human rights that is mostly mentioned.

One might assume that the AI report, for instance the one published in June 1999, is the report on human rights violations, generally speaking in 1998. This is however not the case. AI deals with three main groups of violation: 1) the so-called prisoners of conscience (sometimes called political prisoners), 2) torture, and 3) the death penalty. The main purpose of the organization is to persuade governments to release these prisoners, and to abolish torture and use of the death penalty. Points 2) and 3) also go for ordinary prisoners, i.e., people punished for non-political crimes.

Categorization

The main purpose of the AI annual report is stocktaking of the internationally known numbers of prisoners of conscience in each of the countries of the world, about 190 countries. Some introductory chapters deal with broader subjects. The 1999 edition, covering 1998, lists 142 countries for smaller or larger violations of human rights. It must be born in mind that Amnesty does not distinguish between violation out of negligence, stupidity, ignorance, etc. and systematic violations.

Any death in custody that points to peculiar or mysterious circumstances tends to activate Amnesty, and no country will leave this listing before satisfactory reparation is paid to the victim or relatives. This means that a country in which, let us say, one policeman has unjustifiably maltreated a citizen will remain in the AI surveys for years until legal investigations are concluded, and if a breach of the law has been ascertained, until the victim has been compensated.

The activities of the year

Information is given in useful appendices of AI visits to countries with special human rights problems (137 such visits in 1998), and the number of countries that have ratified various international conventions, etc. It is here, incidentally, that we find out that 112 countries have ratified the UN Convention against Torture, a number that has increased to 118 as we go into print (November 1999). What is missing in the 1999 report (405 pages) is an index in which to find the frequency of various kinds of violations such as torture, executions, detention, etc. (1)

Amnesty International, however, is not a static organization. It has done a lot to further human rights work in general at the United Nations and within regional intergovernmental organizations, not least in 1998 — the year in which the Universal Declaration of Human Rights celebrated its 50th anniversary. AI, together with five other organizations, launched a campaign “The Coalition to Stop the Use of Child Soldiers”. The AI report observes that a Working Group under the UN Human Rights Commission drafted an optional protocol to the Convention against Torture.

However, the outcome of the work was disappointing. This protocol aimed to create a global inspection system for places of detention as a way of preventing torture and ill-treatment (like the European Torture Prevention Convention that was set up and has now been practising since 1989). Despite work on this subject since 1992, a small group of countries (their names are not given, but one may guess that they are mainly from Asia) opposed a strong protocol; they played an obstructive role by making suggestions that aimed to limit the scope of this instrument. They finally succeeded in blocking not only the final adoption of all substantive articles discussed during the 1998 session, but also the Working Group’s report. Thus doubt has been cast on the future of this whole idea.

Focus on the Middle East

The 1999 report also records that Amnesty submitted information of the use of torture in Egypt to the UN Committee against Torture (CAT). This Committee had taken the rare step in 1996 of issuing a public statement that torture was widespread and systematic in that country, and had made more than one recommendation to combat this practice.

Amnesty International likewise provided information on Israeli torture methods. (As late as September 1999 the Israeli Supreme Court, after years of international pressure, decided that the Israeli Intelligence Service Shin Bet was no longer permitted to use so-called moderate physical pressure (e.g. shaking) against detainees, because it had no legal foundation. According to Israeli human rights groups, about 850 people were exposed annually to this kind of interrogation — ed. note).

The AI annual report is vital for anyone engaged in human rights work. However, there is a need to modernize its presentation, for instance, an index should be provided. Personally, I would also like to see a list of countries that systematically, not just occasionally, violate human rights.

Note

(1) Amnesty, however, has informed me that the organization separately published a list, known to the secretariat of the national sections, on the main categories of violations that are pin-pointed in the annual reports. The following are listed (with page numbers of the 1999 report attached): extrajudicial executions, disappearances, torture and ill-treatment, prisoners of conscience, unfair trials, detention without charge or trial, death penalty, and human rights abuses by armed opposition groups. This list can be obtained upon request from the national sections (Reference: POL 10/06/99).
Cross-cultural practice – the Multicultural/Multimodal/Multisystems (Multi-CMS) model


Two American psychologists, Sharon-ann Gopaul-McNicol and Janet Brice-Baker, have worked with immigrants in the US for some years. They have described their experiences of the importance of ethnic and cultural differences in the handling of psychological problems in the book Cross-cultural practice: assessment, treatment and training as a manual for others working in the same field.

The book starts with a short historical summary of the development of psychology in the US, from being centred around the predominant Anglo-Saxon culture and its norms to an acknowledgement of the need for new approaches to the assessment of psychological problems, treatment, and research in the work with culturally different population groups. Multiculturalism is being promoted as “the fourth force” in psychology (after behaviourism, psychoanalysis, and humanism), and the profession is encouraged to accept and to become involved in the cross-cultural approach.

There follows a systematic description of some problems in the assessment of psychological problems in clients of foreign cultures. Three chapters deal with the problems of children, parents, and couples, respectively. There is a short description of how children with post-traumatic stress disorder (PTSD), adaptation problems, and culture-dependent different behaviour may be assessed as having ordinary psychiatric conditions such as depression or attention deficit hyperactivity disorder (ADHD). Psychometry and intelligence-testing are described in considerably more detail, and, covering 11 pages, at perhaps too much length. The focus, sympathetically enough, is to find the child's strengths and potential instead of once again to confirm an obvious academic deficiency. The basis for an assessment of parental skills is the understanding that an essential part of the parents' role is to help their children to acquire a stable and secure identity. It is of foremost importance to accept instead of to judge behaviour that may have its background in other norms or problems in connection with immigration and social status. The chapter on the problems of married couples caused by cultural differences is somewhat superficial and uninteresting, by contrast with the two previous chapters.

Then comes the book's core: the treatment of clients with cultural backgrounds other than that of the therapist, and the Multicultural/Multimodal/Multisystems (Multi-CMS) model. The therapist must have self-insight with respect to race, ethnicity, culture, training, and socioeconomic background, and his own motives. It is important not to start the therapy with an ethnocentric, paternalistic attitude: “Clients from oppressed groups are all too familiar with what people think is 'wrong' with them. Positive feedback stressing the individual's strengths will be much more productive.” (p. 76-7) The problems of interpretation are described briefly and precisely. The Multi-CMS model may appear a bit confusing at first, because it is a synthesis of most of the existing theories and treatment systems, but the authors' experience is that it is best to have a broad and flexible approach to the problems of working with foreign culture clients.

Multicultural counselling is based on an analysis of the acculturation process, which has three phases according to Helm: a preencounter phase, in which Western culture is idealized, a transitional phase, in which the Western world rejects the foreigner, leading in turn to ethnocentrism and “spiritual rebirth”, and a final phase, in which biculturalism has been achieved, and experiences from both cultures can be used constructively to create a new stable identity.

Multimodal therapy is based on the fact that most problems have more than one cause and one solution, and that the interaction between multiple modalities must therefore be analysed, i.e. behaviour, feelings, senses, images, cognition, interpersonal and biological elements. Various therapeutic modalities are discussed, such as family therapy, group therapy, and individual therapy, together with their strengths and weaknesses in various situations.

Multisystems approach means that various system theories form the framework of the treatment course. The treatment is based on two axes: the treatment process itself, and the levels at which the therapist may intervene, i.e. the individual, the family, friends, place of worship, social service agencies, etc. Circularity is preferable to linearity, meaning that there is no fixed therapeutic schedule to be followed point by point – one can choose various approaches as appropriate.

The three approaches are integrated in the Multi-CMS model, which has four phases in the therapeutic course:

1. The assessment process, in which the therapist first explains his role vis-à-vis the client/family, who typically are referred because of a child's problems at school. Confidence has to be created, problems to be clarified, the acculturation phase to be decided, and the therapy's aim to be agreed.

2. The educational therapy process, in which the problems of the culture encounter are handled in a primarily pedagogic way.

3. The psychological treatment process, in which one can use a behavioural, affective, or cognitive approach according to what is most suitable.

4. The empowerment treatment process, in which networks are used and plans for the future are made.

The last part of the book deals with how to integrate a multicultural attitude at university level, supervision of cross-cultural work, and the aims of future research.

Though covering a wide field, the book is quite thorough and instructive. Its strength is its pragmatic approach. It is based on broad experience within the field, and most cases are good illustrations of the authors' views. The Multi-CMS model is complex but inspiring, and it can be applied in therapeutic work with cross-cultural problems either in its entirety or in part. It is based on the work with immigrants in the US, where it may be most suitable for general use. Certain passages may sound slightly naive, such as a “happy-ending” therapy case with the Matthews family: “[...] Taiesha joined a youth group that was monitored by West Indian adults in the community. She built a wonderful network of friends...
who themselves had gone through cultural conflicts while in transition. Mr. Matthews eventually agreed to join a Black male self-esteem group, which focused on such issues as "the invisibility syndrome" as it pertains to Black males and the psychology of being a Black male in the society [...]"

(p. 110)

The book suffers from political correctness and predictability. It does not provoke the reader and only suggests queries with respect to his/her culture and concepts of normality. The discussion is too short and superficial. An essential concept such as "culture" is defined only as "a way of living that encompasses the customs, traditions, attitudes, and overall socialization in which a group of people engage that are unique (not deficient) to their cultural upbringing" (p. 5), and this definition is not discussed in relation to other known interpretations of the concept.

Not many will turn their backs on the book because of professional dogmatism; everybody can use it with different weighting according to temperament and experience. Nevertheless one might have wished that the authors had been a bit better at sorting out their material and had dared to discuss it in a more problem-orientated way, at any rate to clarify the message.

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Focus on non-State actors


This book makes two very important contributions.

Firstly, it traces the history of Human Rights in Arab countries from the beginning of the present century, thus implicitly challenging the present accusation, both by Arab regimes and by fundamentalist extreme right-wing forces, of Human Rights activists being sold out to the West and merely imitating an alien model that is not rooted in our cultures. Human Rights concepts have been discussed in the Arab world ever since they began to be discussed everywhere in the world; this discussion continues today. Intimately and explicitly linked to demands for democracy, equality between men and women, national liberation of colonized peoples, rights to unionize labour, economic and social rights, and finally political and religious reform, our Human Rights activists have based their analysis on the specific situation of Arab countries, e.g. the prevalence of anti-democratic regimes, the rise of religious fundamentalism, and the need for cultural norms to evolve. As early as 1949, they criticized the Eurocentric definition of Human Rights that prevailed, and this made a major contribution with respect to the evolution of the Human Rights definition towards a true universalism.

Secondly, the book also points at the generalization of torture and other violations of human rights in the Arab world. Such violations are not limited to those perpetrated by States; various non-State actors have now become the predominant perpetrators. While it does not fail to deal with the more 'classical' violations by States (for instance, Israel, Iran, and Saudi Arabia stand for capital punishment; most countries have not ratified the Convention on Torture, etc.), the book's contribution is to identify other areas of violations and to address the role of other (non-State) violators.

In the name of culture, in all concerned countries, discriminatory family laws have been passed that codify the traditionally inferior status of women in matters of marriage, right to initiate divorce, right to alimony, custody and guardianship of children upon divorce, right to equal inheritance, etc. This legalization of cultural discrimination grants impunity to violators in the private sphere; women and children are submitted to physical torture and enormous mental pressure, amounting to psychological torture, within the family; the growing deterioration of their mental health contributes to the global brutalization of society that is taking place because of the rise of fundamentalism.

In the name of religion, fundamentalists have become the major perpetrators of gross human rights violations in the enforcement of their extreme right-wing political programme. They commonly use torture and murder, control over women's behaviour, sexual violence, rape and religiously-blessed rape in forcible 'mutaa marriages', etc. They are responsible for the present brutalization of the whole society and the religiously-sanctified banalization of the private use of torture.

The book also touches on the problem of legal and sexual exploitation of the immigrant, especially female, labour force in rich Arab countries, and the fate of their children.

Two criticisms of this otherwise excellent piece of work:

1. The book obviously fails to apply its own analysis, regarding the major role of non-State actors as perpetrators of violations, to the case study on Algeria; very traditionally, it focuses exclusively on violations committed by the Algerian State, thus leaving aside the vast majority of the violations committed today in Algeria, i.e. those committed by fundamentalist armed groups against the civilian population. Not a word about it. Such a lapse is appalling.

However, the book must be commended for trying generally to contribute to this much needed change in the conception and definition of Human Rights. This example only shows that the mainstream conception of Human Rights still prevails, and how difficult it is to reverse a definition that was conceived decades ago, when States were still considered as the only, or major, perpetrators.

2. The great omission concerns the violations against homo-
The importance of differences


We are living in a world filled with stereotypes about the two sexes. Not exactly truths, but conceptions and social consequences of these stereotypes, to which we have to adopt an attitude.

We know today that there are biological and psychological gender differences; but we also know that, if we take into account the circumstances especially concerning reproduction and the different physical capacity in the light of differences in muscle mass, men and women can enter into relations on the same footing socially, and in family and work-related matters. The precondition for making this possible is that the different hormone production is a contributory cause of the differences.¹

In the light of this information, it is extremely fascinating, and necessary, for there to be an increasing effort to describe and analyse the two sexes' different conditions, together with the many consequences of power relations, to which the stereotypes and social differences are a particular contributory cause.

Gender and catastrophe is an outstanding and important contribution to the study of the consequences of different types of catastrophe, and the differences in the consequences for the two sexes, primarily focusing on women's conditions.

The book's editor, Ronit Lentin, is course coordinator of the M.Phil. programme in Ethnic and Racial Studies at Trinity College, Dublin, where she lectures in sociology and women's studies. She has collected contributions with experiences from an unusually wide spectrum of catastrophes, including war and environmental catastrophes, e.g. the French atomic explosions in Polynesia and several famines. Almost regardless of the nature of the catastrophe, women are affected particularly with respect to their sexuality and reproduction. But this is also where women are most vulnerable, where they experience gruesome oppression, and where the general oppression of women shows itself.

Both sexes are affected by catastrophes. Both sexes suffer as a result of catastrophes, but women's sufferings have either been concealed or exploited. The oppression of women, e.g. in the form of rape, is concealed, while women's care for children is emphasized and thus exploited. Monuments are erected for the victorious or fallen soldiers, but there are no monuments for the women who carry the burden of rape and perhaps a following pregnancy.

There is an example of an interesting attempt to give women redress in Bangladesh, where it is estimated that up to 400,000 women were raped in the war between Pakistan and Bangladesh. Santi Rozario writes: "Sheikh Mujibur Rahman gave these raped women the honorary title of 'war heroines' with the intention of giving them a status in society's eyes equivalent to that of the 'freedom fighters'. However, with a few exceptions, neither the Bangladeshi people as a whole, nor their own brothers, fathers or neighbours were prepared to accept them back as members of the society. They had lost their virginity and purity and were merely a source of shame." (p. 264)

The failure of this rehabilitation attempt was caused by several factors. As a result of social changes, a large group of women were expelled from the society. The men began to marry very young girls because of the dowry rules, whereby there was a surplus of unmarried women of the same age as the newly married men. But these women were also victims of repression. "Male Bengali society could not protect them, and yet when they were tortured and raped by the Pakistani army, presumably as an insult to Bengali men, those men could only blame and ostracize their sisters, wives and daughters for being victims." (p. 266)

The oppressed becomes the oppressor, instead of using the experience constructively to form a more equal society at all levels. This is one of the things we need to realize and use in order to change matters.

The economy also plays an important role with respect to the way people are treated, also in a modern society. Relief measures are delayed, provisions become unpayable, or the existing resources (sometimes even large ones) are withheld because of the large profit obtained by some greedy persons. There is money to be made from famine and suffering.
We know it from our own times, and it is also documented in abundance from catastrophes in earlier times, e.g. the famous 1845-51 potato famine in Ireland. It is estimated that one million human beings starved to death, and many more migrated.

Margaret Kelleher has made an interesting analysis of women’s conditions based on the Irish famine. She questions the assertion that women can endure more starvation than men because of their different capacity to store body fat. Even though this may appear so,2 she points out that it is a very complicated area precisely because of the gender roles. The man is still considered the supporter and head of the family, even though he is not in many cases. In any case he has to have food. Here we succumb to the fact that the man is assigned the gender role stereotype as protector, who is to take care of women and children. A role that eventually causes repercussions, because the man can be a real protector only in very rare cases. When, through no fault of his own, he fails to live up to this role, it affects both himself and the women, such as the example I have given from Bangladesh, which appears to be common. We might be able to bear letting ourselves down, but letting others down is much less bearable. Therefore we must eliminate those who remind us of the failure.

Women as mothers are used in the media to illustrate the extent of the catastrophe. Previously, and now, the mother with the child at her breast, for whom she does not have milk, is eye-catching. But Margaret Kelleher shows in her analysis that it has a drawback. “[It] is used to spell the ultimate catastrophe, a collapse in the natural order. Associations of the female with nature and domesticity are more than familiar, but their use within famine representations runs the risk of suggesting that famine too is a breakdown in nature rather than political and social crisis.” (p. 250-1) Other chapters in the book also illustrate the same complex of problems in regard to catastrophes other than hunger.

The book covers some important subjects, subjects that should not be concealed: _Genders and genocides, Women in a war zone, and Sexualized slaveries._

Not all the authors have succeeded in showing the gender perspective in all cases. The story is sometimes so horrible that that is what becomes most important. It is important as well. The consequences with respect to health as well as socially for the original Polynesian population after the French atomic explosions provide an awful story, where both women and gender differences are lost in the documentation. It is okay, because women’s conditions have been discussed in most of the other chapters.

Someone might ask, why do we need these kinds of books? We are drowning in stories about wars, injustice, and their consequences. Do we need to know more about the wickedness in this world? The answer is yes, because we can distance ourselves from the everyday stories. It is the recognition of what happened, the historical repetition, which necessitates that we must realize the circumstances. With this insight, it is hoped that we can make the world just a little better. The repression we have seen in women’s lives in connection with different wars and catastrophes cannot continue. Somebody’s eyes have seen. Now what has been seen must be utilized for change. That is why a book such as _Gender and catastrophe_ is important.

### References


### A constructive approach to the fight against torture


This book, written by prominent experts, covers a wide range of disciplines, all relevant to a comprehensive understanding of torture. _Part I_ gives the reader a historical and systematic overview of the international rules and procedures that have been developed since World War II within the United Nations, regional organizations, and International Humanitarian Law. This and the chapter on the Optional Protocol are especially valuable for non-lawyers who lack insight into the complexity of all the powerful and conflicting political issues that are at stake in the efforts to implement the principles of human rights. At the same time, the authors have succeeded in presenting the rules and procedures, not as an overwhelming bureaucracy, but as useful instruments in the long and difficult historical road to the rule of law.

_Part II on Torture crimes_ gives a picture of the now widely accepted view that the perpetrators are rather ‘ordinary men’ who become ready to execute torture by the brutal socializing techniques of totalitarian regimes. The instructive chapter ‘Dance, sister, dance!’ describes realistically the horror of the torture acts.

A chapter on non-state actors of torture reminds the reader that the practice of torture has now spread to a variety of organizations, and that a vicious circle has been established between state actors and resistance movements. _Part III on Victims of torture_ has a constructive focus on the development of treatment and rehabilitation. Procedures integrating both somatic and psychological elements are now practised in many centres in the world, and teaching and training within this field are growing. A highly relevant chapter on torture...
BOOK REVIEWS

among asylum seekers draws attention to the fact that this issue is probably underestimated, and that studies find frequencies of 4 to 35%, varying within different refugee populations.

Part IV on The struggle against torture gives the reader an overview of the sensitive relationship between foreign policy and torture. The difficulties in enforcement of the conventions are illustrated by examples from different parts of the world. The chapters on Truth Commissions and the role of non-governmental organizations show how this field is now open to new initiatives and evaluates their possibilities and limitations.

In part V, Final reflections, the authors live up to the offensive and optimistic tone of the book’s title. It catches up with the celebration of the 50th anniversary of the Universal Declaration of Human Rights and tries to renew the vision that heroically proclaims “No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”

The book is highly recommended to professionals and human rights activists as an inspiring source in the long and hard work for the eradication of torture.

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A useful guide for helping refugees


This book was written on the basis of extensive knowledge and experiences gained while dealing with a vast number of Cambodian people, victims of the civil war in Cambodia from 1979 to 1991. There are 17 chapters, each written by different author(s).

As the name of the book suggests, it was written as a guidebook for mental health workers dealing with traumatized Khmer people in Cambodia.

Review of chapters

Khmer mental health in the border camps by Nee Meas describes the camps meant for displaced Cambodians at the Thai border. The problems of camp life, especially for women and children, are described very well. The chapter also highlights the importance of integrating local traditional practices with modern medicine in order to provide better services for the community.

A model called KCBM by Svay Tor describes the “bicultural health program” called the KCBM model. KCBM stands for Kruu Khmer, Counselling, Buddhism, and Medication. The traditional healing practices and the religious beliefs in the Khmer culture have been combined with modern medicine in this model to provide a bio-psycho-social approach while dealing with the problems of displaced Cambodians settled in the camps at the Thai-Cambodian borders.

Khmer traditional healing by Soeurn Hem describes the traditional ways of classifying illnesses, and the traditional healing practices in the Cambodian culture.

Counseling as mental health treatment by Barnabas Mam describes the Khmer traditional counselling and the Western model of counselling for dealing with mental health problems. It also describes how these two models could be integrated to provide better services for people suffering from a range of mental health problems.

Healing practices of Buddhism by Venerable Hok Savann describes how the illnesses could be managed by Buddhism and meditation. It also describes four basic kinds of grief or depression, and highlights the importance of “keeping balance”, “living with the right perspective”, and “handling mental conflicts” in order to get relief from the sufferings.

Use of psychiatric medications by Kathleen Allden describes four basic diagnostic groups of mental illnesses, together with their features. It also describes the modern drugs for use in various disorders, and the precautions to be taken when using those drugs.

Causes and treatment of depression by Richard Mollica and Sokhom Chan describes the causes, types, symptoms, diagnosis, and management of depression, particularly in the context of Khmer culture.

Trauma related illness by Lany Lang describes the various types of trauma that were experienced by the Khmer people during the Cambodian civil war. The chapter also lists the physical and mental symptoms of trauma, and describes the traditional and modern methods of managing these traumatized people.

Domestic violence: consequences and treatment by Malis Oeur-Chum gives the background for domestic violence in the Khmer culture. It also describes the symptoms of domestic violence in the family and in the victims, and succinctly mentions the management of domestic violence in the Khmer culture.

Alcohol and substance abuse: symptoms and treatment by Sokhom Chan describes the various drugs that are used in Cambodia. The withdrawal symptoms of various drugs, and their management by the KCBM model, are also described.

Rape and sexual violence by Phaly Nuon describes the background for rape and sexual violence. It also describes the emotional, social, and physical consequences of rape, and the bio-psycho-social model of treatment for the victims.

Psychosis and head injury: symptoms and treatment by Chris Sochan describes the features of functional and organic
psychoses, and their management. It also describes the management of dangerous patients, and some long-term measures that are needed for brain-damaged patients with personality changes.

*Special problems of the handicapped* by Kowith Kret gives a picture of a typical Cambodian family. It also gives the Cambodian views of physical and mental handicaps, citing three examples. The sources of social support in Cambodia, and the KCBM model for the management of handicapped people, are described.

*Children and the family* by Richard Mollica describes the physical, psychological, and social needs of children. It also describes the symptoms of psychological trauma in children, and the coping mechanisms used by these traumatized children. The author highlights the importance of speaking directly to traumatized children in order to know their feelings, thoughts, and expectations. The management of these children is described clearly.

*Importance of education* by Anne Dykstra describes the importance of primary education, the current status of primary education in Cambodia, and the immediate ways of improving it.

*AIDS: support of people and families with AIDS* by Kathleen Cash describes the HIV virus, its mode of transmission from one person to another, people at risk of AIDS, misconceptions about AIDS in Cambodia, management of people with AIDS, and some primary preventive measures for HIV infection.

*An emerging model of mental health care in Cambodia* by Jim Lavelle and Savuth Sath describes how the 400,000 Cambodians who fled to the United States between 1980 and 1990 were helped jointly by Western physicians and mental health professionals, teamed up with trained Cambodian mental health counsellors. This model, developed by the Harvard Program in Refugee Trauma (HPRT), was appropriately called "bicultural partnership". Today, the Western physicians and the mental health professionals are working together with the local primary care physicians and 57 trained Family-Child Mental Health Counsellors (FCMHC) in Cambodia. The authors also highlight the importance of acknowledging the limited available resources in Cambodia, and of furthering the philosophy of community diagnosis.

**Comments and criticisms**
- Though the book was written as a guidebook for those working with Khmer people, it could be used all over the world, but because of socio-cultural similarity, it could be especially useful in the Asian countries.
- The book does not give any references, though some statements would have been better emphasized by suitable references. For example, in the chapter *Use of psychiatric medications*, the author writes: "Many Cambodians have experienced severe trauma but most have not developed PTSD." (p. 44) This statement should have been supported by suitable references.
- Because several authors were involved, it is quite understandable that the chapters are not uniform in presentation and level of standard. Some chapters are quite professional, others simple and basic.
- All the chapters in this book are short and precise. They are diverse but interesting and centred around mental health. The language is plain and simple, and the expression good. The book is handy in size, the prints is large enough and double-spaced, the quality of paper is good. Because of these qualities, the book is reader-friendly, and the reader would like to read the book at one sitting.

**Conclusion**
This is a fine book that gives broad guidelines to people involved in the field of mental health and in the care of traumatized people, not only in Cambodia, but also in other parts of the world. I congratulate the authors, editors, and publishers for this great initiative.

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Manipur, India
6-8 February 2000

Forensic Medicom 2000: The World Congress of the Millennium on Forensic Medicine and XXI Annual Conference of the Indian Academy of Forensic Medicine

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Marrakech, Morocco
11-14 May 2000

1st Regional Congress of the World Council for Psychotherapy (WCP) in Marrakech

"Families and Psychotherapy: Transcultural Aspects (Examples of the Arab and Mediterranean Families)"

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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 are 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 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