

Torture – a public health puzzle in Europe

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PREFACE

Niels Steenstrup Zeeberg has an MA in Economics as his academic background. He worked as a project coordinator at IRCT for 4½ years, but decided to extend his practical knowledge from that work through the "Stop Torture Omnibus Programme" (STOP), which aims to increase public awareness of torture in order to help torture victims and to contribute to the prevention of the worldwide practice of torture.

In practice, Niels Zeeberg, his wife and two children, plus a cameraman are visiting rehabilitation centres, first in Europe – as outlined in this publication – and subsequently

around the world, centres which he had got to know through his work at IRCT.

Background material and client data were collected, based on these investigations and through the team's activities in relation to the programme, including interviews at the centres and contact with organizations and committees that work with the prevention of torture and the financing of rehabilitation facilities. The analysis of the above data, the study of related literature, and not least an evaluation of financial considerations in relation to planning strategy, have resulted in the publication *Torture – a public health puzzle in Europe*.

H.M.

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I. ABSTRACT

The background for the present study was public health obstacles for torture survivors in Europe experienced during 4½ years' employment as project coordinator at the International Rehabilitation Council for Torture Victims (IRCT) in Copenhagen. This motivated a 3-year world tour (Stop Torture Omnibus Programme – STOP) in an old British double-decker bus. Illuminating barriers and facilitators for identifying and providing torture survivors with adequate health services in Europe was a primary task during the first part of the programme.

The study base in this qualitative study was:

- the centres in 22 European countries and in Turkey, which were visited. For practical reasons, the countries included in the study base have been divided into three different categories, referred to as: "Established Market Economies", "Former Eastern Europe", and "Turkey". This has been done in order to ease the structuring of the information gathered. However, it does not necessarily indicate whether it is possible to generalize main findings from one category to another or between countries within the same category, because very different scenarios were found, not only within the same categories or countries, but sometimes even within the same region or city.

Turkey (geographically divided in an European and an Asian part) was included in the study base because it was considered that findings important to the structuring of the identification and rehabilitation processes of torture survivors in the rest of Europe might be revealed when exploring this, in many respects, very different setting. Government-sanctioned torture is an ongoing problem in Turkey, but the existing rehabilitation centres show good results in treating torture survivors and in improving the sequelae of torture¹⁸.

- interviews with 31 torture survivors and 75 professional staff members working with torture survivors at 39 rehabilitation centres in 22 of these European countries. (In the following Europe means Europe and Turkey – either parts)
- interviews with 17 experts in 13 other bodies working with the prevention of torture or financing of rehabilitation services
- a field study, staying at rehabilitation centres for a short period of time, talking with as many as possible of the parties involved at the rehabilitation centres
- an extensive literature study.

The study had two aims:

The primary aim: to show characteristics of the efforts and abilities of health sectors in Europe to identify and provide rehabilitation services for torture survivors, using interviews carried out with key persons, combined with a field study and a literature study.

The main finding is a general lack of access for torture survivors to adequate rehabilitation facilities throughout Europe. This is expressed by inability to identify torture survivors, lack of qualified personnel, lack of comparable data, political indifference, lack of public awareness, inappropriate asylum procedures, and insufficient supply of rehabilitation services.

The secondary aim: to discuss planning of a more adequate framework for promotion of the health of torture survivors, using the Precede-Proceed model.

The proposed interventions concern:

- need for implementation of screening programmes for certain risk groups (e.g. refugees from areas with a history of torture)
- inclusion of education of relevant professions in the education curriculum
- obligatory postgraduate education for asylum officers and health, social, and legal personnel working with the defined risk groups;
- development of a uniform client monitoring system
- advocacy work by involved peers, health providers, community leaders, and decision-makers
- development of a reinforced standardized asylum policy by the European Union Commission (EUC), and in the next stage by the United Nations
- allocating funds from the established market economies in Europe to the EUC budget line and the United Nations Voluntary Fund for Victims of Torture, standardized demands to the EUC members to develop reinforced rehabilitation services at national and local levels.

The study concludes that an integrated intervention upgrading of both the identification process and the present rehabilitation services is necessary in all European countries (except the Netherlands). Because of ethical and humanitarian principles additional need (identification) must be balanced with supply (treatment facilities). The plan must include education programmes, and the treatment model must take present limitations of human resources into consideration. The health, social, and legal personnel must improve their ability to equip the politicians and decision-makers at all levels with valid information committing them to act. Advocacy work and developing a uniform monitoring system are the suggested means. It is suggested that, with the EUC, Europe has an instrument that allows it to set high humanitarian, ethical, and legal standards in its member countries, and to influence these standards in neighbouring countries.

II. INTRODUCTION

That torture is a public health problem in today's Europe, and in Turkey, is unquestionable; it is indeed a fact. During the last five decades, Europe has been facing several waves of groups of torture survivors.

The first main wave comprised the survivors of the Holocaust, the camp survivors. Then the survivors of the Gulag camps, the Franco regime, and survivors from the STASI, the KGB, etc. Until the early 1990s, government-sanctioned torture was still ongoing in Northern Ireland¹ and in the Basque region of Spain². A large number of these torture survivors are in need of treatment and social recognition³. However, the problem continues. Europe's established market economies have been facing a continuous massive refugee stream for decades. The former Eastern European countries are experiencing the same development today. Many of the asylum seekers and refugees living in our countries today are torture survivors. Numerous studies have indicated the magnitude of the problem^{4-6,17}, but few have discussed the complete lack of coherent facilities in the health sector to deal with the torture survivors. The present and growing need for rehabilitation services for torture survivors represents a challenge to the health sectors in all European countries.

Quantifying the proportion of torture survivors in a population is, however, very difficult. One reason is the shame and guilt feelings that are characteristic for torture survivors^{3,20} because these hinder the survivor from seeking professional help from the health system.

However, findings in Montgomery's study⁷ and similar studies^{4,5,8,9} prove that, when taking into consideration the number of torture survivors being treated at the European rehabilitation centres today, what we see is merely the tip of the iceberg.

In the present qualitative study, it is assessed as more important to obtain *insight* and *understanding* by observing and asking *how?* and *why?*, rather than attempting to answer the questions *how often?* and *how many?* because unfortunately the building up of an adequate system for the rehabilitation of torture survivors in Europe is still in a very initial phase.

Over a period of nine months, all the rehabilitation centres (listed in annex 1) we knew of in the planning phase, and several we heard of along the way, were visited in order to investigate and observe how clients were recruited, and how the medical and social intervention was organized by the health care system, and in some cases by the social system as well.

Initially, a questionnaire (annex 2) was forwarded to the rehabilitation centres before our visit. However, many of these questions had already been answered by the rehabilitation centres, and some were published in an International Rehabilitation Council for Torture Victims (IRCT) publication¹⁰. Most of these questions were of a quantitative character, asking "how often" and "how many". It had become clear before our first visit that the extremely varied scenarios under which the rehabilitation centres were operating called for a more field-oriented study. An interview guide for our semi-structured interviews was forwarded to most of the centres visited before our arrival, in order to enable the informants to be prepared for the character of the questions they would be asked (annex 3). However, investigation of the functioning of the health sectors' contribution to the identification and rehabilitation of torture survivors could not be clarified by using similar structured or semi-structured interviews alone, but on the contrary by staying at the centres for a short period of time, and illuminating relevant characteristics through dialogue with as many as possible of the involved parties.

In this way, an attempt was made to clarify the experiences, intentions, and actions of torture survivors, health professionals, and decision-makers, in order to discuss and evaluate the present recruitment of torture survivors and rehabilitation services for them provided by the diversified health sectors.

A. Aims of this study

The aims of this study can briefly be described as:

Primary: To reveal characteristics of the efforts and abilities of health sectors in Europe to identify torture survivors and provide rehabilitation services for them, using interviews carried out with key persons, combined with a field study and a literature study as tools.

Secondary: To discuss how a more adequate framework for the promotion of the health of torture survivors could be planned, using the Precede-Proceed model (PP-model) as a tool.

III. DEFINITIONS

A. Defining torture

Torture has a definition of universal validity laid down in the United Nations Convention against Torture (1984, Article 4) as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such reason as obtaining from him or a third person information or confession, punishing him for an act that the person or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person or for any reason based on discrimination of any kind ...".

The international prohibition of torture is stipulated in the Universal Declaration of Human Rights of 1948, Article 5 as "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment".

In the UN Assembly, the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of 1984 was agreed upon by consensus. Article 4 furthermore states: "Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction."

Though agreed by consensus, only 100 countries [spring 1998 - ed.] of the UN's 196 member countries have ratified this convention. Even among these countries, several are still practising government-sanctioned torture. In Europe, neither Ireland nor Belgium has ratified the convention. This study limits itself only to work with survivors of government-sanctioned torture.

B. Defining Post Traumatic Stress Disorder

An exact definition of Post Traumatic Stress Disorder (PTSD) (1) is given in the American Psychiatric Association's (APA's) DSM-IV classification system¹² (and in the World Health Organization's (WHO's) ICD10 classification system). The definition of PTSD in the WHO ICD10 Classification System is slightly different from APA's definition¹².

The essential feature of PTSD is the development of characteristic symptoms following exposure to an extreme traumatic stressor¹³. In this study the stressor of concern is torture.

The APA concludes: "The disorder may be especially severe or long lasting when the stressor is of human design (e.g. torture, rape)." It is important to note that the PTSD symptoms are characteristic not only for torture survivors, but also for persons who have experienced a "psychologically traumatic event that is generally outside the range of human experience".

Frequently, the disturbance initially meets criteria for Acute Stress Disorder (2) in the immediate aftermath of the trauma. The duration of the symptoms varies, complete recovery occurring within three months in approximately half the cases; symptoms persist in many others for more than 12 months after the trauma.

C. Defining asylum seekers and refugees

The Convention Relating to the Status of Refugees was drawn up by the United Nations High Commissioner for

Refugees (UNHCR) in 1951. It has been ratified by almost 120 countries⁹ and defines a refugee as:

"... any person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it".

The Convention also stresses the basic principle of non-refoulement, according to which refugees may not be forcibly returned to a country where they have reasons to fear persecution⁷.

There is an important distinction between refugees and internally displaced persons. Internally displaced persons have not crossed any border in search of protection¹⁴. Examples of such groups included in this study base as "refugees" are Turkish torture survivors originating from the south-east province of Turkey (Kurdistan), and torture survivors from former Yugoslavia.

As the national government in principle is responsible for the protection of internally displaced persons, the above mentioned refugee conventions do not apply, even though the national government is frequently responsible for the human rights violations that caused the displacement.

In this study, the difference in the definitions of an asylum seeker and a refugee is that asylum has been granted to the refugee but not to the asylum seeker. The term "refugee" also covers internally displaced persons.

D. Defining "access" and "screening"

In this study "access" is defined as the available resources for identification, treatment, and support of torture survivors in a given area.

The below two descriptive indexes show how access can be measured:

- the weighted sum of waiting time on treatment, travelling, and actual duration of treatment.
- the weighted sum of the difference between ideal and actual number of treatments, personnel, and equipment in a given area.

"Screening" is understood in its broadest sense in this study¹⁵, and thus refers both to:

- identification of torture survivors using a test or an examination procedure on previously defined groups of asylum seekers (selective screening), with the purpose of offering torture survivors adequate treatment, and
- case-finding, when the torture survivors who approach the social and/or health sector for other reasons, or who are unaware that their complaints are sequelae of torture, are identified as such and offered proper treatment (e.g. a general practitioner (GP) receives a refugee as a client who complains about continuous sleeping disturbances, nightmares, headache, etc. He is aware that such symptoms may be linked to torture, and if the client is likely to have a background with torture experiences, he informs the client that such sequelae are normal for torture survivors, and that he can be helped, offering him/her referral to specialist treatment at a rehabilitation centre for torture survivors).

IV. MATERIALS AND METHODS

A. Materials

We have tried to make sure that the data collected are rich (Approx. 40 hours videotaped interviews, oral (not taped) interviews, and relevant literature), varied (actors representing numerous disciplines in various settings), and not countable measures, because those characteristics are considered arch-typical for a qualitative study.

Taped interviews have been carried out at 39 rehabilitation centres in 22 countries, with 31 torture survivors and 75 staff members at rehabilitation centres, and with 17 experts from 13 other bodies working in this field.

The field study also comprised not recorded interviews and work with health personnel and torture survivors at rehabilitation centres in Europe and Turkey, as well as literature studies.

The duration of our stay at the centres varied from one to five days. Previously recorded information, and observations made after the visits have been used in the study.

The informants have been torture survivors and specialists representing numerous diversified disciplines (in particular health personnel, but also social workers, journalists, legal experts, etc.). The interviews are available on digital video tapes. Furthermore, a list of the organizations, bodies, and individuals visited is enclosed (annex 1).

Concerns regarding identification and rehabilitation of torture survivors in areas with ongoing armed conflict are not included in this study, e.g. East Turkey (Kurdistan) and Yugoslavia (Kosovo). A recent work¹⁶ provides thorough discussions of the situation in such scenarios.

1. Selection bias

It is important to consider whether the material is representative of the ideal study base.

Our ideal study base would have been all actors within the field. The visited rehabilitation centres can be considered a representative majority of all European and Turkish rehabilitation centres¹⁰. Before our visit, the manager or medical director of the centre was invited to select staff members, and if deemed safe (section IX.B.1.), which torture survivors would be relevant, and who would volunteer to be interviewed.

At all centres, interviews were carried out with two or more staff members representing different disciplines.

However, we must consider that sample bias may influence the findings in most studies carried out in this field, due to failure to choose a representative sample group of torture survivors. We did not attempt to choose a representative group of torture survivors, but instead to sustain our information with in-depth interviews with key persons.

We are facing numerous different scenarios, which might bias the types of persons who were consulted at the rehabilitation systems. The scenarios include:

The torture victim

- dies under torture
- survives and stays in the country where he was tortured, or the torture survivor
- has fled, is not granted immediate asylum, and there are/are no rehabilitation services for refugees before asylum has been granted

- is a programme refugee or has been granted asylum, is identified and picked up by the health or social system in the country, but no adequate health or social system exists
- is a programme refugee or has been granted asylum, is identified and picked up by the health and social system in the country
- is a programme refugee or has been granted asylum, is/is not identified, and help is/is not available.

Approximately half of the rehabilitation centres that were visited have a policy of not allowing anybody but staff members to communicate with the torture survivors (except from ordinary courtesy conversation). This is because the centre often functions as a safe-house for the torture survivors, and because the centre's ability to rehabilitate the torture survivors depends on an established confidence. Consequently, this step can be seen as an attempt to protect the torture survivor from the risk that an unskilled interviewer may seriously jeopardize the rehabilitation process by perhaps retraumatizing the torture survivor.

However, the findings obtained from the personnel at the rehabilitation centres may in some cases even reflect the true opinions of the torture survivors better than our interviews with the torture survivors themselves. Torture survivors have a very pronounced confidence gap³⁻¹⁷, and the important bridging of this confidence gap^{30,17} between the torture survivor and other people has already been established by the personnel working for and with the torture survivors at the rehabilitation centres. Consequently, they have been considered reliable sources.

2. Information bias

Rehabilitation centres for torture survivors are often relatively fragile organizations, even in Europe. They need public and political support to obtain a financial basis, and the torture survivors attend the rehabilitation centres only when they are convinced of confidentiality. This makes the rehabilitation centres very careful with respect to the persons and organizations to whom they give sensitive information.

The situation in Turkey is even more complicated, and the problem is much more pronounced. There is no real freedom to speak or write, and the government does not hesitate to prohibit or close down centres that criticize their practice¹⁸. Health, legal, and social workers engaged in the work with torture survivors often do so under threat in Turkey. One of the board members of the TOHAV rehabilitation centre in Istanbul was killed by the secret police in 1994 (published in the Susurluk Report). Professor Veli Lök, President of the Human Rights Foundation of Turkey's Izmir branch (a rehabilitation centre for torture survivors), has received two anonymous phone calls with threats that, if he continued to work with "the torture survivors", "something bad will happen to you". At all rehabilitation centres for torture survivors in Turkey, staff members reported threats, or infiltration attempts by the authorities, civilian policemen pretending to be clients, accountants or journalists trying to obtain critical information. In a trial in Adana, the authorities are demanding the names and addresses of the clients at the Adana rehabilitation centre for torture survivors (the Adana Trial¹⁸).

Unfortunately, such threats also exist in Austria. Dr. Thomas Wenzel (3) has received two phone calls threatening him not to work with "the foreigners" or "something bad will happen to you or your family". People engaged in the work with refugees have received letter bombs (incl. the former mayor of Vienna).

Consequently, it may sometimes be difficult to obtain objective information.

However, many of the persons visited knew me in advance (from my work as project coordinator during 4½ years at the International Rehabilitation Council for Torture Victims (IRCT)). Furthermore, being able to forward a recommendation of the STOP programme from Dr. Inge Genefke (Secretary-General of IRCT) made it easier for us to be accepted at the centres.

By staying at the centres for a short period, and by being able to contribute to the work at the centres, it seemed possible for us quickly to establish professional confidence, which enabled us to carry out interviews in a collegial atmosphere, with few communication barriers such as doubt and hesitation.

B. Methods

This work is a qualitative and *exploratory* study¹⁹, with elements of evaluation and comparison. It studies the health care of torture survivors in Europe and Turkey by illuminating the functioning of health services specifically aimed at identifying and rehabilitating torture survivors. Because the functioning of the rehabilitation centres was not evaluated in depth, the study cannot be referred to as a *programme review*¹⁹. A group of countries and rehabilitation centres were compared with respect to their organization of the identification and rehabilitation process of torture survivors, and this constitutes the *comparative* element.

The study contains a *descriptive survey* of the context, purpose, process, and outcome of several ongoing programmes. As the information collected is very rich, and a large number of characteristics are studied, only main findings are presented. The study addresses *descriptive*, *analytical*, and *empathic* elements, as well as *action research*. Examples include attempts to illuminate some findings that may lead to the answer to some of the following questions:

- the descriptive element: What is the need for rehabilitation services for torture survivors, and how are the rehabilitation centres distributed geographically?
- the analytical element: What are the determinative processes causing the present state of the health care system and the health status of the torture survivors, and what are the consequences of rehabilitating or not treating them?
- the empathic element: What are the characteristics of the torture survivors?
- action research: How can we identify the torture survivors, and how can we help to change their health status? How can we intervene and feed the information back to the actors and decision-makers?

1. Methods for fulfilling the primary aim of the study

The primary aim of the study was to depict characteristics of the organization by health sectors in Europe and Turkey of recruitment and rehabilitation of torture survivors. The investigation methods that were found most adequate for this aim are:

- interviews with torture survivors and key persons acting in this field
- field study
- literature study.

The "Social Reconnaissance" sampling method¹¹ has been applied in the efforts to determine "relevant aspects of the

social nature, processes, and needs" of the torture survivors, using social and legal information, and health personnel working for and with torture survivors as informants and interviewees. It is important to note that a large part of the effort to improve the understanding of the torture survivors was through the experiences of these personnel, because talking with torture survivors about their perception of their own needs is often very complicated.

Torture survivors were interviewed only when they volunteered, and when the persons responsible for their rehabilitation agreed to it and found it advisable. They were interviewed in different ways, individually and in groups. The torture survivors were all invited to tell their own story, and to say how they perceived the general situation of torture survivors in their geographical area. Interventions were normally made only to clarify contents of the interview or to end it.

2. Methods for fulfilling the secondary aim of the study

To fulfil the secondary aim of the study, i.e. to discuss planning of a more adequate framework for the promotion of the torture survivors' health, the PP-model was applied. This tool has been used to structure the available information, enabling us to discuss possible future interventions.

By using the PP-model, an attempt was made to structure the findings in order to clarify the health care situation of torture survivors for the decision-makers who are responsible for the health promotion planning.

The main reason for using the PP-model in this study is its ability to lead the user to think deductively. In this case, it has been considered a great advantage to start with the final consequence (that there is little awareness of and limited access to adequate rehabilitation services for torture survivors) and work our way back to the causes.

Only the first five phases of the procedure have been applied, because they allow us to structure the study's findings. The three omitted phases address process, impact, and outcome evaluation. These are of course equally important phases, in particular with regard to the sustainability and flexibility of a planned programme. However, it was considered irrelevant to address these concerns in this study, because they demand that implementation of the health promotion initiatives such as the proposed is actually planned.

There are three steps in each phase of Precede¹¹, which in this case are as follows:

1. assessments by the torture survivors themselves, and by the personnel working for and with them, of their problems, needs, aspirations, resources, and barriers
2. documentation of the determinants of the desired goals
3. priority of problems, needs, or goals based on perceived importance and presumed changeability.

In order to analyse the data gathered through the interviews, the following steps were followed:

- the interviews were watched, and listened to
- findings and quotations were written down
- differences between thoughts, beliefs, and emotions of the interviewees were considered
- motivating factors as presented by the interviewees were noted
- relevant information was categorized into the three categories of the PP-model's phase 4: predisposing, enabling, and reinforcing factors.

3. General concerns about the research process

In order to sustain the level of quality throughout the research process, an attempt was made to keep stringent corre-

spondence and coherence in the analysis, despite the diversified scenarios on which the work is based. When statements essential to the work led to unclear interpretations, an attempt was made to clarify the question either by getting back to the source or through additional literature studies. The interviewees are torture survivors and experts working within the field, and much of the information gathered through the interviews has proved verifiable through literature studies. Thus, it has been attempted to keep a high validity of the information used.

As the taped material was targeted for editing and showing on a Danish public service channel (DR2), the intersubjectivity of the presentation of the findings had high priority. The main findings are presented so that they can be understood by non-specialists.

We have seen client records and have had access to talks with clients, seen pictures documenting trauma caused by torture, and examined relevant research articles upholding the statements given by the interviewed persons. Efforts have been made to keep the reliability of the investigation as a whole as high as possible. We used equipment of high technical standard, and compared those of our interviews that were transcribed (4) with the tapes.

In order to enable a generalization of our results, a questionnaire (annex 3) was given to a strategic selection of multidisciplinary actors working within the field in very diversified settings.

V. IDENTIFICATION OF TORTURE SURVIVORS

The first and most obvious determinant for a torture survivor to become a client at the rehabilitation centres is whether he wants and thus seeks treatment. Another important determinant for who and how many torture survivors are received at the present and future rehabilitation centres, is the ability to identify the torture survivors, and to make them, and the personnel who refer them for rehabilitation, aware that they have access to rehabilitation services, and to convince both parties that treatment is beneficial.

A. Ethical concerns

Ethical questions arise when considering whether to initiate an effective identification programme for torture survivors, as happens so often when a screening programme is considered. However, running an effective identification programme of torture survivors should not result in victimizing them and/or others unnecessarily. Due to non-existent or inefficient identification programmes and the well-known feelings of shame and guilt that characterize sequelae of torture^{12,20}, torture survivors are often reluctant to seek professional help from the health system, or refrain completely.

Statements from health personnel obtained in our interviews in Estonia and Austria indicate that torture survivors have a general disbelief in authorities, due to the participation of various authorities in their torture. Doctors have frequently participated before, during, or after torture²⁰, leading to further torture survivor disbelief in health professionals and increased reluctance to seek professional help.

There is a great need to boost the torture survivors' faith in the authorities and in the intentions of the system and its

ability to help. This holds for recently arrived asylum seekers and for torture survivors who live in a country without being identified as a torture survivor or without being offered an adequate rehabilitation programme.

It must be entirely up to each individual whether he wants and seeks treatment or help, but it is also necessary to ensure that an adequate system for the rehabilitation of torture survivors is available, that the torture survivors have access to these services, and that they are aware of these facts.

Consequently, we are faced with a contradiction. There is the risk of victimizing people unnecessarily by carrying out a screening programme on a large population group with few torture survivors. This should be considered in the light of the human and social costs of not being able to identify and help the torture survivors.

Thus, ethical concerns with regard to initiatives taken to identify torture survivors depend heavily on the group of torture survivors one addresses. This is why ethical considerations are included in section number V.D.-F.

B. Tools for the identification of torture survivors and the pitfalls of such tools

It is necessary to consider the tools presently available for recognizing the sequelae of torture. Systems such as the DSM-IV, the APA system for identification of PTSD, and WHO's ICD10 do not sufficiently cover the whole spectrum of the sequelae of torture. The two systems are not similar, but they are comparable with regard to classification of PTSD²¹. The section below briefly discusses some of the apparent deficiencies in these two systems.

After World War II, the persons who had serious post traumatic sequelae in the broadest sense were not believed, and there were no treatment programmes because the disorders were not known. Today, we know the concept of PTSD. We are aware that people who have endured extremely traumatic situations have serious and long-term, often life-long, sequelae if they are not treated^{3,12,22-24}. We also know that there is a clear correlation between these symptoms and the trauma¹², meaning that the torture survivor's sufferings have been caused by the responsible torturers.

Several studies of Holocaust survivors and camp survivors^{3,20,21,23,24} reveal that the survivors have a broad spectrum of symptoms not covered by PTSD, including serious feelings of shame and guilt, self destructive behaviour, psychosomatic symptoms, somatic disorders, and somatic pain disorders^{3,20,21,23,24}. The torture survivors therefore do not suffer from PTSD alone, but also from a large group of other serious medical and psychiatric conditions.

Consequently, only to work with the concept of PTSD in its narrow sense can be a pitfall in the work with rehabilitation of torture survivors. Torture can lead to serious illness in the survivor, affecting many systems of the body and mind. Treatment requires more comprehensive and refined approaches. Therefore, all the rehabilitation centres visited either had a multidisciplinary staff or referred their clients for specialist treatment.

Torture trauma is often very complex, its physical and psychological forms being interlaced. It is important not to neglect these complex aspects of torture sequelae and focus only on the psychological effects. A made-up example is given that focuses on only psychological and only somatic aspects (not interlaced): "When the torture survivor has concentration and memory problems, which are both very

pronounced symptoms of torture, this might be caused by psychological post traumatic factors, like PTSD, or it might be caused by real brain trauma and malnutrition. This causes memory and concentration deficits as well."

There has been much criticism of and discussion about PTSD, which is considered a controversial diagnosis by some^{25,26}. However, bearing in mind the limitations of the system, and that PTSD symptoms are probably part of a universal reaction to torture, though not necessarily capturing the essence of traumatization²⁷, the SCID questionnaire, which forms an integral part of the APA's DSM-IV classification of PTSD and the equivalent ICD10 questionnaire (CIDI), must probably be considered the best tool for an initial identification of torture survivors. The SCID questionnaire is a structured clinical interview for DSM-IV that allows the psychiatrist to diagnose PTSD. The CIDI is a semi-structured interview guide for the ICD10 classification system.

C. Target groups

As noted above, this study limits itself to work only with survivors of government-sanctioned torture. The same symptoms are suffered by other groups, e.g. UN soldiers who have experienced torture and other human rights abuses in, for example, former Yugoslavia, survivors of accidents or disasters, etc.

However, important differences distinguish the torture survivors from these groups of survivors:

- the experienced traumatic event has been purposely inflicted on them and/or on their family and friends in front of their eyes
- the stressor (torture) is of human design
- the treatment facilities.

Most European hospitals have excellent psychiatric departments that deal with sequelae of accidents and disasters. Studies have shown these sequelae of battle experiences and other unusual, markedly distressing events in soldiers²⁸. The authorities are very well aware of this problem and they are prepared to deal with it at their hospitals.

The fact that there is only limited access to rehabilitation services for the survivors of government-sanctioned torture in Europe raises the problem of "Apartheid in the Health System"²⁹, and focuses our attention on the following main groups:

1. asylum seekers (refugees who have not been granted asylum and some of whom still live in refugee camps)
2. refugees (including internally displaced persons, Turkish torture survivors originating from the south-east province of Turkey (Kurdistan), and torture survivors from former Yugoslavia)
3. survivors of the Holocaust and Gulag, or subsequent torture in European countries.

Each of these groups represents specific identification problems, which furthermore vary from country to country.

D. Asylum seekers

Several basic criteria determine whether a successful identification of torture survivors among asylum seekers can be

carried out. Examples include legislation, asylum procedure, education level of asylum personnel, etc.

A discussion is presented below of some of the central concerns that face the authorities in European countries when reconsidering their efforts and ability to identify torture survivors among asylum seekers.

1. Ethical and legal concerns

Torture sequelae frequently prevent the torture survivor from presenting his case under the present conditions of European asylum hearings. If the torture survivor suffers from severe PTSD, he should be treated before the asylum hearing. This is not only a humanitarian or an ethical principle; it is also a legal principle, because the torture survivor, for obvious medical reasons, is unable to give adequate information.

Many European countries have changed to new and quicker asylum procedures. There is a risk that many torture survivors are still in a state of acute stress at the asylum hearing. This can be caused either by an early asylum hearing or by other stressors, such as linguistic problems, cultural problems, the shock of having been deprived of liberty in the destination country, uncertainty about the outcome of the asylum application, uncertainty about the future, and the conditions under which the asylum hearing is taking place (retraumatization due to interrogation-like environment).

The torture survivors are therefore unable to present their case coherently. One of the most frequent reasons for denial of asylum in many European countries is that presentations lack coherence or are incomplete. This is the case even though it is common international medical knowledge (APA DSM-IV and WHO ICD10) that the most characteristic disturbance in seriously traumatized persons, persons who for humanitarian reasons should be protected by asylum laws, is deficits in concentration memory. There is quite a broad range of symptoms that nearly all torture survivors show, especially under stress. One is the inability to memorize certain details of the traumatic situation. This is so central that it is part of the APA and WHO definitions of PTSD. It is part of every doctor's medical training today, or it should be. However, this is not taken into account in most European asylum procedures. They are mainly based on the medically absolutely incorrect idea that only those who clearly state every detail are to be believed.

2. Asylum procedures in Europe

Applications for asylum are dealt with according to domestic laws in the European countries. Efforts were made by the European Union (EU) to introduce a standardized asylum policy for its 15 member countries in the Amsterdam Treaty, with common rules and one common border³⁰.

Despite the fact that the asylum laws in most European countries contain a passage stating that "persons must not be sent back to a country where they risk being subjected to torture", the asylum procedures generally do not protect the torture survivor from that, because they are often based on assumptions that are against all medical and scientific knowledge.

Today, the procedures for asylum hearings have been speeded up in most European countries. This has both advantages and disadvantages for the asylum seeker.

An obvious advantage is that the inhuman waiting time, common in many asylum cases, has been diminished. Authorities are trying to settle cases that have been running for 6, 8, or even 12 years without a final decision.

However, due to the quicker asylum procedures, several new pitfalls are health hazardous for the torture survivors.

Health hazardous asylum procedures; the case of Austria

This subsection is based on literature studies and interviews in Austria with health, legal, social, and administrative personnel working at:

- ESRA: NGO – rehabilitation centre situated in Vienna, mainly working with medical, psychological, and social rehabilitation of Jews
- Hemayat: NGO – rehabilitation centre situated in Vienna, mainly offering psychological assistance to Arabs
- Zebra: NGO – rehabilitation centre situated in Graz, a multidisciplinary team of health, social, and legal personnel mainly working with refugees from the former Yugoslavia
- Vienna University Hospital, Thomas Wenzel: Psychiatrist, working with rehabilitation of torture survivors of varied ethnic and geographical backgrounds
- Simon Wiesenthal: Documentation Centre, documenting Nazi crimes during World War II (drawing parallels with the human rights abuses in Serbian concentration camps).

In most Schengen countries (5), closing the borders has become increasingly effective. The number of asylum cases in Austria during 1998 is so far less than 1000. Austria has often been referred to as "The Fortress of Europe" with its borders precisely coinciding with the Iron Curtain. There has for decades been a movement of people to Europe. However, today there is strong pressure from the EU on Austria to close its border effectively. One of the agreements of the Schengen Treaty (5) is that, when a refugee is caught somewhere in another country in the EU, he should be taken back to the first EU country where he arrived. This is very often Austria, because it is geographically on the main road from several East European countries (Slovakia, the Czech Republic, Hungary, and Slovenia). These countries are in turn the main road to the Third World countries, and thereby for professionalized migration into Europe.

The acceptance rate and proportion of asylum seekers granted asylum in Austria have been dropping steeply over the last six years, accompanied by new laws that make it very difficult even to apply for asylum. For example, today decisions must usually be made within the first 48 hours after the arrival of the asylum seeker. This makes it impossible to obtain adequate legal advice, and to get out of basic medical conditions, such as malnutrition, dehydration, PTSD, hypertension etc., which prevent the asylum seeker from presenting his case coherently during the asylum hearing.

There has been a movement to accept fewer than 1000 refugees per year in Austria. However, the acceptance rate is much lower. This has led to a high pressure on the refugee camps in several Eastern European countries, combined with massive problems of illegal immigration³¹.

The number of refugees accepted by the Austrian authorities is decided not only by the Schengen quota for Austria. As in most other European countries, the national legislation on asylum is complex. There are quota refugees and specific countries with which Austria has an individual policy for acceptance. However, the most important development is the steep decrease in acceptance rates as well as in the asylum appeals, not because fewer people want to appeal, but because they are not admitted into the asylum process.

To identify a torture survivor within 48 hours of arrival presents a big problem. Experience of working with torture survivors has shown that, for confidence to be established, a

doctor needs many sessions with a client, and that without confidence progress with treatment is difficult. The same confidence problem exists in the identification phase.

The screening process of torture survivors among the asylum seekers in Austria is not adequate, as in most European countries. There are two main reasons for this:

1. The problem of retraumatization is important if we set high ethical and human rights standards. The personnel who receive the asylum seekers and conduct the asylum hearings should be careful not to retraumatize the torture survivors among the group of asylum seekers, because we know that scenes which bring the trauma to mind can be seriously destructive to mental health in the way of retraumatization.
2. There is practically no medical screening. The asylum officer who carries out the interview has the right to decide on his own whether someone is in need of a medical examination. The 48 hour time frame gives such a tight schedule that the torture survivor usually has no chance of having a second opinion or of acquiring expertise on his own, before he is returned.

Unfortunately, the situation is so bad in Austria that the health personnel involved with the work for torture survivors have only little time to reflect on such issues as retraumatization and integration. The practical issue they are stuck with is the basic need to protect those who have survived torture against unjustified disbelief. They have to focus on the forensic aspect, obtaining enough reliable information to prove that a torture survivor has in fact been tortured. (The same problem is faced at the only rehabilitation centre for torture survivors in the UK. According to their information officer, almost 30% of their work concerns proving that the asylum seekers have been tortured. Such proof is necessary in order to help the torture survivors to improve their chances of being granted asylum).

Furthermore, the expertise of psychiatrists specialized in the sequelae of torture is often completely ignored. When reliable physicians, well trained in the field of torture sequelae, identify a torture survivor, his expertise is often not accepted. A study comparing the acceptance rate of such medical findings in Austria and Israel³² documents that the medical findings have been taken into consideration in a positive way in only 30-40% of the cases in Austria, compared with 80-90% in Israel.

So a broad range of subjective decisions can be, and apparently very often are, taken by asylum officers.

According to Dr. Thomas Wenzel (3), another problem is that some physicians employed by the Austrian ministry of the interior to conduct medical screening of torture survivors among asylum seekers write medically incorrect statements. They are easily recognized politically by their obvious right wing leanings. Such cases of professional misconduct must be considered very grave.

When considering the asylum procedure, it is important to remember that it is often the deciding factor for the survival or health of the torture survivors, and/or their families.

The torture survivors received in Europe have very often fled from ongoing torture and ill-treatment, so the fear of being returned to these conditions is naturally a very big stressor. It is important to carry out the screening at a very early stage after the asylum seeker arrives in a country. This will make the refugee or the asylum seeker feel secure, and enable him to believe in the intentions of the new society in which he finds himself. Creating confidence in the system, and enabling the health personnel to treat people with sequelae

of recent torture, will ease the whole rehabilitation process very much. Despite this, there are cases in Austria of people not being granted asylum up to eight years after arrival.

But with the 48 hour rule the torture survivors face an even worse development, because they are refused so quickly that they do not even come into this bad situation. They are returned to the country from which they fled, or to a country through which they fled, when such is declared safe against persecution by the UNHCR. It is called "the third country paragraph". Iran, for instance, is one of these countries despite the fact that government-sanctioned torture is an ongoing problem there, and that there are no rehabilitation services for survivors of government-sanctioned torture except in the refugee camps at the border with Iraq. It has been proved that asylum seekers from this area are a risk group, and there is a high probability that they have in fact been tortured⁷.

Nevertheless, refusal rates of asylum seekers in Austria, as in most European countries, are high, and people still assume that the asylum seekers are lying about having been tortured. From a medical point of view, the realistic situation is probably the opposite.

Furthermore, it is an extreme form of retraumatization for the torture survivor to fear being sent back to his home country, or that information that was given when applying for asylum will be handed back to the authorities in that country in order to verify its validity. This directly endangers the health and/or life of the torture survivor and his family. There are several well-documented cases of this in Austria.

The above description depicts a situation that is comparable with the situation in the other Schengen countries. However, there are several countries, including established market economies, in which the situation for the torture survivors among the asylum seekers is much worse. These are countries where (examples in brackets):

- survivors and the problem of torture are not officially recognized (Ireland, Portugal, Spain, Slovenia, Slovakia)
- the rehabilitation centres do not deal with torture survivors among the asylum seekers but only with refugees (Denmark)
- the rehabilitation centres do not deal with torture survivors among the asylum seekers but only with survivors of the Holocaust, Gulag, or subsequent torture in the country (Rumania, Latvia)
- no rehabilitation services are available for torture.
- there are long or closed waiting lists at the rehabilitation centres (Sweden, England).

So the horrible situation we see unfolding at the moment is that there is practically no, or very little, protection for the torture survivors among the asylum seekers that we receive in Europe (e.g. Denmark³³).

3. Refugee camps – a health hazard for torture survivors

If an asylum seeker is not rejected immediately on arrival in his destination country, a new health hazard occurs^{30,34,35}. In almost all the European countries that were visited, the asylum seekers, whose asylum is not rejected immediately, spends the waiting time until a final decision is reached in refugee camps.

Most of these refugee camps closely resemble prisons. In reality the asylum seekers are deprived of their liberty in the destination country. This fact, combined with the uncertainty about the outcome of the asylum application, is a serious mental health hazard for the torture survivor³⁰.

It is far from optimal to place asylum seekers under prison-like conditions (often for several years), because they have not committed any crime. It must be considered unacceptable particularly for torture survivors because of the obvious impact the stay will have on their mental health. The Netherlands is the only European country today that has had regard for these health hazards for torture survivors in their asylum procedure.

4. A model for screening asylum seekers

The World Psychiatric Association (WPA) has a group that is working out a proposal on how more adequate asylum procedures can be carried out in practice³⁶. One of the major challenges is how to identify torture survivors among the asylum seekers. Based on ideas developed, discussions, and experiences gained during this field study, several suggestions are outlined below.

In order to avoid victimizing all asylum seekers, introduction of risk group criteria would be a first step in developing an adequate screening model. This would ensure that asylum seekers who stated torture, or asylum seekers coming from certain proven risk groups, for ethnic, religious, geographical, political, or other reasons, would automatically be taken out of the usual procedures and offered a medical screening by independent doctors and/or health personnel with the required expertise. If additional examinations were necessary, the torture survivor could be referred to a specialized hospital.

This special function could, for instance, be centralized at a university hospital. Additional examinations (see section number X.B.) might include X-ray, computer assisted tomography scans (CAT scans), or even a magnetic resonance images (MRI) in rare cases. Adequate screening can usually be done within a few days, providing the necessary resources are available. Only then is it possible to assess the consistency of what the asylum seeker is stating, or did not state, in order to determine whether the person has sequelae of torture.

Giving the asylum seeker a temporary health insurance might increase the chances of making all the necessary examinations to determine whether the person is a torture survivor.

In Bulgaria, the ENIO rehabilitation centre in Sofia has excellent cooperation with the authorities. In Autumn 1997 they signed an agreement that gives them the responsibility for educating asylum officers in identification of torture survivors, and gives the asylum authorities the responsibility for referring the identified torture survivors to the ENIO centre for treatment. Rehabilitation centres in the Netherlands also have close cooperation with the asylum officers.

E. Refugees

Since the first large groups of refugees came to Europe in the early 1970s, at that time in particular from Vietnam and Chile, several waves of torture survivors have arrived. They include torture survivors from within Europe (in particular former Yugoslavia).

Decades of neglecting the consequences of not identifying and offering rehabilitation services to torture survivors have led to a situation in which the only ways for the torture survivors to be picked up by the health system are by being referred to specialist treatment by health service gatekeepers (GPs or health centres), or by hearing about rehabilitation services from other torture survivors or via the media.

Due to this negligence, the detection and treatment of torture survivors move to the primary care sector. The long-

lasting influx of refugees to Europe, and the inability to identify torture survivors, suggest that these patients may be prevalent in primary care.

GPs are often unable to identify the mental and physical signs and symptoms of torture.

It is a big problem that most physicians in Europe have no training in recognizing the sequelae of torture, and are therefore unable to diagnose them. This lack of training can lead to terrible misinterpretations of symptoms. A made-up example is given below, in which a doctor without training in PTSD diagnoses his patient as neurotic:

You are a Bosnian camp survivor, you are broke, you cannot concentrate. You sleep for only two hours at night. You continuously see the flashbacks of your friends killed, burned, and you cannot push this image away, you cannot concentrate, you are irritable, you do not have one good day in your life, you cannot get a job. You go to a GP, you do not know that these are normal after-effects of torture. You feel ashamed, and find it improper to talk with the doctor about your torture, which you do not connect with your symptoms. Maybe you are so ashamed of what happened to you that you have not even been able to tell your own family about it (you are a Muslim man and were gang raped by the prison personnel). You go to the doctor several times and complain about different bodyaches, headache, and inability to sleep at night. He finds no physical sign to explain your complaints. So the doctor, who referred you to a couple of his colleagues who could not find anything wrong physically, gets tired of your frequent visits and feels certain that your symptoms indicate neurosis. He decides to give you a pep talk. Then you are told by the doctor: "Well, nothing is wrong with you! You should pull yourself together and get some work! You are just lazy!"

As stated above, the central concern of the European authorities in reconsidering their efforts and ability to identify torture survivors among refugees is to ensure that obligatory courses for all health personnel who are in contact with refugees are held and attended.

Within the time-constrained, pragmatically focused primary care setting, emphasizing the link between current symptoms and current functional impairment may increase the interest in, and recognition of, torture survivors with PTSD or other sequelae of torture.

Whereas the situation for many asylum seekers and their families might be endangered when information is handed back to the authorities in their home country, the situation for refugees is often much better. The British authorities (Scotland Yard) protect numerous refugees who have been tortured and have received anonymous or official death threats (fatwa). Such people are given protected addresses, etc.

F. Survivors of the Holocaust, Gulag or subsequent torture in European countries

Europe has faced, and is still facing, impunity problems, in the kind of amnesty given to a large number of World War II, Stasi, and KGB torturers and executioners.

An example of amnesty given to former torturers is given below:

1. Impunity – still a barrier for identification of torture survivors; the cases of the Baltic States and Poland

The interviews in Estonia, Latvia, and Poland with survivors of the Holocaust and Gulag all contain long passages in

which the torture survivors praise the work of the rehabilitation centres and thank the personnel. They show great gratitude for the help which is given to them, and emphasize how much it has helped them. They are invited to tell their own story, which they do, some in detail, some in short, but all very moved emotionally. They are happy about our initiative to come and film them, and take interest in their situation and destinies. A central issue, mentioned by several people, concerns complaints about the system, which, even today, does not seem willing to compensate them, or to support the rehabilitation services and thereby also recognize the problem.

The claims for compensation will be a first sign for the torture survivors of social acceptance of them as survivors of injustice. So the compensation problem is not only limited to its financial importance for the survivors (because they are often too ill to work). The impunity problem was also addressed several times during the interviews with the personnel at these rehabilitation centres.

The three Baltic states were forced to sign a treaty in 1994 with Russia's President Jeltsin, giving amnesty to all torturers and executioners who worked for the former Soviet Union during their occupation of these countries. In exchange, Russia withdrew her military forces. This, and the fact that about 45% of Latvia's population are Russian (in Riga more than 50%), has prevented the national governments from initiating identification and compensation programmes for the large numbers of torture survivors. According to the health personnel at the centres, approximately 400,000 Holocaust and Gulag survivors still live in these three countries, 200,000 in Lithuania alone.

2. Professional misconduct; a case from former East Germany

An example from the patient group of Dr. Thomas Wenzel (3) shows that impunity and professional misconduct is also an ongoing problem in former East Germany:

A woman who had been tortured by the Stasi (Secret Police) in former East Germany applied to the court for compensation because she had serious PTSD. She had periods of depression and was quite handicapped by the sequelae of torture. The doctor to whom she was referred, and who wrote the expert report, was a former doctor for the Stasi. He wrote that she was not qualified for compensation because she had a panic disorder, which he referred to, incorrectly, as a biological disorder. The woman was diagnosed as having had this disorder before her imprisonment by the Stasi, and he concluded that the disorders could not be connected in any way with the torture she claimed she had suffered.

This is a grave example of professional misconduct when a person with a gatekeeper function was biased against the torture survivor, prevented the torture survivor from getting access to treatment, and was a barrier to the identification of torture survivors.

G. Subconclusion

Since one of the most important findings of this study concerns the very obvious deficiencies in the identification processes of torture survivors, it would have been very interesting to be able to ask torture survivors who were not identified until several years after their arrival in the country, about their opinion on what went wrong, and how they think the system could be improved.

Apart from such deficiencies, it is very unlikely that selection bias would influence the findings of this study, because it mainly addresses problems of organization and not questions such as the prevalence of torture survivors or, for instance, the strengths of the association between torture and PTSD.

The determinants for successful identification of torture survivors call for diversified interventions, depending on the target group. However, there is one common consideration: the demands on the personnel dealing directly with the torture survivors in the identification process (asylum officers, GPs, and other personnel with gatekeeper functions). These personnel groups must have undergone postgraduate training in the sequelae of torture, which manifest themselves in the behavioural and reaction pattern of the torture survivor.

Having addressed some of the problems concerning identification of torture survivors, an important ethical concern has been left out deliberately.

The above-mentioned (see section number V.A.) ethical concern of identifying torture survivors without being able to offer them an adequate treatment programme is another major contradiction that might arise if the implementation of better identification processes is not combined with the strengthening of the treatment facilities in order to assure a balance between need and supply.

This leads directly to the next section, which discusses different rehabilitation approaches at the centres, and their characteristics. This underlines the necessity of introducing a complete programme, which again represents a major financial and organizational challenge.

VI. MODELS FOR ORGANIZING REHABILITATION SERVICES IN EUROPE

A. The concept of rehabilitating torture survivors

The concept of rehabilitating torture survivors in Europe dates back to the early 1950s, starting in Norway and Poland.

In 1974, Amnesty International formed its first medical group, in Denmark. The primary task of this group was to try to diagnose torture by systematic examination¹⁷. The work of this group, with Dr. Inge Genefke as prime mover, led to the establishment of the first real multidisciplinary rehabilitation centre for torture survivors in the world – the Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen, Denmark. With its extensive information, training, and advocacy work, this centre and the International Rehabilitation Council for Torture Victims (IRCT), which derived from it, still serve as role models and collaborators for many of the rehabilitation centres and initiatives for torture survivors worldwide.

B. Existing models

As already indicated, the diversified scenarios that are prevalent in Europe require different organizing approaches to set up adequate rehabilitation services for torture survivors.

Our experiences from visiting the centres, hospitals, and institutions are that the following different archetypal models for rehabilitation services for torture survivors seem to prevail in Europe:

1. medically dominated independent rehabilitation centres treating refugees only, using long-term treatment methods, and mainly using own staff
2. medically dominated rehabilitation centres treating refugees and asylum seekers, using long-term treatment methods
3. independent rehabilitation centres dominated by psychologists treating refugees, with long-term treatment methods
4. independent rehabilitation centres with psychologists and doctors in central positions, treating both refugees and asylum seekers, with long-term treatment methods
5. independent rehabilitation centres dominated by psychologists treating both refugees and asylum seekers, with long-term treatment methods
6. understaffed independent rehabilitation centres based on volunteer workers
7. mobile rehabilitation centres
8. day clinics
9. polyclinics
10. rehabilitation facilities integrated in the public health service
11. rehabilitation centres focusing on alternative treatment methods (art, drama, music, rolfing, and penduling).

The settings were very diversified, and the means available to the centres, not surprisingly, very varied. This variation was apparent not only from country to country, but also from centre to centre within the same country, and even within the same city, depending on numerous different determinants, including political system, governmental support, support from local authorities, EU or non-EU member, public awareness, and the number of torture survivors living in the area.

There are several reasons why the models, undoubtedly all well meant, are not more uniform in their approaches. The short history of rehabilitation centres for torture survivors, and professional rivalry, surely influence this development. However, a major flaw is that a uniform monitoring system has not been developed and applied. Such a system would provide comparable data and enable the centres to compare the efficacy of their treatment models, and adjust them accordingly.

The relatively scarce means also contribute to the development of rivalry rather than cooperation, which seems to be the major argument against placing rehabilitation services in the private sector. The limited financial means and human resources available for the rehabilitation centres force the NGOs to fight over the same money. This undermines cooperation and results in a waste of expensive administrative man-hours, which could have benefited the torture survivors much more if spent on research. Allocation to the rehabilitation centres of sufficient funds to provide the torture survivors with adequate treatment would eliminate this problem.

Europe is experiencing an alarming public health problem with respect to the torture survivors due to lack of capacity in this sector. Their numbers and applications for treatment have caused long or closed waiting lists at most rehabilitation centres in Europe; for instance, waiting lists have been closed for more than two years at the RCT in Copenhagen.

However, it is not considered a primary challenge to discuss the efficacy of the prevailing models at present. The

overriding problem is to motivate the decision-makers to focus on the problem, and to commit themselves to providing a legal and financial framework that would allow the rehabilitation centres and gatekeepers to provide adequate treatment for the torture survivors.

VII. PERCEPTIONS OF IDENTIFICATION AND REHABILITATION SERVICES

This section provides examples of the different types of information gained from our interviews (annex 3).

A. Perception of identification and rehabilitation services as experienced by selected torture survivors among the interviewed asylum seekers

In Austria a torture survivor from Iraq was interviewed. The interview, which he requested himself, showed that his asylum case had been running for eight years and was still not completed. It was apparent that this had had a negative effect on both his health and his belief in the Austrian society. This interpretation of the essence of the interview was sustained when later, on verbal agreement with the torture survivor, we asked his psychotherapist (3) whether his impression of the client matched ours.

The in-patient torture survivors at the resocialization unit of the Phoenix Rehabilitation Centre in Wolfheze, the Netherlands, had felt very confident about the intentions of the Dutch authorities since their arrival; they had been identified as torture survivors on arrival, and were offered treatment while their asylum cases were not yet completed. The integration and resocialization unit worked well according to both personnel and clients. The clients' ability to cope with integration into the Dutch society is developed in this unit. The Phoenix Centre for Psychiatric Treatment of Refugees is an in-patient rehabilitation centre at a general psychiatric hospital in Wolfheze. It comprises three departments – a closed ward, an open ward, and a resocialization ward in which the clients are responsible for washing clothes, shopping, budgeting, cooking, etc. However, they are carefully watched and supported by the experienced personnel, who at this unit are specialized nurses and a social worker.

The environment is quiet, the wards located in individual buildings. Consequently, the clients' impression of the centre, which is important for them¹⁷, is that it is independent (of the authorities) and not a hospital environment, even though it is in fact a department of a public general psychiatric hospital.

The clinic offers rehabilitation services to asylum seekers and refugees. Several conditions, from schizophrenia to depression, are diagnosed, while PTSD is an almost ever-present complicating factor.

The talks with this group of torture survivors were enriching and informative. They were very positive about the Dutch model for identifying, rehabilitating and integrating asylum seekers, and sounded confident that they would be able to integrate in their new country.

B. Perception of identification and rehabilitation services as experienced by selected torture survivors among the interviewed refugees

We interviewed two torture survivors, a man and a woman, both from Iraq, at the Iraqi Human Rights Foundation in London. Only the woman allowed us to videotape the interview. The man was afraid that the interview would be seen and recognized by the Iraqi authorities, and that his family, still there, might be killed or tortured as a result.

Both were very surprised to learn during the interview that a rehabilitation centre for torture survivors existed in London. The man, a former high-ranking soldier who deserted and fought for the opposition in the Gulf War, had clear physical signs of torture. The woman was obviously distressed from having lost several family members and having witnessed torture.

The geographical barrier for access to treatment is apparent; there is only one rehabilitation centre in England, situated in London, while some 300,000 Iraqi refugees are spread over the whole country. An example of a solution to this problem is given in the section below.

Examples of the perception of identification and rehabilitation services as experienced by survivors of the Holocaust, Gulag, or subsequent torture in European countries are given in section number V.F.1.-2.

VIII. GEOGRAPHICAL BARRIERS; THE CASES OF THE CZECH REPUBLIC AND HUNGARY

The need for rehabilitation services at the rehabilitation centre RIAPS (annex 1) in Prague, the Czech Republic, has changed dramatically during the past year [1997 – ed.]. Today, most of the refugees who had fled to the Czech Republic from former Yugoslavia have returned to their country, leaving only about 2000.

These refugees are placed in five camps, all in rural areas, and they are therefore not able to come to RIAPS for treatment unless they stay as in-patients. This is necessary in a few very serious cases, but is in general too expensive for the centre, and also bad for the client, who is separated from his daily environment and/or family.

In Hungary, the local office of the United Nations High Commissioner for Refugees finances a programme, the Cordelia Foundation, which was until recently in a similar situation.

However, the situation led them to rethink their approach. They decided to establish a mobile unit to visit resettlement places for the programme refugees and asylum seekers, where it conducts rehabilitation services for them, whereas rehabilitation of Holocaust and Gulag survivors, and of survivors of torture by the repressive Soviet occupation, especially from the 1950s and 1968, is situated at the University Hospital in Budapest. This initiative has proved very successful in breaking down geographical barriers.

IX. COMMUNICATION BARRIERS

The entire aspect of communication represents great hurdles in the identification and the rehabilitation process of the torture survivors. With respect to torture survivors among the asylum seekers, the problem first occurs when the torture survivor arrives at his destination country. The torture survivor and the authority representatives who are responsible for identification of torture survivors need to communicate. At a later stage communication between the torture survivor and the health personnel at the rehabilitation centres becomes necessary. Seen from a general European perspective, the problems of communication that are characteristic for torture survivors must be taken more seriously in the future. Several obstacles must be understood and avoided or eased; from a health organizing point of view these obstacles represent a great challenge.

In Canada, not engaging an interpreter when the need arises is considered a human right abuse. The Canadians talk about "the human right to be understood".

Of course there are other ways than the use of interpreters to overcome the language barrier. In general it would be better not to base rehabilitation programmes only on interpreters, who have to be supervised when they work with traumatized people. Several demands should be fulfilled: interpreters should have supervision, high professional standards, and some experience and special training.

An alternative solution arises when someone from the same culture, talking the same language (and/or dialect) as the torture survivor, is available to interpret. Refugio (annex 3) in Munich, Germany, has experimented with using a distant family member as interpreter (e.g. the niece of the Bosnian woman and torture survivor we interviewed at the centre), but the torture survivor and the family member must be prepared to do it, and even then it may lead to other barriers such as shame and feelings of guilt.

Another solution is to employ therapists (i.e. physicians and rehabilitation specialists) who speak the most important languages (the languages that are most frequently used by the torture survivors from the recruitment area) or to teach therapists those languages. This would allow a person-to-person treatment, which from a psychotherapeutic point of view must be considered better than working with an interpreter, because the presence of three persons leads to an unclear role definition.

Using interpreters is often necessary, but the therapist must always bear in mind that an interpreter does not simply translate the words used in the conversation; he interprets them, which of course gives the interpreter's individual influence on the conversation. Thus, a change of interpreter sometimes sheds a totally different light on a client³⁷.

So using an interpreter can be a good help, but it is far from optimal in long-term treatment programmes. Early intensive education programmes in the language spoken in the destination country (or region), as is practised at the Phoenix Centre, the Netherlands (section VII.A.), diminishes the time during which the use of interpreters is needed.

As indicated, there are many problems in using interpreters in the rehabilitation process. Some are discussed in section IX.A., and others (non-verbal therapy) in section IX.B.

A. Working with interpreters at rehabilitation centres for torture survivors, including the case of the Netherlands

This section is based on our interviews with interpreters, health personnel, and clients at the centres. Personal reflections on the problem have been added.

Although some patients at most rehabilitation centres speak the same language, several patients will not find anyone at the clinic with whom they share a common tongue. Using interpreters, for instance in psychotherapy, is far from ideal, but it is very often the only possibility in the initial phase of a rehabilitation process. Sometimes interpreters are not used for economic reasons, sometimes there is none, or they are not available, in the area of concern. In these cases, the rehabilitation centres must apply alternative methods.

At most rehabilitation centres in the established market economies in Europe, patients come from all over the world. However, the Netherlands is a special case in this respect, which is why this country has been chosen to depict an ideal situation in terms of access to interpreter services.

The Dutch government offers 24-hour free use of interpreters to all organizations working with asylum seekers and refugees³⁷.

Torture survivors at the Phoenix Centre start to learn Dutch as soon as their mental health status allows (section VII.A.). They are also encouraged to practise these skills when speaking with the therapists. Furthermore, the torture survivors are offered labour market targeted training early in their rehabilitation, e.g. in computer science. This early integration programme, which applies also to asylum seekers, gives great confidence in the Dutch system, and consequently eases the rehabilitation process and later integration of the torture survivors into Dutch society.

In-patient clinics such as the Phoenix Centre are of course not always ideal, because they may result in victimization of the torture survivor. However, the Dutch health system also offers rehabilitation services for torture survivors at day clinics and poly-clinics when this is deemed sufficient by the health personnel and is requested by the torture survivor. The decision lies with the torture survivor and his or her family, but the torture survivors receive professional guidance from the health sector representatives.

B. Non-verbal therapy; the case of Hungary

Non-verbal therapy is used at some centres in the initial phases of the treatment process, either due to lack of access to interpretation services or because the personnel are convinced that this approach gives better results.

The team working at the Cordelia Foundation's mobile unit (section VIII) comprises a non-verbal therapist and a psycho-therapist who work together until the client is able to understand and speak Hungarian.

The idea is to move the deeper parts of the soul of severely tortured persons, and to measure progress in the health status of the client using special dynamic drawing tests. Auditory, painting, and motoric elements are part of the treatment process.

An attempt is made through drama and the above-mentioned elements to reassemble the fragmented part of the ego, enabling the torture survivor to cope with the new society.

X. PREVENTING TORTURE AND REHABILITATING SURVIVORS IN A COUNTRY PRACTISING TORTURE; THE CASE OF TURKEY

In Turkey, as in approximately one third of the world's countries, government-sanctioned torture is an ongoing problem^{18,38-42}. The human rights situation in Turkey, neighbour to a former Eastern Block country (Bulgaria) and to one of the countries referred to as "established market economies" (Greece) and thereby the European Union (to which Turkey is applying for membership), has not improved, rather deteriorated, since the 1982 constitution, which was made to "protect the Turkish state". In today's Turkey, when a person is in custody or imprisoned, torture and ill-treatment are the rule rather than the exception. The case of Turkey is used to depict the "armaments race" (6) between the health personnel and the torturers, and to illustrate torture prevention and rehabilitation initiatives in a country where torture is an ongoing problem. This struggle has prevented some torture methods; it has also led to several important findings, but has unfortunately led to the invention of new torture methods that are becoming increasingly difficult to detect and prove. Consequently, it is highly relevant to the present study, because it shows why special training is necessary for the health and social personnel who are in frequent contact with the "risk groups" and have gatekeeper functions for the rehabilitation services.

A. Rehabilitation facilities for torture survivors in Turkey

Only two organizations, Tohav and the Human Rights Foundation of Turkey (HRFT), offer rehabilitation services for torture survivors in Turkey. Tohav has only one branch, in Istanbul. HRFT has four centres and will be initiating a fifth in Diyarbakir this summer [1998 - ed.]. The other four are in Adana, Ankara, Istanbul, and Izmir.

The Izmir branch of the HRFT is working with documentation on torture, rehabilitation of torture survivors, and research to prove positive findings of torture, physical and mental, in order to provide their clients with an "alternative medical report". These activities are further clarified in the following paragraphs.

The centre collects the materials on torture and human rights abuses which come to their knowledge from their clients. This material is then sent to the HRFT documentation centre in Ankara. The Izmir clients are mainly torture survivors from detention centres and prisons in Izmir and its surroundings, and refugees from the south-east province of Turkey (mostly Kurds) who fled to this area.

Three doctors (two somatic, one psychiatrist) work full-time at the Izmir centre, together with a social worker and two secretaries. Approximately 50 volunteer doctors work for the centre for the public good or for a symbolic fee.

When a torture survivor applies to the centre for treatment he is admitted directly for treatment. The doctors at the centre take a history, conduct an examination, and make an initial diagnosis. The torture survivor is then referred to

specialists within the network of volunteer specialists, who examine the torture survivor again and make a more comprehensive diagnosis. Based on this, an "alternative medical report" can be provided to the applicant upon request.

The torture survivor is then offered treatment and rehabilitation according to his needs. The torture survivor is normally in need of specialist treatment, and is therefore referred to specialists in the network. The full required treatment is rarely carried out at the centre.

1. Alternative medical reports

In countries such as Turkey, it is necessary to offer alternative medical reports to the torture survivors because they only very rarely get correct medical reports from the official forensic doctor or other official doctors used by the authorities.

If torture survivors do not get such reports, they cannot apply to the court, in order to punish their torturers. The writing of false negative reports is everyday practice in Turkey.

At the Izmir centre, 50% of the clients have fresh physical evidence of torture. The centre receives an average of almost one torture survivor per day. Even when the torture survivors have fresh physical evidence of torture, the official medical doctors often do not write about it in their reports. There are several reasons for this:

1. The doctors are under pressure from the authorities, the police. The policemen join the client when he goes into the examination room. According to the chairman of the Turkish Medical Association's branch in Mersin, most policemen do not even know that it is illegal for them to stay with the person during the examination. Even when the doctors see signs of torture, they are under pressure and cannot write the correct findings. They fear punishment and torture, as has been the case with numerous Turkish doctors during the past few years^{18,40}. This therefore causes false negative reports or incorrect reports.
2. Before the visit to the doctor, the police will have informed the torture survivor that if he even mentions having been tortured, they will transfer him back to custody, where they will continue the torture. So in many cases, the torture survivor does not talk about the torture during the examination. The frequent presence of the police during the examinations intensifies the fear of the clients and the medical doctors. Because the clients have no complaints, and from fear, the doctors do not examine them properly. Consequently, signs of torture are not seen.
3. Bruises and most other visible physical evidence of bodily torture of course disappear after a while. Before the torture survivor is taken to the doctor, he is often kept so long in prison that every sign of physical torture has disappeared. This is also common practice in Turkey (ref. the Manisa case below). As the doctors often have inadequate equipment and knowledge about the possibilities of proving torture after physical evidence has disappeared, the doctors write incorrect reports.
4. Lack of knowledge is an equally important problem. The doctors are not always sufficiently trained to give these kinds of medical report. They do not know about the sequelae of torture. This is not only a Turkish phenomenon (described further in section number V.E.).

However, a specific Turkish problem in this regard is the use of GPs. When a client is to be transferred from custody to prison, he must be checked by a medical doctor. In a relatively small city like Mersin (half a million inhabitants), GPs

are responsible for completing forensic medical reports. The workload is often overwhelming, because the police come with the prisoners in "bundles". The GPs are not capable of identifying mental signs of torture, nor physical signs that are no longer visible. Real examinations can be carried out only in larger Turkish cities, where a forensic department is present. But even then, such an examination is rare.

Consequently, most torture survivors are given incorrect medical reports from the official doctors.

2. The involvement of the HRFT in the Manisa case

The Manisa case is a very obvious example of professional misconduct, of issuing false negative medical reports indicating no signs of torture. In Manisa, 16 children aged 12-19 were imprisoned in 1995 because they were suspected of being members of a guerrilla organization; they were severely tortured by several different methods – beating, electrical torture, sexual torture, psychological torture, etc. Why is this case special, and how did it get such extensive public attention, as was the case? First, the tortured persons were children. Second, the children came from middle-class families, and were taken into custody from the street, apparently because one of them had been writing on a wall. Third, a member of the Turkish Parliament, Mr. Sabri Ergül (the Izmir deputy of the CHP – Republican Peoples Party), came to the detention place and demanded to see the children. He was kept waiting, and finally went inside the police station, opened a couple of doors, and before anyone could hold him back, he was in the room where the children were kept. There he saw the 16 children lying on the cold floor, blindfolded and naked, while police officers were raping and sexually harassing them. Ever since, he has been one of the most devoted human rights fighters in the Turkish parliament.

Directly after their period in custody, the children were transferred to the prison. The HRFT doctors were not allowed to examine them. But meanwhile, as the law prescribes, they had been examined by the official doctors. Each child received three or four medical reports, 57 altogether, and each report stated that there were no signs of torture. It has later been proved that they were all false negative reports.

Even though the HRFT doctors were not allowed to examine the children, they were allowed to see the medical reports through the lawyers representing the children. The HRFT signed an official document claiming that the examinations carried out according to the medical reports were not in any way sufficient material to prove that the imprisoned children had not been tortured. The medical reports were actually forms that the doctor had to complete on police request and in the presence of the police. They contain one sentence only: "There are no torture findings on the body of the person", followed by the doctor's signature.

Such a report is of course very insufficient technically and scientifically; it cannot show that a person has not been tortured. The doctor should first write the client's history of the torture, and should then decide which examinations are necessary to investigate the allegations. If there are claims of sexual torture, as in the Manisa case, the person should be examined by specialist doctors, e.g. specialists in proctology, whose findings should be included in the report.

As the HRFT were not allowed to examine the children, they sent them a letter through their lawyers, inviting them to write down their complaints and depict them on some enclosed topographic figures from a forensic medical book. The children's written answers were returned from the prison to the HRFT through the children's lawyers. One child

depicted complaints in and around his anus. He still had pain 2-3 weeks after a policeman had violently forced a truncheon into his anus. He also had problems defecating. The children all wrote similar stories. A questionnaire was also enclosed in the material forwarded to the children, including three questions: How were you examined by the doctor? Were you asked whether you were tortured? Were you naked during part of the examination? The answers proved that the children had not been properly examined.

On this background, the HRFT made commentary reports.

After the release of the children, the medical doctors working within the network of the HRFT examined ten of them. In seven cases very obvious psychiatric findings proved, even after one year, that they had been tortured. Having carried out full examinations of these torture survivors, the HRFT could provide them with alternative forensic medical reports, without which they had no proof that they had been tortured. The children applied to the court on this background.

B. The "armaments race"

The main part of the work at the Izmir branch of the HRFT is of a scientific character. All the doctors in the network and at the centre have formed a research group.

As mentioned before, 50% of the clients at the HRFT Izmir have fresh physical evidence of torture. But in order to prove torture after the findings have disappeared, the doctors at the centre have to hear the history of the torture survivor, and conduct a thorough examination according to this. Psychiatric examination and advanced investigations are also performed. Examples include bone scintigraphy, ultrasonography, electromyography, CAT scans, MRIs, and biopsy (if the torture survivor has suffered electrical torture).

The doctors working at the centre have to improve their methods scientifically in order to prove torture when physical evidence is not visible on the body. The torturers "improve" their methods constantly, trying to make them undetectable, in order to avoid being charged; trials bring public and international attention to the problem, and sometimes even result in punishment of the torturers. This mechanism is referred to as the "armaments race" between torturers and forensic personnel.

1. Advanced investigations prevent torture

A case from HRFT Izmir demonstrates the use of bone scintigraphy, which has contributed to the eradication of falanga torture in the Izmir area:

In 1990 a female nurse from an Izmir hospital was taken into custody, where she was severely tortured for two days, suspected of kidnapping. Her colleagues at the hospital came for treatment to the hospital where Professor Veli Lök, today Chairman of the Izmir centre, works as an orthopaedic surgeon. He found that this was a case of falanga (severe beating on the soles of the feet); examination of the soles showed swelling and red discolouration, and there were other findings indicating falanga (e.g. hyperextension of the big toe)⁴³. The psychiatrist found that she had severe PTSD. On admission to the centre, she was crying and was intensely fearful because she thought that the staff were policemen. She has been treated at the HRFT for 3½ years and is now considered healthy. She still attends for follow-up. She lost both her trials in Turkey (the local court in Izmir and the Ankara Appeal

Court) because she could not recognize her torturers (she was blindfolded during the torture). Consequently, she has appealed to the European Council's Court of Human Rights, where she has won the first of two parts of the trial. The court will reach a final decision this summer [1998 – ed.].

Specialists to whom she was referred by the HRFT treated the physical sequelae of falanga. Bone scintigraphy helped to prove to the court that she had these sequelae; positive findings are still present seven years after the torture.

Electrical torture is not new. But to prove it has also required new advanced investigation methods. At the Izmir HRFT, several clients had visible signs of application of a cathode to the body. In 1990 RCT in Copenhagen found a way to prove electrical torture on the body through punch biopsy. However, the torturers in Turkey quickly found out that they should keep the person imprisoned until the spots from electrical torture had disappeared, in order to make it harder to prove electrical torture. After this they have developed the method in order to make it undetectable. Torture survivors in Turkey now complain of being wrapped in wet sheets in pools of salt water during the electrical torture. This method apparently leaves no visible signs on the body, because the wires can be attached to the wet sheet, covering most of the body.

2. Struggling to prevent torture; results of the HRFT trials

The following case from HRFT Izmir will show that bone scintigraphy has led to the disappearance of falanga and squeezing of the testicles in Izmir and its surroundings.

In the early 1990s, the HRFT gave numerous medical reports to torture survivors⁴², especially following falanga. These reports enabled the torture survivors to apply to the court, and a short time later some of the torturers were punished. The legislation then changed in Turkey, and, because of this, the torturers were released.

The HRFT made in total 76 alternative medical reports until 1997. Approximately one fifth of these were commentary reports, meaning that the torture survivors were not examined by the health personnel at the HRFT. Those reports were only comments on the material, e.g. reports already submitted by the prison doctors. In 63 cases, the torture survivors were examined. Bone scintigraphy, psychiatric and other relevant examinations were made. In the further juridical development, 30 of these people did not, according to Professor Veli Lök from HRFT Izmir, apply to the court because of fear. In 12 cases, the prosecutor did not start a trial. Two cases did not pursue the trial (they did not attend in court).

In 32 cases, the alternative medical reports were taken into consideration in court. The results of these cases were as follows:

In 11 cases, the trial was decided in favour of the torturers. The most frequent argument was that the tortured people did not recognize the torturer. However, they stated that they could not recognize the torturers because they were blindfolded. In these cases the torture survivors appealed to the European Court of Human Rights. One was the nurse mentioned above (section number X.B.1.). Cases such as hers which are appealed to the European Court of Human Rights cause bad publicity for the accused country. As a consequence, many similar cases are not pursued because an agreement will be reached between the two parties, and the torture survivor is compensated.

Among the rest, the trials have ended in favour of the torture survivors in four cases, in the remaining the trial is still ongoing.

Despite the limited success rate in winning the trials, the staff members at the HRFT Izmir are satisfied with their results. And with good reason. Some cases resulted in the punishment of the torturers, and the trials resulted in the disappearance of falanga as a torture method in the Izmir area of Turkey. This was because the torturers were afraid that the torture survivors would go to court and win their case against them.

The work at the centre has also resulted in the elimination of "twisting and squeezing testicles" as a torture method because in 23 cases the centre succeeded in proving the sequelae of this torture method using dynamic scintigraphy.

So, as both falanga torture and twisting and squeezing of testicles as a means of government-sanctioned torture have been eradicated in this area by use of scintigrams as evidence in the court room, the work at the HRFT Izmir branch has proved preventive. It has also resulted in the development of methods that enable the rest of Europe to prove torture sequelae, even several years after the physical findings have disappeared.

XI. PLANNING HEALTH PROMOTION FOR TORTURE SURVIVORS IN EUROPE

The reason why the quality of life concern "access" has been assessed subjectively is to illuminate the situation of torture survivors in Europe and provide decision-makers with a view of the situation of the torture survivors through the eyes of the torture survivors themselves, and through the eyes of the personnel working for and with them.

A. Phase 1 – precede; social diagnosis

The "Social Reconnaissance" sampling method¹¹ has been applied in the effort to determine "relevant aspects of the social nature, processes, and needs" of the torture survivors, using social, legal, and health personnel working for and with torture survivors as informants and interviewees. It is important to note that a great part of the effort to enhance the understanding of the torture survivors has been through the experiences of these personnel, because talking with torture survivors about their perception of their own needs is often very complicated (section IV.A.1.).

Torture survivors were interviewed in different ways. At two European rehabilitation centres (Estonia and Poland), they were interviewed in groups, while on four occasions interviews with individuals were carried out (Latvia, England, Austria, and Croatia).

In the very different setting at the Phoenix Centre in Wolfheze, the Netherlands, talking and socializing with the clients were allowed. Having practically "moved in" to the centre, we participated in all social events during the four days we stayed at the "resocialization unit" (the department where the torture survivor is being prepared for integration into the Dutch society).

Our interviews and literature studies have been sources for finding social indicators. The social diagnosis resulted in the following:

Quality of life concern: Access to adequate rehabilitation services for torture survivors.

The magnitude of this problem becomes apparent when it is studied further. First of all, it can be concluded that the problem influences both health and social concerns. Thus it influences the individual (the sufferings of the torture survivor and his family) and the society (disintegration, racism, etc.).

The problem is conceived as extremely important by the influenced people and by the people who are aware of and confronted with the problem. But as public awareness of the problem seems very low, and because the problem does not affect the majority of people, it is not of much interest for many of those who are not influenced by it.

The frequency of the problem varies from country to country. However, its importance is obvious, taking into consideration the present need for rehabilitation services, the estimated actual need for rehabilitation services, and the continuous migration to Europe.

The predominant social, somatic, and mental symptoms of torture often cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning"¹².

1. Social indicators

Many of the listed social indicators interact and vary according to the individual and the scenario. It has been decided not to attempt to rank the indicators, because ranking them based on the available data would have little scientific value, and because it is not important for the purpose of this study. This has been attempted in other studies^{3,20}. Nor is it interesting to investigate the extent to which some factors could be excluded as others are superior to them. The purpose is merely to depict problems, needs, and barriers associated with the social problems of the torture survivors, as they are perceived by the torture survivors and the actors working in this field.

The social indicators listed below are compiled from our interviews and literature studies:

- access
- achievement
- alienation
- awareness
- compensation
- cultural problems
- discrimination
- fear
- equity
- hostility
- inability to pay/no health insurance
- linguistic problems
- performance
- quality
- social acceptance/despair
- unfair asylum hearings.

B. Phase 2 – precede; epidemiological diagnoses

The list of vital indicators highlights the fact that the essence of torture sequelae is not necessarily captured by the PTSD²⁷. The indicators listed below express the most frequent and severe symptoms that have been revealed in this field study and in literature studies^{3,5,12,20,22,23}.

Examples of health factors influencing "access" are listed in the below section.

1. Vital indicators

- anxiety (nervousness)
- change in mood (emotional instability)
- depression
- feeling of general tiredness (fatigue)
- feelings of insufficiency
- headache
- impaired concentration
- impaired memory
- irritability
- loss of initiative
- restlessness
- sleep disturbances and/or nightmares
- somatic pain
- vertigo.

Dimensions

- distribution
- duration
- functional level
- incidence
- intensity
- longevity
- prevalence.

C. Phase 3 – precede; behavioural and environmental diagnosis

The causes of the social and health related problems of the torture survivors are investigated in the behavioural and environmental diagnosis. Separating behavioural and non-behavioural causes of the social problem "lack of access" has proved difficult, because sequelae of torture are often expressed in behavioural changes or impairment of the torture survivor. Consequently, it is important to emphasize that the behaviour which has caused the health problem (e.g. political opponents, student and/or union leaders, journalists, human rights advocates, and religious or political minorities¹⁷) is of no relevance, because we are dealing with sequelae of a cruel man-made illness. Instead, it is important to identify the forms of behaviour that may be barriers for solving the health problems associated with the lack of access.

As in the other phases of the PP-model, no attempt has been made to rank the behavioural indicators in terms of changeability and importance.

Examples of behavioural factors that are barriers to "access" are listed below.

1. Behavioural indicators

- coping
- culture/religion
- hopelessness
- perceived need
- sense of a foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span)
- shock of having been deprived of liberty in the destination country
- uncertainty (e.g. about the future due to fear of the outcome of the asylum application)
- utilization.

Dimensions

- frequency
- persistence
- severity.

2. Environmental indicators

- economy
- geography
- identification
- lack of qualified personnel (e.g. only one psychiatrist in Albania)
- policy
- poor education of personnel with gatekeeper functions
- public awareness
- racism
- refugee camps
- supply of adequate rehabilitation services
- social disintegration
- transportation.

Dimensions

- accessibility
- affordability
- equity
- ethical standards.

D. Phase 4 – precede; educational and organizational diagnosis

This phase of the PP-model deals in particular with the psychosocial behavioural determinants. The enabling factors are determinants for the environment.

1. Predisposing factors

The predisposing factors are individual prerequisites for behaviour and lifestyle. They are personally related factors that provide motivation for the behaviour of the torture survivor, influencing the assessed quality of life concern. They have the character of socioeconomic status, age, gender, beliefs, values, perceptions, family size, etc.

- age
- attitudes
- belief in preventability
- belief in susceptibility
- confidence
- culture
- education
- experiences
- family (and friends') support
- initiative
- knowledge (awareness)
- motivation
- perceived needs and abilities
- race
- religion
- self-esteem
- sex
- socioeconomic status
- temper
- values.

2. Enabling factors

The enabling factors facilitate realization of a motivation¹¹. Both formal and informal methods have been applied in the

attempt to illuminate the reasons for the behavioural and environmental barriers to "access".

The informal methods have been to gather "opinions" from torture survivors, scientists, and professional staff working for and/or with torture survivors.

The formal method has been to carry out literature reviews.

The enabling factors influence both "Behaviour and Lifestyle" and "Environment".

Skills for enabling behaviour change by personal resources

- ability to engage in active employment
- family therapy (therapy for secondary victims of torture)^{17,44}
- interventions aimed at enhancing integration and engaging torture survivors in training programmes
- participation in asylum hearings by politically unbiased persons with a mature personality and a knowledge of human behavioural patterns of torture survivors
- postgraduate education of personnel with gatekeeper functions
- quick asylum procedures with respect to humanitarian, ethical, and legal principles.

Skills for enabling behaviour change to influence environment

- advocacy work increasing political awareness
- geographical accessibility
- information work increasing public awareness
- integrating SCID or CIDI as tools for an initial identification of torture survivors
- interpretation services by specially trained interpreters³⁷
- mobile centre units or transportation facilities to rehabilitation centres for torture survivors
- alternative therapy methods (non-verbal i.e. art, drama, music, etc.).

3. Reinforcing factors

The reinforcing factors are the consequences of a behaviour that determine whether the torture survivor receives feedback and is then supported socially. Examples of such feedback include social benefits, physical benefits, tangible rewards, and perceived rewards. Reinforcing factors include:

- less uncertainty due to short waiting time before decision is reached in asylum cases
- education adopted in the curricula of all health professions
- improved perceived health (physical, mental, social)
- international recognition of problem (UN Committee against Torture, European Council Committee for the Prevention of Torture, international tribunals against the torturers, etc.)
- opportunity to attend labour market reintegration programmes
- peer leader
- snowball effect (one torture survivor receives treatment and finds it beneficial – tells his friend who ...)
- multidisciplinary rehabilitation facilities
- compensation and social acceptance
- role modelling.

E. Phase 5 – precede; administrative and policy diagnosis

Phase 5 of the PP-model includes an administrative and policy diagnosis that should result in a health promotion plan for increased access to rehabilitation services for torture survivors. The model operates with two categories that are

addressed below, i.e. "Health education and research" and "Policy, regulation, organization".

1. Health education and research

Health education and research are essential for the promotion of torture survivors' health. Initiatives that facilitate education and research programmes include:

- obligatory postgraduate education programmes (by experienced personnel for community physicians, GPs, and others with gatekeeper functions)
- developing a uniform monitoring system enabling valid research.

2. Policy, regulation, organization

Before implementation of the assessed means for improving access for torture survivors to rehabilitation services, incompatibilities with existing policies, regulations, and organization must be considered.

Administrative diagnosis

The policies, resources, and organizational situation in the visited countries are very diverse. Consequently, these conditions as facilitators or barriers of access for torture survivors to rehabilitation services vary considerably. This has affected the ability to analyse and generalize considerations about resources for the area as a whole. However, a number of factors seem to be prevalent. Those are listed below. The administrative diagnosis consists of three steps:

a. ASSESSMENT OF RESOURCES NEEDED

It has been obvious that both financial and human resources are important barriers for matching the actual need for rehabilitation services in Europe. Closed or long waiting lists prevail at approximately half of the 35 visited rehabilitation centres, despite the present inability to identify the majority of torture survivors living in Europe. This, and the fact that recruitment of qualified personnel is difficult for the centres (due to limitations in financial and/or available human resources), indicates that there is definite under-capacity of experienced staff in the European health sectors to sustain and develop the present services.

b. ASSESSMENT OF AVAILABLE RESOURCES

Apart from the Netherlands, no European country seems to have allocated the necessary resources to provide access to adequate rehabilitation services for all three mentioned target groups. However, the existence of adequate rehabilitation services for survivors of disasters and catastrophes, who often show similar symptoms, indicates that the necessary human resources may to some extent be available, or that the necessary knowledge is present to initiate education programmes.

c. ASSESSMENT OF BARRIERS TO IMPLEMENTATION

The barriers vary remarkably from country to country:

- lack of public awareness
- political unwillingness
- economic limitations
- political deadlock (impunity/amnesty).

3. Policy diagnosis

The policy diagnosis consists of two steps:

Assessment of policies, regulations, and organization

Though Ireland and Belgium have not ratified the UN Convention against Torture, this alone does not determine

the degree of access to rehabilitation services. Lack of possible sanctions limits the UN Committee against Torture in its effort to influence relevant policies and actions of the countries (e.g. Turkey has ratified the Convention but government-sanctioned torture is practised).

The European Council Committee for the Prevention of Torture (CPT) has 40 member countries, including Turkey. The Committee's only possibility for sanctioning a country violating the laws and regulations agreed upon is to give a "public statement". Even though the CPT's reports on the situation and recommendations to the country are confidential, all countries, except one, have until now agreed to make them public. This country also represents the only case where the sanction option has been used (twice) – Turkey!

Assessment of political forces

The European Union Commission (EUC) budget-line and the UN Voluntary Fund for Victims of Torture represent two unique instruments for international support of rehabilitation programmes in countries with limited financial and human resources, or lack of local political initiative. The EUC has a unique possibility to influence or standardize regulations for an adequate asylum policy in its member countries (as in the Amsterdam Treaty – section number V.D.2.).

The human rights situation in a country is a determining factor when the EUC considers the inclusion of new members (e.g. Turkey). Consequently, such a determining factor is a political force because it makes it economically attractive for prospective countries to respect human rights. Other "negative" political forces are available for the established market economies, e.g. applying political conditions to trade, bilateral aid, and lending⁴⁵.

Advocacy work at all levels is an important political force (e.g. the IRCT's network and lobbyism).

XII. CONCLUSION

The voluntary work of, for example, Amnesty International's Danish Medical Group, and the pioneer work of, for example, RCT Copenhagen has been path-breaking, bringing about the current level of awareness and of rehabilitation services for torture survivors. However, it is obvious that further steps must be taken to address the torture survivors' need for access to adequate rehabilitation services. Such further steps require basic changes in the society. The society must finally acknowledge that adequate identification and rehabilitation facilities for torture survivors are a necessary part of the social treaty in any democratic society.

Invaluable and alarming indications of the long-term effects of not having adequate identification and treatment facilities for torture survivors are provided by several studies of concentration camp survivors^{3,23,24}. The costs of not being able to identify and help the torture survivors might not only be of a human and social character; they may also cause such serious financial burdens for the society that a prompt but thoroughly planned intervention might even be economically beneficial.

In order to change the health status of both primary and secondary victims of torture, the health, social, and legal personnel engaged in working with torture survivors must improve their ability to feed valid information with respect to the severity of the situation back to politicians and decision-makers at all levels.

The failure to do so may be due to the general problem for studies aiming at explaining and quantifying causes and effects of rehabilitation efforts, namely that the rehabilitation centres only rarely use the same monitoring system.

Consequently, registered data that are comparable from centre to centre are very scarce. This is a major barrier preventing researchers from carrying out valid scientific research with unambiguous and significant results⁵. Developing a uniform monitoring system would allow centres on a world-wide basis to use the same visitation and registration system. Such a system would provide the decision-makers with valid arguments for an intervention because they would be able to make rational choices based on comparative programme reviews¹⁹. It would also commit them to act.

The determining processes that have caused the present state of this part of the health care system and the health status of the torture survivors have apparently been lack of awareness and/or political willingness to realize the extent of the problem, and to deal with it. These specific requirements were separated from the existing public health services perhaps because early treatment approaches (The University Hospital in Copenhagen, 1980) showed that the hospital environment affected the rehabilitation process negatively¹⁷. Eventually the responsibility was placed outside the public health sector.

Arguments can be made with respect to governmental versus non-governmental rehabilitation programmes. However, as both approaches have been successful in comparable scenarios (the Phoenix Centre in the Netherlands and RCT in Denmark), this aspect does not seem to determine the adequacy of rehabilitation services.

The need for a multidisciplinary team at the centres, and the fact that health, social, and legal concerns are often inter-laced, indicate that a structure of rehabilitation centres outside the public health sector might be preferable. However, whether the responsibility for providing the services lies in the private or the public sector is not a central issue at present. Nor is it of great importance to discuss the efficacy of the existing models at present. The central issue now is to commit the decision-makers to act. They must provide a legal and financial framework to allow the health, social, and legal professions to address this public health problem in the same way as they address other health problems with comparable social, human, and financial impact. This must include a framework for implementing necessary education programmes for the required personnel.

With the establishment and expansion of the EUC budget-line, the EU has a historic opportunity to set high humanitarian, ethical, and legal standards for identification of torture survivors and provision of rehabilitation services for them in its member states. Setting such standards as primary criteria for considering membership of applicant countries could also influence the standards beyond the EU's present borders.

It is important to remember that eradication of government-sanctioned torture is a cornerstone of every sound democracy, but so are the ethical principles regarding re-foulment of asylum seekers, proceedings against former torturers, and the ability of a society to identify and treat survivors of the most cruel man-made interrogation and repression instrument – torture.

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Notes

- (1) PTSD has classification code 309.81 and is defined in APA's DSM-IV classification system pp. 424-9.
- (2) Acute Stress Disorder has classification code 308.3 and is defined in APA DSM-IV classification system pp. 429-32.
- (3) Thomas Wenzel, MD, Lecturer in Psychiatry, Institut für die Beforschung Posttraumatischer Erkrankungen, University of Vienna
- (4) 83-minute interview with Dr. Thomas Wenzel and 61-minute interview with Professor Veli Lök, Izmir branch of the Human Rights Foundation of Turkey.
- (5) The countries which on 14 June 1985 signed the Schengen Treaty are Germany, France, Belgium, Luxembourg, and the Netherlands. Italy signed in 1990, Spain in 1991 and Portugal in 1992. Austria became an observer in 1994, and the Danish Parliament decided to sign it with several reservations.
- (6) Refers to the torture methods that seemingly change every time the health personnel have success in proving sequelae of a torture method in court. This is further described later in this section.

Annex 1

Visiting schedule from September 1, 1997 to February 26, 1998

RCT and IRCT
Copenhagen
Denmark

Röda Korset, Rehabiliteringscenter for tortyrskadade flyktingar
Malmö
Sweden

TORTURE



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