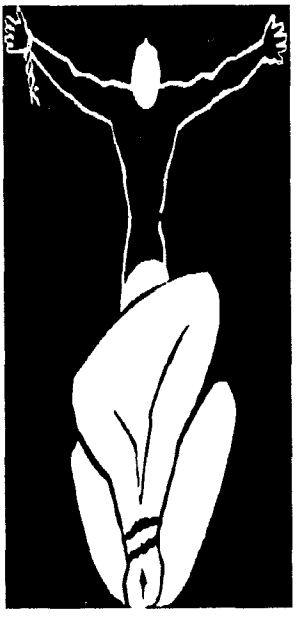


Human Rights and Health Professionals

Toward an Education Program for the Asian Region

PSYCHOSOCIAL TRAUMA PROGRAM
Peace, Conflict Resolution, and Human Rights
Center for Integrative Development Studies
University of the Philippines



Human Rights and Health Professionals

Toward an Education Program for the Asian Region

Proceedings of the Seminar on Medical Ethics, Torture, and Rehabilitation

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Abbreviations

AAAS	American Association for the Advancement of Science
AI	Amnesty International
BBC	British Broadcasting Corporation
BMA	British Medical Association
CCVT	Canadian Center for Victims of Torture
CPT	Committee for Prevention of Torture
CRC	Children's Rehabilitation Center
CRC	Convention on the Rights of the Child
ECPAT	End Child Prostitution, Child Pornography and the Trafficking of Children for Sexual Puposes
ICRC	International Committee of the Red Cross
IRCT	International Rehabilitation Council for Torture Victims
MAG	Medical Action Group
NCHRI	National Commission for Human Rights in India
NGO	Non - Governmental Organization
NPA	New People's Army
PHR	Physicians for Human Rights
PST	Psychosocial Trauma Program
RCT	Rehabilitation and Research Center for Torture Victims
STRT	Stress Tension Reduction Therapy

TFDP	Task Force Detainees-Philippines
UN CAT	United Nations Convention Against Torture and other Forms of Cruel, Inhuman or Degrading Treatment or Punishment
UNCHR	United Nation's Commission on Human Rights
UNICEF	United Nation's Children's Fund
UNVFVT	United Nation's Voluntary Fund for Victims of Torture
UP-CIDS	University of the Philippines-Center for Integrative & Development Studies
WCC	Women's Crisis Center
WMA	World Medical Association

Foreword

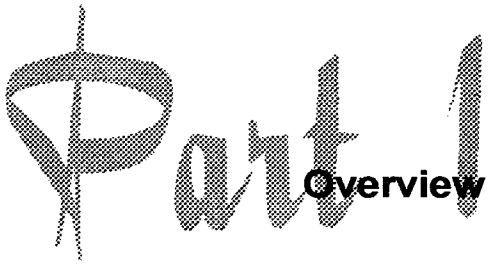
MARIA CYNTHIA ROSE BANZON BAUTISTA

Human Rights and Health Professionals: An Education Program in the Asian Region documents a holistic training seminar for health professionals engaged in human rights work and the care of torture victims. Against the backdrop of the torture situation in the world, the participants of the October 1996 Bangkok seminar were reminded of the laws, legal policies and procedures governing human rights. They spent days intensely discussing the ethical issues surrounding the involvement of health professionals in torture, the physical and psychological consequences of those who suffer from it and the issues in the care of torture victims with special needs—women and children. They also reflected collectively on the nature of their relationship with torture survivors. But the seminar was more than a cognitive experience. It allowed the caregivers to release their tensions and pent-up emotions that have built up through years of dealing with human rights abuses. The participants ministered to each other even as a *Qigong* Master shared healing exercises in the Oriental tradition.

Several years ago, the Psychosocial Trauma Program of the UP Center for Integrative and Development Studies conducted a similar seminar on the care of torture victims and caregivers in the Philippines. Anyone who reads the published proceedings of that seminar and this publication will be struck by the common elements in the experiences of Filipino torture survivors and caregivers their counterparts in other countries. The forms of torture, their consequences for the victims and the pain of the caregiver who reaches out to them are almost the same regardless of race, culture and class. The only heartening insight from the commonality of experience is that the complex war against torture must be waged on all fronts and that the international arena is an effective stage. Seen in this light, the Bangkok seminar, which linked health professionals from different continents, is a small but invaluable contribution to ending human suffering borne out of the torture inflicted on a victim's body and soul.

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Maria Cynthia Rose Banzon Bautista
Executive Director
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and Development Studies



"Repression and torture are powerful instruments used in many parts of the world and the methods employed are similar regardless of the many cultural differences."

Dr. Inge Genefke

Torture in the World Today: A Situationer

INGE GENEFKE

TORTURERS learn from each other. They also learn from each torture they participate in. Repression and torture are powerful instruments used in many parts of the world and the methods employed are similar regardless of the many cultural differences. The purpose of torture is to break the will, if not the person of the victim.

When we started our work against torture in the beginning of the 1970s, we knew nothing. Today we can say we know how torture affects the individual; how it is done, its long and short term effects; the methods to diagnose and rehabili-

Dr. Inge Genefke is the medical director of the Rehabilitation Center for Torture Victims in Denmark.

tate the victims. Our knowldge on torture is quite established, programs, books and other materials are readily available. This is a far cry from where we started. At that time, we had to learn and create from nothing.

The first torture victims came to Denmark from Latin America, specifically Chile, Argentina and Uruguay. There were also victims in Europe. I particularly remember the Greek victims. We went to Greece after the downfall of the military junta and torture victims sat down with us, describing the methods used in detail. That was how our work began. It was very difficult for the victims to talk about torture and we couldn't be of much help to them then. Of course, we conveyed our report to some doctors, but we didn't have the same structured program that we have today.

We are deeply grateful to the first victims who shared their horrible experiences with us. Now we have a program not only for nurses, psychologists and doctors but also for policemen, judges and so on. Such linkages or contacts can be invaluable in our work as caregivers.

The purpose of torture is to break the will, if not destroy the person of the victim.

In discussing torture, we have to mention important conventions and declarations that are vital references in our work. They are important weapons in our hands. For instance, the United Nations Convention Against Torture lays down the ethical guidelines on the use of torture. This document allows us to cite the legal provisions when neccessary.

It is interesting to note that in the United Nations World Conference on Human Rights in Vienna in June 1993, there were powerful countries who wanted to remove the section on torture. Had they

been successful the resulting silence would have been a big step backward.

We recall the untiring effort of human rights workers in fighting this position in the 1993 Conference. They negotiated and talked, held seminars and press conferences. They also managed to talk during the plenary. Thanks to all those efforts, the final document from Vienna includes an entire page on torture expressed in a strong language. It states unequivocally that the practice of torture should be stopped immediately and relevant declarations be fully implemented. The signatories to this landmark declaration total 185 countries.

The final document from Vienna includes an entire page on torture expressed in a strong language.

Apart from the ethical framework and guidelines found in the UN Convention, there have been other areas of committed work for us in preventing torture and confronting the problem of indifference towards human rights in general and torture in particular. We are constantly pressuring key officials: the Human Rights Commissioner as well as decision-makers in Brussels and Geneva to address the relevant issues. When we meet them, we say we are not only Danes but an International Organization of very professional people — doctors and psychologists fom diffrent parts of the world.

Since we talk with one voice, people listen more and more. Now we have a joint program where we train professors of physical therapy from all regions of the world. We teach the teachers how to teach physical therapy for torture victims although this has been very dangerous for workers in some countries.

Let me now present slides from different parts of the world showing images of torture. In one slide is a child in Guatemala scarred with cigarette burns. This

demonstrates how easy it is to create pain with simple instruments. It took us years to understand why torturers use cigarettes and matches and bottles and plastic bags and simple things. Now we know that when you come out of a torture chamber and you see a bag or bottle or cigar you feel you are back there and you have anxiety attacks. Explaining the dynamics of the torture to the victims helps them cope.

Another slide shows a very common torture method (called *submarino*) : the victim with his head submerged in water mixed with urine and excrement. To verify the use of this torture method, signs of ecchymosis and stomatitis are explored.

A drawing from Turkey, painted by the victims themselves, shows a more sophisticated torture method involving a doctor. We call him a "doctor at risk." He takes part in torture. He can be a prison doctor, a medical doctor, a forensic medicine doctor, or a military doctor. His assistance makes torture more efficient.

Explaining the dynamics of the torture to the victims helps them cope.

Another torture method is *falanga*. A slide shows one way of beating at the soles of the feet. I heard about *falanga* for the first time in Greece. From the victims' account we now know that *falanga* can be done with boots or without the boots on. The instruments can be sticks, truncheons, or whips. The position may also vary. The victims can be lying down or sitting in chairs, incurring a lot of back pains. Or they can be lying with one foot here and suffer low pain in their heads instead of in their feet. We learned about this from Prof. Veli Lok and his comprehensive research on *falanga* victims. Although evidence tells us that *falanga* is not practised in some parts of Turkey, we also know that it is not only the feet that may be hit but also the ankle and the knee. In fact a great

part of the body is traumatized when this particular torture method is used.

Another slide demonstrates the method called "Palestinian hanging." This is a horrible way of hanging. Hanging does not only disturb the nerves and the blood vessels but the whole body as well. Moreover, hanging for more than 20 minutes will cause paralysis. This method is used in the Gaza area.

Another method of torture is putting the victim in a container of about 80 cm. in diameter. The victim is kept there not only for one day but sometimes for months or even years. People tortured in this way simply break down.

Regardless of the method used, torture is a perverted way of getting victims to break down.

Torture victims are stripped naked and different methods of torture are used on them: electrical, sexual, psychological. Often the torture begins with beating which brings on physical exhaustion. This is followed by psychological torture in the form of threats, isolation, being made to listen to the screams of others and watch the people they love tortured.

In the beginning, we wondered which was worse — to be hung, electrically tortured or beaten up. Now we know better. Regardless of the method used, torture is a perverted way of getting victims to break down. There is a myth that one can resist torture. So persons being tortured try very hard to resist. And when they finally sign the white paper or give names wanted by the torturers, they break down and feel so humiliated. They become absorbed in guilt over giving in.

Having steeped ourselves in the study of torture over the last decades, we have built the confidence to sit down with intelligent poeple, professionals and poli-

ticians all over the world. They listen to us although we are not very smart politically because we are good doctors and our analyses are based on scientific knowledge. The respondents of our countless interviews have had no reason to lie. Their claim that torturers are perverted has been supported by medical observations. In our discussions, we do not expose countries as a general rule; we did that only once. There are many organizations like Amnesty International who expose countries where torture is prevalent. As professionals we expose the phenomenon of torture.

But what do we present to other professionals and politicians? Basically, we tell them that the victim is humiliated in psychological torture. Putting them in the shoes of the victim, we say: You are treated like a dog and can never forget that humiliation. After the physical torture, the body becomes a mirror of what you have been exposed to. Anxiety and depression settle in. You feel you are a different person. You used to be strong; now you feel weak. You have nightmares and headaches; you cannot concentrate; you have loss of memory, shame and guilt; you cannot sleep.

The intent of political torture is to break down the personality and destroy the identity of strong persons.

The intent of political torture is to break down the personality and destroy the identity of strong persons. Political torture is inflicted on strong individuals: politicians, student leaders, union leaders, leaders of ethnic minorities. After torture most of them are unable to do what they had been doing before. They become broken or feel they are broken.

Torture is painful. Victims are unprepared, totally defenseless and often blindfolded. I don't like to go to the dentist because I am afraid of the pain. But

after treatment I know the pain will stop. But in torture, one experiences both physical and psychological pain. The pain is acute and chronic. The victim does not know when it will stop, adding to his or her psychological pain.

Torture is an effective instrument of power in the hands of government agents.

Those in power know this. This is exactly what they intend to do. Torture is an effective instrument of power in the hands of government agents. Our definition of government-sanctioned torture is: torture performed with the knowledge of government, responsibility is accepted by government; it is initiated by and often institutionalized by government. As a form of institutionalized violence, government-sanctioned torture undermines democratic processes.

In the beginning, we did not know that as doctors we could assist torture victims beyond giving them consolation or relief. Now we have all this research and project demonstrations related to torture methods, to therapy and so on. By means of humanitarian work, we now have valid, scientific results to back our talks with government and other relevant groups.

Our inspiration in this work is Leo Eitinger, the father of victimology. Originally from Czechoslovakia, he escaped just before WWII to Norway. A Jew, he was taken by the Nazi to Auschwitz where he was tortured. Later, he helped the other prisoners. He went back to Norway and led the movement after the war. He did very important research on the concentration camp victims. Leo Eitinger has always been a leader for us, a spiritual force.

We have established a documentation center in Copenhagen. We have 24,000 items concerning torture. We have also managed to create a budget line of

about $6 million in the European Union specifically for the rehabilitation of torture victims. This is rather small and we are working very hard to generate more funds. We have also made a survey of how much money we need worldwide.

It is not just the torture victim who suffers. The whole family also anguishes. We consider this in our center, where we offer several therapeutic approaches to holistic healing: psychological, social, legal, spiritual, and cultural.

It is very important not to assume that the patient has a premorbid psychopathology. We are working with so many models: couples therapy, family therapy, individual child therapy, group therapy and so on. There are also counseling models. Moreover, there are many centers and initiatives from all over the world. We have contacts with 143 countries and the group is still growing.

I conclude with a poem written by one of the most courageous doctors in this work, Juan Almendras from Honduras:

It is not just the torture victim who suffers. The whole family also anguishes.

When the morning dew is born
the smile sleeps in the oppressed body
of those that cry in the silence of torture,
they nail the scars on the map of suffering
mutilating bodies, humiliating the spirit,
and annihilating thought,
they killed dreams and paralyzed emotions
the technique of terror imprison the silence
the morning dew will be born again
the new conscience will come
peace, justice and happiness
because there will not be torture someday.

I also wish to end with the words of the late Senator Jose W. Diokno of the Philippines.

> *"We will struggle on, no matter how long it takes or what it costs until we establish a just community of free men and women in our land, deciding together, working and striving together, but also singing, dancing, laughing and loving together."* □

Torture and Health Profession: The Thai Perspective

VITHOON EUNGPRBHANTHA

TORTURE is illegal in civilized society. Yet not everyone is aware that it is a form of human rights violation.

Torture may be classified in six categories:

1. *Common Crime*: Battery, homicide, kidnapping and sexual assault are all forms of torture.

2. *Women and child abuse*: This is an offense in many countries but it is differentiated from common crimes because of its characteristic of concealment in the family.

Dr. Vithoon Eungprbhantha is a diplomate of the Thai Board in Forensic Medicine and adviser of the Health Law.

The perpetrators are usually closely related to the victim and in some instances they are protected by familial law. A special program is needed to identify and abate the incidence of this type of torture in the community.

3. *Discrimination*: This occurs practically in all parts of the world among different groups of people. Torture may arise because of social structures and cultural practices or traditions that give rise to discrimination based on class, nationality, race, caste, ethnicity, religion, age, gender and disabilities.

4. *Abuse of power or authority*: Large-scale corruption in the governmental administrations and in the law-enforcement agencies is common in many countries, particularly in Asia.

In some countries, the law imposes severe and brutal punishment on the offender, such as the death penalty.

Corruption spawns abuse of power and denial of the basic rights of the citizen. Abuse of power in high places can bring about armed conflict within a country. Abuse of power among law-enforcement agencies may engender the criminalisation of the authorities. This is seen in instances wherein high-ranking officers support the criminal against society rather than society against the criminal. This is another category of torture associated with human rights abuse.

5. *Severe and brutal punishment by law*: In some countries, the law imposes severe and brutal punishment on the offender, such as the death penalty. Amnesty International has declared such punishment as cruel, inhuman and degrading and violative of the right to life.

Some states have laws which enable government agencies to detain any citizen without trial for an

unlimited length of time in the name of national or state security. Such act should also be in this category of torture.

6. *Torture in warfare*: This is a special category of torture which takes place in an area under military control in war time. The soldier who commits torture against a civilian or an enemy soldier violates International Humanitarian Laws (Geneva Conventions) and should be prosecuted as a war criminal.

The private health care institutions are mostly run by public companies with a business orientation.

Perspective from Thailand

Following are some observations derived from my experiences with torture in Thailand:

1. *Inadequate legal safeguard.* I have found many defects in the criminal justice system of this country which denies protection and help to the victim of torture in Category 1 (common crime). The main defects are in three areas:

- *In the medico-legal service system.* Set up 60 years ago by the Code of Criminal Procedure, Thailand's medico-legal service system has seen little change. It has become incompatible with the health care service system which, during the last two decades, has far developed particularly in the private sector.

The private health care institutions are mostly run by public companies with a business orientation. Thus they provide services for a fee, even in the medico-legal service. Under the old concept of law and practice, the physician in a public hospital provided medico-legal service gratis and the law-enforcement agencies did not pay any fee.

But today, when the victim of criminal torture goes to a private hospital to seek treatment of physical and mental injury, the doctor doing the medico-legal service for the law-enforcement agencies — who issues the medical certification on the injury — cannot charge his service fee to the government. So the victim ends up paying the fee. The public sector does not provide medico-legal service. Is this fair to the victim?

Another medico-legal service is the post-mortem inquest in case of unnatural death. In Thailand, the post-mortem inquest is the responsibility of the police officer and the chief provincial public health officer (usually a medical doctor) or any doctor in the staff of any hospital. If neither of the latter two is available the local public health officer or "district doctor" should take over. Because of his many administrative duties, the chief provincial public health officer cannot always be available to perform post-mortem inquest. But so far no staff of any hospital has been appointed to do this function.

The public sector does not provide medico-legal service. Is this fair to the victim?

Consequently, most cases of post-mortem inquest are carried out by a police officer without autopsy because he is often assisted by someone who is not a medical doctor. The legal autopsy services are provided by the Institute of Forensic Medicine of the Police Department in Bangkok and by some medical schools' Department of Forensic Medicine. But the medical schools have limited capabilities in this work. Moreover, all services are rendered free of charge.

This situation does not provide incentive to young doctors to go into forensic pathology practice. Thus, the serious shortage of qualified forensic pathologists impacts on the quality of post-mortem inquest services.

In the period between 1987 and 1992 about eight percent of bodies autopsied at the Siriraj Medical School were not identified. The Institute of Forensic Medicine announced on television news sometime ago that the number of unidentified bodies brought to its laboratory for legal autopsy are increasing yearly.

In the period between 1987 and 1992 about eight percent of bodies autopsied at the Siriraj Medical School were not identified.

The quality of medico-legal service should reflect on the efficiency of human rights protection in the country. But the system needs urgent reforms.

- *In the law-enforcement agencies.* A study on the incidence of sexual assault shows that the number of victims of such crime attended to at a hospital in Bangkok was much higher than that of cases of such crime brought to court at a given time. That means only a small percentage of sexual assault cases are brought to trial and most of the perpetrators are not arrested.

What accounts for this? One of the non-government organization (NGOs) which have provided legal and moral support to the female victims of sexual assaults for many years, the Friends of Women Foundation, has found that the most significant factor which bar legal action in such cases is that the maltreatment comes from all levels of the law-enforcement agencies themselves.

Let me summarize how the victims were treated along the process of legal action.

The maltreatment begins when the victim-complainant is subjected to questioning at the police station. She cannot be protected from public humiliation; her right to privacy is usually violated. The rude

and insensitive method of police investigation injures the victim's feeling. The police investigators usually take the attitude that the crime is not so serious, and they persuade or pressure the victim to settle the matter out of court.

In the next step the victim is taken to the health care institution for physical examination and collection of biological evidence from her body. She is handled by health professionals in the same way as they regard patients in general, without any psychological and moral support. I have studied many reports of rape trauma syndrome from the medical literature, but I have yet to come across a case report in Thailand even as the incidence of such crime is rather high. This clearly reflects the low degree of awareness of psychological trauma of women among health care professionals in this country.

The police investigators usually take the attitude that the crime is not so serious, and they persuade or pressure the victim to settle the matter out of court.

The last step is when the victim is brought to court to testify for the prosecution. She must confront directly the perpetrator and his lawyer and has to be cross-examined by the accused's lawyer, who often poses nasty and contemptuous questions.

The following statement of one rape victim published in a newspaper reflects the depth of her anguish.

> *"Every time you leave court you feel half dead; you get hammered flat by the pain and humiliation... I don't understand why we have to be subjected to this when all we are trying to get is justice."*

Which explains why most victims of sexual assault shun complaining to the police, or if they have

done so, some withdraw the complaint and desist from further legal action.

About 12 years ago many countries, led by the United Kingdom, took cognizance of the human rights abuses on sex crime victims and introduced changes in practice of police investigation of rape cases. Today, the Thai Police Department has begun using female police officers to handle such cases in some police stations in Bangkok. But this is still a pilot project, a response to the pressures from many NGOs for change.

Today, the Thai Police Department has begun using female police officers to handle rape cases in some police stations in Bangkok.

However I believe that the crime of sexual assault cannot be combatted without reforming the law-enforcement agencies of the country.

- *Legal loopholes.* The Thai legal system is very similar to that prevailing in Europe. This is because we have many codes — civil and commercial code, civil procedural code, penal code — and criminal procedural system with the same inquisitorial style as those in Europe. For instance, the Thai prosecutorial system has been influenced by the English way brought over by lawyers who graduate from English law schools.

The traditional practice in court, particularly for criminal trial, has followed the English style even if we have no jury. That has caused confusion among young lawyers in today's practice. The trial of individual criminal cases consumes so much time before a decision is handed down. There are many loopholes in Thai law practice. To demonstrate, let me tell you the story of a man who may be the most unlucky person in the world.

This poor man was arrested and prosecuted, together with other men, for the murder of a young woman. The accused were kept in jail for many years during the trial. Then the court of first instance convicted them to many years of imprisonment, and the appeals court upheld their conviction. However, the appeals court offered to grant them temporary release if they could put up the required cash bond. All, except our poor man, were able to comply with the requirement and were released. Our man was kept in jail for six to seven year before the Supreme Court cleared all the accused of the crime. Alas, our man had died in jail months before the final decision was issued.

He died an innocent man. His family got into financial trouble but received no compensation from the state or any government agency. Soon after, the eyewitness to the crime was arrested and charged in court with perjury. Pleading guilty before the judge, he revealed that the police had guided him in his perjured testimony.

The battered-child syndrome is a form of child abuse that is diagnosed by a health professional — a pediatrician or pediatric psychiatrist.

In this century this should be an unbelievable story. But it is a true story exposed in the newspapers at the beginning of 1996. It was called the Sherri-Ann Case. Sherri-Ann is the name of the slain young woman.

2. *Women and child abuse.* Child abuse in Thailand is not uncommon. There are many forms of torture in this category. The battered-child syndrome is a form of child abuse that is usually diagnosed by a health professional — a pediatrician or pediatric psychiatrist. The child suffers from severe punishment of any kind. Trying to seek legal action to protect the victim usually proves

futile. Many NGOs, such as the Children Foundation, provide help and rehabilitation for children who are victims of this type of torture. There are plenty of reports in the media about child abuse. In the newspaper "Krungtep Thurakit" (25 September 1996) I found this advertisement:

"Stop and think a while before inflicting harm on your children.
"Severe punishment makes children fly away from home.
"They will be the victims of rape.
"They will be homeless.
"They will become drug addicts.
"They will become criminals and be executed.
Whose mistake will this be?"

In Northern Thailand the girls are brought by their parents to sex business agencies.

The advertisement which needs no further explanation was put up by the Centre for Protecting the Children's Rights. It clearly reflects the situation at the present time.

The other form of child abuse is sexual abuse. In Northern Thailand the girls are brought by their parents to sex business agencies. They later become prostitutes.

The most serious form of child abuse is child killing. Some months ago the public was shocked by the terrible news on the headlines of many newspapers in Bangkok. A five-year-old girl was found dead in the toilet of a school in Bangkok. She had been raped and strangled. A few days later the suspect was arrested, a young reformed drug addict who had been released from prison a week before. On TV, he looked confused and agitated. In court he pleaded guilty and was sentenced to die. The case is on appeal.

Women abuse is also common in Thai society. Most women coming from the low socio-economic class often become victims of abuse by their husbands. The police usually do not take any legal action against the husband.

Some months ago a newspaper in Bangkok reported a serious case of battered-wife syndrome. This is how the case came about:

Most women coming from the low socio-economic class often become victims of abuse by their husbands. The police usually do not take any legal action against the husband.

A young wife fled her house at night with the help of a friend. She sought help because her husband had threatened to kill her. She had suffered from her husband's brutalities for many months after their marriage and could not take the physical and psychological violence anymore. She wanted a divorce. Evidence of the brutalities were found on her body, such as bruises and traces of cigarettee burns.

Before she fled she had been detained in the house and threatened with a pistol by her husband, she had to do whatever he wanted. Pistol in hand, her husband forced her to walk completely nude to the nearest grocery store to buy medicine for him. He walked behind her and warned anyone not to intervene. An eyewitness reported to the police. Although a policeman came, he did nothing but took down notes of the event. Incidentally, the husband's father is a general in the Thai army.

The Friends of Women Foundation was called to help. Other NGOs concerned with women's rights gave support. They brought the victim before the premier and the head of the police department. They filed a complaint with the police, and legal action is now being pursued.

The victim in this case requires physical and psychological treatment and a long period of rehabilitation. The perpetrator probably suffers from mental disorder. Unfortunately, there is no mental health law in Thailand.

The abuse of power by the governments in the past have led to some terrible situations.

3. *Discrimination.* Luckily, in Thailand there is no obvious discrimination as regards nationality, ethnicity, age and gender. Discrimination has not caused torture in Thai society.

4. *Abuse of power.* The abuse of power by the governments in the past had led to some terrible situations. The last one is known worldwide as the Bloody May Events - the events of May 17-20, 1992. The *Physician for Human Rights* and *Asia Watch* had published a full report of the event. The losses in that episode are: more than 40 persons killed, many hundreds injured and some disabled, and some suffered mental shock which required long- term psychiatric treatment. Around 60 persons disappeared.

The abuse of power by high-ranking military officers and politicians persist and many serious crimes often involve government authorities.

5. *Death penalty.* Even if the death penalty remains in the penal code and the courts have meted the capital punishment on many criminals, only few were executed in the last decade; most have had their sentences commuted.

6. *Torture in warfare.* Not having served in the army, I have not encountered torture in this category. I only hope this region is at peace and the prospect of torture dim. □



"A keen awareness of and sensitivity to human rights violations, particularly torture, among health professionals would go a long way in ensuring that the rights and dignity of every individual are protected and upheld."

Paulynn P. Sicam

Objectives of the Seminar

JUNE PAGADUAN LOPEZ

The UPCIDS-PST program: evolution and history

Let me give you a background of how we came to organize this seminar. The Psychosocial Trauma (PST) is a subprogram under the larger Peace, Conflict Resolution and Human Rights Program which is one of several programs being run by the Center for Integrative and Development Studies (CIDS) of the University of the Philippines. At CIDS multidisciplinary teams produce research materials that aim to shed light on issues of national concern.

Dr. June Pagaduan Lopez is associate professor of psychiatry and the program director of the Psychosocial, Trauma, and Human Rights Program of the University of the Philippines.

How we came together as a group of health professionals, mostly physicians, is an interesting story. In 1972, martial law was declared in the Philippines. No less than 20,000 people became victims of illegal detention and disappearances. As physicians, we could not close our eyes to what was happening to our country. Needing to find a meaningful role in the political situation, we joined other sectors – religious, workers, students, peasants and others. We formed a group called the Medical Action Group. Through MAG we expressed our opposition to the abuse of human rights and organized assistance to the survivors of torture in a more systematic and effective way.

One of the most courageous opposition leaders, a symbol of the human rights struggle in our country, was the late Jose W. Diokno, a former senator who was himself tortured and detained for years by Marcos. In 1983, accidentally but very fortuitously, Senator Diokno met Dr. Inge Genefke in Geneva and learned about the latter's program for teaching physicians about the treatment and rehabilitation of torture survivors. Thru the help of the United Nation's Voluntary Fund for Victims of Torture (UNVFVT) four of us were able to attend the first International Seminar on the Rehabilitation of Torture Victims and their Family in Copenhagen.

As physicians, we could not close our eyes to what was happening to our country.

Objectives of the program

The UP-CIDS Psychosocial Trauma and Human Rights Program undertakes policy-relevant research on the level of direct victims and survivors as well as communities exposed to armed conflicts.

We also aim to review and revise our medical curriculum, as well as the curricula of relevant disciplines. We have started to examine the curriculum of our University's medical school to serve as a model on how human rights education can be integrated into the medical curriculum. This task is facilitated by a presidential order requiring the school system at different levels to include the teaching of human rights.

Our program explores and assesses a range of interventions for caregivers, communities and individual survivors. We try to look for interventions that are appropriate to our culture and that utilize the limited resources of our country and communities. Our background as NGO workers allows us to accomplish these objectives because our research unit is able to work closely with development and community workers.

Our program explores and assesses a range of interventions for caregivers, communities and individual survivors.

We publish reports on psychosocial trauma and human rights in the Philippines including a quarterly journal that highlights our research and related activities. We hope that the quarterly will be a venue for publishing the results of the scientific investigations of our international colleagues. The Program also produced a book on caring for torture survivors, based on the proceedings of a meeting held in Tagaytay City, Philippines in 1994.

One of our goals is to organize workshops and conferences on issues and policies pertinent to psychosocial trauma and human rights. And this we do locally as well as internationally. These are important venues for giving back what we have learned after 13 years of working in collaboration with such organizations as the IRCT, the UNVFVT, the Physicians for Human Rights (PHR),

British Medical Association (BMA) and the American Association for the Advancement of Science (AAAS). The curriculum we put together that will be pilot tested and subjected to critique in this seminar is one of the products of our work with colleagues in these organizations.

We also aim to set up a data base and a library of materials, information, research and statistics. In addition, we hope to continue publishing the highlights of our research in the major newspapers and advocate their incorporation into the policy making process.

We try to look for interventions that are appropriate to our culture and that utilize the limited resources of our country and communities.

Finally, the idea for this seminar was inspired by the findings of our study on the Knowledge, Attitudes and Practices of Physicians Regarding Torture conducted two years ago among Filipino physicians. We discovered that there was generally:

1. Low awareness of torture;

2. Low awareness of the existence of universal standards and the professional code of conduct concerning torture; and

3. Poor attitudes (in the general population of health professionals) on human rights and torture.

These findings prompted us to organize human rights courses because we think it is critical to educate health professionals, about their ethical duty to protect anyone from harm as well as to refrain from participating directly and indirectly in the practice of torture.

Objectives of the seminar

We hope to attain the following objectives in this seminar:

1. To create an awareness of and sensitivity to the existence of torture in the Asian region among health professionals;

2. To disseminate information on international humanitarian law regarding the prohibition of torture and ethical responsibilities of health professionals, in the detection of torture, and in the care for survivors of torture; and

3. To initiate the creation of a network of caregivers in the area who will document the incidence of torture and treat survivors, exchange data and experiences with their colleagues in the region, and advocate for the complete eradication of torture in their respective countries. □

We hope to continue publishing the highlights of our researche- and advocate their incorporation into the policy making process.

Concept, Content, and Process

PAULYNN P. SICAM
AND JUNE PAGADUAN LOPEZ

Concept

The promotion of human rights education is a growing concern in the Asian region where most countries have just begun to awaken to the universality and indivisibility of human rights. However, the awareness of basic rights and freedoms and the organizational and professional skills needed to pursue and protect these rights are still quite new to activists in the area.

Ms. Paulynn P. Sicam is a former commissioner of the Philippine Commission on Human Rights and a columnist of The Manila Times. **June Pagaduan Lopez** is the director of the Psychosocial Trauma (PST) of the University of the Philippines.

Even less aware of human rights and its connection to their work are those in the health service sector, made up of doctors, nurses, social workers, psychologists, and other caregivers. Yet, the health sector is a key area in human rights advocacy. A keen awareness of and sensitivity to human rights violations, particularly torture in its various forms, among health professionals would go a long way in ensuring that the rights and dignity of every individual are protected and upheld.

A comprehensive education program in human rights, medical ethics and torture, and training in treatment and rehabilitation for Asian health professionals was therefore drawn up by the Psychosocial Trauma and Human Rights Program (PST) of the University of the Philippines' Center for Integrative and Development Studies (UP-CIDS) and presented to various international agencies for possible funding. Called "A Human Rights Education Program for Health Professionals in the Asian Region," it was envisioned as an intensive five-day course for people who are already involved in the work or are willing to start a program of treatment, rehabilitation and research for torture survivors.

As envisioned, the program would provide a forum for the exchange of ideas on the ethical responsibilities of medical and other health practitioners vis-a-vis the incidence, practice and participation of health workers in torture and the care of torture survivors.

Such awareness, knowledge and skills must be developed among health professionals especially in those countries where torture is still employed

in a casual or covert manner in the course of counter-insurgency and/or law enforcement operations, or in situations of ethnic strife and other situations of armed conflict.

The human rights education program would be implemented for health workers in so-called "cutting edge" areas in the Asian region, where no centers or programs exist for the treatment of torture survivors.

Assumptions

The organizers proceeded on the assumption that there is very little professional expertise in the region on the care and treatment of torture survivors. A lot of the caregiving which exists is spontaneously given by bleeding heart advocates, and growing more out of the crying need of the moment rather than the availability of trained professionals. And the very few centers in the Region notably in Nepal, India and the Philippines are far from making any real in roads in the critical areas where torture remains a an overt or covert practice of the state dealing with criminality or dissent.

The PST program decided that it would be important to train health personnel who are already doing the work of caregivers. The focus would be on imparting skills, knowledge and attitudes to direct caregivers, not administrators of programs for the care of torture survivors. The organizers wanted an intensive sharing of experiences, an exchange of ideas and the surfacing of the issues commonly encountered by field workers. Although the participants were not expected to have had eminent training in handling torture survivors, they were expected

to have had sufficient experience to share in the discussion groups.

The organizers therefore did not plan the seminar to be a traditional teaching seminar. The participants were supposed to learn from their own experiences and from one another. It was hoped that at the end of the seminar, lessons learned in actual practice would be integrated into a theoretical framework. Resource persons were there merely to give theoretical and cognitive handles to a practice that has, of necessity, been purely intuitive.

Selection of participants

The PST's NGO partners in the region were asked to recommend participants to the seminar who fit the criteria. There were also individuals who applied, on their own. But to aid in the selection, each applicant was asked to respond to the question: "Why should I be in this seminar?"

The responses were revealing. Most of the applicants were not only caregivers of trauma victims and survivors; they were themselves survivors of violence and torture. The responses also confirmed the assumption that many caregivers felt that they lacked the necessary skills to perform their work well.

Twenty-seven applicants from 10 countries were chosen to participate in the program. Of these, 10 were residents of the Cambodian Mental Health Training Program, the only doctors in training to become psychiatrists in Cambodia where professionals, including mental health personnel, had been routinely hounded and/or killed by the Khmer Rouge.

Eight applicants were professionals working with survivors of trauma due to violence coming from the Indian sub-continent: Sri Lanka, India, Nepal and Bangladesh. Two Bhutanese refugees working with other refugees in camps in Nepal were also selected to participate.

Also chosen were three doctors doing research on medical ethics from the School of Basic Medicine of the Peking Union Medical College in Beijing; two Australian nurses working with bar girls in Thailand; a psychologist working with children in Indonesia; and a family practitioner from New Zealand who works with refugees.

Of these 27 chosen applicants 22 actually participated for the training seminar on October 2 to 5, 1996 in Bangkok, Thailand.

Selection of venue

The seminar was held at the Student Christian Center in Bangkok. The Center is a quiet oasis lined with ancient trees and profusely decorated with orchids in full bloom, in the center of downtown Bangkok. The participants slept in comfortable rooms, and ate generous home-cooked meals in the Center's dining hall. The seminar sessions were held in the main hall of the Center. Airy and comfortable meeting rooms were made available for small group meetings and workshops.

The choice of a quiet, low-key and unassuming venue was a conscious one. The serenity and privacy that the Student Christian Center accorded gave reverence to the highly personal and painful process that the participants and the resource persons were about to undertake.

Just as deliberate was the choice of Bangkok as the venue for this important seminar. In the whole of Southeast Asia, Thailand is probably the most politically neutral place with regard to human rights advocacy work. Although the Philippines enjoys wide latitude in pursuing sensitive political matters such as human rights, this is not always appreciated by its Asian neighbors who feel threatened or confined by what they perceive to be the Filipinos' aggressive stance on the matter. Hence, it was important to choose a place where participants and their own organizations would not feel intimidated one way or the other, either by the state of development of human rights advocacy or the official intolerance to it.

Program design

The seminar was designed as a five-day workshop which would combine historical, theoretical and technical information with hands-on, experiential and inter-active learning.

The short but interesting history of international efforts on the prevention of torture would be described to provide the participants a perspective on the work already done.

The theoretical background would consist of lectures on the role of health professionals in the promotion of human rights, the phenomenon known as torture, the international covenants and conventions regarding torture, and guidelines for monitoring prison standards.

The technical aspects would cover the detection of physical and psychological trauma in tor-

ture victims, the use of forensics in medico-legal investigations of torture cases, and the ethical issues regarding the involvement of health professionals in torture.

Torture and other forms of violence against women and children would be included to reflect an important concern of the PST Program.

The practical applications would be tackled in the final module on caring for torture survivors, caring for caregivers, and research and documentation of torture cases.

The lectures

Dr. June Pagaduan Lopez introduced the projects of the University of the Philippines' Psychosocial Trauma program while Professor Erik Holst, vice president of the International Rehabilitation Council for Torture Victims (IRCT) and Dr. Inge Genefke, medical director of RCT discussed the development of the IRCT network. Dr. Bent Sorensen, also of the IRCT network, reviewed the evolution of international covenants and conventions on the eradication of torture and other forms of cruelty.

To provide the theoretical underpinnings of the seminar, the organizers tapped the network of experts from the IRCT.

Dr. Genefke, gave an introductory lecture on "Torture Today," to acquaint the participants with the lay of the land. How does torture happen? Who are its victims? Who are the perpetrators? Where does torture happen? What are the means by which human beings express man's inhumanity to man?

Dr. Sorensen introduced the provisions of the United Nations Convention Against Torture and Other Forms of Cruel, Innuman and Degrading Punishment, which was passed in the General Assembly by consensus in 1984, and the work of the UN Committee Against Torture in ensuring that countries that have ratified the Convention follow its provisions. He also mentioned the Vienna Declaration of 1992, the UN Convention on the Rights of the Child, and the Council of Europe's Convention for the Prevention of Torture as sources of pertinent international standards and provisions prohibiting torture.

Dr. Sorensen also made a presentation on guidelines that health professionals should follow for monitoring prisons: the physical layout of a prison, the services it provides, and the tell-tale signs of maltreatment of inmates that one should watch out for.

Professor Holst lectured on the role of health professionals in promoting human rights. He zeroed in on the challenges facing the World Medical Association and the various national medical associations regarding torture.

On the second day, participants were given the technical information needed to be effective in the detection and treatment of torture in survivors. Dr. Veli Lok of the Human Rights Foundation of Turkey gave an academic and scientific presentation on the detection and management of the physical sequelae of torture while Dr. Bhogendra Sharma of the Center of Victims of Torture-Nepal tackled the same topic, but from the point of view of a field-based professional who runs a community center.

A paper on the application of forensic science to human rights investigations, written by Dr. Robert Kirshner, director of the International Forensic Program of the US-based Physicians for Human Rights, and Kari Hannibal, Membership and Education Coordinator, of Physicians for Human Rights, was delivered by Professor Richard Pierre Claude. Physicians for Human Rights has done pioneering work in the use of the science of forensics to detect the use of torture on victims of human rights violations.

Dr. Fleur Fisher represented the British Medical Association (BMA) as a mainstream organization that has pioneered in advocating for the ethical responsibilities of health professionals in relation to torture. She discussed the BMA's experience in the protection of health professionals who uphold human rights as well as the persecution of those who violate it.

The psychological sequelae of torture, its assessment and management, was the subject of the first lecture of Dr. Lopez. She highlighted the development of psychological symptoms based on the primary intention of torture to maim the individual not only physically but most of all psychologically. She also outlined the basic principles of post-traumatic therapy as it applies to survivors of torture.

A study of children victims of violence, including torture, was the subject of the paper of Prof. Elizabeth Protacio-Marcelino, Ph.D., research director of the UP-CIDS PST program . She presented the highlights of two recent PST researche on children in situations of armed conflict which were also the Philippine's contribution to the UN multi-country study on children and war.

Rebecca Gaddi, program coordinator of the PST program, presented a study in progress on Filipino women victims of torture. The value of Gaddi's paper was not in its conclusions, because it is still a work in progress, but in the issues it poses regarding the uniqueness of the experience of the female torture survivor. With the dearth of materials on women victims, it is only now that the question is raised whether or not there are gender issues in the rehabilitation of torture survivors.

A talk on children in prostitution by Amihan Abueva, executive secretary of End Child Prostitution in Asian Tourism (an organizing partner of the workshop) raised the relevance of the issue of commercial sex and violence to children. Although child prostitution does not involve state violence, per se, it promotes institutional violence which, like domestic violence, has become a sad phenomenon in Asia.

The holistic approach in caring for survivors was the subject of the presentation by Palesa Mahlangu, a member of the IRCT council from South Africa. She introduced the concept of university-based community programs set up by NGOs heavily dependent on trained but non-professional manpower as an approach to the care of victims and survivors of state violence. Although based on the South African experience, Palesa Mahlangu's presentation was relevant to the Asian setting, particularly in her ability to simplify complex psychological concepts and to communicate these to laymen.

Caring for caregivers, or how to take care of one's own emotional and psychological needs while caring for the emotional and psychological needs of others

was tackled by Dr. Lopez. To model a framework for self analysis Dr. Lopez shared her evolution as an activist, as a health professional and as a caregiver. She emphasized to the participants the importance of being grounded and rooted while caring for their clients lest they may suffer early burnout and become victims themselves.

The lecture on research issues in the care of torture survivors: ethics and methodology, were included in the program. Delivered by Dr. Lopez, the discussion emphasized the importance of research and documentation in this area of work, and encouraged the participants to embark on such projects even with limited resources and expertise.

The workshops

In order to facilitate dialogue and participation, the participants were divided into three workshop groups. Aided by facilitators, safe in the company of sympathetic peers, they were encouraged, in the first workshop session, to talk about the socio-political conditions and human rights situations in their own countries. They were also given the opportunity to share their experiences, views and opinions on their own exposure to victims and survivors of torture and other forms of political violence. In the process, the participants were able to look at the involvement and roles played by local health professionals in helping the victims and survivors of such violence.

The second, third and fourth workshop sessions were integrated in the last day of the seminar. Two other workshops were held. Both sought to surface the problems, needs and priorities of torture survivors and identify possible responses and solu-

tions to these problems. The participants were also asked to recommend strategies, resources and activities that should be included in a plan of action for caregivers in the Asian region. This action plan became the output of these final workshops. (See **Appendix B** for the workshop guidelines)

Qigong

Anticipating the difficulties that the participants would encounter during the seminar as they recalled and examined their work as caregivers, the organizers invited Master Li Jun Feng, a Manila-based *tai chi* and *qigong* teacher from Beijing to introduce the seminar participants to *qigong*, a system of mental and physical exercises that helps the practitioner return to a state of tranquility and wholeness.

Under the expert guidance of Master Li, participants met each morning with an hour of meditation and movement exercises. And every evening, at the end of the last session, mentally and emotionally exhausted caregivers unwound to the proddings of the Master to regain their equanimity.

Socials and rituals

The program was kicked off by a welcome dinner for the participants and resource persons at the nearby Asia hotel, with Dr. Vithoon Eungprabhant of Mahidol University as guest speaker. A cultural show by young Thai students capped the evening.

A cultural night was held on the evening of the second day. Every one was required to wear

something native to his or her own country and every delegation was asked to prepare a native dance or song. What transpired was a riotous evening of community singing and dancing as participants released their pent-up emotions, unleashed by the heavy topics and discussions of the first two days.

The end of the conference was marked by another party, a farewell dinner in the traditional Thai manner, and a ritual - a candle-lighting ceremony which captured the spirit of the seminar, and the commitment of the participants to carry and pass on the light of knowledge, practice and commitment in the service of the most unfortunate of their brethren.

Evolution of the seminar

It is an accepted fact that it is necessary to give first time participants in a seminar adequate grounding in the basic theoretical and practical knowledge about the subject. Lectures defining terms and describing processes, as well as discussions of the international instruments that have been drawn up to protect people from torture and promote their human rights are important inputs which give the participants a firm theoretical handle on the nature of their work.

However, as the conference progressed, it became clear that the balance had to be maintained between the objective, theoretical and technical information and the expressed need of the participants to address the issues related to their own concrete, subjective experiences. Too much of one would frustrate the participants' need for the other.

As early as the first day, it became evident that some of the participants were themselves victims of violence and survivors of torture. In Cambodia, for example, hardly anyone could escape the harshness of forced labor in the work camps where all Cambodians had to serve during the Pol Pot regime. There, young boys and girls saw their weaker relatives die of starvation and torture.

Another issue that emerged was the participants' lack of confidence in their own skills as caregivers. They entered the work out of necessity - somebody had to do it - often without benefit of formal training. There was also a lack of professional and material support for their efforts. The participants spoke of the need to feel safe in their work, to be free from harassment and threat of bodily harm, arrest and detention. They needed professional support from their counterparts abroad, especially in the more developed countries, by way of scholarships, training programs, exchange of materials and expertise. They also needed political support for their work. However, the participants stressed that this had to be orchestrated with them by foreign support groups and calibrated so as not to put in further jeopardy those that such advocacy intended to protect.

They also expressed the need to be less alone in their work, to have the opportunity to process their own experiences with the help of their peers.They longed for training in listening and facilitating skills, to elevate the quality of their organizations and the services that they deliver to their clientele. The participants also spoke of the need for recognition in a job that is so thankless, very few want to get into it.

Mostly, they spoke of early burnout, which is common among workers in the demanding and stressful work of caregiving.

It was in recognition of these issues, and the desire of the participants to process them, that the organizers decided to restructure the conference after the second day. They decided to be less formal and structured, use less classroom type lectures in favor of a more process-oriented approach. In response to the issues raised, the session on caregiving and rehabilitation was extended, and less time was given to research, which seemed to be the least of their interests. Due to the language problem (many participants had inadequate command of English) and perhaps for reasons of security, many of the participants were more comfortable sharing in intimate small group discussions than in plenary sessions. Thus, more time was set aside for workshops, and participants were encouraged to process one another in private. The facilitators also made time for private consultations for participants who felt an urgent need to process.

What started out as a standard seminar dominated by lectures and note-taking became a highly interactive, complex, draining, often painful but ultimately cathartic experience for the participants, resource persons and facilitators.

Problems encountered

Although the PST program has been active in the training of caregivers among health professionals in the Philippines, this was its first experience in mounting a holistic seminar for health professionals in the Asian region. The organizers came away with valu-

able lessons learned, to be applied in future seminars of this kind.

In the course of the seminar, it became clear that while the program carried all of the issues pertinent to the subject of torture survivors and caregivers, there was a need to redistribute the emphasis of the meeting. Most of the participants came not only to learn theories and techniques, but to unburden themselves of the stress of their chosen careers, with and among their peers.

While the invitation stated that English would be the language of the seminar, not many of the participants were comfortable with it. In order to impart the necessary basic knowledge, there was a need to speak to the participants in their own language. Likewise, it would have been easier to process their personal and professional concerns if the therapists and facilitators spoke the same language.

The participants came from countries with varying degrees of tolerance for advocates of human rights and the eradication of torture. This made it difficult for them to express their true opinions and feelings in a public venue like a seminar which was intermittently covered by the international media.

Conclusions and recommendations on future program design

Future seminars of the PST will take the lessons learned in the Bangkok seminar into account. The following changes will therefore be effected:

1. A more thorough needs assessment survey must be conducted in order to anticipate the problems that arise in the course of the seminar.

2. Creative and participative teaching techniques will be developed and utilized to impart the theoretical and technical aspects of the subject of torture and human rights.

3. More time will be provided to process the issues that arise in the course of the seminar.

4. Regional training seminars will be conducted among linguistically homogenous groups and translators will be hired.

5. For the protection of the participants, future seminars will be closed to the public, unless it is necessary, also for the protection of the participants and organizers, to invite the media. □

Part 3

Laws, Legal Policies, and Procedures

"The biggest step forward was the Convention Against Torture and Other Forms of Cruel, Inhuman and Degrading Treatment and Punishment, passed by the United Nations General Assembly in 1984. This has become our Constitution."

Prof. Bent Sorensen

Monitoring of Prisons

BENT SORENSEN

ACCORDING to the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,* each state party shall keep under systematic review interrogation rules, instructions and practices as well as arrangements for the custody and treatment of persons subjected to any form of arrest, detention and imprisonment. This monitoring should be done by impartial organizations such as medical associations.

Dr. Bent Sorensen is a professor of surgery and special rapporteur of the UN Committee Against Torture and a member of the European Committee for the Prevention of Torture (CPT).

What do we look for when we inspect or monitor prisons? We look for signs of torture and inhuman or degrading treatment.

Torture is not the same as inhuman or degrading treatment. In most countries, in peace time, torture is hidden whereas inhuman and degrading punishment happens in the open. Torture occurs in police stations while inhuman or degrading treatment occurs in prison. Almost all states deny torture, but some are proud of it.

In September 1996, the representative of the United Kingdom, Michael Hubbard, advocated a more austere prison regime. I know the prison system in the UK; if it is made just a little more austere than it already is, conditions there would become inhuman or degrading. As for torture, they try to make excuses for it. We fear terrorism, they would say. On the other hand, the frequent excuse for inhuman or degrading treatment is budgetary. "We don t have money," they would say.

The frequent excuse for inhuman or degrading treatment is budgetary. "We don't have money."

How do we find inhuman and degrading treatment? We find it by simple inspection, by using your ears and eyes when you are inspecting. But first, you must be sure of your mandate. You must have a group and you must have given notice to the person you want to see. You are allowed to see all of the premises. First of all, when you go to the prison, you must determine whether it is old, ill-repaired. Nearly all prisons in the UK were built in 1849.

Then you look at the dormitory or the cells. Examine the lights, the ventilation. Is there a hole in the roof? Are there no windows, no light? What about the beddings and furniture. You compute the number of prisoners per square meter. You compare the number of bunk beds with the number of persons. There should be space for each prisoner to keep his/her belongings.

Sanitation is extremely important. Count the toilets. Are they what you call BCs or Asian toilets? How clean are they? You should compare the prisoners' toilet with the toilet for the prison guards. That is a good epidemiological system: You should always compare.

It is equally important that the prisoners can wash themselves, their utensils and clothes. Examine the washing area, the shower area and the area for washing clothes. Count the number of showers and compare this with the number of prisoners. And what about privacy? Can you have a shower in privacy? Or are there prisoners coming and looking at you when you do it? How about access to it, maintenance and sanitation? □

International Covenants and International Humanitarian Law

BENT SORENSEN

DR. Inge Genefke has already explained the 1948 Universal Declaration of Human Rights. Article 5 of that Declaration says, "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment." This article has proven to be vital and it has been invoked often.

Dr. Bent Sorensen is a professor of surgery and special rapporteur of the UN Committee Against Torture. He is also a member of the European Committee for the Prevention of Torture (CPT).

Torture remains a reality

After the Second World War, nobody thought torture would occur again. But torture remains a reality,

hence the number of declarations against it in recent years. The biggest step forward was the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, passed by the United Nations General Assembly in 1984. This has become our Constitution.

Torture is not a popular concern. It took three years before 20 countries ratified this declaration. Article I defines torture as severe pain or suffering, psychological or mental, inflicted intentionally on a person by a public official. Our concern is government-sanctioned torture, not torture that takes place in situations of domestic violence or civil wars. The definition of torture could be broader but this Convention was written between 1979 and 1983 when conditions were very different. We had then an East-West problem, a North-South problem and these problems account for the limitations.

The role of the UN committee against torture

Articles 4 to 16 of the Convention describe the duties of the state. These include educating people about torture, rehabilitating victims, punishing perpetrators, and reporting cases to the Committee Against Torture (CAT).

The state is obliged to ensure that a detainee is interrogated correctly

The Convention states that the torturer should be punished regardless of where he has committed the torture. Torturers are outlawed. It is the duty of the state to punish them and to report them to the CAT.

The Committee consists of 10 experts, selected from various countries for their competence and high moral standards, who represent not states but themselves. It has three duties. The first is to receive

reports from states. When a state ratifies this Convention, it has to write a report about how it has implemented it in its domestic law and in practice. The report is sent to the Committee which, together with the delegation, discusses the report in a public meeting, makes some suggestions, and sends it back to the state concerned. The report is included in the annual report sent to the Secretary General. So the whole world will know what is happening in this country. The idea is to make torture a popular concern.

We go by the three M's: moral rehabilitation, money for compensation, and medical rehabilitation.

The Committee examines the situation in countries and sees to it that the provisions of the Declaration are upheld, including Article 2 which states that no torture is allowed and there is no excuse for torture whatsoever. An order is no excuse.

How did we carry out our work in Guatemala? First we said to Guatemala, "There is torture in your country." Their answer: "No, those reports are lies, fabrications, fantasies, deliberate misinformation. We have ratified the UN Convention. Naturally we have no torture." Then we showed the picture of a street child burned with cigarettes by a policeman. We know his name, the date it happened and where it happened. The reply: "This is not torture. It is moderate physical pressure, a special procedure, a kind of third degree. It is not torture."

Denial of torture

Then we showed them the picture of a street child whose hair was glued together. The glue was very difficult to remove because it was solid glue. "What do you call this?," we asked. "Well, it is not torture," they replied. "It is necessary. We fight terrorism to preserve national security. We are collecting intelli-

gence reports and extracting a confession." And we countered: "What? This is a street child! Was she a terrorist? They burned out her eyes, raped her and beat her to death!"

When is torture a necessity? Read our answer very slowly. There is no excuse for torture whatsoever.

Reports like this are more effective when they are made public. In 1991, a British BBC television crew covered our documentation of torture cases in Northern Ireland. We counted 30 to 40 torture incidents in a month. After the BBC report came out, the number went down to 10.

Another provision we want to strictly enforce is Article 3, which says no state party shall expel, return, or extradite to another state a person who is in danger of being subjected to torture. This is especially relevant to European countries and some Asian countries. What it means is that an asylum seeker or a murderer who has been sentenced cannot be sent back to the country of origin if there is a strong possibility that he or she will be subjected to torture.

For sure, it is not the duty of the doctor to certify that someone is fit for flogging.

Paragraph 2 of this Article says that in such cases we should ascertain a consistent pattern of gross, flagrant violation of human rights. We can do this with the assistance of Amnesty International and Human Rights Watch. Article 2 allows a person to report such a violation of the Convention by a country only if that country has ratified the Convention.

Education on torture prohibition

Another special concern is Article 10, which says that each state party shall ensure that education and information regarding the prohibition against torture

is fully included in the training of law enforcement personnel, whether civil or military, and of medical personnel, public officials and other persons who may be involved in the custody, interrogation or treatment of any individual subjected to any form of arrest, detention, or imprisonment.

In a South American country, more than a hundred anaesthesiologists participated in torture.

In this regard, we make special mention of torture and doctors at risk. For instance, we have a slide that shows a doctor overseeing a Pakistani being given a foot massage as treatment. He was there to ensure that the treatment was done correctly. Just before the massage, the person had been flogged in the city square. He had a microphone pinned on his body so everybody could hear him screaming. And that same doctor signed a medical certificate about the victim's capacity to endure torture. The doctor looked on during the torture session and whenever he saw the victim fainting and bleeding, he would say, " Stop, we have to treat him." Then they waited for two weeks to begin another torture session.

For sure, it is not the duty of the doctor to certify that someone is fit for flogging. According to the Hippocratic Oath and other statements of medical ethics, no one is fit for flogging. It is not the doctor's duty to see whether a person can stand punishment.

Medical professionals become part of torture

But there are doctors who continue to be involved in torture. In a South American country, more than a hundred anaesthesiologists participated in torture. Because of this, after the restoration of civil government many people did not dare go to the hospitals for fear of running into their former torturers.

Another evidence of doctors being implicated in torture is an x-ray of a skull with a two-inch nail imbedded in it. The victim died two days after the x-ray was taken and the cause of death was reported as meningitis. It happened in the Philippines: a doctor falsified the death certificate.

Yet another significant provision of the Covenant is Article 11, which says each state party shall keep under systematic review interrogation rules, instructions, methods of practice as well as the arrangements and custody of persons subjected to any form of arrest and detention or imprisonment in any territory or jurisdiction. In short, the state is obliged to ensure that a detainee is interrogated correctly.

We also have the U.N. Convention on the Rights of the Child which was adopted in 1989, signed in January 1990, and enforced a few months later. This constitutes the biggest success in U.N. history. By the end of May, it had been ratified by 187 States. It is very easy to see which countries did not ratify it: Cook Island, Somalia, Switzerland, United Arab Emirates and USA.

The state is obliged to ensure that a detainee is interrogated correctly.

Corporal punishment prohibited

What has the Committee on Torture got to do with children? Article 1 of the Declaration specifically refers to the problem of corporal punishment. It prohibits corporal punishment even between parents and children (although the latter is not within our mandate). We often deal with street children. Article 3 deals with asylum seekers, most of them children. We also deal with armed conflict in Article 22 and we know children suffer in armed conflicts. We are rather specific about children when we talk about torture.

What does the Committee on the Rights of the Child (CRC) say about torture? Very little. Article 57 says no child shall be subjected to torture or to cruel, degrading or inhuman treatment or punishment. Again the focus is on punishment. And their concern is street children, children in education programs, asylum seekers, child soldiers.

We go by the three Ms: moral rehabilitation, money for compensation, and medical rehabilitation.

We try to remedy the insufficient reference to torture in the Convention by means of a meeting between the CAT and the CRC. The CAT meets twice a year. When we deal with Article 14 - rehabilitation - we go by the three M's: moral rehabilitation, money for compensation, and medical rehabilitation.

Also, we in the Council of Europe have the Convention for the Prevention of Torture (CPT), started in November 1989, with a representative from each country. The members should be of high moral standard, competent, independent, impartial - and available. The last is a serious requirement: I had to resign as Professor of Surgery to be considered available. What do we do? We send delegations to countries. We have the most wide-ranging mandate.

Our targets are all persons deprived of their liberty. We visit police stations, asylums, camps, mental hospitals. We are allowed to go in, periodically, with or without notice. Or we may talk in private with anybody we want to talk with. We look at premises, papers. We write a report and send it to the government concerned. We suggest improvements. The work is based on the two Cs — cooperation and confidentiality.

We are concerned only with prevention. We have nothing to do with punishment. There is no condem-

nation of the country, no public meeting. Everything is confidential but we tell the state in a meeting with them, "This situation is dangerous; stop it." And the good news is, they follow our advice.

You should not duplicate this effort. The U.N. Committee Against Torture has its definition of torture. In Europe we have none. We set our own threshold. What constitutes inhuman or degrading punishment varies from country to country. If we are in Sweden, we expect everybody to have a clean towel. In East Turkey, we don't expect that. In short, we should set our own threshold. □

Excerpts of the Open Forum

Claude: Who can file a report? Can you compare the CAT and the European Union? Who has the ability or standing to file a report?

Sorensen: Anyone may file a report with the CAT. In the European system, you can appeal to the Court. In both cases you should file the report from the country where you are accused. And you should have exhausted all the domestic remedies. You can appeal on behalf of yourself, or a lawyer or an NGO can do it in your behalf, but in no case should the appeal be filed anonymously. All reports are kept confidential so you need not be afraid to name names. The procedure is easy to follow; you may file through the fax.

Rasalingam: I have two questions. The first has to do with the case of Guatemala. How is it possible for your group to go to that country and get their state department to stop denying torture? The second question is: Isn't the forced repatriation of asylum seekers or refugees being done mainly by European countries, including Denmark and Norway? What tool is there to stop that?

Sorensen: With regard to the first question, there are two Committees, the UN and the European. In the CAT in Geneva under the U.N., there are special rules about going into a country. We followed this sys-

tem once in Turkey and it was very difficult. We couldn't inspect. In the Council of Europe, on the other hand, this is a big thing now. All 39 member states, among them Russia and the former colonies, are represented round the clock in all zones. It is a duty to go into a country and inspect. So that is the difference. We have to, we are obliged to do it and we go everywhere.

As for the second question, yes, it is mostly Western countries — not only Europe but also Canada — which are engaged in the forced repatriation of refugees. But if you explain the condition the CAT will deal with it. How can we do that? We have a system of rapporteurs. The report is published, with or without the name of the complainant. So the situation is publicized.

Claude: There is a strong statement on the punishment for torturers in the U.N. Declaration. How do you differentiate between this punishment and torture?

Sorensen: Not all punishment is torture. A torturer can be fined or sent to jail. And we do not say a torturer should be kept in isolation. Torturers should have a fair trial and fair punishment.

Lopez: I just want to test your system in this case. We have a real situation where we have a 15-year old girl, an overseas contract worker, convicted in Saudi Arabia for killing an employer who raped her. The punishment was supposed to be the death sentence but this was commuted to 100 lashings, with a physician attending, because of the intervention of the Philippine government. To be honest, we have not done anything about it. What could have been done under the CAT system?

Sorensen: Sadly, nothing. According to the definition of torture in Article I, severe pain and suffering arising from lawful sanctions is not covered by the Convention. This is a sad reality but had we insisted on its inclusion many countries would not have signed the Convention or would have voted against it. So we can't do anything. Some people tell us we should now try to change this state of affairs. I am not one of them. I think we can do a lot of important things with the Convention as it is and we should do that instead of spending 10 years to change four lines which will give us much more to do.

Kali: In Iraq, radioactive substances were used against some people. After two days of interrogation, they would say to the victim, "Thank you, you said everything we need. Now goodbye. Would you like to drink something?" The person would accept and they would offer him a traditional drink, yogurt with water, with radioactive thadium or strodium mixed in it. After 10 days, the victim would start to feel pain and after two days, he is dead.

About five or six such cases have been referred to our center. An Amnesty International mission composed of foreign doctors found this radioactive substance in the bones of the deceased. We are collaborating with our University in Athens to start this kind of examination to find something. Another case, also from Iraq, involves the filming of all kinds of torture — torture of children, torture and rape of women, different kinds. They put the person in one small room with a television and he is tortured. Afterwards he has to sign everything. Another method of torture is the use of virtual reality. This method leaves no signs, no scars, nothing.

Genefke: I think it is very important for us to know all these things and these methods of torture that would show no physical signs. We should be aware that they want to create psychological problems for the victims. And we should be prepared to go to the trials and say that we know now after many years of work that there are psychological problems after torture. We now have in the World Psychiatric Association a special session on psychiatry and torture. We have decided to create a panel of esteemed psychiatrists who know about torture worldwide and who are ready to attend trials as witnesses for the victims.

It is a sad and historical fact that torturers are never punished. You go to Latin American countries, you go to African countries, and this is the case. I am sure you know about the Truth and Reconciliation Committee which has been established by the South African government. There has been widespread torture in that country but it is very difficult to punish the torturers. I think we have to concern ourselves with this. In Chile, there are many torturers who remain unpunished. We have been treating Latin American victims who go back and meet the torturers in the street. They write to us about it.

Meeting your torturer has different effects on people. We have to talk about and relate to this problem. I think we need to find some very well known torturers and, following the Convention Against Torture, put them on trial and judge them. I think that is one aspect of prevention. They tried to do that in Holland when Pinochet went there. The attempt was very effective in making dictators realize at least that there will be a lot about human rights violations and they don't like this talk.

Lopez: I think part of our discusion is describing a relatively new phenomenon related to armed conflict in developing or third world countries: the phenomenon of young soldiers, teenagers, adolescents who are involved in inflicting torture especially in ethnic conflicts. In my country, there was an unfortunate incident in the underground movement involving very young individuals as torturers. They were put in the revolutionary army at a young age and in a situation where they could not but participate in torture. This is a sad phenomenon that should be studied.

The problem is not simple. The creation of a torturer is complicated. Our answer after an inchoate understanding of their mindsets and how they developed is the education of the miltary and police as enlightened by the value system of those who perpetuate torture. It is not simply a matter of letting them know the Conventions, of letting them know they can be punished.

Sorensen: That is a very difficult problem. Also, there are countries where torture is being used systematically and where it is widespread; you find all policemen using torture. And you wonder how that can happen. Quite ordinary family fathers, nice persons become torturers. They rationalize torture in this way: the persons being tortured are not human beings. They are called "damned communists" who blow up supermarkets, who kill friends, daughters, wives of policemen, etc. They are not considered human beings. □

The Role of Health Professionals in Promoting Human Rights

ERIK HOLST

I HAVE been asked to talk about a very broad subject: the role of health professionals in promoting human rights. Because I am a medical professional and my experience comes from the medical profession, most of what I will say will have a medical background.

I find it natural to start with the Nuremberg Trials. Next year is the 50th anniversary of the trials in Nuremberg where the human rights abuses of medical doctors in the Nazi concentration camps were revealed.

Prof. Erik Holst is the vice-president of the International Rehabilitation Council for Torture Victims in Denmark and a professor of social medicine.

The revelation shocked the world's medical profession. While the Nuremberg Trials were about human experimentation and not torture, what we heard there was terrible. Doctors were involved in clinical medical science, in experiments on how much cold people can stand, on the kind of medicine to be given to people to be infected with deadly diseases, and so on. We thought there were only a few doctors. But now we know that medical workers in other countries have taken part in terrible atrocities. This has not been documented. For instance, we still have to know the truth about what happened in the Japanese concentration camps.

The medical association began putting its act together after the war. The Geneva Declaration, made in 1964 by the World Medical Association, says that doctors should maintain utmost respect for human life even under threat, and they should not use their medical knowledge in ways contrary to the laws of humanity.

No one should be subjected to medical or scientific experimentation without his or her free consent.

When the United Nations elaborated the U.N. Declaration of Human Rights in the International Covenant on Civil and Political Rights in 1966, they reiterated the question of torture. It was affirmed that no one should be subjected to torture. Equally significant, no one should be subjected to medical or scientific experimentation without his or her free consent.

Even at this time, cruel medical experimentation and torture were intertwined in people's mind. The World Medical Association in Helsinki laid down guiding principles for medical research involving human beings in 1968. These were revised in Tokyo in 1975 to include provisions for stronger protection of patients in human experiments. At that meet-

ing my esteemed colleague Dr. Fleur Fisher articulated her concern for the ethical dilemmas and challenges to doctors at risk of becoming directly or indirectly involved in torture. This was when the medical professionals finally got a grip on the issue and tried to deal with it. Dr. Bent Sorensen then forwarded a definition of torture, a clear definition, that is broader than the U.N. definition in that it does not exclude legal punishment.

Even at this time cruel medical experimentation and torture were intertwined in people's minds.

Nonetheless, the narrow concern for human experimentation persisted until 1994 when Jonathan Man, who used to be the "Czar of AIDS", led the first international conference on health and human rights. Although this was not the first gathering on human rights (many of which have been organized by IRCT, for example), it was probably the first international conference where all aspects of health and human rights were discussed and human rights was recognized as an essential pre-condition for physical and mental health. Jonathan Man talked about health and human rights, a new paradigm for medicine. With this first international conference the concern shifted from organs to the whole human body, from diagnosis to therapy, from physical function to social function.

Dr. Fisher will deal with the topic of preventing doctors from getting involved in human rights violations as part of their ethical commitment. I will give some examples of the medical promotion of human rights in situations of torture, based on what I have learned over the past six years in my association with Dr. Inge Genefke and her campaign on behalf of torture victims.

The World Medical Association has authored many resolutions on health and human rights. Our colleagues

in the Indian Medical Association, for example, have taken up the challenge to members of the medical profession aware of human rights violations. Medical Associations in fact have a vital role to play in calling attention to such violations in their respective countries. The World Medical Association charges the national Medical Associations with these tasks:

1. Review the situation in their own countries to ensure that violations are not concealed by anyone for fear of reprisal from responsible authorities;

2. Give clear ethical advice to doctors, especially those working in prison systems;

3. Provide an effective machinery for investigating unethical practices by physicians in the field of human rights;

4. Protest alleged human rights violations through communications that urge the humane treatment of prisoners and seek immediate release of those who are imprisoned without just cause; and

The World Medical Association has authored many resolutions on health and human rights.

5. Support individual physicians who call attention to human rights violations in their own countries.

We now turn to the initiatives which we started in Copenhagen to help provide support for torture victims. We are working in the International Rehabilitation Center for Torture Victims (IRCT), whose first headquarters was in Copenhagen. It was a national initiative that became international in scope.

The IRCT's mission is to assitst torture survivors and their families; support research in all aspects of torture; support the training and education of health professionals and other relevant professions

on the medical, legal, and ethical aspect of torture; accumulate and disseminate information about torture and the possibility of rehabilitating persons who have been tortured; and support national and international initiatives and agencies engaged in preventing torture.

The IRCT's mission is to support torture survivors and their families

The early centers—those in Europe and North America—dealt with refugees who were tortured in their home countries. In Copenhagen the center receive victims of torture from Latin America. The center in Minneapolis, Minnesota (USA) was established very early on, recently celebrating its tenth anniversary. Holland has several centers. Australia, which receives large numbers of refugees from oppressive regimes, also has centers.

In the Philippines, work in this area started even before the end of the Marcos dictatorship and some of our colleagues there have focused specially on children. They have also started to move out of the big towns and are beginning to serve the outlying districts. We were shown a slide of the building that now house the university-based Philippine team engaged in research development.

Although Chile is another country that was under a dictatorship, it became possible at one point to offer services to victims of torture. In Pakistan where human rights violations and torture are endemic, it also became possible to start centers in Islamabad and Lahore. At the end of November, we will go there to conduct a seminar on the medical aspects of torture.We hope this will lead to the setting up of services in Karachi where the need is very acute.

In Nepal, the center is in Kathmandu but Dr. Sharma is serving many patients in refugee camps.

We also started work in Bangladesh but it has been difficult to get things moving there. We are glad to know that some of their doctors are present here; maybe we will see further development in that country after this seminar.

This (showing slide) is the center of Berlin, which became a focal point for dealing with refugees not only from East Germany but also from Yugoslavia. It used to be a hospital so it is not as homelike as some of the others. The center in Moscow started even before the democratization over there.

But when there is a dictatorship, instances of torture are rarely reported. When democratic conditions are restored, that is when thousands of victims come forward. This is one of the problems we have to explain to politicians. In Chile, for example, although democracy has come back, we have to spend a lot of money on rehabilitating torture victims. But the politicians are beginning to get the message.

When there is a dictatorship, instances of torture are rarely reported.

We have centers in Romania, Albania, and Zimbabwe. When apartheid ended in South Africa, it became possible to set up centers and to try to deal with victims who had not been served in the past. This is Capetown (showing slide). There are also activities in the townships. Another center is in Johannesburg. There is one in Nairobi, Kenya, as well as in Uganda where Idi Amin provided some of the worst examples of physical torture we have come across.

This (showing slide) is the most recent center in Adana, in southeastern Turkey. It is the fourth center opened in Turkey. Kuwait needed a center after being occupied by Saddam Hussein for six months. And

a center was set up in Gaza after the Palestinian authorities took over. We have been told that the production of victims of torture is still going on down there even under the new system. So liberation does not necessarily lead to the abolition of torture.

Liberation does not necessarily lead to the abolition of torture.

There is also a new center in Peru where the doctors, nurses and therapists have to work in very difficult circumstances because they have to toe a very fine line between the Shining Path [guerrilla organization] and the government: if a doctor helps torture victims, he is likely to be incriminated by the other side.

Here (slide) is a message written by our friends in Paris, written by Dr. Helene Jaffe. At their center, there is a poster that states: *a little kindness never hurt anybody.* One of the questions we are confronted with is: how can treatment be used in the fight against torture? We are often asked: why do we not prevent torture but only repair the damage it inflicts? We say: this is the normal way of medicine. We look at the patients, try to help them as well as we can, try to understand what the disease is, and to deal with it in a rational way. No wonder only one or two doctors deal with prevention while the rest deal with what we have not been able to prevent.

But these were criticisms in the early years. More recently, we have begun to be appreciated better because we provide the strongest documentation of torture. How can we provide this documentation without hurting our patients? I think it is important that we offer utmost confidentiality. If they have the slightest doubt that what they are telling us will end up in the official files, then we might as well forget about any form of communication. We must observe strict confidentiality. As a former teacher once told

me in medicine you are nor allowed to use your patient as a bulldozer, even if you have a marvelous example to prove a point in changing the system. Your first concern is the patient and she or he should not be used as a battering ram.

In the fight against torture, medical statistics constitute a formidable weapon. They have credibility whereas other types are sometimes considered lies. For example, our report that more than 3,000 clients were received at the centers in Turkey was acepted. Now the Turkish government has stopped denying the existence of torture in their country. Although they are trying to silence the source of information.

In the fight against torture, our weapon is documentation. Doctors should be systematic in their documentation and, without breaking confidentiality, supply these to those who are fighting against repressive regimes. The role of organized medicine—medical councils, associations, forensic medicine—is to collect this evidence and somehow channel it in a way that will not incriminate the doctors supplying the information and reveal the identity of the victim. Building up this kind of information system is very important.

Your first concern is the patient and she or he should not be used as a battering ram.

Over the last two and a half years, the Indian Medical Association has courageously embarked on a major information program. To our great pleasure, they have been joined by the National Commission for Human Rights in India (NCHRI). In a training course like this one, the Chairman of NCHRI personally appealed to doctors to report within 24 hours any death in detention. Failure to do so will mean an attempt to cover up the crime. He explained that unless doctors supply him with this information,

he cannot act. He also promised to authorize doctors who would be willing to visit prisons in the various districts, upon their nomination by the Indian Medical Association.

Human rights violations include more than government-sanctioned torture. There is domestic violence, urban violence, criminal violence, internal and international armed conflicts. Health professionals have a role to play in each of these and I believe they are ready to act. But if they are to be motivated to take action, first they have to be made aware of the problems. □

Excerpts of the Open Forum

Holst: In many countries NGOs have access to prison. In so-called democratic countries, you always have access and NGOs are allowed to go in. In Chile where there has been a lot of torture, people can go inside prisons. You have to try to force this issue (of being given access) but it also depends on the tradition in your country.

Irwanto: I would like to ask Dr. Erik Holst to clarify what he said about having worked with the medical association of Indonesia. I know the medical association in Indonesia is not an effective professional group; it has not paid any attention to the many medical malpractices in my country.

Holst: I believe that you can make the medical professionals do many things if you explain the facts clearly and tell them it is their duty to do something about it. I think this is a global phenomenon. We have been criticized by philosophically-minded people who say doctors only want to do something while we have to do the thinking. If you want to appeal to the thinking of the medical profession, you have to sound convincing. If they have the slightest doubt that you are just trying to sell them a message or some kind of ideological thinking, they will be very suspicious. If you show them a broken leg they know what to do. They will do it and they will sometimes do it even under threat. But maybe not if they are alone.

When we interacted with the Indian Medical Association it was an experiment because there were no records of the treatment of torture in India. We believed there were a lot of problems there. Everybody was talking about Kashmir but somehow we felt that the Indian situation was more closed, especially for people coming from Western Europe or America. India did not want external influence.

We were surprised that the Indian Medical Association had enough guts to face this challenge. They had been writing about this as early as 10 years ago but admitted not doing anything about it. When we first discussed the issue of torture with them, they admitted it was a big problem with seriuos consequences. But, they pointed out, people in India are dying of hunger. "Why is hunger a bigger problem than torture?", we countered. The Indians agreed that it was a problem big enough to deal with so they started putting their engines into gear. They developed training courses and a correspondence course for people who want to be counselors or who want to render assistance to torture victims.

The Association is planning a manual for prison visitors. They are working closely with the National Commission for Human Rights. They introduced this debate in the Asian forum, in the Confederation of Medical Associations of Asia and India. We spoke in front of all these medical associations. As a result, we are now going to Indonesia in the beginning of December. We are going to try to produce the same effects in their association.

What kind of people are right for this task? Are they the doctors who are activists? Would it not be

more effective if all doctors were to recognize the problem and acknowledge that they have a responsibility to support the few who are actually working with victims of torture? This is my philosophy. If the medical and legal faculty of a university starts accepting a thesis documenting death in detention as a legitimate scientific work, even if it is politically not very welcome, other doctors may start doing this kind of work?

I would say this is a long shot. But for us in Copenhagen even to dream about moving the problem of torture this much in Asia was also a very long shot. Now we are here, you are here, and the same thing will happen in December in Indonesia and in Pakistan at the end of November. Each time we convince people that this is legitimate and some of them will take the torch and go farther, we move farther away from a situation we thought was extremely difficult to change. □

Ethical Issues on the Health Professionals' Involvement in Torture

FLEUR FISHER

BESIDES my present clinical work at the Center for Rehabilitation of Torture Victims, I have also worked for the British Medical Association (BMA), which has 110,000 members, about 80 percent of the doctors in the United Kingdom. The doctors are from every specialty, every level, from students to consultants.

The BMA has recognized and promoted the responsibility of doctors regarding human rights and we make it our responsibility to expose the human rights abuses resulting from medical work. One of the primary roles of our medical association is the prevention of torture.

Dr. Fleur Fisher is the head of Ethics, Science, and Information Division of the British Medical Association.

First of all, what does society expect from doctors? Medical ethics are universal, spanning all cultures - transcending cultural differences. Doctors are expected to abide by them. Thus, we need to start with a few questions: What is the link between human rights and medical ethics? What are the duties of a professional association, particularly of a medical and a nursing association?

Changes in the doctor-patient relationship

The BMA has recognized that the doctor-patient relationship in the West has changed. It has changed from that of paternalism where the doctors know best to one which I think can most reasonably be described as a partnership. Our patients — however we come in contact with them, whether in a catastrophe or post-torture, illness, stress, or damage — tell us all about their lives. They tell us their experiences and what they hold dear and important. Hopefully, we keep ourselves up to date on the scientific aspect of medicine of epidemiology, investigation, and the methods of treatment. Hopefully, we keep up to date with the benefits or risks of the different approaches for a particular patient. But at the end it is the patient who knows what really helps. We can see that in the way that the doctor-patient relationship has changed. It has empowered the patients all over the world.

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Principles of the partnership

The ethics of that partnership has three important principles which are not always easy to ensure in different societies.

Informed consent. The patients should know and understand what is going to happen to them and they give their consent, which includes agreeing that im-

portant facts about them be known by the personal doctor. This means consent for research, for treatment, and for investigation. Not to obtain their consent is considered an assault.

Confidentiality. This is a fundamental precept in medical ethics from their beginning in Greece. Whatever data the patient shares with the doctor during the consultation will only be shared, distributed, or discussed with others with the permission of the patient. I will just note briefly how worrisome this is in our times, now that we have information on computers and networks. We should be particularly careful with inputs on patients subjected to torture because those systems can be accessed easily by anyone who is computer-literate.

Medical ethics involve our duties to other people, particularly our duties to our patients as individuals.

Respecting autonomy. This is on respecting the individuality of the patient and respect for justice and human rights.

For more than 10 years, the BMA has taken a lot of interest in upholding these principles, such as for example in the way that medical schools have been misused. At worst, society's laws are violated as well as the rights of individual patients. One way to protect our doctors is by conducting big letter-writing campaigns. If doctors are arrested without proper charge, if they are put in prison without charge, if they are not treated for their illnesses, we mobilize human rights organizations like IRCT and the Amnesty International to write to all sorts of influential people - the ambassador of our country, the head of state, the head of the prison service, etc.

Medical ethics involves our duties to other people, particularly our duties to our patients as individuals.

In this regard, we should be familiar with the Declaration of Helsinki for the World Medical Association, even if not all of the National Medical Associations around the world are bound by it. The Declaration upholds that above all else should be the protection of the patient's welfare – and we should hammer that into our heads. Thus, medical schools cannot be used in any way that is damaging to the patients.

Medical ethics prohibits the participation of doctors in torture

The Tokyo Declaration, on the other hand, states that doctors shall not countenance, condone, or take part in torture. It is a gross breach of medical ethics to contribute to torture.

I stress that we must not take part in torture, we must not agree that the patient is fit to be flogged, and we must not take part in designing methods for torture.

Medical ethics may be violated in different ways, even if doctors are not directly involved in torture. In countries where torture is officially sanctioned, doctors may have to sign a form saying that their patient is fit to receive physical punishment. He may approve that a patient is ready to be flogged. That is obviously a breach of medical ethics and of the responsibility to the patient.

In Israel, Horamamaton and other doctors started the Physicians Human Rights Group between Palestine and Israel. Two years ago, they uncovered a form which doctors signed. It stated that a Palestinian prisoner was fit for a particular form of physical punishment. That form did not officially exist but it had a strong political impact. It is very important that we know about these issues. I stress that we must not take part in torture, we

must not agree that the patient is fit to be flogged, and we must not take part in designing methods for torture.

Abuses against patients

What usually happens in Great Britain and in other societies is that we are aware of torture or human rights abuses but we do not say anything about it. For instance, I managed a big unit of a mental handicapped hospital, community services, and a pediatric unit for six years. One thing that I discovered while walking around one day is that the women patients being given a bath during Sunday afternoons were hosed down by male nurses – and this was in Great Britain! That was torture, an abuse of human rights on dignity. That is a small issue but we have to keep our eyes open in ensuring the dignity and human rights of our patients.

It is not medically truthful to say that the patient died of meningitis while he obviously had a nail knocked through his skull.

Veli Lok has made clear that in military repression or in a repressive regime, as in Turkey, it is only too common that forensic pathology or investigation reports are not accurate. For instance, postmortem reports are not reasonable and are dishonest. It is not medically truthful to say that the patient died of meningitis while he obviously had a nail knocked through his skull.

Medical ethics is part of human rights

We are looking at medical ethics as a very specialized subset of human rights. The key to the element of our work in the BMA is trying to educate the doctors in medical ethics and to help them in the moral analysis of the patient. So that as doctors their actions reflect the respect for the individual which is the core of human rights and medical ethics.

That is why about 10 years ago, we started looking at the grossest cases of violations of the rules and disrespect for medical ethics and human rights. For example, in 1986 we started to set up a working party. We heard what was happening in South America. Our investigations produced torture reports and it identified doctors – people that society thought they could trust – taking part in torture. It shocked the British doctors and the public. Following that we received all sorts of letters, visits, fax, and phone calls. Doctors from around the world who were concerned and aware of the involvement of doctors in torture contacted us because they did not know who to talk to, report what they know, and find support.

The international community of physicians should reiterate their stand that doctors have basic ethical principles, the most basic is that we should not damage our patients.

In 1992, we published another book called **Medicine Betrayed**. The main conclusion of the report is doctors do and still take part in torture in some countries. We felt that the most important and effective prevention of this involvement of doctors in torture is to *educate them in the principles of medical ethics, require the promotion of medical ethics, and give real support to individual doctors.*

Recently, a senior doctor came to me one morning and said she had a friend, an Iraqi doctor, who received a phone call from Jordan. It was from a doctor in the Iraqi army and he actually used all of his family's savings to cross the border to Jordan. He reported that doctors in the army were refusing to amputate the hands and feet of soldiers who deserted. When the deserters are caught, the doctors are expected to maim them.

Doctors can be tools of a repressive state

The doctors in the Iraqi army want and need international support. The international community of

physicians should reiterate their stand that doctors have basic ethical principles, the most basic of which is that we should not damage our patients. Particularly so, we are liable to violate this primary principle especially if we have patients in closed situation — doctors working in the prison, in the army, or the airforce, where they may be easily forced to break the principles.

We need to highlight the importance of medical ethics and its connection to human rights in the medical curriculum.

One of the conclusions of this report is: if doctors feel that they are in a risky situation of being asked to do things against the doctor-patient relationship, they can call or report to their own medical association. They may also report to the WMA, the International Committee of the Red Cross, the BMA, or the American Association. But we have to recognize that doctors in many countries where torture prevails do not have independent medical associations to run to. They badly need our support.

The need for world solidarity among medical practitioners

In Syria where the medical association run by the repressive government imprisoned doctors without trial for over 15 years.

I was in Israel two years ago with a staff of physicians from human rights groups. The Israeli doctors I was with, a heart specialist, an emergency physician, an emergency surgeon, and an accident surgeon were very emminent. We all felt terrible when we saw who were beaten-up and tortured in prison. We urged the Israeli Medical Association to have a hot-line where doctors could report incidents like this in confidence. It is unfortunate that the Israeli Medical Association was not prepared to do this.

It is important in this work that we band together internationally for mutual protection. This can help

us put pressure on repressive governments and medical colleagues who work with them.

As doctors we have to devise codes and guidelines for the profession. We need to highlight the importance of medical ethics and its connection to human rights in our medical curriculum so that future doctors would better understand the issues. We also need a national medical association to look into what is happening to the legislations in our countries and continue monitoring and lobbying for changes.

We need to set up venues for and systems of international exchange, share expertise, and support associations that are vulnerable to harrassment or any form of violence.

The BMA is a good example of what medical associations can do. With a big membership and sufficient resources, we are able to support a big publicity department that conducts press conferences. Our parliamentary division lobby among the members of parliament. With people monitoring the developments in the parliament, we can make a lot of noise if we think a legislation is not good. We link with other groups, like lawyers groups, church groups etc. For instance, the legislation on people seeking asylum in the UK is still outrageously bad and its amendments have made it worse. We still are not seeing progress on this but at least we have made efforts as doctors in working with other sectors and professionals.

Apart from creating a legislative lobby, the work of the association also includes investigation of complaints against torture and the defence of doctors who acted correctly in blowing the whistle on human rights violations. (Whistleblow means exposing and reporting the violation to the proper authorities.) It is more likely for someone to report anomalies or violations of ethics and human rights to be ignored rather than supported.

We need to set up venues for and systems of international exchange, share expertise, and support associations that are vulnerable to harrassment or any form of violence. It is imperative for us to raise conciousness on abuses on an international level, organize political lobby groups and meet with other medical associations. But what can we do as individual doctors? For physicians like me who are working in hospitals, it is easy to ensure adherence to the medical ethics. In a hospital setting, any maltreatment is due to a doctor's weak sense of medical ethics. But what can we do if we find ourselves in a situation or workplace where human rights abuses seem to be "inherent" - particularly if we are working in a prison?

Sharing detailed information about the patient is not that necessary in police investigation.

In the BMA we did a report on the medical care of individual patients who were held in police stations. We discovered that the medical records were often mixed up with the rest of the records. As such, there is neither privacy nor continuity in the medical records of those held in prison. As a consequence, people were carried roughly even though they had epilepsy or their medication was not properly given because their condition was not adequately recorded.

But even the doctors themselves violate certain ethics. For example, they think that the police should know everything about the patient. Sharing detailed information about the patient is not that necessary in police investigation. The doctor may state that the patient or prisoner is too ill and needs to take medicine at particular times although the diagnosis must be kept confidential.

Doctors are breaking the silence

For doctors in repressive regimes, it is easier to get information from international medical associations

than from their own national organizations. But we have seen that links between national associations are very crucial. What we plan to do now is to have a new publication – five years after the publication of the book *Medicine Betrayed.* We are going to call this one *Changing the Culture of Silence.* It is about what national medical associations should do to protect human rights. We believe that it is easier **not** to say what is wrong – and this even happens in the UK where we are relatively free. There are people who do say what is wrong and we spoke yesterday with Bent Sorensen about the Scottish hospital doctor who reported that a prisoner had been beaten up by the staff and that his wound had not been attended to for several days.

What actually happened was nobody wanted to know or care. What was dreadful was that the doctor was anxious to care for the prisoners, whatever their behavior, background, past, and characteristics. This particular doctor was dismissed. The loss of an ethical doctor in Scotland prisons was a failure of the medical associations as well as everybody else.

The trust worthiness of doctors is even more urgent for those who deal with victims of torture who are trusted with numerous secrets.

The patient's interest as first and foremost

In closed institutions like refugee camps, psychiatric hospitals, children's homes, and vast homes for old people, patients are vulnerable. It is our duty to keep the trust of our patients. The trustworthiness of doctors is even more urgent for those who deal with victims of torture who are trusted with numerous secrets.

We, in the BMA, are very much concerned about computer data that are accessible via the information highway. In England, the patient's pertinent information – the medicine that he

or she takes, the treatment, billing, epidemiology, and plans are all in computerized data bases. Sometimes, the information is tapped for research and other purposes. My question is, "have we obtained this with the patient's consent?"

Information about refugees and victims of torture — even if they are medical in nature — can put people's lives at risk.

Government's stand on privacy

Information about refugees and victims of torture — even if they are medical in nature — can put people's lives at risk. Open access to such information is therefore, dangerous. We have a big fight with government on this issue. They tell us only to inform the patients on who have had access to data about them. As doctors, we argue, on the other hand, that patients must agree first before information about them can be released. This debate is rendered moot by the possibility of obtaining information from existing central databases such as those kept in the UK.

Data gathering can be abused

That is why I am quite convinced that while we are looking at the human rights abuses we should also look into the unacceptable practice of gathering information for research or other purposes. We have to recognize that managing data which identify patients is a critical-system risk-management issue which we have to be very careful about. It may sound wonderful to have everything on computer but we could put patients who are victims of human rights at risk in whatever country they are. We have to be careful about doing this as a matter of routine because it can undermine medical ethics and the relationship between doctor and patient. The information we have about patients can be used either to support state interest or big business, or access and control a group

of patients. Thus, we have to ensure proper ethical guidelines to cover every issue.

In BMA the values we discussed – respect for the patient, confidentiality, upholding dignity and autonomy of the patients – highlight the need to obtain a patient's informed consent before doing anything with data. Our respect for the human experience dictates our adherence to ethical principles and norms even under pressure from repressive political regimes.

For doctors to sustain ethical commitments that may run contrary to dominant political forces, the support of colleagues in a medical association is vital. We must to be able to support these doctors when they report violations. International support particularly helps profesionals in fragile and dangerous situations. It is also important to stress the responsibility of the universal community to support and protect the standards and principles of the doctor-patient relationship because medical ethics is a subset of human rights.

We need to be able to support these doctors when they report violations.

We have to work hard together. Considering the risks in the advanced age of information technology – we badly need to send e-mail messages to each other. This is a tremendous help as we can be in touch much more quickly than we could before. I get a few questions on my e-mail about medical practice but there are people who are apprehensive about raising human rights issues or reporting abuses. But they need not identify themselves, they could just state the country where they are from. By working together and keeping in constant touch, we can change the culture of silence in medicine about the role of doctors in the abuse of human rights. □

Medicolegal Investigations and Torture

ROBERT KIRSHNER AND
KARI HANNIBAL
DELIVERED BY RICHARD PIERRE CLAUDE

DR. Robert Kirshner and Kari Hannibal were unable to attend the seminar because the United Nations has commissioned Physicians for Human Rights, among other groups, to do some extremely important work in the former Yugoslavia. Dr. Kirshner supervises about 50 forensic scientists now working there; Kari Hannibal is the project administrator.

Dr. Robert Kirshner is the director of the International Forensic Program Physicians for Human Rights in the United States while **Kari E. Hannibal** is the membership and education coordinator. The paper was delivered by **Prof. Richard Pierre Claude**, consultant to Human Rights Watch and Physicians for Human Rights.

The Physicians for Human Rights has asked me to bring along several copies of their most recent report entitled *Medicine Under Seige in the Former Yugoslavia.* It is a retrospective report of the tragedies there from 1991 to 1995. The focus is on medical neutrality. This is the hyper-concept that pulls together the norms found under the international laws on human rights, international humanitarian law, and medical ethics. Although this is an area that the ICRC is familiar with, it is frustrating because there is no adequate classification of all the violations falling under the heading "medical neutrality."

Medicine Under Seige in the former Yugoslavia is perhaps the first report to develop a full-scale classification of violations of medical neutrality.

Medicine Under Seige is perhaps the first report to develop a full-scale classification of violations of medical neutrality. This is extremely important because it lays the basis for the next step — the development of a protocol or a checklist for field studies of medical neutrality violations. Copies of the report may be obtained free from Physicians for Human Rights in Boston.

Hannibal and Kirshner's paper, titled "The Application of Forensic Sciences to Human Rights Investigation," begins with three case studies which they believe prove the effectiveness of the forensic sciences.

Forensic evidence establishes the truth

The first case study refers to Argentina. Between 1976 and 1983, thousands of people were arrested by government forces and taken to secret detention centers where they were tortured and killed. The bodies were cremated, dumped and buried as unidentified persons in cemeteries around the country. With the help of independent forensic

experts, a national commission investigated and uncovered the truth about these murders. Forensic evidence was a critical element in the conviction of Argentine military leaders in 1985 for the crimes of murder and kidnapping and many others. There have been a number of references to the impunity with which human rights violators commit their crimes. Such impunity is being questioned in new democracies and, as the Argentina case shows, careful forensic work plays a critical role. It helped the Argentine Supreme Court in reviewing the criminal trials of the members of the previous military junta. The careful documentation of evidence has resulted in some convictions.

Forensic evidence was a critical element in the conviction of Argentine military leaders in 1985 for the crimes of murder and kidnapping and many others.

A second case demonstrating the effectiveness of forensic work in human rights investigations took place in 1981 in El Salvador, in a situation in which women and children from six villages were rounded up and shot by government soldiers. They were buried in a mass grave in El Mozote. For years the government of El Salvador, with diplomatic support from the United States government, denied that this massacre took place despite press reports of the existence of the mass grave. Forensic scientists excavated the grave in 1992 and recovered the remains of at least 143 bodies, 131 of them children under the age of 12.

A third example of this kind of forensic work, sponsored by the Physicians for Human Rights, involved a 35-year old Palestinian prisoner in an Israeli jail who died of a heart attack two weeks after his arrest. The prisoner suffered from an undiagnosed case of arteriosclerosis. He complained to the judge about the beatings he had received during interrogation and showed his inju-

ries in court during a hearing to consider an extension of his detention. The judge ruled that the man could be held for eight more days but had to be examined by a prisoner doctor.

The man died 12 hours later. Before he died, he had been kept for over seven hours in a freezing cold area, his hands cuffed and a sack covered his head. He had also been under interrogation for two hours and forced to exercise. Although he was suffering from symptoms of a heart attack when a paramedic came to visit him, the paramedic did not detect these because he could not conduct any medical tests.

The Palestinians doubted the Israeli investigation and called in an independent forensic pathologist who concluded – contrary to the findings of the Israeli chief medical examiner – that based on external pathology the prisoner had died of a heart attack precipitated by emotional pressure, physical exertion, and freezing temperature. The victim had been forced to remain standing and was not given proper medical care.

The intervention of a forensic specialist can be crucial to winning the trust of victims and their kin and in determining the truth.

Security officials denied that the treatment excluded the court-modelled measures on physical pressures sanctioned by the government. Nonetheless, this case proves that the intervention of a forensic specialist can be crucial to winning the trust of victims and their kin and in determining the truth.

Objectives of forensic science

What are the objectives of forensic science in the service of human rights? The authors of the paper identify four objectives. The first is humanistic: that

is, to confirm to the victims' families the identity of those whom they think are missing and to put their minds to rest about the fate of their loved ones. Forensic scientists can perhaps also provide them an opportunity to make a proper and decent burial.

The second objective is to establish a very solid and empirically-based historical record. "Historical" because we have seen examples over and over again of historical revisionism, an official denial that the situation ever took place. Careful forensic scientific work can reveal the full scope of criminal activity and violations of humanitarian law which forbids the indiscriminate killing of civilians under wartime conditions.

The third objective is the prize we often look for when we talk about the impunity with which violators disregard human rights. This is to develop legally admissible evidence that will result in the conviction of those responsible for crimes associated with human rights violations. Closely related to this is a preventive strategy carrying the message that criminals will not get away with their crime, and that they will have to pay a price.

Closely related to this is a preventive strategy carrying the message that criminals will not get away with their crime.

The fourth objective is deterrence — to forewarn one and all that there are groups and individual medical professionals who watch out for and collect evidence of human rights violations, specifically torture. They can supply sufficient evidence to bring human rights violators to trial some day.

Dr. Kirshner and Hannibal's paper argues that whatever the conditions — whether those illustrated in the secretive village massacre in El

Mozote or the large-scale and substantially organized killings of thousands of Argentines, whether totally public or strictly private – these crimes should be investigated in the same way that criminal homicide is investigated.

Dr. Kirshner and Hannibal also review the recent history of forensic sciences, pointing out that there were not many cases of forensic science serving human rights until 1982 when Amnesty International initiated some work in El Salvador. Then in 1984 the American Association for the Advancement of Science took on substantial responsibility for forensic work in Argentina. The latter persuaded a group called the Minnesotta Human Rights Advocates to initiate discussions about the development of a common set of guidelines that may be used for systematic forensic work.

Local forensic teams such as the one in Guatemala are now doing very sensitive and challenging work.

As a result of this, by 1989 an important document called *The Protocol for Preventing Arbitrary Killings Through Adequate Investigations and Autopsies* was formulated. The general principles for the prevention of death and the conduct of adequate medicolegal investigations were drafted and later adopted by both the UN Economic and Social Council and the General Assembly in 1989. The Minnesotta Protocol and related guidelines are brought together in the United Nation's publication, *Manual on the Effect of Prevention and Investigations of Extra Legal, Arbitrary and Summary Executions.*

Dr. Kirshner and Hannibal mention many places where the forensic sciences have been brought to bear in the service of human rights, among them: Argentina, Libya, Bosnia, Brazil, Chile, Columbia, Croatia, Czekoslovakia, El Salvador,

Ethiopia, Guatemala, Kenya, Kurdistan, Iran, Iraq, Mexico, Panama, Paraguay, the Philippines, Romania, South Korea, Taiwan, Venezuela, and the West Bank in Israel. The authors also talk about the various groups involved in the forensic work and of course they include the local teams.

The determination of cause or manner of death and the detection of signs of torture are particularly important.

South technology transfer

One of the marvelous results of the involvement of the American Association for the Advancement of Science in forensic investigations on the disappeared in Argentina was that, under the new democratic regime of President Alfonsin, an Institute for Forensic Sciences was established. This Institute has been training various other forensic teams, including one in Guatemala. This is an interesting example of what we call South-South technology transfer. Local forensic teams such as the one in Guatemala are now doing very sensitive and challenging work.

Generally, the types of forensic assistance that have been requested in the past have been in the area of forensic pathology and forensic anthropology. Assistance given has taken the form of providing forensic evaluation of autopsy reports and photos where foul play is suspected, documenting evidence of torture of living or deceased persons, detecting and evaluating the causes of lesions, and determining whether injuries occurred before or after death. Forensic toxicologists can detect the use of drugs or poisons. Forensic experts may investigate suspicious deaths, usually deaths that occur in police or during military custody, by means of autopsies and second autopsies.

Sometimes these experts are allowed to visit the scene of the death and interview persons who may

know something about the murder, suicide or untimely death. They may also be asked to submit their findings to the investigating corps. Arranging for the exhumation and identification of the remains of persons who died under questionable conditions entails investigating reports of single or mass graves, conducting the exhumation, collecting antimorgan data on possible victims, talking to cemetery workers and reviewing medical records and cemetery logs, examining the human remains for clues, and comparing the findings with antimorgan data already collected. The determination of cause or manner of death and the detection of signs of torture are particularly important. These missions may also involve presentations before courts of law of the findings and returning the remains to the family members for proper burial.

A notably important and major task taken on by Physicians for Human Rights and the American Association for the Advancement of Science, both NGOs, is organizing training programs for local scientists, members of the legal community, physicians and representatives of human rights organizations.

Forensic scientists are taking the risk, hoping that their efforts might make a difference

A forensic investigation under United Nations sponsorship is now taking place near Vukovar, Croatia. Physicians for Human Rights has entered into an agreement with the United Nations to conduct an investigation on a mass grave near Hugugar which may contain the remains of about 200 Croatian patients evacuated by Serbian forces from a hospital on November 20, 1991 and shot dead in a deserted field. When Hugugar was taken over by Serbian forces, the latter agreed to evacuate some 420 Croatian hospital patients to Croatian health

territory. Witnesses say that the Yugoslav National Army soldiers and reservists separated the wounded military and civilian males in the hospital from other patients. Witnesses saw the patients being taken away from the hospital by Serbian soldiers and transported to a garage where they were beaten. The witnesses also saw vans loaded with about 20 patients being driven away from the garage and returning 15 to 20 minutes later.

"Never doubt that a small group of thoughtful, commited citizens can change the world."

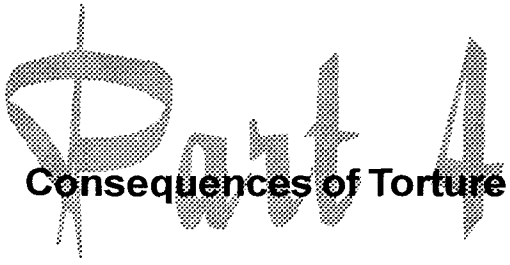
Investigators now have a list of about 180 patients and 30 staff members who were at the hospital at the time but who remain unaccounted for. The grave site was discovered in October 1992. Russian soldiers belonging to United Nations protection force have guarded the site until this year. A preliminary investigation indicated up to 200 bodies buried there. The remote location suggests that the executioners sought to bury the bodies in secret. The pattern of spent metal casings of machine-gun bullets and the location of the bodies reveal how the executions were carried out. The grave had not been disturbed since the time of the execution and internment. In September 1996 the Physicians for Human Rights sent forensic scientists back to the site to fully determine the facts.

Violation of medical neutrality

This incident of about 120 patients marched out of the hospital, murdered and buried in a mass grave is a ghastly example of a violation of the principle of medical neutrality. What will become of such a heinous crime is what we are all waiting to see. We now have an institution in The Hague which has begun proceedings and has received evidence associated with the killings. It remains to be seen whether humanity is up to the task of putting to-

gether an international tribunal to try such violators of humanitarian law.

The forensic scientists who have volunteered to undertake this extraordinary effort are taking a risk. The whole thing might end up being an exercise in futility (considering the impunity with which some sectors have violated humanitarian law). But forensic scientists are hoping that their efforts might make a difference and I think that's what distinguishes so many people who are involved in human rights work: they recognize that the chances of success may be low but their moral courage and thoughtfulness impel them to take the risk. This calls to mind a statement of Margaret Reed, a famous anthropologist, made many years ago about such risk-taking: "Never doubt that a small group of thoughtful, commited citizens can change the world. Indeed, it's the only thing that ever has." □



Consequences of Torture

"The situation of health professionals in this work varies from one country to another because we have different cultures and we have different political conditions."

Dr. June Pagaduan Lopez

Psychological Sequelae of Torture: Assessment and Management

JUNE PAGADUAN LOPEZ

Socio-political context of the Philippine experience

WHEN we began our work on torture, we did not know much about this work. Today, we can share the experience gained through more than fifteen years of engaging in the psychosocial rehabilitation of torture survivors. The task may sound daunting but it is not as complicated as you might think. We hope that by sharing our insights, we can somehow spur the enthusiasm of those who are just entering, or contemplating to enter, this challenging field.

Dr. June Pagaduan Lopez is associate professor of psychiatry and the program director of the Psychosocial Trauma, and Human Rights Program of the University of the Philippines.

How simple can one's basic assumption be? First, we do not need a complicated analysis to see that torture is a serious problem. Second, it takes only a moment to recognize that as health professionals, we cannot continue to be healers in our own societies if we do not acknowledge the existence of this problem.

What gave us the courage to organize the Medical Action Group, Inc. (MAG) was our inability to continue denying this problem and the concomitant realization that it was more harmful for our spirits to remain passive in the face of the moral dilemma posed by torture of political activists in our midst. Thus, unmindful of the dangers, (many of which we were not conscious of), we embarked this seemingly reckless mission to find meaning in our lives as professionals and as healers in a situation where caregiving was urgently needed yet solely lacking. Filling the need then was our reason for being.

We do not need a complicated analysis to see that torture is a serious problem.

The situation of health professionals in this work varies considerably from one country to another because we have different cultures and political conditions. The situation of health professionals working with survivors living outside their countries also differed from those working with compatriots. In Europe, for example, caregivers and health professionals live in relatively peaceful conditions. However, they have to deal with problems of exiles and refugees who have been forced to leave their homes and families and live with people of another culture.

Working in our country had its advantages and disadvantages. A common language and sense of our political and social environment facilitated our work and ensured the interventions that are largely

appropriate to our culture. Our families, friends, organizations and communities as constituting support systems was another advantage. The disadvantage, however, was that both caregivers and survivors live under continuing conditions of political repression with the real risk of being its receiving end. As caregivers, we were vulnerable to the same dangers that our patients or clients faced.

There is no single approach to psychosocial trauma work among torture survivors.

Having experienced running an organization under the very repressive conditions of martial law and then through the transition years to political liberalization, we learned that *there is no single approach to psychosocial trauma work among torture survivors.* There are many approaches depending on the specific political and social conditions prevailing in a particular historical conjuctures.

The aim of torture

To understand the psychological effects of torture, one must go back to how this negative stimulus is defined. Torture is the infliction of severe, physical or mental pain on an individual at the instigation of a public official in order to extract information as well as to punish, intimidate or destroy the person. This explains why even after all the information has been extracted, the individual is most likely to continue being tortured. In Third World countries — in Latin America, Asia and Africa — torture is a state's recourse in defending itself. Government agents are not only interested in getting information but also in undermining movements that threaten its existence. Torture is the instrument used to destroy the members of underground movement and to one and all the fate of those who engage in subversive activities.

The Philippines is a small country about 300,000 square kilometers in land area with a population of 70 million. The figures vary but almost four out of ten people live below the poverty line. Many are severely malnourished. Our maternal and infant mortality rates are significantly high.

Torture in my country has to be viewed in the context of our political history. It was most prevalent in the period of authoritarian rule when a progressive movement committed to the liberation of the country from poverty and exploitation organized effectively by various sectors -- people who had the courage, intelligence and dedication to fight and risk their lives. In short, the state was threatened not by a weak but by a strong determined and dedicated group in society with strong links to media. This is why government had to muster its resources to break the backbone of the movement -- the core of its strong willed committed membership.

Torture is practiced by the state to supress and eliminate a progressive movement that wants to liberate the country from poverty and exploitation.

Psychological symptoms

Of the 102 tortured political prisoners surveyed in 1991 in Metro Manila, most complained of body aches and pains. Eighty three (83) cases had bouts of depression. This is hardly surprising. A depressed Oriental or Asian, or a Filipino, does not say, "Oh, I am depressed today or I have lost all of my hopes for tomorrow." Filipinos, like most Asian, do not usually express feelings in clear psychological terms. When we are sad or depressed, we say "I'm not feeling well," "I have a headache," or "I feel weak."

One explanation for this is that our culture does not reinforce complaints, especially psychological

complaints. When a person complains of psychological symptoms, people tend to dismiss this by saying, "Oh, that is your problem, you can get out of that, it is only in the mind. But when one says that he or she has a headache, then the problem is considered legitimate and the person does not have to face people and perform as usual. I think we cannot conclude that a person who does not complain of characteristic psychological symptoms has not been tortured. Among Filipinos, and I would like to say among Asians, the complaints are very somatic or physical.

We cannot conclude that a person who does not complain of characteristic psychological symptoms has not been tortured.

Dr. Rasmussen is the first person ever to make a systematic study of sequelae, and torture, both physical and psychological. In the cases that we studied, we found that there was a high incidence of somatic symptoms which include headache and fatigue. The incidence of complaints of weakness was more than 50%. Turning to the psychological symptoms, depression rated highest. Other psychological symptoms were anxiety, memory disturbance, hallucination, sexual disturbance and suicidal ideation. I would also add alcoholism to the list. Although we did not pick this up from our survey of political prisoners, who could not have been alcoholics while in prison, we observed that many of those who left prison suffered from alcoholism.

The more important thing here is not so much the comparison of the findings from different investigators but a list of possible psychological problems we can expect to find when assessing the psychological status of torture survivors.

I have been asked whether self-mutilation happens among survivors, especially among sexually

abused women. Self-mutilation is indicative of a more severe psychopathology found among many disturbed cases. These individuals may sometimes be diagnosed as having a "borderline personality disorder." They are people prone to drug abuse and uncontrollable impulse. They self-mutilate to convince themselves that they are still alive. Sometimes the self-inflicted physical pain is their way of eliminating the numbness and the emptiness that they feel. None of the torture victims we studied showed severe psychopathology.

We have seen, however, other forms of severe, albeit temporary reactions. I have a patient, who was severely tortured. He was made to witness the torture of his wife while the military threatened to torture his children. He also continues to be harassed by the government with press releases stating that he is still a leading suspect in the bombing incident that killed several persons in a political rally in 1971. During extreme stress, he develops psychotic symptoms which worsen when he does not take medications. Fortunately, they only last for a brief period, and can be managed with medications over a short time. We do see a number of these cases occasionally.

Self-mutilation is indicative of a more severe psychopathology found among borderline cases.

The development of psychological sequelae

We have to understand the torture process to understand the trauma and severe reactions of the persons subjected to it. The torture does not start after the military or police has taken you to the detention camp. It starts when they arrest you, and take you away from your home or your group. The message is – we are in power and you are powerless.

In my country, you are not brought to a military camp or an official detention place outright. Again, the point is to break your spirit, to remove you from your family, comrades and friends, to impress on you that you are in their hands and there is nothing you can do about it. You are completely at their mercy, from the time they blindfold you to the time they shove you into a car driven around the city until you arrive at the safehouse and subjected to interrogation. Notice the paradoxical use of the word "safehouse."

We have to understand the torture process to understand the trauma and severe reactions of the persons subjected to it.

What happens then? The interrogation proceeds and accelerates with a "good" guy and a "bad" guy alternately asking questions. Then they bring in somebody billed as the "terror" – who will intimidate and make you fear for your life. After this, somebody comes in and says, "I am your friend. I know your father, I can save you, please cooperate, but I cannot control my men forever." They will bring you cigarettes, even ice cream, and they will allow you to make a phone call. What follows is that you lower your guard. You cease to be in a fighting or resisting mood. Now your mind is mixed up. You have this feeling that you can be killed but also sense the possibility that the "good" man can save you.

Imagine how it feels. Everything is dark around you but there is that glimmer of light that makes you hold on to the possibility that somebody will come and save you. Yet, you do not know what lies behind that door – is it the good guy or the bad guy, your savior or your torturer? What is being undermined is your ability to predict what will happen in the next moment. Allowed to sleep, you do not know when they will return and wake you to resume interrogation. They come back, awaken you and start asking questions. Then they tell you to go back to sleep, say-

ing they'll come back for more questions. It is a deliberate way of destroying your sense of control. And *here lies the key to torture – it is about you being powerless in the face of strangers who have the control over your fate.*

You are deprived of food and water. You feel terribly tired and weak but your mind is still strong because you tell yourself, "I am prepared for this. I knew they would do this to me. When I decided to fight the oppressive state, I knew I could be killed." There you are, the body is weakened but the mind is trying to remain tough.

Now, this is the story of my female patient. A man comes in and introduces himself as the officer of the arresting group. He says he does not like what his men are doing. He says: "I will protect you but I am only one in this group. I cannot control my men forever. You should not make them angry. You should not frustrate them because all we want is our reward. We want our money. We need information from you because we want to get your group. Now if you will cooperate, I will protect you." Then he adds that he knows her father, uncle, sister and so on. In that state, her mind starts to weaken.

Here lies the key to torture — it is about you being powerless in the face of strangers who have the control over your fate.

For many of my patients, this was the breaking point -- the horror of realizing that it was all a trick, a game.

The purpose of all this is to make you give in – to provide the information the torturers want and intimidate you into giving up your commitment to your cause. To make you believe that you cannot do anything because the state is all powerful whereas you are nothing. This is the message.

For women, there is another dimension to the torture. Not only are you made to feel you are powerless, but you are also made to feel dirty because of the sexual torture you have been subjected to. The additional message is: you are powerless, unclean, unworthy and unfit. Both men and women survivors can suffer from sexual dysfunction after torture. They are unable to be intimate again because they have developed a defense mechanism called *splitting*. This is especially true of some of our women patients. They deny their bodies. They no longer see their bodies as integral to their personhood. They no longer relate to other people with their bodies. But even while this happens, especially to their loved ones they do not realize it because these defense mechanisms become deeply buried in the unconscious.

If we are sensitive enough, we know that we are talking to persons, torture victims who remain imprisoned in their own minds.

All of the eight women we interviewed, in varying degrees, used "splitting" to survive and cope with the sexual torture. Unfortunately, this defense mechanism may stay long after the torture. When this happens, the survivor remains captive within her own mental cage. We do not need any sophisticated psychiatric knowledge to recognize this. If we are sensitive enough, we quickly realize that we are talking to persons who remain imprisoned in their own minds.

Principles of psychotherapy with torture survivors

Assumption of psychological health

How do we deal with survivors of torture? Many torture victims were strong, physically and mentally healthy people before torture, and most probably, even after. They are normal people reacting normally as

any human being would to an abnormal and perverse situation. The first thing we do is to help them stop blaming themselves. Some survivors castigate themselves for many things -- for having been caught; for revealing information under pressure; for the death or capture of other comrades; for the blame they are now receiving from their family; or simply, for joining the movement. It is important that such self-blame is not allowed to continue by helping the survivor see the experience in a more healthy, if not positive way.

We remind ourselves that survivors are strong persons, individuals who had the courage to leave their families to fight with their lives for something they believe in.

For a survivor, it is normal to feel angry at the self, if not those who give blame. Frequent questions are, "Why am I feeling this way? Why am I different? Why am I more afraid now? Why am I more distant?" There is worry that comrades may chide him or her for doubting or questioning the essence and worth of his or her sufferings for the cause. As caregivers, we have to point out constantly that, that these are natural reactions of that psychological captivity.

Focus on "the here and now"

The second thing to do is to focus on the more immediate and recent events in the torture survivor's life. This means giving attention to his or her strengths and coping skills, that is, the person's natural ability to handle adverse experiences which he or she had used before the experience of torture.

We remind ourselves that survivors are strong persons, individuals who had the courage to their families to fight with their lives for something they believe in. We have to help bring back that realization to each person — the capacity to deal with

the trauma of torture. We try to help the survivor somehow regain strength by guiding them through problem-solving situations. We do this by focusing on the recent events, the demands of day to day life, "here and now."

Torture victims are normal people reacting normally as any human being would to an abnormal and perverse situation.

At this point, I would like to emphasize how crucial our orientation is in our work among torture victims. Many, if not most of us, are western-trained psychiatrists and psychologists. If the Freudian framework is strong in our training, our tendency is to look into the past to explain the current behavior of the person.

We try to look for the traumatic experiences of the person as a child and connect them to symptoms we are seeing today. This exercise is very unproductive in this situation and is not useful at all in the treatment of any kind of traumatic experience arising from torture, rape, or criminal violence. Childhood experiences or the weaknesses of the person are not our immediate concern. While we may look for possibilities of problems even before the trauma, that can enhance vulnerability, this is not the essence of post-traumatic psychotherapy. It is the establishment of the connection between the symptoms and the nature or intention of trauma which, in the case of torture, is the instilling of powerlessness in its victims.

Equity and partnership
in the therapeutic relationship

The next principle that guides us applies to the relationship between caregivers and survivors. It is important to recognize that we are equal partners in this relationship. This means we should

consciously avoid aggravating the sense of defenselessness or powerlessness of the survivor by encouraging dependence.

Caregivers who are not trained as mental health workers, think that being kind by volunteering to do everything for the person in need is beneficial and therapeutic. But torture victims are essentially strong and proud and therefore must not be rendered helpless. Moreover, our good intentions are not served well if in the course of our work we generate dependence and burn out in the process.

We have seen some caregivers in the NGO community fall unconsciously into this trap. In psychological treatment, this is not what is asked of us. It is true that we have to address the economic needs of our clients and help them find other forms of support but we have to be aware that they are partners in the healing process and have to feel that they are on the same level in this relationship as their caregiver.

It is important to recognize that caregivers and survivors are equal partners in this relationship.

The need for a holistic approach

Our caregiving program is holistic in approach. We do not separate the psychological from the medical, the physical, or the social help we give. We are also problem-oriented . We focus first on what the patient is coming to us for before we begin to take care of psychological problems. If the presenting problem is money for an artificial arm we have to take care of that first. It is important to address their immediate concerns before they can tell us their whole story. It is important to have a multidisciplinary team, and the first one who sees the patient must address the patient's most immediate problem.

We have a group of young volunteer doctors who give free services and medicines. Most of our funds go to free medicines and food. Apart from giving free health services, we visit the prisons. Since prison authorities in the Philippines allow the children and the spouse to visit and even to stay for several days, the family is occasionally present in our visits. We then give the political prisoners physical and medical examinations. We train non-doctors to take the patient's vital signs and temperature and provide acupuncture, acupressure and other alternative healing methods.

It is important to have a multidisciplinary team, and the first one who sees the patient must address the patient's most immediate problem.

Our next step is to help them come together in a group to talk about their problems as prisoners. This is an empowerment exercise, giving them a feeling that they are back in control and can do something about their problems collectively. We do not conduct one-on-one sessions often as group sessions are more economical given the scarcity of volunteer doctors. Furthermore, this approach helps develop the feeling of cooperation and solidarity among prisoners. Opportunities for creative expression are available in the group sessions. We provide materials for those who have artistic ability and try to market their artworks outside. The earnings go to their families. During fellowships, we sing with them the same revolutionary songs that they used to sing making them feel that their struggle is not over even if they are in prison. The visits and fellowships help the political prisoners see that they are not alone and that there are many people who look at them as heroes despite their imprisoned state.

Another intervention is our community outreach which is a component of our rehabilitation

program. We hold focused dialogues with the community and with the families. During these dialogues, they share what they feel about what is happening in their community.

Most of the time these communities continue to experience military harassment because the military consider them sympathetic to the rebels. It is not surprising to imagine that the members of the family and community also suffer from a different form of torture and this is what we bring out in our talks with them.

Being aware of the self as a caregiver

Through various activities, we should not forget that we are as human as our clients. As two human beings in a relationship, we affect our client as much as our client affects us. When we treat the survivors, it is not surprising to find ourselves questioning our own thoughts, feelings, behavior and values. We will experience all sorts of feelings and it is imperative that we have a way of reflecting on them with our colleagues, our supervisors or our teams. If we are not aware of these feelings and the possible effects of the survivor on us, then we cannot be effective healers. We will be like a blunt knife that can even inflict more wounds on our patient.

Another intervention is our community outreach program which is a component of our rehabilitation program.

Recovery and reintegration

We go back to the torture victim and ask how else to make this person who has suffered greatly whole again. Filipino or Oriental psychology figures at the point when we view the totality of the person. We recognize the *loob* of the person as his inner being, and his *labas,* as his relationship to the world. (*Loob* literally

means inside while *labas* means outside) (*Editor's note: This framework is discussed in detail in the author's article on the "Valuing Process." See page 203.*)

Torture survivors have to be made aware of their inner self, their mind and spirit, and their relationship with others. The awareness of where their sense of wellness and wellbeing and their peace of mind come from, and where their power lies, is crucial in weaving pieces of themselves into an integrated whole. And with this, the mind and body flow and merge in harmony.

We do not think of ourselves in isolation existing independently of others.

Unfortunately, in many cases of torture, especially those involving sexual means, the body disappears from consciousness and is forgotten in the depths of the unconscious. As a consequence, a break between mind and body develops and is what we want to heal. This break can also occur between the inner reality (*loob*) and the external reality (*labas*), or the shared self, of a person. We do not think of ourselves in isolation existing independently of others. We generally think of ourselves in relation to others or the way people think of us. Our social environment forms our external reality. When something distressing occurs in our external environment, a disturbance is created in our inner lives. In the case of torture, the disturbance inflicted on victims is far reaching, it requires heroic efforts for them to find meaning in the torture experience, integrate this into the other aspects of life and feel whole again.

Survivors may choose not to be involved again in political activities. Sometimes I get into a problem, because as a psychiatrist and activist, friends in the movement expect me to convince people to go back to the underground or resume fighting in the hills. It is not easy because some people define the peace in terms of

feeling safe and far from harm. Some desire more than safety, they want coherence, meaning and a sense of empowerment in their lives. The achievement of this kind of peace requires tapping their own inner resources to act on dreams in which the movement may no longer be paramount.

Let me end by showing you this beautiful picture clipped from Time magazine about 15 years ago. It is a picture of a Laotian family reflecting the value of togetherness in times of severe conditions. This is what we want our rehabilitation program to achieve, and which to my mind it has been able to do. We dream of restoring back to the person and the family their sense of well-being and wellness. If we are able to do this single act, then I believe we can indeed help create a better future not only for ourselves and our families but for the wider society as well. □

Excerpts of the Open Forum

Rasalingam: Dr. Lopez spoke about the multidisciplinary approach to treatment that is supposed to evolve in any rehabilitation center. We know that each discipline or science has a particular way of dealing with a situation. A medical professional depends more on his or her clinical skill and art to treat patients. We also know that communicating well with patients is important, especially when there is impending death. It is very difficult for doctors themselves to speak, but when dealing with torture survivors there is a need to speak and give expression to the experience. Therefore, the members of the multi-disciplinary team must know how to speak and communicate to gain insights and knowledge from each other and to get in touch with the treatment process. Do you think there is a need for professionals to have a similar kind of training and approach?

My second point is on the sexual torture that takes place. Even men suffer from this. It is not only women who are likely to be subjected to sexual torture and suffer feelings of being dirty. There are also men who have been tortured and who are told they are no longer sexually capable. Their sexual progress is undermined. Men are unable to speak about this situation because we are not ready to ask those questions in the open. Because of the relative silence of men on this issue we believe that they are more able to deal with this situation better but I do not believe that this is really true.

Lopez: The holistic approach is an imperative. I am a product of a western medical education. It can happen that doctors end their responsibilities to their patient after they have made a prescription or written their orders in the chart. Their lack of sensitivity to other aspects of the patient's life has to do with a very specialized technology orientation which tends to disregard nonmedical factors. My involvement in values education and humanistic medical education with a multidisciplinary orientation in my country springs from my realization of the gaps to be filled in this area.

I credit my experience with torture victims for this realization. For it became clear that I cannot confine myself to the traditional role of a doctor when I am dealing with victims of torture. In a third world setting where resources are limited we have had to expand our roles beyond those ordinarily expected of physicians. I have to be a social worker. I have to be a lawyer sometimes, when I try to facilitate the resolution of a long-drawn court case that is causing my patient nightmares.

And I go to the Commission on Human Rights to look for somebody I know and plead for my patient. These are the things that an ordinary doctor is not willing to do or is not committed to do.

Working with torture victims expanded my understanding of what it really means to be a doctor. Otherwise, I would probably be an ordinary physician who specializes in cutting up patients and views the person only in terms of organs and systems. I was challenged to shift my framework and my paradigm because of my human rights work.

As to the second question, you are right about sexual torture. As you said, it is very difficult for men and

even for women to discuss sexual trauma. We have an ongoing study on gender and torture which is an expanded version of our case studies of sexually tortured women. This study looks at trauma as differentially experienced by women and men. However, I have reason to believe that women are particularly vulnerable to sexual torture because of the prevailing culture with pervasive myths about women's sexuality. Sexual torture is done not only to destroy the woman, it is done to destroy the entire family. The sexual torture while inflicted on the woman may be directed to destroying her husband. The effect of having your wife raped in front of you is just as traumatizing as being raped yourself. So it is the personal damage and potential damage to the family and community that the state uses to terrorize people who threaten its existence.

Irwanto: I notice that torture survivors often seem to have a highly altered pain threshold. Have you observed this with people who are sexually tortured?

Lopez: Yes, definitely, even a light touch produces extreme reaction. We have seen this in the 18 patients on whom we tried the Danish type of stress tension reduction therapy (STRT) which combines pressure and massage. The study was a collaboration between a STRT expert, Dr. Helle Larsen (Ph.D.) and myself from 1986 to 1987. The sexually tortured victims would jump when touched on the inner sides of the thighs or at the back. The worse cases would react when touched anywhere. Yet, the irony here is that while they have a low threshold for bodily pain, they have cut off their minds from their bodies. They walk around in close to disembodied states. Because their bodies

have become an infinite source of pain denying their bodies has become an effective psychological coping mechanism. It is interesting to note that some of the sexually tortured victims would not look at their bodies in the mirror.

As these victims heal we observe the tremendous effect of making them come to terms with their bodies. But healing is a slow process. Because of the denial of the body we cannot solely rely on verbal methods to help the victims. We have to explore indigenous ways of healing trauma. The non-verbal treatments are very important, be they accupressure, massage, *tai-chi, qi gong* or yoga. We have to offer non-verbal methods that rely less on mental exercises or logic as these methods would gradually make the survivors get more in touch with their bodies and ultimately, their sexuality .

Mahlangu: In our experience in South Africa, we found that it is not only the rape victim's sense of touch that is affected but all her five senses. A touch, a smell, a sound can trigger the memory of the rape. If people breathe in a certain way or if there is a similar smell, any of these may trigger a reaction. Thus, we always examine the five senses and see which one has been affected the most.

Vanni: There is similarity between the problems in our country and Philippines. When, as caregivers, we help the survivor to recover his or her spirit, even his militancy, will this not bring in complications that may provoke political questions on the objectives of your program ?

Lopez: The important thing to remember as a healer and a therapist is this – you are not making the decision for the person. The person decides if he or she wants to go

back to same militant struggle. It is important to help the survivors clarify at what level his or her involvement will be this time. Some survivors continue their studies. Many join so called legal organizations where they feel safer.

But there are also people who just wish to be safe and we should support them in this. Sometimes my activist heart wishes to bring them back to their militancy. I want to please my comrade friends but that is not my job. Our primary responsibility is to support the patient's wishes, and if his or her wish is to feel safe and be with his or her family, then we respect that. If he wants to go back to the hills, then I respect that, too. We are there to help survivors discover their own resources for pursuing that decision. Whatever decision the survivors make must bring peace within themselves and give new meaning to their lives.

Rasmussen: The remark that we are not getting the right figure on the frequency of men and also of women who report that they had been sexually abused during the torture was extremely important. You cannot expect spontaneous reporting. When we went to Greece in 1976 and examined Greek survivors, we had a rather low frequency of cases spontaneously telling us that they had been sexually abused. We were two Danish doctors with interpreters coming from another culture. Our interpreters hesitated to ask the men if they had been sexually abused. Then we decided to make a follow up study on Greek men survivors to find out if there were hormone level changes in them after the torture, especially after sexual torture. This time, we had a questionnaire and we got a much higher frequency because we specifically asked for it.

I think rape is one of the last things that you disclose. We found women who never told their husbands what they had been through. It is a delicate question.

I also would like to make a comment on Dr. Lopez's excellent presentation about the necessity of taking the culture into account. There is no one way of going about our work. I think we have to respect that there are different ways where you can use your own culture in your treatment approach.

Fisher: It is very interesting to hear you say that women sometimes feel very dirty after their sexual molestation. It reminds me of Dr. Richard Mollica, a psychiatrist from the United States who has done pioneering work in this area. He compared men to a diamond which when dropped in muddy water can still be retrieved. A woman, on the other, is like cotton wool which when put in muddy water will be totally irretrievable. A woman who was raped becomes an isolated woman. Now, how does that work in the Philippine setting? Is this common?

Lopez: I think this is why organizing work and education are very important processes within the healing program. We have to educate the public and the family about this so we can better prepare them to welcome back and support the victim. The survivors themselves have to realize also that they are not alone in what they are feeling because it is shared by others.

It is not easy. In fact, when we did a case study of eight women survivors of sexual torture, they refused to come together initially. We explained to them that as part of the research, healing therapeutic sessions would be done with them after the interview. We felt it was our ethical duty to relate with rape victims as hu-

man beings not as mere research objects. It was very difficult for them to come together and be known. When they finally did come together, there was still a lot of pain even if these survivors were raped and sexually tortured 15 to 20 years ago and are now leaders of the women's movement.

Irwanto: We have observed that this type of patient loses interest in their families, friends, and relationships. They do not want to work. They become a social burden or family burden. What about the recurrence of psychological symptoms?

Lopez: The question suggests that social withdrawal is a symptom among survivors. It is not a single symptom but is indicative of an overall effect on the person. The image of being caged in a box captures what is actually happening.

As for the recurrence of symptoms, it is difficult to make scientific assertions because we do not have the opportunity to follow up patients on a long-term basis. Moreover, the problems we have been dealing with are chronic. They have not been addressed right from the start, and are surfacing only now. Meanwhile, the patients have grown older, they are in their mid-life and may be undergoing a crisis as reflected in an increase in their alcohol consumption. Some have become more abusive toward their wives and children.

It is difficult to attribute these behaviors to the trauma inflicted 10 to 15 years earlier although it may be a recurrence. We cannot be conclusive in this situation.

S. Sharma: I had some questions while working with torture victims among Bhutanese refugees in Nepal. The prisoners exhibited common symptoms like lack of concentration and forgetfulness. They also lost their vision. How do we explain these?

Lopez: The first symptom is easier to explain. This has been noted among other trauma victims. They experience recall problems partly because their memory has been severely impaired by the severe trauma. For the same reason, we have incest victims who remember everything only after so many years.

The lack of concentration is related to a short-term recall problem, similar to not knowing where you placed your keys or your money. Using the computer as an analogy, this is a problem of not being able to retrieve the information because the data was not stored in the first place. This lack of concentration is common even in non-torture victims, depressed patients, anxious patients. The loss of vision is more different to explain unless the trauma affected the eye. □

The Physical Sequelae of Torture

BHOGENDRA SHARMA

(This discussion on the physical sequelae of torture is based on the book edited by Metin Basoglu, ***Torture and Its Consequences****. Cambridge University Press, 1992.)*

WHEN we interview torture victims we cannot expect them to give a spontaneous account of all forms of maltreatment they underwent because they now find it hard to trust others. After all, they were abused by other human beings.

The sequelae of physical torture can be immediate and late. We are going to discuss the sequelae of blunt violence, of blows

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and scars, falanga, suspension, sequelae from strapping, from electrical torture, foreign objects inserted in the body, e.g. bullets and broken glasses, the torture of teeth, temporomandibular joint problems, sequelae from forced positions, sequelae in the musculoskeletal system after stress, and the sequelae of sexual torture.

Torture is aimed at vulnerable points

The physical sequelae of torture resembles the problems encountered in traumatology, sports medicine, forensic medicine, and rheumatology. Torture is usually aimed at the victim's vulnerable points, in the front part of the body or sexual organ which are most often abused.

Some of the immediate physical sequelae are contusions, hematoma (blood collected inside a wound), lacerated skin, abrasions, avulsion (a body part torn away), punctured wounds, burns, strain, and sprain. These may be acquired in accidents, some kind of physical assault, gun fights, or particularly, from torture.

Torture is usually aimed at the victim's vulnerable points

Medical professionals and paramedics need to be very careful in interviewing and helping the victims, otherwise it is very difficult to obtain their trust. The basic principle is to avoid any situation that resembles torture. You do not start asking questions like you are interrogating somebody. The victim will be too frightened to talk. If your examination room looks like a prison or an interrogation center, patients might also be afraid to talk. Avoid anything that resembles their past torture situation like the presence of some kind of instrument or equipment. For example, if you are working in a hospital and you have an ECG machine an electrically tortured victim might feel uncomfortable and sensitive. If certain medical equip-

ment is indeed necessary to help the victim, then you must explain its function and assure the patient that he or she is completely safe.

Another principle is that many patients can easily hurt even if you touch them very lightly. You have to always observe the person while you mobilize, examine, or touch any part of the body and be very sensitive to how the victim feels. It is very important that we should not experiment, be haphazard and careless in these cases.

Many patients can easily hurt even if you touch them very lightly.

The early symptoms of *falanga* — a torture method that involves repeatedly beating the soles of the feet — are difficulty in walking due to hematoma and swelling. Swelling causes extreme pain. As we know we have a fascia — a strong tissue below the skin that limits the space for swelling. Usually, after the *falanga* a victim is forced to walk, jump, or dance. This causes excruciating pain and it worsens the extent and degree of sequelae. The late symptom of *falanga* may be pain in the legs and feet, in the deep tibial region and the knee joint, and in the lower part of the leg.



The pain is described as stabbing, cutting or burning usually intermittent, but sometimes it may be con-

stant. The pain occurs during the day and may worsen at night or in cold, damp, and windy weather (especially in Nepal). Sometimes people feel that the pain comes with the night because they recall the torture more often at night. Our friends in Bangladesh said that the pain occurs during the night, either during the full moon or every 15 days. (There may be a cultural factor in the expression of stress.) The pain is accompanied by tingling sensation like pins and needles in the calves and the feet. Usually it sets in when standing and walking but there is no radiation to any part of the body. It is shortly relieved when the person gets up to walk on the cold floor.

Usually, victims cannot cross their legs while sitting nor can they squat. There is the feeling of tiredness, heaviness in the thighs and legs, and a feeling of looseness of the knees and ankles as if they are falling apart. There is a change of gait and consequently a restriction of movement. They cannot roll over their feet properly. Cramps are rare in the calves but when the pain occurs it may increase due to exertion, the symptoms resembling the closed-compartment syndrome.

Usually, victims cannot cross their legs while sitting nor can they squat.

It is important to properly diagnose these cases, using the methods which we will identify.

When we examine the sole of the feet we see the heel with its two balls: the medial and the lateral balls. These balls may be smashed because of the beating. It is not only that the vertical connective tissues (the trabeculae) from the skin to the bone are damaged but also that the tissues between the fat pockets are torn. Usually between the skin and the bone there are vertical trabeculae that protect the movement of the fat which acts like a cushion. When we palpate or

feel our feet, normally we do not feel the bone because of the fat. But when the feet are beaten the vertical trabeculae are destroyed and the fat moves around because it is semi-liquid. It moves around and you can easily feel the bone. When the patient walks there is pain. The springiness is lost and lower back pain happens because the gait becomes tense. Usually the patient wants to either bend his knees or adjust his position to relieve the pain and ease discomfort in the back. These positions are not normal for the body, thus, they cause or worsen the lower back pain.

On palpation, plantar aponeurosis is tender and rough and due to tendinitis, the support of the longitudinal arch is disturbed.

The diagnosis can be done by inspecting the heel from behind. While an individual is standing, the heel normally has a rounded contour but in cases of falanga, it is smashed causing it to look broad, flat, and compressed. People who walk barefoot in the hills have a very thick corneal or outside layer of the skin of the feet. In those cases we have found some difficulty in diagnosing. This may also happen in other parts of Asia where village people often walk barefoot.

There is direct and indirect tenderness of the proximal and distal tibiofibular joint. So when you press the side of the knee and ankle joints there may be pain on the other side. There may also be gait problems—dysesthesia without segmentary pattern. Sometimes victims do not feel anything and other times they are hypersensitive, jumping when you touch a sensitive part. This resembles a reflex sympathetic to dystrophy which we are not going to discuss because this is not commonly found in torture victims.

Diagnostic Tools

On palpation, plantar aponeurosis is tender and rough and due to tendinitis, the support of the longitudinal arch is disturbed. There is normally a longi-

tudinal arch in the foot but in the *falanga* cases this arch becomes distorted which causes flat feet. Walking is difficult, and muscle fatigue happens especially in the flexor digitorum accesorium and the peroneus longus. This is not very easy to diagnose in most cases. One of the methods we commonly use in many centers is the passive extension of the big toe. If you place the big toe on a flat surface and lift it for about 20 degrees – this is where the tension normally starts – this can normally go up to 70 degrees. In cases of *falanga* torture victims the extension may go higher than 70 degrees. This is one of the diagnostic tools we often use in Nepal.

In cases of dissection it has been reported that the muscle compartment of the soles becomes tight and inelastic and there is the risk of a closed compartment syndrome. One of the important things to do in physiotherapy of *falanga* victims is to note the mobility of small joints. Before physiotherapy small-joint mobility is restricted in the victims. But when you start mobilizing in physiotherapy, they become hypermobile, more than in normal cases. This can also be applied in other torture cases where there is severe maltreatment of the joints. The normal tightening of the interosseous membrane does not occur if tibialis posterior is not activated.

One of the important things to do in physiotherapy of falanga victims is to note the mobility of small joints

We have noted that muscles, joints, and ligaments of the skin are affected in the falanga cases. I emphasize that not only one part is affected but several are affected at once. For example, the exteroceptors and propriceptors are disturbed causing balance and space orientation to be disturbed.

Treating *Falanga*

In treating cases of *falanga*, supported footwear – a little tight, although not very tight – elastic band-

ages, and sports tapes can be helpful. Most of those who come to see us wear no slippers because they cannot afford to buy a pair (which does not help improve their situation!). We give them tape or elastic bandages for the back and feet. We also ask them to walk even for only 15 minutes in the bandages and this helps ease the pain. In many cases, we cannot completely cure the victims of *falanga* because the tissues have been severely destroyed. But we can minimize a lot of the symptoms.

In many cases, we cannot completely cure the victims of *falanga* because the tissues have been severely destroyed.

In *falanga* victims it is extremely important to reestablish the function of the pelvic joints as these are affected. The space orientation and the sensory motor for training are also important. There are impulses coming from the periphery to the cerebellum, very important impulses from the neck muscles, that have to be reestablished. These things are usually done through physiotherapy. Thus I want to emphasize the importance of physiotherapy in the treatment of torture victims.



Drawing by Dudu Gerstein.

Effects of Suspension and Other Types of Torture

Now we will discuss suspension. This is a method of torture (we call it "Palestinian suspension") where the victim is suspended upside-down or hung using

a variety of methods and positions. The victims may be strapped by rope, straps, handcuffs, and shackles.

The various forms of hanging have different effects. If the victim was suspended upside down, his sole is less likely to be affected but other parts — particularly the shoulders or other joints — can be affected. So it is important to note in the interview how he was suspended. In cases of suspension burning and cutting pains occur in the joints. When the victims say that it feels like cutting, this refers to no segmentary pattern. There is a sensation of tiredness and heaviness of joints and the limbs — hyperesthesia especially of distal joints. There are vasomotor and pseudomotor changes and very often symptoms persevere for months or years. There are symptoms of acroclavicular joint and sternoclavicular joint but hypermobility is rare.

Suspension affects the upper and middle costovertebral joints. Survivors interpret the resulting pain as cardiac pain.

Suspension affects the upper and middl costovertebral joints. Survivors interpret the resulting pain as cardiac pain. Victims say, I have pain in my heart. But it easily disappears with physiotherapy. This is one of the very rewarding signs of healing that helps them a lot. Tendinitis near the joint is common and there may be fibrosis of the ligaments. Many of the victims perceive their joints as being loose while in reality they are not. This is probably due to wrong information from the afferent mechanoreceptor of joints, capsules and ligaments. Suspension focuses in joints which are badly damaged. That is why wrong information is transmitted from that part of the body to the brain. In cases of long-hair suspension, there is dysesthesia and loosening of the skin that can cause pain.

In cases of electrical torture, electrodes are usually applied on very sensitive areas such as the genital

organs, on the front part of the body, or on the fingertips. Mobile electrodes, shock baton, and fixed electrodes may be used. There may be skin changes and myoglobin liberation where in most cases the findings may be similar to blunt trauma.

Sexual torture is one of the most frequent mental and physical tortures that have been used on men and women

In cases of sexual torture, the victims may find difficulty in urination and defecation and experience pain during intercourse. Sexual torture is one of the most frequent mental and physical tortures that have been used on men and women —especially women. After sexual torture there is pronounced dysharmony of the musculature of the pelvis. When you walk or move the pelvic musculature does not work properly and there is shortening and tightness of the psoas.

Victims of sexual abuse complain of discomfort in the abdomen, the leg, and especially in the pelvic region. This is due to muscles that are not working properly.

The effects on the musculoskeletal system after stress, physical torture and psychological torture can cause somatic symptoms. Sometimes we hear complaints of chest or back pain. After psychological torture like confinement or other forms of deprivation, there may be changes in posture like drooping or bowed head, increased cervical lordosis, raised shoulders, increased thoracic kyphosis and lumbar lordosis, change in pelvic inclination, and dysharmonic musculature. □

Detection and Management of Torture

VELI LOK

I will speak about the cases which are difficult to diagnose. In daily medical practice, we need diagnosis for two purposes: first, to begin treatment and second, to give a medical report or an alternative medical report.

The need

To begin the treatment you do not need advanced diagnostic tools; a detailed story, a detailed physical examination, a psychiatric examination and x-rays are enough. Advanced diagnostic tools are not necessary because they give the victims some

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discomfort. They are also expensive. But to give a medical report you need to use these advanced diagnostic tools which I will speak about. Unless you have strong, scientific proof in your medical reports, they may not be accepted by the judges. In addition, the physical findings or the so-called acute symptoms and findings disappear in two or three weeks. In fact, when you examine the applicant after two or three weeks you may have to give a negative report. In many cases physical findings disappear in three weeks.

But first let me show you some overheads.

About our organization: our working group is composed of specialists, some of them neurologists and pathologists. We started this work in 1989. We now have four centers. By 1995 we had seen more than 700 cases.

We need diagnosis for two purposes: first, to begin treatment and second, to give a medical report.

As Dr. Sharma already explained, immediate physical signs usually disappear within a few weeks. Although some chronic or late findings continue, they do not have a lot of diagnostical specifications. And the patients could have some subjective complaints. Indeed, diagnosis is very difficult in the later cases as well as in the acute cases. What we do is to tell these patients to apply to forensic doctors for an official medical report. Then we tell them to apply to our medical chambers to get a medical report.

From a video film we have made, one can see a torture victim two days after he was tortured. He had been taken from the street, brought to the police headquarters and tortured. There are very obvious signs of beating on the hands as well as some signs of electrical torture: more than 200 electrical spots. One is an anode point; the other points are for cathode.

There are also some electrical burns on the glands of the penis. But as doctors we do not often get the chance to see such fresh signs.

It is difficult to make a diagnosis two or three weeks after torture.

We have also documented evidence of *falanga,* the swelling of the foot. You have to examine this very carefully, it takes time to do it. You have first to ask for the complaints and then carefully examine the patient's whole body, especially the back and the spine. On the calf you can find many things. Here you can see some wounds and the swelling of the foot and the calf. Of course the swelling is not only due to trauma but also to standing for a long time. The main complaint (in the case of the picture projected on the screen) was on the right foot. Since most people are right-handed much of the trauma is inflicted on the right foot during *falanga.* The inner side of the right foot absorbs most of the beatings. Here you see hematoma; ecchymosis and swelling are obvious plus the tenderness of the ankle and the inner side of the foot.

When we see the patient after one week, we find that many findings have disappeared. Only a few spots can be found. While the findings on the foot are still there and the swelling has not disappeared, it is usually better than before. Some electrical burns remain, however.

After two weeks, there are no more traces of electrical burns. On the hands you can see almost nothing although some ecchymosis and the swelling have not disappeared.

After three weeks, the physical findings have disappeared. It is therefore difficult to make a diagnosis two or three weeks after torture. If you

want to make a diagnosis, you have to do the advanced examinations. But first upon admitting the applicant a very detailed story must be pieced together afterwhich a physical examination must be done very carefully. A psychiatric and laboratory examination, including an x-ray, have to be conducted as well. In all these activities, visual documentation by photography is very important. Video taping has obvious advantages and must be done if possible.

Bone scintigraphy as an effective method

For beating and *falanga,* a bone scintigraphy is essential. It is done with radiopharmaceutical material, such as 99 technitrum, which goes to the hydroxyapatite crystals where the bone repair takes place. This bone uptake will be recorded by the gamma-camera. There are three phases: the first and second phases constitute dynamic scintigraphy while the third phase is static scintigraphy. The first two phases are done in the first five minutes of the application while the third is done after two or three hours. With the gamma-camera a photograph will be taken of the whole body. Afterwards the photograph can be magnified.

Bone scintigraphy can remain positive even after seven years.

Bone scintigraphy can remain positive even after seven years. It is a very sensitive method. It can register even 15% changes in the body. X-rays, which are less sensitive can catch only 1.5% of the changes.

Bone scintigraphy has been used extensively in the practice of medicine, especially when dealing with stress fractures, fractures and fissures, fractures of small bones and infections, and bone tumors. It is also used to detect trauma in an abused child.

In our first case, photographed in 1989 one month after the patient had been tortured, the positive signs are evident. In the second photograph taken one and a half years later, you can see that the findings are continuous. The third one was taken four years later, with a zoom lens. Another one was taken after 18 months and the other, after 31 months. The findings are continuous.

Electricity is very harmful but you cannot see its effects on the surface of the body.

Normally the findings continue for many years although we have had one case where they disappeared. In one photograph you can see the dynamic scintigraphy findings on the testicles which had been squeezed. In cases like this we can catch the findings even 70 days later. There are chronic cases where findings can still be detected 11, 12 or 15 years later.

What have been the results of our use of scintigraphy? We have used this method on 59 cases. Among the 26 acute cases, we had 81 percent positive findings; among the falanga cases, 80 percent. We can tell you that this is a very effective method.

Other advanced diagnostic methods

We use other advanced diagnostic methods as well. Biopsy is very effective in detecting electric torture. We had one case involving a woman medical student who had been tortured with electricity. Electricity is very harmful but you cannot see its effects on the surface of the body. We examined her thoroughly but found no signs of torture on her body. Then we got a biopsy of one body part and only then did we find very typical pathological findings.

Another method is magnification. Ultrasonography sometimes helps us detect signs of suspension and hematoma. MRI can sometimes help. Finally their

EMG is very helpful in detecting signs of suspension. There is a group in my country that specifically uses EMG and they have obtained positive findings on 90 percent of the chronic cases they have handled.

Alternative medical reports

After completing this kind of examination, a medical report is prepared. If there is an earlier medical report, ours becomes the alternative medical report. This report is submitted by the Commission of Medical Chambers which I head. For many years now we have been preparing these alternative medical reports which have been accepted by the courts. Twenty-eight of our cases did not apply for a re-trial [using our report] because of fear and other reasons. The prosecutor did not accept the appeal of 12 others for the reopening of their cases. But of 11 alternative reports assessed by the courts, three have resulted in sentencing and trials are continuing for nine others. Only one case did not result in a sentence. I can tell you that at the end of this work there have been very little results. But if we continue we can get more results.

Torturers pay considerable attention to avoiding any permanent physical sign

Torturers pay considerable attention to avoiding any permanent physical sign of torture on their victims. Thus, physicians should make use of every possible tool, including advanced diagnostic assessment, in order to verify malpractice (i.e., torture). Physical examinations and x-rays alone are generally not sufficient for verification and may sometimes give rise to negative reports. Detailed analysis is necessary and physical examinations should be made with psychiatric evaluations by experienced specialists. Advanced diagnostic tools such as ultrasonography,

MRI, EMG, audiometry, biopsy and scintigraphy should be used if necessary. Sometimes psychiatric assessment alone may not suffice for the diagnosis of torture. The patient should be informed beforehand and ethical rules must be observed.

An alternative medical report should meet technical standards. Financial aid for the increasing cost of advanced diagnostic assessment may be mobilized from the United Nations, the European Community and volunteer organizations. Afterall, the alternative medical report is an efficient tool of physicians for the prevention of torture as shown in our case. One practical consequence of our work is that *falanga* is no longer being used in our country although it is still practised in Istanbul. □

Excerpts of the Open Forum

Kalli: Veli Lok described very concrete methods that can diagnose even the sequence and duration of the torture. I'd like to inform you that there are international laws or covenants that protect refugees from being forcibly returned to their country when there are valid reasons to fear that they will be tortured again. In my country we accept many refugees although we do not always grant asylum. (In any case) it is very important for us to utilize the diagnostic tools on hand to certify torture victims so they are not sent back (to their countries of origin) and subjected to further pain.

Lok: It is neccessary to show specific signs of torture. Otherwise, people cannot go to court. In my country at the beginning of this year we had a case of 16 tortured cases who failed to obtain a positive report from a doctor. So they came to us. We were able to give them reports supported by technical findings which their lawyer submitted in court.

Sinha: Dr. Veli Lok, Dr. Sharma, how do you get these references? Do they come directly to you or are

they directed to other medical doctors or other agencies? And once you see them, how do you follow them up? Do you confer with the doctors who referred them to you? And do you have any refugees? Do you charge them when they see you?

B. Sharma: We have several referral systems. It's not very systematic but it works. One of the reasons the patients, come to our center is that some of the doctors who established a separate center, an independent NGO, used to work with the English-speaking hospitals. And we used to treat torture victims from the pro-democracy movement. Many of them were referred by human rights organizations. We also train medical doctors and other health professionals so that some cases can be treated locally. We have a list of doctors and health professionals who refer cases to us and to whom we refer the cases we have seen.

Rasalingam: Dr. Veli Lok, thank you very much for your convincing slides. Obviously, you have done some pioneering work. In New Zealand, we get some refugees and asylum seekers. We have established *falanga* treatment and the cases are being followed by doctors with no problems. For the asylum seekers we have to make a report. But we have not gone so far as to perform biopsies or scans and our reports are being challenged. The question is who funds the advanced investigation that you do? It must cost you a tidy sum.

Lok: We have obtained our funding from the United Nations Voluntary Fund, the European Union, the Danish Embassy, Oxfam and other private donors. IRCT provided a grant to do this research. Assuming our funds are spent, how do we find another foundation to support our work? In my country each scintigraphy examina-

tion costs around $100. You can prepare a project proposal for this kind of work, with a budget, and send it to the United Nations. There are other possibilities for funding to explore.

Sothearith: My name is Dr. Sothearith. I am a Psychiatry resident in Cambodia. I would like to ask you one question: If we have no (technology for) bone scintigraphy and biopsy, how can we make a complete report on a patient?

Lok: We don't need all of these advanced investigations for treatment. We can do physical examinations and take the patient's history. Then we will know what treatment to give. The scintigraphy is for (gathering) scientific evidence. If you want to convince the international community that torture is happening, these advanced diagnostic methods are important. But if a torture victim comes to you and you are unable to do scintigraphy, you can proceed with the treatment. We don't do scintigraphy in all cases.

Sorensen: I think the point is that you can detect positive findings even long after the torture has taken place. It is important that we realize that torture victims can't present themselves after some time and still be able to show positive findings. Under such conditions the authorities may say to them: No findings, no torture. In the Izmir case we were able to come up with scintigraphic findings for 80% of the victims. But a very important point is that negative findings don't mean the person has not been tortured. □



Torture of Women and Children

"The main aim of the torturer is to destroy the integrity and identity of the victim, and one of the best way to do that is to attack his or her sexual identity."

Rebecca Samson Gaddi

Issues in the Care of Women Torture Survivors

REBECCA SAMSON-GADDI

Introduction

TORTURE is an unacceptable act worldwide, being a form of human rights violation under international humanitarian law.

The United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment states: "Torture means any act by which severe pain or suffering, whether physical or mental,is intentionally inflicted on a person for such purposes as obtaining from

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him or a third person information or a confession, punishing him for an act he 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, when such pain or suffering arising only from, inherent in or incidental to lawful sanctions."

The main aim of the torturer is to destroy the integrity and identity of the victim, and one of the best way to do that is to attack his or her sexual identity.

Sexual Torture

According to Larsen (1996), there is no definition of sexual torture more valid than the victim's own sense of what constitute being sexually tortured. In other words, physical rape does not have to happen for a woman to feel sexually abused/raped and to have her boundaries violated. Personal boundaries vary from woman to woman. These differences have been culturally influenced and determined. Varying degrees of exposure to violation of the self result in equally traumatizing feelings.

Rape is the most often used form of torture on women. By its very nature, rape is intentionally used to cause severe psychological trauma.

Rape is the most often used form of torture on women. Judith Herman equates rape to violation. She says the purpose of the rapist is to terrorize, dominate and humiliate the victim and to render her utterly helpless. By its very nature, rape is intentionally used to cause severe psychological trauma.

In discussing women and torture, we will surface certain issues which we think have been raised for some time, but which until now are wanting of satisfactory answers.

ISSUE 1: *The use of gendered-forms of state-sanctioned violence, specifically inflicted on women,*

has become an official part of the military procedural structures.

It has become an official standard operational procedure (SOP) for the military to use torture on political detainees who in its mindframe represent anti-State forces to be destroyed. In Asian countries, torture has been used widely to punish human rights activists.

Whether in a state of war or not, military personnel use rape and other forms of sexual abuse on women.

Women detainees are not spared from torture. In fact, there are customized forms of torture used on women to make extraction of information more efficient. Whether in a state of war or not, military personnel use rape and other forms of sexual abuse on women. Their psyche as mothers and nurturing wives is also tortured by threats of killing their husbands and children.

Raping subversive women in times of political upheaval and instability, when the state is said to be in jeopardy, has become integrally related to mainstreaming the social order (Enloe 1988; as cited in Hilsdon 1995). This means raping women, to punish them for their political involvement, has been made part of the structure of keeping the "order" that the ruling state wants to prevail.

As Fletcher (1991, as cited in Lykes 1993) said, military dictatorships use rape as a terrorist act to control women who go beyond the "limits established by the patriarchal system of society." It is actually a form of quieting women from further expressing their sentiments and dissent.

ISSUE 2: *There is difficulty in actually knowing the prevalence of actual torture; more so sexual torture.*

Even as military and police institutions deny the use of torture, it is a well-established fact that investi-

gations and counter-intelligence procedures routines include torture. Nonetheless, the incidence of torture is difficult to monitor because it is done covertly and survivors have many reasons for not being eager to report it.

The incidence and extent of sexual torture is even more difficult to monitor. Women are ashamed to relate the rape or sexual molestation experience for fear that they would be ostracised by society and by their own families and friends. The consequent feeling of being "unclean" increases their vulnerability to the social stigma attached to being a victim of sexual abuse. This stigma worsens psychological sequelae which may further deter the survivor from reporting. This factor considerably accounts for the underrated reports and statistics on sexual abuse in general.

There are few gender-sensitive service-oriented groups or entities that handle cases of women survivors of sexual violence.

Second, there are very few gender-sensitive service-oriented groups or entities handling cases of women survivors of sexual violence. Not unless the government initiates greater collaboration with NGOs on this matter, sexual abuse will continue to occur unreported.

Third, women victims of sexual torture and violence may feel the justice system itself is not women friendly. The judicial process can often be a retraumatization for the victim.

ISSUE 3 : *Legal system inadequacies make it difficult for sexually tortured women to obtain justice.*

In many countries, rape is recognized as a military form of punishment or intimidation. The burden to prove the truthfulness of the act is on the

woman, and if she fails to do so, she may end up being punished while the perpetrator is set free.

Dr. Mahboob Mehdi's study asserts that torture has been interwoven in the socio-cultural life of Pakistan. Laws allowing torture still exist. Political changes which affect laws on family have put women in very vulnerable legal positions. As a result, these changes have affected the way sexual torture has been defined and put women in a situation of easy persecution.

Women survivors of sexual torture and violence feel that the justice system itself is not women-friendly.

Mehdi further explains that rape and sexual torture of women in prison can, theoretically, be denied on strictly legal grounds, since it is unlikely that the proof of rape can satisfy the stringent requirement of Pakistan law — confession of the rapist or evidence of four male, pious Muslims who are eye-witnesses to the act of penetration. This is definitely a lose-lose situation for women victims of rape in Pakistan.

In the Philippines, the difficulty in proving rape lies in the common belief that rape victims are physically beaten. As such, she must have sustained bruises in her body as proof of resistance to the assault.

ISSUE 4: *Since rape and other forms of violence have a differential effect on women than men, particularly on their self image, therapy of women victims requires a different approach.*

The common complaint of women victims is that they are not understood by their therapists from a woman's perspective. Women victims are sometimes blamed for what happened to them. According to Toni A. Laidlaw (1990), this kind of conclusion is based on the assumption of free choice, where we are made to be responsible mainly for all that happens to our lives.

Laidlaw explains that so called feminist therapists (she being one of them), have evolved a feminist consciousness and have attempted to eradicate sexist assumptions that weaken the traditional approach to therapy. From the viewpoint of women, feminist therapy has put more emphasis on listening to women's experiences and their interpretation of the meanings of these experiences in their lives. As a result, they began to understand that women victims were actually reacting to unhealthy and oppressive circumstances surrounding them, to structures and systems that either ignore or undermine their potentials, apart from simply identifying the direct cause or source of the trauma.

The common complaint of women victims is that they are not understood by their therapists from a woman's perspective.

Laidlaw points out that feminist therapists believe the long silence of women has to be broken. Changes have to take place within the woman and as she relates to society. This means victims have to feel empowered in the process of their healing. A gradual deconstruction of perspectives, in terms of the socio-political and cultural factors that influence, deter or undermine women's way of thinking and development is necessary in achieving their empowerment.

ISSUE 5 : *Therapy, aside from being gender-sensitive, has to be culture-sensitive.*

A form of therapy found to be appropriate to women victims of torture is the mutual support group. This approach has been used by the Canadian Center for Victims of Torture (CCVT). Rather than conducting one-on-one therapy sessions, the mutual support groups serve as venues through which the victims can collectively find practical ways of coping with the trauma.

Some women's groups in the Philippines have used the mutual support group and family approaches. For example, the Women's Crisis Center, which takes care of battered and raped women, encourages women to discuss and share their experiences together and provide support to each other. The families are consciously made part of the process.

Mutual support groups serve as venues through which the victims can collectively find practical ways of coping with the trauma.

A study conducted on eight Filipino women ex-political detainees, reveals that all of them experienced torture and sexual abuse. We interviewed each one separately at first. Later, groups sessions were held where the women survivor-respondents shared their experiences, feelings and insights after having re-opened the wounds of past events.

Apart from the mutual group support, family approaches to healing sexually tortured women have come to be used in the Philippines. Filipinos give importance to family members, relatives and friends, who strongly reinforce feelings of self-worth. Since the family is instrumental in inculcating traditional perspectives which link a woman's self-worth to sexuality, the same institution can provide the necessary support when a member is sexually violated.

It should be noted, however, that there are certain cultures where the retelling and sharing of past experiences are not as therapeutic. This was one of the findings of the CCVT among some Somali women victims of sexual abuse. They claim they are better off putting everything in the past and starting life anew. The Western approach to therapy, which assumes that the victim will not find peace if she does not work through her past experiences, may not be applicable to some cultures.

Hence, during the healing process, it is important that the therapist makes the victim understand the nature of the sexual abuse committed against her, its effects, and the dynamics between her personal experiences and the culture of the society she lives in.

Furthermore, certain norms and beliefs have to be deconstructed. Women have to understand that virginity or chastity as measures of one's femininity and personhood are culture constructions. These are not the be all and end all of their being. Such a view will make it easier for women victims to pick up the pieces of their life after sexual torture.

Changes have to take place within the woman and as she relates to society. This means victims have to feel empowered in the process of their healing.

ISSUE 6: *Women have a high risk of suffering multiple trauma throughout their entire life.*

In the study done by the UPCIDS - Psychosocial Trauma and Human Rights Program cited earlier on the eight women ex-political detainees, two of the repondents were actually raped. They also revealed their experiences as victims of incest, one by her father and the other by a cousin. It was not explicitly stated, but deconstructing their narrations revealed that it was easier for the two women to set aside the physical abuse committed by the military during their detention but not the psychological torture resulting from their loved one's brutality or incestuous act.

ISSUE 7: *Women are in a vulnerable position even during therapy, hence ethics in therapy relation have to be well defined and appropriately observed.*

Therapy is a crucial phase in a victim's recovery. For women victims of sexual abuse, it is necessary

to establish trust and make the victim feel safe and assured that the therapist is completely on her side.

As a feminist therapist herself, Marcia Hill (1990) sees the therapeutic relationship as one in which the therapist, as caregiver, is responsible for maintaining clearly defined roles, or boundaries, with the client. Failure to maintain this clarity is tantamount to committing incest, she avers.

The therapist and the client must work together toward empowering and restoring the client's autonomy, by helping build up her strengths and potentials.

Power relations must be consciously taken into consideration. The therapist is considered the person in power, he or she being more knowledgeable as to how the problem can be solved; and the client is the one powerless, relying on trust and, at certain points, dependence on the therapist.

The therapy process requires ethical considerations that the therapist must observe. Primarily, the therapist should be able to provide an increased range of choices for the victim without imposing on her values and perceptions. So great is the expectation from the therapist that she has to view therapy relationship not only with understanding but, with respect.

Lastly, the therapist and the client must work together toward empowering and restoring the client's autonomy, by helping build up her strengths and potentials.

ISSUE 8 : *Certain general ethical considerations may be applicable to victims of torture and violence. But are they applicable to women victims?*

I am referring here to the issue of neutrality and disinterest. Herman (1992) defines neutrality for the therapist as not taking sides regarding the victim's inner feelings and conflicts. It also entails a conscious

decision not to affect the victim's decisions. Disinterest means the therapist abstains from using her power over the victim to gratify her own interest.

Being a feminist and not a therapist, I am inclined to think that the ethic of neutrality is adequate in dealing with women victims. Like feminist therapists, I believe that one cannot be totally neutral. Because however one looks at it sexual torture or sexual abuse is a violation of basic rights. Somehow the therapist has to make a stand for the victim to be open to understanding the woman's plight.

Again, Marcia Hill calls this a taking of a therapeutic stance: a belief in the basic rightness of the client's way of being in the world, i.e., an understanding that people choose the best level of adaptation available to them. The therapist has to understand and be able to reframe the meanings of the victim's experience. She must be able to enter into the victim's world of experience, and make the victim see for herself the meaning of her reality based on her own perspective of things.

It is necessary in therapy to establish trust and make the victim feel safe and assured that the therapist is completely on her side.

However, I would like to move a step further. One's experience has to be seen and discussed in the light of other experiences. Perhaps only then can one see the true meaning of one's experience.

As mentioned in the beginning, there have been few studies and discussions on torture and sexuality. This is an area for further research and conceptual clarification. After all, torture becomes more complex when taken with issues emanating from specific experiences that only women feel and encounter. □

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Excerpts of the Open Forum

S. Sharma : I am also working with rape victims in refugee camps. I'm interested to know how you organize group therapy sessions for rape survivors. In our case, it is difficult to invite the rape victims and organize some group activities for and with them because of the social stigma. When they come to us, family members or neighbors – would say, "Oh you are going there because you have been raped!" Thus, even those intending to accompany a rape victim avoid us for fear of being labelled. How can we work out our problem?

Lopez: I agree with you and our study was in fact inspired by that same difficulty. The women we interviewed were raped 20 years ago or earlier and they are now known leaders in our women's movement. Many of them are also taking care of other victims of violence.

This is where research is a good entry point. We invited these women to talk to us in the interest of research and they were assured of the confidentiality of the interviews. We told them that their case studies will not be published as anonymous cases are easily identified in a small professional community. We also invoked a participatory process. The women helped us design the research framework and the research methodology.

In a sense, our study demonstrated how research can be therapeutic because we are not conducting studies on torture simply to extract information or prove a theory. Research here is a means of education and therapy for many of our victims. Up until the study these women thought that they had recovered fully in the past 20 years. And yet when they told us their stories they realized that some of the wounds were still fresh. Our speaker mentioned three cases with an incest experience lurking in their subconscious and many of them had been abandoned by their husbands and have not been able to have normal sexual relationships. The research made them realize these problems.

After they agreed to be interiewed, the next step was to convince them that for their well being and ours since we were affected by their stories – we would like to get together for a healing process. That was when they agreed to come for a group session to get to know each other better. All eight of them, who for years had kept their stories close to their chests, joined us in the healing session. And that was how we closed the research successfully. I think you can do the same in a creative way and find out that research is a very good entry point to helping other victims.

Marcelino: That is a very significant question because I think it addresses us as caregivers. Sometimes we don't even have to be therapists or social workers or university professors. We just have to be caring women. I think what is essential is finding an entry point in this type of work. Sometimes you can reduce it in the simplest way – by saying, "Just be yourself and open yourself" – to be able to care for others.

That was s how I came to work with children and how June (Lopez) got to work with women and other

victims. We were simply there. We did not begin by declaring: "We have a program or we have a plan or we have money." Those came after. When we started, we merely wanted to help a friend. I wanted to help a mother who beat her child because she was acting up. I told myself I have to do something. And that started me on this long road.

We can share the techniques we have learned. But I think the real entry point is your ability to connect with another person in a loving and caring relationship.

My second point is that we cannot romanticize this work because there are many risks involved. One therapist who we believed misused and abused the practice of his profession by molesting the women who had asked him for help had to be exposed. That he was male added to the problem. He sued us for oral defamation. It turned out well for us because all the women we sought to protect supported us.

In the Asian context you begin when you are ready, you end when you are finished. Take your own time, as Master Li would put it, "Take your own time, take your own pace." Find your grounding. I think whether by yourself or with your group, you will have to find your center because that is where your strength lies. □

Torture of Children

ELIZABETH PROTACIO-MARCELINO

LET me start by telling you where I come from and how I started my work with children. I usually begin my story with a denial that I was a torture victim.

When the team of the IRCT (International Rehabilitation Council for Torture Victims) came to the Philippines, I recounted to them the experience of children I had met, mostly stories of torture, pain and loss. I felt very lucky, I said, not to have been tortured myself. Inge Genefke then looked at me

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straight in the eye and incredulously asked, "You were not? Weren't you in prison?" But I was not physically harmed, was my answer. And Inge said, "So what happened to you?"

I was kept in a room right next to the torture chamber. I heard the screaming and crying. When silence returns, the victims would be purposely shown to me. Anticipating that I would go next, I would take a bedsheet and tie myself to the bed to indicate resistance in case I was raped. But my father was a high-ranking military officer and I was not touched at all. Well, I wasn't tortured physically but psychological torture and deprivation techniques were applied on me.

Then yesterday, as June (Lopez) was presenting her slides, I was a bit impatient. I had seen those pictures of torture victims more than a hundred times. But when she flashed a slide showing a keyhole, that brought back a vivid prison memory and I became very uncomfortable. I thought June was going to disclose my whole story to all of you. Then I realized she was telling someone else's story...but it might as well have been mine.

We need to redefine "torture" to fit the special situation of children.

In my story, it wasn't a keyhole but a tiny hole left by a pulled-out nail in the plywood wall of the room where I was held. It was my only source of light for two weeks, the only way I could know whether it was night or day. At the end of the second week, I had developed skin problems. Later on, I was locked up together with other women, most of whom were workers and trade union organizers. I was the only professional in the group. There were children, too, because some mothers wanted their children to stay with them. Some of the children had

been "in prison" for so long they went to a nearby school together with the children of soldiers. I noticed that these families needed help.

As a professional and to save my sanity, I started counseling some of the mothers who were beating their own children because they were so stressed. That was how my work with children began — as a torture victim. Now I believe that I am a survivor.

What may be a relatively slight maltreatment for adults may cause children severe pain and suffering.

Our work with children today adheres to the International Declaration on Human Rights and the Convention on the Rights of the Child, the essence of which is protecting the best interests of the child. The Convention has four basic components: *survival, development, protection,* and *participation.* With these in mind, we need to redefine "torture" to fit the special situation of children. The current definition uses general terms to include all human beings regardless of gender or age. It does not acknowledge the more specific effects of torture on children, as well as factors relating to their situation. What may be considered a relatively slight maltreatment for adults may cause children severe pain and suffering. They are more vulnerable because their physical, psychological, intellectual and social development is still incomplete.

Children as indirect victims

Moreover, children are not only direct victims of torture as in cases of arrest, detention and imprisonment but are also affected indirectly. Our study focuses on direct victims although there are many more indirect victims among children who witnessed the arrest, detention and torture of their parents, or refugee children whose families and communities were forcibly displaced. Generally, indirect

victims are more naughty or difficult to control. Not realizing that this is the result of being an indirect victim, parents spanked their children to instill discipline.

This insight is drawn from the findings of our study that documented 415 cases of tortured children. Under an umbrella project called the "Graca Machel Study" which was done in 42 countries our research objective was to assess the situation 10 years after the Children's Summit, and to look at the impact of armed conflict and violence on children. We also aimed to identify the physical and psychosocial effects of torture and to assess local and international efforts to protect the children from such sources of suffering.

Surprisingly, we were the only country team that was able to submit a paper on torture. Three or four other country teams failed to do so because of the high risks for their researchers. Our paper will be presented in November to the United Nations General Assembly, together with all the other reports on children and families at risk.

Not realizing that this is the result of being an indirect victim, parents spanked their children to instill discipline.

Lack of attention in documenting cases of children victims

We covered about 14 provinces and all regions in the Philippines from 1972 to March 1995. Our sample had more males than females, and the males belonged to an older age group. The incidents of torture were culled from documents built up by several human rights organizations, among them the Task Force Detainees-Philippines (TFDP), the Medical Action Group, and my own center, the Children's Rehabilitation Center. Serious and systematic documentation started in 1982, although TFDP had incomplete files from the mid-70's.

The study had several limitations. Most of the case files did not specifically inquire into the plight of the children. Typically, we would find detailed descriptions of problems reported by parents but only passing mention of the fact that their children had also been beaten up. The research team also faced the problem of obtaining medical records. Some of the cases were reported only after many weeks or months had elapsed so the marks of torture were gone. Note also that many victims reside in remote areas with very little access to medical assistance.

If it's hard to get adults to share painful experiences with strangers, it could be 10 times harder with children.

You can imagine the amount of data digging we had to do. Given six months to sort out information from 1972 to 1996, we had to stop at 415 cases because deadlines had been set. Otherwise, more cases could have been documented. It is unfortunate that some of the victims who had already grown or were still in transition to adolescence or adulthood refused to talk about their traumatic experiences. We were lucky 10 children agreed to be interviewed.

Getting children to share their traumatic experiences

We employed a multimethod approach: secondary research, case studies, and face-to-face interviews. Let me focus for a while on our indigenous methods of interviewing and storytelling as this was vital to obtaining information from tortured children. If it is difficult for adults to share painful experiences with strangers, imagine it to be 10 times harder for children. First, they do not express their feelings verbally and second they find it difficult to recall the traumatic incident. Against this backdrop, we veered away from the usual question-and-answer method. We immersed ourselves in the communities, working,

playing and doing things together with the children. The questions were asked in a very indirect way (which is typically Asian). Our stories were pieced together from the tales expressed by the children in contrived play activities.

Inge (Genefke) and June (Lopez) have discussed the physical effects of torture so I won't go into detail. Our findings are that the methods employed for both adults and children were basically the same. The difference was in terms of how the pain and suffering were felt, expressed and reported.

The children were detained, charged in court, released, missing, or they had escaped. They were arrested on suspicion of being members or supporters of an armed dissident group, members of cause-oriented groups, or participants in protest actions. Others were detained for alleged criminal offenses. Most of the victims of torture were suspected members of an armed dissident group, active participants in the struggle. They were not just passive recipients of our services.

The most common method of physical torture was beating. Other methods caused disfiguration, mutilation, and permanent disability.

The military was identified in the files as the primary perpetrators. In some cases, individual soldiers were named by the children. Paramilitary groups and the national police were also identified as human-rights violators.

The most common method of physical torture was beating. Other methods caused disfiguration, mutilation, and permanent disability. We had one severely tortured boy who was hit repeatedly on the ears with a thick piece of wood. But he didn't tell anyone about it even if he could hardly hear

anything. He was so quiet and withdrawn. It was only after a year that we found out about his damaged eardrums. He was afraid to be touched by a doctor, and when medical treatment began he said it was even more painful than the torture itself. We saw the need to educate and orient doctors on how to handle torture cases.

Boys were commonly beaten up, threatened to be killed, tied down, made to sign false statements, shot, and stabbed.

Psychological torture of children

Our study also documented incidents of mental or psychological torture, among them:

1. *deprivation techniques* — include blindfolding, isolation and perceptual deprivation;

2. *coercion techniques* — forcing victims to sign false statements, disclose information, incriminate others, torture other victims, be photographed with incriminating evidence, and even to drink urine or eat such things as a part of an ear, soap, or cement;

3. *threats* — directed at victims that they will be killed, tortured, raped;

4. *humiliation* — in which the children were paraded around town, forced to perform degrading acts, or made to dance naked before their torturers; and

5. *sexual torture* — insertion of the mouth of a softdrink bottle or an eggplant in the genitalia, penile penetration, undressing, fondling, etc.

The boys in the sample (n=172) were commonly beaten up, threatened to be killed, tied down, made to sign false statements, shot, and stabbed. As expected, the torture method commonly used on girls were rape and the threat of rape. The physical effects

of torture on children are magnified because their bodies are soft, delicate, and still developing. I don't really know the extent of magnification since I'm a child psychologist and not a medical doctor.

Psychological imprints of torture

What were the psychosocial effects of torture on this children? They developed *fear and anxiety*, expressed as generalized fear of the immediate environment, excessive stranger anxiety, and sleeping problems. After 20 years some victims still refused to talk about certain fears. General helplessness and apathy were also among the children's reactions. They were excessively dependent on adults. In the cases we have documented, the children would be withdrawn, just sitting there, not initiating anything, not answering any of our questions. If at all, they would say, I don't know, I don't care, I don't want to. Sometimes a child would hide for an hour behind a door at the center, saying over and over, I don't like...I don't know...I don't want. The parents would spank them, not understanding what was happening.

Some children displayed withdrawal and aggressiveness at the same time, although there were more cases of severe withdrawal.

The boy with damaged eardrums avoided talking to us, but not to his friends. For about a year he barely spoke a word other than yes or no. He was very industrious, not missing any of his chores, but he just wouldn't talk to us. This is a common response from children who feel they have lost control over what is happening around them. If their parents can't protect them, who can?

Sudden behavioral changes. Some children displayed withdrawal and aggressiveness at the same time, although there were more cases of severe withdrawal. Withdrawal responses are more common

among Asian children than aggressiveness, because they are socialized to conform, obey, say yes, not to answer back to one's parents. It is important to note that we sometimes find it hard to differentiate between severe withdrawal or simply normal conforming behavior! We had a boy who talked only to his pet pigeon. So we used toy animals to help him open up in our sharing session. But one day the mother became very angry with the boy and killed his pigeon, further reinforcing the child's withdrawal.

Victims of sexual torture experience shame, fear, anger, denial, and physical and emotional numbing.

Learning problems. Some children who used to perform very well in school suddenly dropped out or obtained failing grades. This is to be expected. If minor family problems can cause children to display these signs, what more conditions of extreme stress due to torture.

Victims of sexual torture experience shame, fear, anger, denial, and physical and emotional numbing. They feel complete helplessness and hopelessness. They are also subject to panic attacks.

Social effects of torture and detention

Apart from the physical and psychological effects, detention and torture also result in social effects. It is commonplace for the family to be robbed of their belongings, their few prized possessions, cash and livestock. It would not be unusual either for them to be cut off from the community, who fear further reprisals by the military. These things heightened the helplessness and apathy of the victims.

The effects are aggravated by certain factors, the more important of which are the social environment and individual predisposition of the child. Note that

any child's body is naturally weak to start with. Moreover since the victims or survivors came from poor rural families, most had nutrition and health problems which worsened the physical and psychosocial effects of torture. The failure of adults to explain what is really happening to the child aggravates the situation. Parents do not only have difficulty explaining, they sometimes deny the incident, or invent a story to cover up the truth. A mother would tell her boy that his father was away on business and would be back soon, but in reality he was in prison. For two years, another mother kept her husband's death a secret from her two sons. When the boys noticed that their father had stopped writing letters and sending Christmas and birthday cards, they became angry. One day the mother saw them throwing darts at their father's picture and screaming at it. We convinced her to confront her own denial of her husband's death. And when she did, telling her children the truth after two years and crying as she spoke, the family began the process of healing.

The factors aggravating the effects of torture on children include the inaccessibility of basic services, continuing militarization, and the slow justice system

Fears and helplessness are the usual effects of torture on a family. A serious aggravating factor is poverty. That is why we often provide economic support in our interventions.

In the community, the aggravating factor is the social stigma attached to children and families who have been victimized. Adults who fight for a cause are sometimes considered heroes, particularly by the media. But children have to contend with the serious social stigma in school We had a girl who resented her teacher's saying that the New People's Army (NPA) were bad people who stir up trouble, kill and steal. The girl stood up and declared, you can't say that because my father is with the NPA and he is a

good man! Her friends began avoiding her and she eventually dropped out of school. Worse, she was scolded by her mother for having told the truth about her father.

In the larger society, the factors that worsen the effects of torture on children include the inaccessibility of basic services, continuing militarization, the slow justice system, inadequate policies and laws, to name only a few.

Medical and fact-finding missions are conducted to extend medical help and relief to the communities.

Culture of violence

Essentially, the child is caught in a culture of violence, also referred to by Gustavson as a triangle of chaos: loss, separation and exploitation. The exploitation does not end after the torture, but continues as society itself is caught in a web of exploitation which happens in the home as well as in communities subjected to military repression. Understanding this triangle of chaos requires an assessment of the risk factors which are the deprivation of basic needs, limited or no access to basic services, social restrictions and control, economic dislocation and disrupted livelihood, and disrupted community life and practices. In militarized communities the people were not allowed to pray together. In one of our healing sessions, the community held a religious procession, carrying the image of the Virgin Mary, to express their grief over the death of a member. It was a community ritual that in some areas became impossible to perform because of social isolation and other restrictions.

Short- and long-term intervention strategies

Our intervention strategies address the needs of the children, families and communities. Often, the

first intervention that we provide is emergency relief, including first aid, food and shelter assistance, or whatever the child and family need to survive. Medical fact-finding missions are conducted to extend medical help and relief to the communities. Aside from providing services, these missions are also concerned with documenting the political, social and economic situation in the communities.

We also have long-term interventions which involve organizing the community. Instead of immediately bringing in intervention frameworks, we use the community's existing structures and resources. Its own coping and support systems, based on their rich culture, should be tapped instead of relying entirely on Western interventions. We have to be culture- and gender-sensitive in our approach, and this includes the use of the local language, their rituals, practices and institutions. I acknowledge that factors external to the community can be positive—money can be put to good use—but we need to highlight the community's own resources.

We encourage the children's participation in the recovery efforts.

We encourage the children's participation in the recovery efforts. Training, advocacy and social mobilization are some of the interventions which are based on the capabilities of the community. The referral system and the economic support systems are also part of our interventions.

Individual and group therapy

Psychosocial intervention, on the other hand, involves counseling and therapy with individuals or groups. These are provided by professionals and paraprofessionals with adequate training.

Group therapy or group work is more often used rather than the individual approach. This is appropriate in the Philippines because the concept of the "self" is closely related to the "other" (or the *kapwa*). Therefore group sharing is very important; the children can find support in each other.

Prayer was a common means of coping that we particularly noticed among children who had been tortured.

The need for group support is more pronounced in children, since they tend to share more with peers than with adults. This is the reason for play therapy as one of the cornerstones of our work at the Children's Rehabilitation Center. We also teach the children skills to help them cope economically and psychosocially.

Prayer - the first coping mechanism

Prayer was a common means of coping that we particularly noticed among children who had been tortured. When asked questions like, how did you react when you were tortured? how did you cope when you saw your father being tortured, or being killed? a common answer would be, I prayed. I referred to the standard texts on coping mechanisms and found no official "label" for it. Some psychologists call it a crutch. At the Center, we include discussions on faith in the children's play activities because they pretend to be priests or nuns, and dream of being one someday.

Parents often complain that their children are hallucinating. A badly frightened mother reported that her son has been talking to somebody invisible for about ten years. In fact, some of the children themselves say that they often talk to their "invisible friends" or to an angel. Recently I met one boy who was our client when he was five. Now 18 and living in the

United States, he confided to me that he still has his "playmates" with him, and that the idea makes him feel secure.

Communities each have their own indigenous and spiritual means of coping. At a training seminar in Sri Lanka, we performed a ritual with flowers and candles. Rather than treatment practices, we wanted to emphasize healing practices. Healing is holistic, and includes the mind. body and spiritual dimensions.

Treatment vs. Healing

Practitioners and trained professionals in the field often confront a dilemma: will center-based interventions be more effective than community-based interventions? In other words, will we espouse treatment or healing? In the Philippines, practitioners are trained in Western theory and methods in which treatment is the model applied in psychosocial help. But treatment is a disease model: there is a disease, there is a cure. In contrast, healing includes the spiritual dimension, which others dismiss as "quackery" as they relate it to faith healing. These people probably fail to notice that most Filipinos first bring their health problems to a faith healer, astrologer, herbal doctor (*albularyo*) before going to a medical doctor or psychologist as a last resort. Unfortunately, at this point, the patient may have become seriously ill.

In the Philippines, practitioners are trained in Western theory and methods.

I think that center-based intervention is better when the community is not safe to work in. But if work can be done in safe conditions and you need support, it is better to be right there in the community.

Enhancing resilience in children

Our research also revealed that children survived their torture experiences not only because interventions were provided but because of their own resilience. Some of them recovered completely even without intervention. Certainly however, I'm not advocating that we should not help these children because they will bounce back anyway. I am here to emphasize the need to build skills to enhance resilence in children. We need to build on what we have in our cultures. If religion is a strong element in a culture, we must not be afraid to use or talk about it as a coping mechanism. The community will relate to these local rituals of healing rather than to therapy which may appear very foreign to them.

Unfortunately, up to this very day there is no "safe environment" in my country.

I would like to end by saying that our ultimate goal is recovery and reintegration. Treatment alone cannot cure a person. Patients have to recover and reintegrate in a society which is safe. When we help children, we not only help stop the cough, the headaches and the nightmares, but we must also ensure a safe and secure environment. Unfortunately, up to this very day there are still many unsafe environments in my country.

A secure economic base is also important. One cannot be "safe" if you have nothing to eat. Although there are resilient children and resilient communities resilience is not enough to ensure their survival if we do not stop the war and the torture.

We also have laws to protect us. But speaking for myself, I would rather rely on the protective mechanisms within us. I feel that healing ourselves first is

the best way to healing others. This includes healing ourselves from burnout. We must heal and protect ourselves in order to give love, care, affection and attention to our children. □

Excerpts of the Open Forum

Rasalingam: You have stated that children will never completely recover without the support of parents or significant adults, or that these adults themselves also should undergo therapy. What experiences do you have along this line that can help us formulate a recommendation to the region where I work?

Marcelino: The Children's Rehabilitation Center is actually a center for the whole family. The child is the focus of the therapy but the parents are also given therapy and counseling. Our summer program includes the parents in the activities and they have their own group counseling. If parents have problems that we cannot address, they are referred to other agencies and support groups and our caseworkers coordinate with these other agencies. That way, the family approach is maintained. But when we are working in a community, the approach enlarges from a parent-child focus to focus on the community and the family.

Rasalingam: Have you dealt with orphans in the Center?

Marcelino: Yes, but they do not stay there long. We do not have an orphanage for children victims of war and other difficult circumstances. We believe that it is better to bring the children back to the communities under

the protection of relatives and friends, rather than prolonging their stay at the Center. We made an exception for five children, who stayed with us for an average of three years because both parents had been killed and we could not find their relatives. One of them was the boy whose eardrum was damaged. He had seen how his father was killed by paramilitary personnel. After a year his mother and brother were killed too. The police even came to the Center to look for him. In these particular cases, we ourselves protect the children.

In most cases, we ask relatives or close family friends to take care of the child. The usual problem is that the families are poor and the Center needs to provide them economic support.

Sinha: As a researcher, I have three questions. How did you arrive at a common conceptualization among the children? An urban child would have a different concept of pain than a rural or a tribal child. Secondly, we have this problem of passive illnesses reported by the person being interviewed. How will you fit them in a medical or clinical slant? My third question is, what are the mechanisms to delineate a withdrawn from a conforming child?

Marcelino: Your first question on the common conceptualization of pain in urban and rural children is very good. This is the old problem of standardizing and setting measures. The children in our study were generally rural, poor and marginalized. There were those who did grow up in urban centers but whose parents migrated from the countryside to the cities to find temporary work and wait out the war in their localities. The Center prioritizes children from rural communities who cannot afford to pay for spe-

cial care. These were the children in our study.

On the second point, should we rely on self-reports or not? Before coming here, I was asked to appear in court to give an opinion as to whether we can believe a child who says she has been raped. Within the discipline, tests can be developed to assess the veracity of a claim. But the tests are paper and pencil tests which arouse nervousness and fear in children What if they cannot read or write or are unable to understand the questions? Their answers could lead to wrong diagnoses.

In cases of torture, rape and trauma I would tend to believe the victim or the child. But I am not saying that children do not lie. Sometimes self-reports have to be validated through multimethod approaches. We also talk to the parents and playmates. There are other ways of observing the child. But as a rule, the child can be believed because it is difficult to manufacture a story of a father being chopped to pieces and his ear being eaten.

On the last question—distinguishing between a withdrawn and a conforming child—as Veli Lok would say, it is a matter of training and experience. There are play activities or play therapy for observing the child. Participant-observation is often used, involving immersion in the child's daily activities or even in structured activities. We provide our psychologists or social workers with a checklist of things to watch out for.

How do you differentiate withdrawal from simple disobedience? There is no hard and fast rule. We have to see the act in the context of the child's environment

and individual history. Of course there are difficult cases. That is when we rely on interjudge reliability where different people observe the child and arrive at a consensus after a thorough discussion.

I would like to emphasize that a caregiver should know and understand his/her own culture—be in tune with the sensibilities of the culture and its ideas of right and wrong. Thus, you can observe by sensing and feeling. We have a word for that, *pakiramdam*, which connotes not only feeling but using all the senses, without speaking. Trust your culture. But in order to trust your culture, you have to trust yourself. To trust yourself, you have to heal yourself. □

Child Sexual Abuse and Torture

AMIHAN ABUEVA

THE Vietnam War was one of the major reasons for the proliferation of the sex industry in Thailand and the Philippines. The main objective was to provide for the "rest and recreation" needs of American servicemen. After the war, the US bases in the Philippines continued to serve as sex dens for vacationing and retired American military personnel. Thereafter, tourism flourished and became a major socioeconomic policy of the government to boost foreign exchange income.

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In the Philippines, Thailand and Sri Lanka, this phenomenon gave a major push to the growth of the sex industry which now includes child prostitution.

Monetary gain from commercial sexual exploitation is one reason for engaging in it. In discussing it as a form of torture, should we consider only specific acts of maltreatment of prostituted children, or should the totality of repeated, commercial exploitation as being a continuous form of torture? If you are emotionally affected by the thought of 415 children who suffered torture in the Philippines as a result of political conflict, think of the thousands if not millions of children who could be the objects of commercial sexual exploitation.

Maltreatment is part of child sexual abuse

Children are maltreated while being recruited into prostitution or forced to stay in it. Actually we have a lot of anecdotal information about children who have been lured or trafficked into prostitution. In 1984, after a fire in the tourist city of Phuket in southern Thailand, the charred bodies of four young girls were found inside a brothel. They had been locked up, and nobody had bothered to let them out. Studies have also been conducted One of them studied some Burmese women who were trafficked into brothels in Thailand. All of them narrated being lured into the area, beaten up, slapped or burned with cigarette butts, to force their submission. Some were raped. With the high premium placed on virgins in Thailand, however, most girls are spared from being raped by their recruiters who can then sell them to customers for much more. The United Nations Commission on Human Rights (UNCHR) made a similar find-

Children are maltreated while being recruited into prostitution or forced to stay in it.

ing when it documented the trafficking of Nepali girls and women into Indian brothels.

Soon after our organization was formed, we started to call the attention of some Asian governments to the possibility and extent of child prostitution in their respective countries. At first, many of them refused to admit that the situation was alarming. During the late 1980s and the 1990s, the issue was very much a part of promoting tourism. This connection is important because it is a problem of the country where the victimized children are, as well as the home country of the men abusers. In Southeast Asia most offenders are foreign men, and only a few women are involved.

During this period of advocacy, it was logical to link the campaign in Asia with groups in Europe, the Pacific and North America.

Denying child sexual abuse as a growing problem

During this period of advocacy, it was logical to link the campaign in Asia with groups in Europe, the Pacific and North America. We focused not only on direct services to the victims. We also aimed to change the political and social context of commercial child sex, child pornography and child trafficking. It was not easy to make people understand that these things were actually happening to children, girls as well as boys. We tried to increase public awareness of the long-term, very serious and life-threatening consequences of child prostitution.

New laws enacted

Our campaign, linked as it was with tourism, convinced governments to at least stop denying the problem. We have had some successes in changing the laws in at least 16 countries. Two major changes have been made. First was the recognition of extraterrito-

rial jurisdiction, particularly by the offenders' countries of origin. Initial changes took place in Germany, later in Australia, New Zealand, Belgium and Switzerland. After a while, five Nordic countries realized they had 30-year-old laws which could be used to cover this kind of crime. Now offenders can be charged with sexual crimes against children if they are able to escape prosecution in Third World countries (which is not unusual considering inefficiency and corruption of the police and the courts). Some criminals have already been convicted, though not very many.

On the other hand, we have also been successful in having some Asian countries change their laws. When we started the campaign, sexual exploitation of children was not yet recognized as a crime in these countries. Only rape was considered a criminal offense, and even then it applied only to women or girls and not boy victims. In the Philippines and to a certain extent Sri Lanka another improvement has been in the recognition that the prostituted child is the victim and not the offender. In Thailand, however, the victimized children are still subjected to some degree of penalty for having engaged in commercial sex. We stitll have a long way to go in this area.

The problems of child prostitution and torture intersect with other problems of a political, economic, social or other nature.

The need for a world-wide effort against child sexual abuse

For the past three years, we have expanded our network to campaign against commercial sex exploitation of children in Latin America, Eastern Europe and Africa. That was when we realized that the problem has been "globalized". Just recently, we learned that it exists not only in the so-called poor countries but also in Belgium, the United States, UK and Switzerland. In the face of such a disturbing situation,

End Child Prostitution, Child Pornography and the Trafficking of Children for Sexual Purposes (ECPAT) together with the Swedish government and in coordination with United Nations Children's Fund (UNICEF) and the Non-Governmental Organizations based in Geneva, launched the World Congress Against Commercial Sexual Exploitation of Children last August 1996 in Stockholm. Delegates from 119 governments attended. They drafted a declaration and world-wide agenda for action to protect children against commercial sexual exploitation.

Looking closely at countries in Asia, we can see that the problems of child prostitution and torture intersect with other problems of a political, economic, social or other nature. For example, I was working on the problem of children in conflict with the law. Almost all the children interviewed said they were maltreated and tortured by the police or by security personnel before and during detention. There were also cases of children being raped inside the jails. As we can see, issues such as children in conflict with the law, child labor and commercial sexual exploitation are just some of the problems that continue to affect millions of children, and where torture is also being used. This is a new challenge to you who are involved in the prevention and eradication of torture.

Child labor and commercial sexual exploitation are just some of the problems that continue to affect millions of children.

I also think there is a need to point out the responsibility of the state. For example, commercial sexual exploitation remains prevalent because of government apathy, the lack of protection for children, and insufficient provision of basic services that will protect the youth. Recent indications show that governments are beginning to accept the fact that they do have responsibilities here.

I could go on and on because there is so much to be done. All participants here right now should take a look at what is happening in their respective countries. Allow me to share some information. Children from China have been trafficked into Thailand for prostitution. A number of Bangladeshi children have been brought into India for the same purpose. Years ago, it was already estimated that at least one million girls and women were engaged in prostitution in India alone. Of these, between 15 and 33 percent were minors or below 18. Meanwhile, we have been informed that Australian men were coming into Thailand, the Philippines and other Asian countries to buy the sexual services of these children. And Thai girls have been found in Australian brothels. Just recently, two men were arrested in Nepal, a British teacher and a Danish national. Twenty-eight boys have testified that they were sexually used by these men. At the rate these incidents are brought to light and becoming an international concern, it is becoming difficult to close our eyes.

Perhaps the definition of torture can be expanded to include other specific experiences that are determined by the socio-political and economic abnormalities in which these children live.

An expanded definition of child sex trafficking

We are also looking into broadening the definition of commercial sexual exploitation to include, for example, children in the refugee camps, children who have to engage in sexual acts to get better food, better housing or to protect family members. Perhaps the definition of torture can be expanded to include other specific experiences that are determined by the socio-political and economic abnormalities in which these children live. There might be overlaps but it would be useful to explore how we can address this.

Aside from public information, advocacy and lobbying legislatures, ECPAT also supports people car-

ing for victimized children. Provisions have been made to support training programs for caregivers of sexually abused children. These have been held in the Philippines, Sri Lanka and Thailand. We want to expand this, identify key resource persons and experts, and develop a worldwide network of people who can work with us. At present, we have a considerable number of Western experts on sexual abuse mostly in the areas of incest, stranger abuse and kidnapping.

Psychological studies have been done on the inner world of prostituted children.

There is at the same time a dearth of research on domestic violence and specific interventions for sexually-exploited children. In the Philippines and Thailand, documentation is ongoing. Psychological studies have been done on the inner world of prostituted children and the like. This is actually one major field where we have to seriously systematize the work.

Let me end my talk with an invitation for you to visit our office which is in the old two-story house behind this building. I'd like to show you some of our materials. One of our first publications was *The Child and the Tourist* with translations into Vietnamese, Flemish, French, German and I think Japanese. There will be a Spanish version. The second book is called *The Rape of the Innocent* while the third one is about the history of ECPAT. We have information kits, a regular newsletter, a monthly bulletin which reprints newspaper articles on the issues we are interested in. By the way, ECPAT was recently transformed into a new organization with an even longer name which actually says it all. It is now called End Child Prostitution, Child Pornography and the Trafficking of Children for Sexual Purposes. This is also an invitation for you to get involved in it. □

Excerpts of the Open Forum

Matin: Child prostitution is indeed a serious problem in our country. Children and women are trafficked to India and Middle East countries, and they suffer terrible abuses along the way. Small children are also being used in so-called camel races in Abu Dhabi and Kuwait, in which spectators are entertained by having camels run each with a child tied to its back. As the camel runs faster, the child cries in fear and the spectators' enjoyment heightens. The rough sport definitely results in the child's death afterwards. This brutality is still going on in Middle Eastern countries. Our children and babies are illicitly brought there to be used as objects for entertainment. Recently there was a state-level intervention and we are hoping that will put a stop to it.

In this business, India serves principally as a transit point. At times some of the children are left behind in India where they are forced to work. Since they have no one to take care of them, they roam around scavenging for food. Some work as servants for old families in New Delhi, Bombay and other Indian cities. Is there any way to save these children? Can your organization intercede such that any person or affected family can ask for your assistance in bringing the children back home?

My other question is also for the organizers of this program. Torture is inflicted on children not only by the police or the military, but also by other social criminals. Is there any possibility that child torturers can be taken up by the state, or by interstate cooperation, so that perpetrators may be punished and this kind of abuse may be prevented?

Abueva: Yes, we're quite aware that children have been used as camel riders. Actually, they suffer not just because of this but by virtue of the fact that they are away from home and very vulnerable to all sorts of abuses and exploitation.

The issue of child trafficking indeed calls for international cooperation. After a seminar held in Delhi, we began studying the possibility of developing more formal links between Bangladeshi, Indian and Nepali NGOs and their respective governments. Take this case which happened early this year. In a series of raids, the Bombay police captured more than 400 women and girls from prostitution houses. Around 130 were Nepalis. The authorities put them all in jail, where there were no facilities for women and girls. Due to the poor living conditions, six Nepalis died. The Nepal government took a long time to come to the rescue. Finally, NGOs in Nepal were able to visit the prisoners in Bombay and an arrangement was made with an Indian NGO to raise money to take the women back to Nepal. The torment lasted for almost six months.

I believe that a more systematic program has to be organized to assist these children victims. Many of them, after six months in the brothels, start to have a feeling of resignation because of shame and

self-disgust. They feel that they have become spoilt goods. They can't go back to their villages because of the stigma. Even at this point, intervention is already very difficult.

All assistance programs have to address the psychological needs of the victims as well. The question of reintegration is complicated. But before we could even address that, we have to work on the prevention aspect too. This situation calls for the attention and work commitment of NGOs but mainly an honest-to-goodness intervention from governments.

Marcelino: Torture does not have a single meaning. It is multifaceted. That is why the definition of post-traumatic stress is sometimes misleading and irrelevant because of the multifaceted character of the problem. We invited Amihan Abueva to speak in order to show that multiple victimization exists in the countries where we work. The context in which we live is really very oppressive and exploitative. And as caregivers, health professionals, we cannot just focus on one area.

Of course it is a question of management, priorities and funds. I just hope that as we sort out the context of our work, our interventions will not be late in coming. I am reminded of a story. A child prostitute entered a Buddhist temple and told the monk, I know this is holy ground. Please pardon me, but I want to pray. The monk replied, it is I who should apologize. Forgive me, for I was not able to protect you.

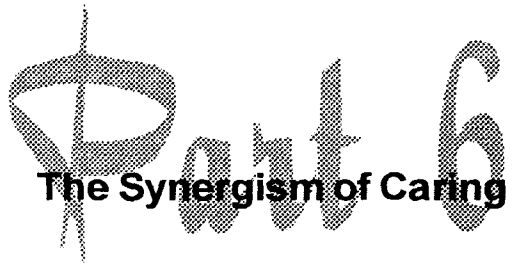
Kalli : Many years ago, torture was something that was kept secret. Now we talk about it. It is on the agenda of the United Nations and there are now many hopes and solutions. Similarly, issues like child abuse and

commercial sexual exploitation were thought of only as attractions used to lure foreign tourists to your countries. Now this terrible evil has knocked the door off the First World. When we met in Stockholm we discussed the possibility of government involvement. All these time this evil has been destroying the children of the Third World but no one discussed it. Now this session makes me a little more optimistic because we have put the problem on the table....Ten years ago I was in the Philippines to talk about torture. One day as I was walking in the street, a Filipino asked me, "What is your work here?" It is about torture, I said. Then we saw a child about two years old, from a village in Laguna, they told me, who "had been used by the Americans." It was the first time for me to meet a child victim. At that time, the issue was not at the fore. After ten years we can say that something is being done about this.

Quite a number of people, even influential persons, are interested in the issue of child exploitation. We have to take advantage of this interest because sexual exploitation is simply bad. It is evil. It is not only a concern in your countries but in the Middle East as well. Women victims of torture with rape is another related issue. Life will not be easy for them afterwards as the stigma of the violation is hard to erase. In our Center, we discovered that one of our staff had been a rape victim but she never said anything to anyone about it. She continues to be silently affected in her daily life.

Cameron: I am lucky I am not representing Australian men...I'd hate to be in that position. Actually I represent sex workers here in Thailand.

We have to remember that there is a community of women who are as concerned as the community of health workers about the sexual abuse of children. And that is the community of women doing sex work. They who see the kids regularly in the front line. They are a huge resource who can protect our children. If we recognize that they deserve our respect, and they feel this positive attitude toward them, they will feel free to cooperate with us in protecting these children. □



"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has."

Margareth Reed

The Valuing Process Between Survivors and Caregivers

JUNE PAGADUAN LOPEZ

VALUE-NEUTRALITY is a basic premise in western psychotherapy. Psychologists, psychiatrists or mental health workers trained in the Western medical system are taught to be value free, that is, to avoid personal and emotional involvement in the cases they are working with .

Dr. June Pagaduan Lopez is associate professor of psychiatry and the program director of the Psychosocial Trauma and Human Rights Program of the University of the Philippines.

Value freedom, however, is difficult to attain and may not be appropriate to trauma therapy.

In her book **Trauma and Recovery**, Judith Herman, a psychiatrist from Harvard University, makes clear that your

client, your patient, or the survivor must feel that you stand along with them in righteous indignation against what has happened to them. This is true for all trauma victims of rape, incest, domestic violence, or torture.

If trauma therapy is not value-free, how does one differentiate between being value-free and imposing your values? What do you do in such a situation?

Merely being sympathetic does not work. You could fall into the situation of your client and give rise to dependency. Not only does this aggravate the situation, it may also be detrimental to you. If you have deliberately fallen into this trap, how do you get out? In this instance, we can think of ourselves as survivors. Relationships with trauma survivors make us particularly vulnerable to losing sight of our professional boundaries — of losing our objectivity because we have crossed the line.

Your survivor must be made aware that you stand along with them in righteous indignation against what happened to them

Ropes of safety for caregivers

So what is the alternative? Judith Herman talks of two most important guarantees of safety for yourself as a caregiver, specially as a psychotherapist. One is knowledge of the goals, rules and boundaries of the treatment relationship. The other is your support system.

Training, or professional knowledge, is basic to knowing these goals, rules and boundaries. It serves as an anchor, a rope you can hold on to. Even if you go down, you know the rope is there for you to use in going up again.

The second requirement in keeping to professional goals, rules and boundaries is self-insight, your ability to know yourself and monitor how your client is

affecting you. That is why we go into therapy ourselves while in training. Unlike surgeons who have scalpels, our only instrument is ourselves. Therefore therapy is not value-free because your values, whether you like it or not, influence how you deal with clients.

Therapy is not value-free because your values, whether you like it or not, influence how you deal with clients.

The third requirement is an opportunity to be supervised, or even to talk or share with a colleague about your work

As I mentioned, the other guarantee of safety for us caregivers is the support system around us. Later I shall discuss the forms of support available to caregivers in the Philippines.

What I want to emphasize for now is that you, are your only instrument in psychotherapy. Therefore, it is important to keep yourself healthy in this kind of work.

Four modules on caring for caregivers

I would like to share what we do in the Philippines to help caregivers keep healthy.

First, we teach them how to enhance coping strategies. As caregivers, you need to be able to teach the survivors some techniques for settling down. The retelling of the traumatic experience may open some old wounds that we must be able to close. The survivor has to feel confident that she or he can dress that wound after leaving your clinic or office. That is why we brought Master Li here, to close the wound that we might be opening. Our daily *qigong* sessions are a kind of dressing for our wounds. Other techniques for closing wounds are yoga, meditation, counseling, and psychotherapy. The choice of techniques would depend on what you are used to in your culture.

Aside from coping strategies, we have sessions on self-empowerment. These are three-day workshops for human rights workers, held in a nice quiet place, much like a Roman Catholic spiritual retreat. The workshop is designed to help the caregivers acknowledge their personhood — that first and foremost, they are persons, human beings, caregivers or political activists.

We call this the Valuing Process Workshop or the Values Education Workshop. There are activities or exercises which make you look into yourself and make you analyze what kind of a person you are. It will help you reflect what your work is doing for you. We also call it self-empowerment workshops where values education is just a component.

Recently we added two training modules. Professionals are given the task of supervising non professionals who work in non-government organizations. The modules on supervision were prompted by the realization that there are too few of us. We cannot be trapped in our clinics just seeing patients day-to-day. Part of our work should be to help potential caregivers analyze themselves and learn more skills to handle trauma victims.

As caregivers, you need to be able to teach the survivors some techniques for settling down.

Our workshops for developing coping skills for self-empowerment are different from similar workshops focusing on the person. Ours are oriented toward enhancing professional skills whether this be through conferencing, one-on-one consultations with a mentor, or peer review of cases.

Team building is another module in the Valuing Process Workshop. We have workshops that address the interpersonal issues within the organization. These

may be leadership or work issues. Again, this is different from the supervision modules, where the supervisor helps you understand where you are correct and where you are wrong in managing your case. In teambuilding, you are addressing the organizational issues, the structure, the relationships within the organization.

There are too few of us. Part of our work should be to develop potential caregivers analyze themselves and learn more skills.

The values development framework

There are two human beings in the treatment relationship with trauma survivors: the survivor and you. We call this the valuing process between the survivor and the caregiver.

We often forget that the treatment relationship is an open relationship between two persons. Sometimes we think we are machines, incapable of being affected by our clients. But that is not true. The earlier we acknowledge that our clients will have an effect on us in the same way that we have an effect on our clients, the more therapeutic and more healing the relationship will be for both of us.

The valuing process is that interchange, the dynamic relationship between you and your client. The term "valuing process" is something I picked up from values educators in my medical school when we started to teach the faculty and students about the humanistic approach to medicine. This was to remind us that the doctor-patient relationship is the main instrument in healing.

We use a diagram to examine ourselves. In values education, we begin with ourselves as models — not as paragons of virtue, but as models of the process. Unlike psychiatry where we are completely non-

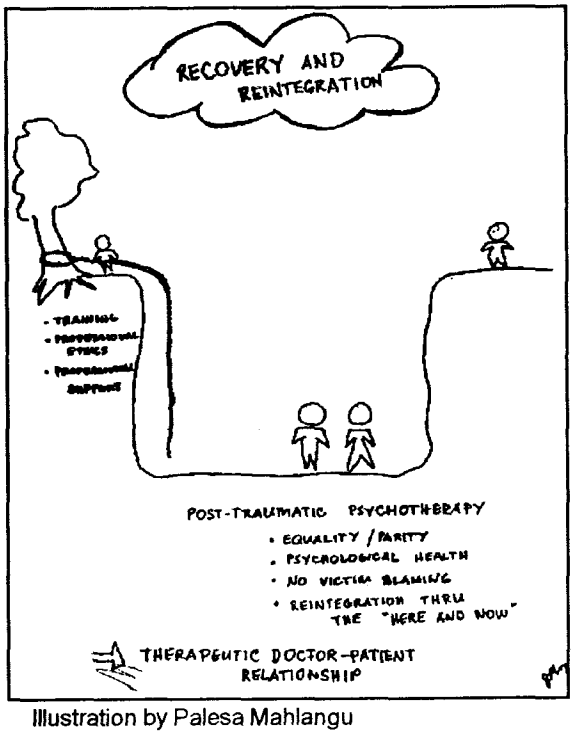


Illustration by Palesa Mahlangu

existent in the process, values education uses oneself in teaching the process and we would like the students to learn.

Taking off from values education I would like to use myself as a model of how to use this framework for understanding ourselves and how we are affected by our patients and their traumatic experience.

I had earlier mentioned the dimensions or aspects of an individual's person. We took the framework of our Filipino psychologists and modified it on the basis of our own experience with trauma survivors.

We often forget that the treatment relationship is an open relationship between two persons.

What we call *loob* in our language refers to one's inner reality: thoughts, feelings, values, the way you see things — your psyche.

On the other hand, the word *labas* refers (very loosely) to one's external reality: your relationship with other people, the way others see you, how you see them, and your relationship with the environment, at home, at work, in your community.

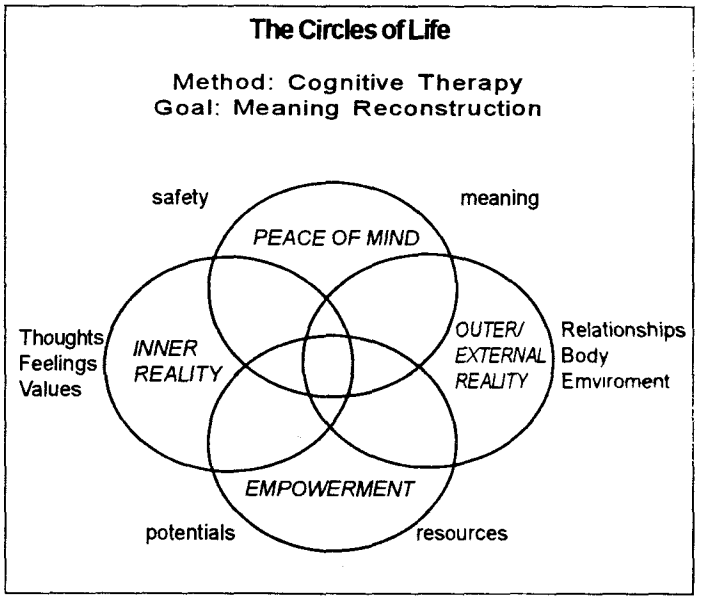
Katahimikan is peace of mind, your sense of peace and wellness. Where do you draw your sense of safety? Is it from being one with God? Is it in finding a meaning in whatever you are doing? Is it in having

a meaningful life? Sometimes we use *kaginhawaan* from the Filipino word *ginhawa* (meaning to breathe or live at ease).

Kapangyarihan is empowerment: where do you draw your sense of control or power, a sense of mastery over your own circumstances?

Unlike psychiatry where we are non-existent in the process, values education uses oneself in the process.

While the inner reality consists of your private thoughts, feelings and your values, the external reality is your "shared self." We emphasize the shared component of the self because Filipinos generally think of the "I" in relation to significant persons. In fact, when I ask survivors whom I have treated, "Who are you? Who do you think you are?" it is not uncommon for them to identify themselves as a farmer or a worker especially if they are political activists. When they answer in our language, they would omit the pronoun, "I" or "me," reflecting the subculture of the political underground which encourages the negation of self in the service of the people. Those of you who are familiar with political movements in your own countries may have observed the same phenomenon.



June Lopez based on an illustration by Edicio Dela Torre

Peace of mind can emanate from simply being safe, physically safe: from torture, death threats, persecution, harassment, exploitation. Some survivors are happy with just that. But there are others who say, "I may be safe from torture now, as an ordinary businessman or a journalist. But why do I still have fears and nightmares? When I see a government soldier, I still freeze." Still others say, "How come I don't feel myself? I'm not the same person. I used to be more daring, more alive."

When asked what would give him peace of mind, one survivor answered: "I want to go home." Unfortunately, he could not yet return to his hometown in the south which he left 20 years ago because his military torturers are still walking around and in fact have been promoted in rank and authority.

We emphasize the shared component of the self because Filipinos generally think of the "I" in relation to significant persons.

Pointers in using the values framework

Get the survivor's informed consent. This is the most basic step in therapy. The other basic prerequisite , however, is that you know what you are doing. As a caregiver, this would determine if the encounter would indeed be therapeutic for both the survivor and caregiver.

Bring back the survivor's shared self. In my sessions with survivors, I ask them to talk about their experiences and how these have changed the way they look at themselves and the way others relate to them. Then we talk about the environment. How did they relate to the environment before and after the torture?

Recognize that every person has a core – an indestructible, immutable core. This also refers to the

survivor's spirituality which is not necessarily related to religion. Others refer to this as higher consciousness or inner being. In other words, this is one's wholeness that remains intact despite the traumatic experience or the adversity. This is where a person derives energy or the spirit to survive no matter what happens.

The survivors used to be fighters, activists. They would not have been activists or fighters if they were not empowered.

Ask about the source of their sense of power. Where do they get their sense of power? What did the traumatic experience do to their sense of mastery, their sense of control over things? The survivors used to be fighters, activists. They would not have been activists or fighters if they were not empowered individuals prior to their experiences. There was a time when they were more empowered than anybody else. All of a sudden many of them experienced torture and they lost this sense of power. It is probable that they still have an inner sense of control that can be retrieved. So you have to go through the exercise of finding out how they were in the past and the circumstances of their lives at present to find out what they still have and what can they potentially have again?

Talk about their potentials; ask about their sources of support. Talk about their resources or what is available to them. Do they have family support? social support? If they were members of the underground movement, what is it doing for them now? Sometimes a survivor will say, "I have no family, no comrades. My comrades avoid me. Either they think I'm a traitor or they are afraid to be identified with me...." So they are completely alone. You need to look into the resources that are left to be further developed.

Take the emphatic position. We must be curious about what the survivor really means to say. Our challenge is to continue giving the survivor an opportunity to uncover, express, clarify every important word that she/he says to you so that he or she will not forget but remember differently.

Move toward meaning-reconstruction. Move the survivor towards a different way of looking at the same experience. In retelling her/his story, you must help her/him to look at the same story from a different point of view. You might say, "Would you consider other meanings to your experience? Would you see this in another way with me?" For instance, someone who has survived a war may think of it as having been meaningless, but the war can also be viewed as the just resistance of a people to exploitation. The survivor may have contributed to this struggle and find in this her/his role in society .

We want this seminar to bring out our humanity, to dispel any illusions that we are rocks of strength who cannot be touched by anything.

Impress upon the survivor that she/he has the power to decide how to react to the situation. This is one very important belief to keep in mind in the face of a situation that is difficult to change. I teach this to all my patients who have gone through some form of traumatic or distressing event, whether it be a heart attack, earthquake, or torture. That in the face of devastating experiences, our greatest power lies in the freedom to choose how to react to the situation. Tell them, you may not have the power to predict what will happen tomorrow — but you can decide how you will take on every moment in front of you. This is the message that should ring all throughout the therapy encounter or interaction with a trauma survivor.

Use the survivor's own words. In communicating to the survivor, use her/his own labels. This tells her/

him that you are in touch with what she/he is saying. Or that you are with her/him. That you are not lost in your own thoughts, in your own analyses and making your own labels.

There must be a clear and strong closure to every session. After you have asked the survivor to retell her/his traumatic experience, you must not leave her/him hanging. It may be important to teach the survivor some progressive relaxation techniques before starting the session.

Apply this framework to yourself before using it on others. Bear in mind that any instrument, including this framework, can do more harm than good. Anything we do has the potential to do harm. Thus, it is important to apply this instrument to ourselves first so as to have a first-hand experience of how it feels. If you find it uncomfortable or inappropriate, then it is ethically incumbent upon you to junk this instrument and use something else.

In the face of devastating experiences, our greatest power lies in the freedom to choose how to react.

Congratulations to everyone for keeping your enthusiasm despite the intensive discussions. It hasn't been easy. A number of the organizers are themselves affected by the presentations and you, yourselves, must be affected too.

But this is what we would like this seminar to be. We want it to bring out our humanity, to dispel any illusions that we are rocks of strength who cannot be touched by anything. I have presented this topic almost a hundred times but I continue to be emotionally affected. □

Excerpts of the Open Forum

Irwanto: Before you jump to another topic, I think there are a number of things to be addressed. First, you said that when you have proper training then you could do this or that. My experience as a psychotherapist is no more than the number of fingers in my hand. To be able to empathize and not get into the problems of our clients and maintain our professionalism at the same time is very hard to do. I think the balancing skill develops with the number of clients we see and the number of times we talk about your experiences with your colleagues.

Second, I want to point out that if we are also a survivor, then we are more vulnerable into being the patient rather than the professional. Thus, if some people recognize that the problem of the clients are exactly what he or she has experienced, isn't it better to refer them to another professional than to take care of them?

Lopez: You are correct about keeping the balance between involvement and professionalism. It's not easy. That is why it is borne out of a long process of training, practice and supervision. I think it is very important to have the opportunity to be supervised by a peer or a mentor, a more senior person, when dealing with trauma survivors. □

Caring for Survivors: The Holistic Approach

PALESA MOKHALE-MAHLANGU

I COME from South Africa, a country plagued with violence. Because of political oppression, our culture has become a culture of violence. Not that we encourage it, but we find ourselves in that situation.

With the rise of political violence in South Africa, other forms of violence have emerged, including crimes, family violence and rape. I am now studying the phenomenon of gang rape as part of my doctoral dissertation. Most of the rape victims are between the ages of 11 and 19. In my study 50 percent of them are children under 13 years of age.

Palesa M. Mahlangu is the principal project officer of the Center for the Study of Violence and Reconciliation in South Africa.

A recent form of violence involves former child soldiers in the liberation struggle. During the struggle they were important in the community. We called them comrades. But they lost 10 years of education and have since become unemployed or unemployable. They are beginning to use torture as a form of rewarding themselves. They either torture by raping or by brutalizing other people, usually school children who remind them of their inability to complete their schooling because they fought in the liberation struggle.

Thus, in the South African context, we talk not only about torture; but about trauma in totality.

With the rise of political violence in South Africa, other forms of violence have emerged including crimes, family violence and rape.

Coming to terms with our experience

Today, people are appearing in front of what we call the Truth Commission to say what happened to them 20 years ago, or 10 years ago. Until recently we did not talk about our experience with torture. Thus, we did not understand that the reason for our lack of sleep, our anxiety that something will happen to us, for our sensitivity to certain noises (my fear of dogs, for example), is our failure to connect these things with what we went through during the years of oppression.

But now, we are beginning to come to terms with our experience. During the oppression, it was better not to be asleep because then you could hear any noise and the police came and you could run away. But now there is nothing to run away from. Now we are realizing that it is abnormal not to sleep.

We try not to talk about post-traumatic stress disorders because we feel that most of those we work

with are not people who are pathological. They are not sick. They are merely responding to an uncommon stress in their lives. Apartheid oppression, like war, is an uncommon stress. We use the word disorder only when we have clinically proven that the person is pathological.

In the South African context, we talk not only about torture but about trauma in totality.

Furthermore, we talk not only about post-traumatic stress, as in most countries, but also about continuous traumatic stress. Because in my country, although political violence has stopped, other forms of violence are common. So we live in a continuously stressful and traumatic environment. Regarding treatment, we shall look briefly at how we differentiate between a patient — in South Africa, we call them "clients" — who is suffering only from post-traumatic stress and one who is suffering from continuous traumatic stress.

Dealing with effects of post-traumatic stress

Let us look at some of the issues on post-traumatic stress and how we have dealt with them in South Africa.

One issue is *memory loss*. We have discovered that memory loss can be a learned behavior. People can actually learn to forget without meaning to. There is the case of a comrade who is now unable to remember names and places. During our struggle against apartheid, comrades were expected not to disclose any name when arrested and interrogated. In this way, if you were killed or maimed, the struggle would continue. In this context, this comrade learned to forget people's names and addresses. He only remembered certain details. So during his detention, everytime the police interrogated him he could talk

in detail about strategies but would never, ever mention anybody's name or number.

Now he is suffering from having a very high position in the government and not remembering people's names. There have been situations where he has to introduce very prominent people and he stands before a crowd in a hall and says, "Today we have Mr. or Mrs..." and then he would blank out. This has been very embarrassing for him. In his diary he always writes the details of what he is supposed to do, but never the name of a person or a place. If he forgets he cannot even remember where he is supposed to go.

In this case, a habit or practice that was appropriate in one situation (detention) has become quite abnormal outside of detention. We therefore had to work with him using strategies similar to teaching a child how to talk and read. He had to consciously remember to ask your name and write it down and read it and practice it.

Lives beyond normal human experience

Apartheid oppression, like war, is an uncommon stress.

Related to learned memory loss as a symptom of trauma is *preoccupation.* I like to think that we have elasticity, that our mind has the capacity to deal with day-to-day stresses. When our child is sick and we don't have the money to buy the medicine, we can deal with it. But somehow we cannot deal with things that are outside the normal human experience. For example, death is natural and we all know we are going to die. But when your child is killed in detention or in front of your house, or dies in your arms, it is a different situation.

We have a case, a mother whose son disappeared about 10 years ago. She is a very prominent civic or-

ganizer, very political. She still doesn't know what happened to her son. When she is supposed to take notes in a meeting, she cannot concentrate. She does not remember where she put the keys. Sometimes she unlocks a door, leaves the keys there and then looks for the keys all over the house. She cannot even remember what she did when she entered the house, being continuously preoccupied with the disappearance of her son.

In our therapeutic interventions we use cultural norms that will help people cope.

In our culture death is sacred. When somebody dies, you need to bury him or her. This is very important: it is part and parcel of what a people believe in. So this woman has been mourning for 10 years. Feeling guilty somehow, she wants to do something. Her preoccupation is: Is my son dead? Where are his remains? How am I going to bury him? Sometimes she walks into the supermarket, sees a boy about her son's age when she last saw him, and runs to the child, thinking she is her lost son.

Interventions to help victims cope

Suppose finally he is found, then she would have nothing more to be preoccupied with. But even if he is not found, there are rituals that could be done to help her get over the mourning. We used dreams and other therapies to help her deal with that. Now things are getting back to normal. She is back at work and functioning. Certainly interventions had to be done to help her.

We have a case of a pregnant woman who had been ripped open by soldiers from one faction. She survived but lost her baby. This incident happened at 3 p.m. on a Sunday afternoon. Even after years have passed, every Saturday night this woman

has to leave her own house to go to her mother's house. For nothing on earth will she be found in her house on a Sunday afternoon.

Our task has been to help her not to remain a prisoner of those soldiers, to feel safe in her own home. In our therapeutic interventions we use cultural norms that will help people cope. The African people, and I would assume most people from developing countries, are a communal people. You don't live alone. You live with people around you, with your family, neighbors, church or whatever. So we had to get the interventions of this woman's family and neighbors, with her consent, to help her feel secure and safe in her house so that on Sundays she does not have to be a refugee.

Violence as a language of expression

Another issue is *aggressive controlling behavior.* I mentioned child soldiers earlier. In Africa even children joined the army, the armed struggle for liberation. They were not forced. Growing up in an oppressive situation, you become politicized. Most of us ended up being involved in the struggle, even militarily, at a very young age.

Aggression has become embedded, a learned behavior.

Now most of these youngsters who grew up in that situation have a problem of aggression. Often, it comes out inappropriately. We have a high rate of crime in South Africa and most of the perpetrators are young people who grew up between 1976 and 1990. They were exposed to violence and violent language is their only means of expression. Now that there is nothing to fight politically they face the fact they are unemployed, unemployable, uneducated, marginalized. They are called militarized youth.

You also hear a lot about those who follow the Zulus, in another part of our country. Long before there was so much political violence in South Africa, there was tribal violence, ethnic violence. The government never did anything to stop it. So children who grew up in that environment continue to feel and understand violence as part of their culture. Now, as grown-ups, they are the ones who are fighting on the side of the old regime. In time and in our context, aggression is fostered by the ills of the state. Aggression has become embedded, a learned behavior.

In our paternalistic culture a wife is blamed for the death of her husband.

Spiral violence

We also find many children being subjected to family violence. Many children who are bullies in school come from alcoholic families, where there is a lot of violence. Sometimes, the violence at home starts at work. The father feels marginalized and exploited at work but cannot tell his boss to get lost and so he takes it out on his wife. The wife cannot tell the husband to get lost and takes it out on the children. The children cannot tell their mother to get lost and so take it out on other children. These other children then take it out on their dogs. When the young children cannot deal with the spiral of violence anymore the rate of suicide among them goes up.

It is an example of *suicidal ideations*. In our high schools, many teenagers are committing suicide. This used to be unheard of in my culture but now it is beginning to be fairly common because of the violence at home. It is interesting to note that among the police the rate of suicide is amazing. Some of them kill themselves because they have to disclose what they did to people to the Truth Com-

mission and they cannot face this. Sometimes they leave suicide notes saying, I have taken my life because of this and this. Although they would not state the details, most of them would say, "Don't blame my wife for this."

In our paternalistic culture a wife is blamed for the death of her husband. When your husband dies, you killed him; when you die, nobody killed you. So police persons committing suicide tend to write, "Don't accuse my wife. I had to take my life because of work stress." Most times they don't really go on a rampage, shooting people before they kill themselves. However, this rampage happens in the white community. (Unfortunately in South Africa we still have to talk of black and white.)

Because situations are sometimes beyond our help, we end up being traumatized too by some of the trauma we deal with.

In the white community, a recent pattern is for police persons to kill their children and their wives before killing themselves. One of them failed to kill himself and ended up in prison because he had killed his wife and children.

We have had a lot of suicide cases but also homicide cases involving revenge killings. People have come to us and said, "I know who killed my mother, I know who did it and I am going to take it out on them." As a therapist, I am placed in a dilemma: should I breach the confidentiality of the doctor-patient relationship? And if I do, is this patient going to be arrested and tortured or is she or he going to be rehabilitated? I have no answer. We cry over the dilemma. Because situations are sometimes beyond our help, we end up being traumatized too by some of the trauma we deal with.

REDO: The Four-Step Treatment Module

On treatment or therapeutic intervention, we train our counsellors in a four-step module that we call REDO: retelling the story, normalizing symptoms, addressing the guilt, and coping strategies.

Psychotherapy is a talking cure. The more you talk, the more healing it gives you

With the first step, *retelling the story,* I refer to one-on-one counselling. We ask the person to tell the story, 10 times if he or she wants to. In some situations people are shy, especially in cases of rape. So we have them tell us whatever they want to tell. Sometimes they go around and around until we say, "OK, do you mean this...?" and they say yes. It is only then that they get the courage to say they are talking of rape.

Encouraging people to tell their story

Psychotherapy is a talking cure. The more you talk, the more healing it gives you. For example, if you are angry at what happened to you and you suppress this energy — anger is energy — a day will come when it will burst out of you. This is just like a volcano that suppresses energy for many years, probably centuries. The day it comes out, it comes out inappropriately. So also with anger, it must be verbalized and accepted. I come from a culture where it is wrong to be angry. But in my sessions, I find people accepting that they are angry. Then they are able to talk about it in an environment that is warm, safe, and not so destructive.

Sometimes we talk of famicide or homicide where battered women, some of them mothers very well respected in the community, kill their husbands. And you ask, How? What happened? They say that half

the time, they were silent victims; they never spoke to anybody about this. Then the anger explodes inappropriately. So we encourage people to tell their story, to relive what they went through. It is already in their heads anyway, whether they say it or not.

I am talking about people who are consciously aware of what has happened to them, not about those who have suppressed and blocked issues. In any therapeutic intervention you will come across issues that are blocked and you try to work stage by stage to unravel them. Is it better for you to have them say it in front of an audience? It is the same with suicidal ideations: better for the person to say what he or she is going to do exactly, step by step. While some people say, that is putting ideas in their heads, it is not as if they have not thought about it already, so it is better if they say it to you — then you can at least measure how far they have gone and see how overblown it is. I believe that talking may relieve some things; when you talk about it with somebody, with an audience, with someone who's empathetic — that in itself helps you to work it through.

We encourage people to tell their story, to relive what they went through

(At this point, the participants started to comment and ask some questions.)

Rasalingam: I get your point. In Sydney, Australia, there is one center that has done a comparative study on torture victims from Latin America and Southeast Asia. They found that in the Latin American countries, the victims were very open about what had happened to them. But the ones from Southeast Asia were reluctant to come out and tell their stories. The study therefore recommends that the approach toward each group be different. What you are trying

to say is that it's definitely much better for the victims to tell their experience. But that may take a long time.

Sasiraj : The retelling of a story is a really controversial issue. Is there any psychiatrist or psychologist in this house who has a different idea? I believe that the retelling of stories is a difficult process. It really depends on the patient or the victim.

As soon as they begin to trust me, they open up.

Mahlangu: Let me say this about retelling the story: it is not difficult when you have tried it. The first thing you ask as a doctor is, What is your complaint? Why are you here? And they tell you, I have a headache. As a psychologist I ask them, how may I help you? So they have to tell me something, from which I can begin. Whatever they tell me I can rephrase in such a way that they will tell me more. Sometimes we get teenagers who come and say: "I don't want to talk to you." Then you have to ask: "but why did you come?" Somehow along the way you will find something that you can elaborate on and they can say it.

What I have found out in my practice is that I should not push people to tell me everything on the first day. Some sessions are just 30-minute sessions. The first session is just to get to know the person. So if they can allow me only 30 minutes to get to know them, I am not going to waste that, I'll try to make it 50 minutes. As soon as they begin to trust me, they open up. Even if I say everything that we talk about is confidential, they may not believe me. I need to prove myself, that I am trying by all means to understand them and to walk that road with them. Then as time goes on they begin to open up.

Ka: Some of my patients work well with retelling their stories. But some become filled with thoughts of revenge when they recall their past experiences of trauma. I have this patient who has a poor impulse-control problem. He came to us because he can no longer control his impulse each time he meets the persons who did him harm during Pol Pot's time. He wants to kill those persons. Whenever we ask him to retell his story, his tension rises and he becomes very furious. He tells us that he wants to kill those persons whenever he remembers what they did to him.

Mahlangu : Yes, that is true. Often there is an element of either guilt or revenge. What we do is to try to have them look at alternatives. For example, we make the patient imagine the person they want to kill coming and the patient killing him. Now that is the first step. "What do you think would happen if you kill them?" we ask the patient. The patient may say, "I'll be happy." "What happens then?" we probe. Then they may say, "I'll get into trouble with the law." Then we say, "If you go to jail, what happens to the people around you and your significant others?" Those who have children may say their children won't be able to go to school. So you try to tap into what is important for them, more than the person who gets on their nerves. You try to make them think more about the persons who mean much to them, and to consider what would happen to these persons. You can ask them, what their wishes are for their children. You ask them to write these down, to talk about their fantasies about their children. And you ask if they go to jail, do they think their children will be able to enjoy what they wish for them?

Do not take them on a guilt trip; be warm towards them.

Do not take them on a guilt trip; be warm towards them. But you try to help them look at the other side

because anger can cloud one's judgment – they cannot see anything else besides the anger. Our objective in doing this kind of therapy is to help people to remember what happened to them differently, not to forget it. In remembering it differently they are empowered to move on, because for as long as they want to kill their oppressors they cannot move on. The ideal therapy is to have them move from this to something else, not to forget it but to work with it in order to become progressive or successful people. I emphasize that the perpetrator must not be allowed to rob you of your whole life. You have a beautiful life ahead, try to make use of it. But I say all this in a context they can understand.

Show them how justice can be obtained, through legal help, reparation or compensation.

Marcelino: I agree with you. But I want to add that retelling the story works when you have started with groups or when you have started in some other way in the community. But usually, verbal retelling does not work the first time. In this situation, you sometimes have to work with symbols or with other ways of getting the story.

I always recommend to let the patient come with another person, with her best friend, or whoever she trusts. And sometimes the patient will allow the other person to tell the story for her, because he/she cannot say it himself/herself. That always helps. In my culture, normally it is difficult to go to a doctor alone. We get somebody to come along. So during the therapy you can ask this somebody, who is waiting outside the room, to come in and join you, with the patient's permission, of course. This is one technique we use.

As for revenge, sometimes victims confuse revenge with justice because for them institutional justice has

always failed. So they assume taking the law into their own hands is actually doing justice to themselves and their relatives. The way to address this is not so much to say "don't take revenge, or, this is wrong." Just show them how justice can be obtained, through legal help, reparation or compensation.

Lastly, I agree with your point about the importance of not forgetting. Once, a child came to me with a stone. I asked him, "Where did you get this stone?" And he answered, "From my heart, from the chest." I asked why he took it, and he said, "Oh, because it is heavy. I have to take it out. It is very painful." Then he threw the stone away. "There, it's gone!" he said. But after a few seconds, he ran to pick up the stone, and started pounding it and took a small piece. "What are you doing?" I asked. He said, "I have to put it back in my heart, in my chest." Why? I asked again. "Because I have to remember. If I don't, I will forget my parents who were killed. I have to remember..." That really hit me. It was an inanimate object, a stone, that helped him in therapy — not my talking or his.

It is important for us to look at the feelings because that is where we can assess whether there is revenge, anger, or a suicidal impulse.

Mahlangu : Yes, we occasionally allow (the patients) to bring companions depending on the case. In some cultures — we have different communities in South Africa — some people may want to bring their wives with them. But we always try to encourage the patient to talk for him/herself. Very rarely do we allow the other person to talk on the patient's behalf.

Because only the patients know their own feelings and thoughts, we try to encourage this as best as we can. But we are not rigid; we are very flexible. We go with whatever works. But it is impor-

tant for us to look at the feelings because that is where you can assess whether there is revenge, anger, suicidal impulse. A lot of guilt also comes up when we talk about feelings.

When people come to us, they are full of sorrow.

Kalli : Tragedy needs a catharsis, otherwise it goes on in other ways. In our country, after the downfall of the military junta, 400 torturers went on trial. Some of them did only a few months in prison but even that was a kind of catharsis. The big personalities of the dictatorship are still in prison, 25 years later. If you ask me whether I want someone in prison for a long time, I say no. Maybe one hour, one day, one month is enough. Sometimes one minute or even one second without freedom is enough. But if you ask the victims, the catharsis might require a longer period. Catharsis is completely necessary to get over a tragedy.

Mahlangu : Let's move on with the four steps in therapy. We are still on the first step, *retelling the story*. What helps us here is what we call "the well of sorrow." When people come to us, they are full of sorrow. In my culture, when somebody in pain talks to you, it is expected of you to hug that person, to understand what she or he is going through. We even say words like, "You are very nice and very warm..." because everybody wants affection.

But in therapeutic intervention this sympathy is not always helpful because what it does is to make the patient dependent. We have to move away from being sympathetic because they already receive a lot of sympathy outside. If I were to meet you in the street, I will be very sympathetic because that is part of who I am. But in therapeutic interven-

tion, we discourage that. When I am being sympathetic, I am listening, I am loving them. But I am not taking them out of the world of pain. I leave them there and most times I leave them to become perpetual victims. Even after 20 years, they will still say, "They did this to me, that is why I did not do this to myself." In some way I gave these patients what they wanted by listening to them. But I did not help them to get out of their world of pain and sorrow.

There is also an element of identification. I myself have gone through some of the experiences recounted by my patients. If you have experienced torture yourselves, you understand what happened. You go in with the patient into the world of sorrow. You help him/her pray. We identify with each other — comrades in struggle, in any kind of struggle. But I am not helping this person to move out of that world. In fact I am joining the person in that world. Probably everytime the clients come to me, I will just continue to join them and they will continue to be victims because I have not helped them out.

We identify with each other — comrades in struggle, in any kind of struggle.

What is required is empathy. With empathy I will let you come and retell your story. I go into that world with you. I go through all the steps with you. But then in time, I'll come out of that world, leave you there and say: When you need me I will be here, but you can walk that road all by yourself.

What I do is to empower the person by helping him/her see that she is not a victim but a survivor. A victim is somebody who cannot come to tell the story, who is dying of heartbreak or is in deep depression. But because he/she is alive and has come to seek help, I think there is something that is very valuable within

this person that has helped her to survive. What I need to do is to help her look at that thing.

For some people, it is prayer that helped them survive. They did not have a gun but they had prayer. When you ask them what they did, they will say, I prayed. Prayer is a way of coping because at that moment, the one who prays does not feel alone. You are communicating and somebody is hearing you. So there is something warm and empowering that you get from prayer and from your faith.

They will know that if they survived the first time, they will survive the second time.

Other people think of their children. That is positive thinking: thinking of someone or something valuable, that they cannot let go of. So whatever happened they did not let go and that helped them. In therapy, we help patients realize this. I have them look at what helped them survive. If tomorrow – given that South Africa is a struggling society – something happens, then they will not feel helpless as if it were happening for the first time. They will know that if they survived the first time, they will survive the second time.

For example, we have carjacking instances in South Africa. One of the things we do for carjacking survivors is to help them make a plan of action. We ask them, "If it happens to you tomorrow, what will you do?" You may think, it won't happen to you because you live in a nice neighborhood. But when it does happen, you know that you will knock down the assailant and the only place you will stop at is the nearest police station. So this knowledge that next time, when somebody who has no business coming to your car comes, you'll just hit him and whatever happens to him, you'll see when you get to the police

station. This knowledge helps the survivor come to terms with what happened.

I am not teaching people to be violent. This is what it is all about: that you, the therapist, go in and then get out but you still stand nearby and say, "I am here if you need me." Eventually the patient will be able to walk a mile by herself or himself without your help.

As for step 2, *normalizing symptoms*, we find that very often people are afraid of their symptoms, thinking they have become loose in the head. When you begin to help them normalize these symptoms, to accept that these things happen to other people who had the same experience, this helps the healing process. Then the symptoms don't become exaggerated or the patients don't begin to have other anxieties about what has happened to them. Instead they will understand that the symptoms arise from the experience. They are able to make sense of what is going on.

In rape victims, survivor guilt springs from the many myths that people believe about rape.

Most of the time, when tragedy happens to us, we want to make sense of it. We want to know why. As soon as I know why I am not sleeping, why I jump when the phone rings, why I am having flashbacks — when I begin to understand all this, that helps in the healing process.

The third step is *addressing the guilt*. We talk of survivor guilt: there is something altruistic in all human beings. We may be very bad but when something happens to someone else, we want to help. Let us say you're in prison and your cellmate is tortured and killed. You feel guilty about his death even if you did not torture him. You feel guilty because you

think, I could have done this or that — I had written a note and taken it underground and told the human rights people that this was happening, then maybe he may not have died. Even though you know that that was impossible, a part of you wishes to have done something and you feel responsible for that person's death. This is part of survivor guilt.

We help them identify what helped them survive the first time or what helped them cope with the situation.

In rape victims, this guilt springs from the many myths that people believe about rape. They say bad girls get raped. If you wear shorts, you'll get raped. But even nuns in long dresses get raped. They say if you're a loose woman or if you are not well behaved you'll get raped. But even the well behaved, and I'll use nuns as an example again, still get raped. So the issue is not what you wear or what time of the day you walk around. But most rape survivors have this guilt that they brought it upon themselves, that they did something that led to the rape. Similarly, most battered women say that their husbands beat them because they did something wrong. So we try to work with them to deal with that guilt.

It is to the fourth step — *coping strategies* — that we devote most of our time. People expect that when you talk of coping, you talk of something they can hold on to, something tangible. Coping strategies include the little things that you do. Prayer is an example. Believing in something is another coping strategy. Positive thinking. Seeking social support from the family, the community. Those can be things that help you cope. So what we do is explore what people can do or what is important for them. We help them identify what helped them survive the first time or what helped them cope with the situation.

The objective of doing therapy is to empower people. As patients talk about what they did, we affirm them. I am not saying we should affirm every little thing. But if it is something that somebody did to help — for example, in South Africa bringing a wet towel or a raincoat to a political meeting is something that you can affirm, because when teargas is thrown at the meeting the wet towel and the raincoat may be your means of survival. So if somebody did that, you affirm it.

By affirming, you empower people because most of them say, "I just want to forget this ever happened to me." But we need to be genuinely honest, following the Rogerian Method of doing things. There is no way you are going to have the person forget what happened to her. You need only to help her understand, to help her remember the incident differently for it to be less painful, and for her to realize that she did something positive, valuable.

When people become helpless, they don't feel they have control over the world anymore.

According to some theories on coping such as those by Lazarus et al. (1984), assuming responsibility is a way of coping. They talk about confrontive coping. So you look at the little things that the patient did and you provide a context for these. And the patient will say, "So, I have done something that made sense!." That way, the patient will remember the situation differently — she will feel empowered.

Let me go back to the point about helping patients become survivors, not victims. If you are a victim you are helpless. Many of us know about the learned-helplessness theory. When people become helpless, they don't feel they have control over the world anymore. Our objective is to help them move

out of that and re-enter the world with the same kind of strength and power that they had before.

Sinha : We are saying that the person does not feel helpless and yet the person is feeling helpless enough to appeal to a god or a supernatural, non-human entity. At one level, we encourage it. At another level, it is an acknowledgement that this world might not be able to help, that the people next to you will not be able to help, your fellow beings are not able to help, and you still appeal for help.

When you have faith in something, you automatically appeal to that higher being to be with you.

Mahlangu : I think that helplessness must be contextualized. For example, if you are being interrogated and electrocuted, you are helpless because you can not fight. However, when we talk about coping strategies, what helps you survive that? You are a helpless being but there is something helping you cope. Then you talk about spirituality. At that moment you appeal to a higher being. But you are appealing not because you are necessarily feeling helpless. It helps you to have faith that somebody will intervene and there is somebody with you even when you are alone. You ask because you need something but not because you are helpless.

It is just an issue of belief and faith. When you have faith in something, you automatically appeal to that higher being to be with you. Some of my prayers have been, "Lord be with me, just let me know you are there and I will be okay," even if I am not okay. These spiritual things are hard to verbalize and to communicate to the next person. But it is something you believe in. I don't think this can be equated to helplessness, to not being able to fight back.

Sinha : One finds victims who have absolutely no faith left, whether in fellow human beings or in God, and yet at some point you want to encourage them to begin the....

Mahlangu : You don't give faith to people. They have to say they prayed. If they did not talk about God and if they think that sometimes people are saying, "I don't want to hear about this God they want me to accept," you accept that. You don't put your value systems into them. Other people may talk about ancestors rather than God. You go along with that. You don't introduce something they didn't say. You only go along with what they say and affirm them. If they say God, fine. If they say ancestors, you'll say ancestors. If they say, I'm upset with God, you don't intervene and say, "Oh, such blasphemy!" You forget your own religious issues now.

They need to be cleansed in a ritualistic way for them to feel pure again.

Let us quickly go through case examples, especially with regard to rape. Also, Elizabeth [Marcelino] talked briefly about rituals. With rape, on top of the other symptoms that were written about in DSM IV, you know that rape victims talk about feeling dirty and they have the compulsion to wash all the time. You try many methods to help them deal with that but they still feel dirty. You may try to use a cultural approach. In my culture I have found that for most people, therapy alone doesn't help in a situation like this. They need to be cleansed in a ritualistic way for them to feel pure again. Whether it is what you believe in or it is against your spiritual beliefs is not your business at this point. It's this person's world. So you don't say, "Okay, I'll go through the thing with you." This is where the family can come in. When the patient says it is okay

to involve the family then you can involve the family and they can go through the ritual.

In my culture there is a ritual wherein an animal is slaughtered, the blood is taken and mixed with water and the rape survivor is washed with it. That blood helps them regain their purity. So sometimes therapy has to be at that level where the person can feel that she has gotten rid of the feeling of being dirty and the compulsion to wash. But I want to caution that this is not something you can suggest. It has to be from where they come; it has to be what comes out of them.

The rape victims feel ugly, they feel something is terribly wrong with them.

There is also the *rape trauma syndrome* for people who have gone through rape, on top of post-traumatic stress. They usually become withdrawn; they feel guilty; they exhibit avoidance behaviour. They sometimes have problems wearing the same clothes they wore when the incident happened. You really have to help them overcome that syndrome. If the victim cannot wear those clothes because of what they remind her of, you need to help her deal with that problem so that when she decides not to wear the clothes it is because she does not want to, not because they are a reminder of the rape.

There is *distortion of identity*: In this case the rape victims feel ugly, they feel something is terribly wrong with them. Obese people also go through a distortion of identity. With women who are gang-raped, there is even more distortion than with single-rape survivors.

We are looking at coping strategies, the final step in the treatment. From the 156 ways of coping enumerated in 1966, the number dropped to eight in 1984.

But those eight ways of coping did not include cultural variables like spirituality, religiosity, positive thinking. So I just decided to use a few and not the eight supposedly empirically researched ways of coping. What I will mention are what I have come across in our practice.

Social support is number 1: support from family, friends, church, neighborhood, community. Those support systems are very helpful.

Religiosity. Whether they are Christian, Muslim or Buddhist, we learn from our patients. I know nothing about Islam and Buddhism so what I do is ask the person I am helping to educate me. If they bring it up, I ask them to educate me and I become a student in turn. So at least I may be able to understand where they are coming from. And they may also feel confident that I am with them, by allowing them to teach me. Sometimes I feel that we lose the people we help because we become aloof. But if we enter their world unconditionally and in a respectful way, together we are able to come up with something successfully.

Whether they are Christian, Muslim or Buddhist, we learn from our patients.

Spirituality. In my country, we talk of traditional healing. We talk of ancestors. If that's the way the person wishes to go, then we do it. I will not say go to this traditional healer and so on. But if I know that something has been done within the family, I will encourage the person to go and talk to the family. If he or she cannot do so and wants me to intervene, then I will.

This is how it is in my country and my culture. We do not find this in the western way of doing

therapy. In the latter you do it only with the patient there and it is done. You only go through the psychological issues and it is finished. This doesn't work with us. We don't have a good social work system. We have to be a social worker and, as June [Lopez] has said, we have to be a legal adviser. Sometimes you have to be this and that, and you play all those roles within limits, trying as best as you can to help.

For me, it makes no sense to talk about psychological issues to somebody whose house has burned down and who has no food for her children.

For me, it makes no sense to talk about psychological issues to somebody whose house has burned down and who has no food for her children. I have to address the patient's bread and butter issues first. I may not be able to give them bread and butter, but it's my business to find out where they can find bread and butter. If it means a phone call, because sometimes some of my people are not fortunate enough to have acquired education and cannot express themselves very well, then I will make that call. When they go to social work places, they are looked down upon and they are not treated well. So I make it a point to go with them sometimes.

In the case of children, if they have to go to court, most of the time we prepare them. Sometimes we accompany them to court. It is very important for them to know that there is somebody who cares. For me this work, more or less, is not just a job. It is a calling. That is why I feel obligated to go an extra mile and not just do my business in the clinic and say this is it.

Now in conclusion, let me recap: In order for our intervention to work, we need to be sensitive to the cultural ethos inherent in those we serve. It is also important to learn from those we serve and to be truly

empathetic by allowing ourselves to enter their world with respect. I think that a holistic therapist needs to value people and their worldview and to respect them. □

Excerpts of the Open Forum

Rasalingam: You said that in South Africa people who fought in the liberation struggle now feel they have nothing to do and they have become a problem. Can this be said of other countries involved in a struggle for liberation? When such countries come back to normality and peace, will these people in the security forces also follow the same sequence of events that you're telling us about? This suggests that with the return to normalcy, big cans of worms will be opened.

Mahlangu: I think that this is a universal phenomenon. Torture or violence affects us univerally. How the perpetrators respond is a power game. When the power is taken away from them, they have to find another way to still feel powerful. Rape is also a power issue. There are some rapists who rape when their ego is tampered with. When there is a failure in their lives, they go out and rape because they want to uplift their ego. So I think, yes, that can happen.

Irwanto: Can you tell us how you cope with the ethical dilemma when you face clients with a very strong suicidal ideation and clients who feel anger and threaten to kill other people.

Mahlangu: It depends. I would ask the clients if they have thought the idea of suicide through. If they say yes, I ask them to explain the process step by step. After talking to them step by step about what they are going to do, I will try to have an agreement with them that they will not do it without calling me first. They may say that the world is so bad but I would ask, "How would you like people to remember you?" They may say, "I don't care." Then I say, "It is important for me to remember you because you have touched my life. I would like to remember you in the way you said goodbye to me before you jumped off the bridge."

I thought about that because I have noticed that often when serial killers are going to be hanged, they all ask for media coverage. They want to be remembered. They want to talk to the media. Sometimes they talk nonsense, but they talk nonetheless. That gave me the idea that in the hierarchy of human needs there is the desire, the need, to be remembered. So I use this.

If I am convinced that the person will commit suicide, by the time they call me I already know where to get help. But if I am not sure that he is going to do that and the contact doesn't work, then I will call the ambulance and have him committed to a hospital.

But with the people I have had committed, I went to the hospital with them to assure them that I am not betraying them – some of them wanted to commit suicide because they felt the world had betrayed them. I say, "I'm not betraying you. This is the best for your health." I also make it a point to visit or call them. I make sure that they get the information that I called only for them to feel that there is somebody who cares. My belief is that people commit suicide because they are crying out for help, they feel that nobody cares.

It is not always the case that you can win over people. There will be those who will kill themselves nevertheless. But with some cases I find that this approach works.

With those who are homicidal, I make a contract. I always say that it is confidential. However, if it is an issue of the patient's life or somebody else's being at risk, I may have to tell someone else without asking for the patient's consent to breach the confidentiality. I will go back on my word and say, "At this point, here and now, I am calling the police, I'm calling security because this is the situation...". I will call whoever needs to be called at that point. But I make sure that I follow the patient up because the police are prone to violence, too. They can exacerbate the situation. I try as much as possible not to call in the police. If I think the patient must be committed, I would rather take her to the hospital than to the police. I am still uncomfortable with the police. But right now we are also training the police in South Africa to handle such cases.

Irwanto: What type of referral system/network are you working with? Do you work with physicians? Can you tell us more about that?

Mahlangu: Yes, we work with child psychiatrists and adult psychiatrists. We work with social workers with whom we have formed a network. We also work with church ministers and some traditional healers who refer people to us. We don't refer people to them but we ask their advice in certain instances. If a patient is from a certain community, we ask her/him who among the respectable members of that community he/she trusts. We try to liason with those people. So one method is

structured and the other is not. If it is an issue of shelter, we try to get shelter or whatever the client needs. We use the legal clinic too.

Fisher: In the U.K., there is a philosophy, an ethos, that if we go to a hospital, for instance, with a patient whom we have committed (I have done that) that act counts as over-involvement. There is a great deal of criticism (to the effect) that you are stepping outside the formal professional role. In England, somebody who does that is often invalidated in the profession. It is not considered a professional act to do, although we may think that it is the only thing to do to be effective.

Mahlangu: That is where I have a problem with Eurocentric ways of doing things. First, in Africa we are not privileged to have multi-disciplinary systems whereby you just refer here and there. It doesn't work that way, at least in most parts of Africa. So you have to do everything. Secondly, as I have said, this is not so much a profession as a calling. If something is a calling, you go an extra mile. That is how I look at it.

Sinha: I find that there is a need to combine the cultural approach and the modern sciences to be able to give an acceptable message to the people you are dealing with. The problem that arises in ritualistic, spiritualistic practices is that one is not able to draw the line. In India, many faith healers are also exploiters. One can classify cultural practices. How have you been able to tell patients that this (particular practice) could be exploitative? How can you make yourself not fall into one category or the other, or not be identified with one of them?

Mahlangu: I am not saying that western ways of doing things are not right. I have been schooled in the west-

ern world. I use the western methods of healing but I am also an African. I cannot divorce myself from who I am so I need to put both in context.

On the issue of what works and what doesn't – I think there are phoney doctors, phoney psychologists, phoney everything. It is not for me to say that people are phoney or not. But one thing I'll say about traditional healers for example is, it is not for the therapist to say where the patient should go. It is for the family to decide on their own who they trust and where they want to go. I cannot interfere with their decision. It is just like religiosity. If you want to go to a minister, that's fine. You go to the person you trust the most.

However, in South Africa, traditional healers are licensed like psychiatrists or psychologists. There is an association of traditional healers. If you want to know if the healer is genuine, you can find out from the association. Also, healing is an issue of expectations. When people come to your room, what they want to see are the certificates on the wall that says you are doctor so and so. The white gown and the instrument make them feel, "I am going to be healed." Those are the expectations they have. People also have a set of expectations of traditional healers. So it is an issue of people being able to make up their minds with the help of the family.

Lopez: I think Roopa's (Sinha) question is very valid in the sense that we know that there are healthy and unhealthy practices, helpful and unhelpful practices. But I also agree with Palesa (Mahlangu) that it is not our decision who they will go to, and whether or not they will go. I also think as professionals it is incumbent on us to check things out.

Unlike in Africa, we don't have an association of faith healers in the Philippines. There are indeed exploiters and I have patients who have been hurt by ignorant faith healers. But for me it is not a big concern because people use their common sense. They know who to go to. The community knows the healers who are true to their calling. I have worked with a priest who does exorcism and if the exorcism works and the person believes that the priest can expel the bad spirits, I am even there with the priest. So my best judge is whether that individual believes in it or not and has made her/his own decision. □

Sheng Zhen Wuji Yuan Gong *(Qigong)*

MASTER LI JUN FENG
WITH ANABEL ALEJANDRINO

Overview

There have been known periods in the history of civilization when the universe compassionately bestows a rare gift to the world in the form of an invention, a perfected master, an extraordinary work of art, or inspired writings that can uplift and transform humanity — sometimes even changing the course of history.

Master Li Jun Feng and **Anabel Alejandrino are the** chairperson and vice-chairperson, respectively, of the International Sheng Zhen Society.

One such gift is the practice of Sheng Zhen Wuji Yuan Gong - a form of *qigong* or Chinese yoga. It is a system of practices to

help people focus, find purpose and contentment in their lives, and regain the feeling of total well-being and wholeness challenged by the world today.

It is out of the desire to share this gift, thereby fulfilling their mission, that the International Sheng Zhen Society, the proponent of Wuji Yuan Gong, strives to spread this practice by participating in seminars and proceedings such as this one.

The practice of Sheng Zhen Wuji Yuan Gong has the power to bring the practitioner back to his or her natural state - the state of happiness and contentment, the state of love - no matter what the circumstances of one's life.

We introduce the practice of Wuji Yuan Gong to the participants of this seminar to help caregivers get in touch with their inner resources and thus better serve the individuals they are helping. It is believed that in order to help these individuals in pain the caregiver must first go through his or her own process. He or she must find the harmony, steadiness, and well-spring of love and compassion within, in order that he or she can truly give. For one can only give what he himself holds within.

How does one deal with torture experienced directly, or vicariously as when recounted to a caregiver? By stepping back and looking at the bigger picture, by going to the very source of one's existence, and by focusing on the highest reality, thereby coming to an understanding of the purpose of human life and the universe. By practicing Wuji Yuan Gong, an inner knowing arises that puts everything in life in the highest perspective.

Significance and relevance

Introducing the practice of Sheng Zhen Wuji Yuan Gong in a seminar on Medical Ethics, Torture, and Rehabilitation only indicates the extremes that exist in the world today. Torture, the resulting pain and

trauma, represent the highest misuse of power. And because power ultimately comes from the universe, the misuse of it mocks God and all of humanity. The victim and the one inflicting the torture are both dehumanized — reduced to dust, so to speak. No act can be farther away from experiencing the highest truth which is unconditional love. Even killing can be compassionate.

Supreme Truth cannot be contained in words. It can only be experienced.

Sheng Zhen Wuji Yuan Gong exalts man. Its practice has the power to bring the practitioner back to his or her natural state — the state of happiness and contentment, the state of love — no matter what the circumstances of one's life. It has been imparted precisely at this time to uplift humanity from the prevailing darkness, as evidenced by the continuing use of torture in the world today.

Insights

Since his English usage is limited, Master Li Jun Feng was supposed to have been accompanied by someone who would help him guide and explain the practice to the seminar participants. But circumstances led him to make the trip on his own from Manila where he presently stays. So without an assistant, he managed to impart the various forms with his limited English. He carried on well equipped with his experience, his love for the practice, and the state that he has attained in the process of devoting his entire life to the teaching of **Wuji Yuan Gong**.

In retrospect, perhaps it worked to everyone's benefit. The truths embodied and imparted in the philosophy behind the practice of Wuji Yuan Gong are difficult if not almost impossible to express in words.

Supreme Truth cannot be contained in words. It can only be experienced. When the mind is put to work, sometimes ideas and concepts that arise tend to be dry and logical if not tempered by the heart. It is the nature of the mind to question and doubt everything, sometimes making it difficult for the truth to shine through. So it is as though words and the mind were bypassed as the participants were led through the practices by the Master, opening the door for them to experience the core of their being in what was being imparted through the movements. Attendance was good and it can only mean that the participants experienced something that resonated within them that they enjoyed.

The sequence of the modules were adjusted because of the desire of the participants to share their experiences early on in the seminar. Whereas before it was rather difficult to make the participants share their experiences and insights, they were particularly giving of themselves in this seminar to the point that the question of ethics came up — may they not be violating the doctor/patient confidence?

Fear and unconditional love cannot exist in the same place.

It can probably be concluded that the introduction of Wuji Yuan Gong in the proceedings may have encouraged the openness among the participants. The opening of the heart and the ability to look within without fear are gifts of this practice. As one learns how to relax the mind and the body, there is a kind of inner courage that surfaces from the indescribable experience of opening the heart. Fear and unconditional love cannot exist in the same place.

Introducing the forms

To receive the benefits of this practice it is recommended that both a non-moving form and a moving one be practiced. Two moving and two non-moving forms were introduced over the four days of the seminar:

1. Zhongtian Yiqi or Sitting Meditation
2. Jiu Zhuan Zhen Dan or Nine Turns
3. Jesus Sitting Qigong
4. Kuan Yin Standing Qigong

In general, the standing forms benefit the body, the sitting forms, when practiced with the contemplations elevate the spirit, and the sitting meditation connects one to the highest reality. The lying form known as Nine Turns improves the circulation of the *qi* (the vital force). This form enhances the general health of the body and the mind and works on balancing the *yin/yang* energies of the practitioner.

All that is asked of the practitioner is to have an open mind and the willingness and the patience to learn. One is asked to simply be committed to what feels natural. If 15 minutes of the sitting meditation everyday feels good then that is fine. Another may

About the ISZS

The International Sheng Zhen Society's work is supported purely by the offerings of all those who believe in and want to help in this loving work. People's time, their bodies, their skills, and their material resources are all offered out of a spirit of love and gratitude so that this work may be accomplished. Copies of the Sheng Zhen Wuji Yuan Gong book and a video are available on order. For more information on seminars in different parts of the world and the work of the International Sheng Zhen Society please write to:

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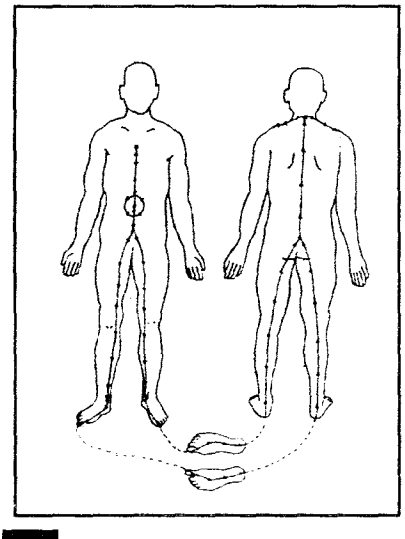
like doing it only every other day. Some may prefer to do two movements of a standing form just before meditation. And still someone else may prefer to do an entire set before going to bed. When the commitment is in place, the rest follows and unfolds in time.

JIU ZHUAN ZHEN DAN

Preparation

Lie flat on your back on a firm surface or cushion. Clothing should be loose and non-restrictive. Lay arms naturally at the sides, palms facing up, and gently close your eyes. Calm the mind and forget worries. Do not think of anything.

Relax the body. Bring your awareness to the tense areas of the body and consciously relax these parts such as the area between the eyebrows, area around the eyes, the neck and shoulders, arms the small of the back legs, etc. The entire body should be very relaxed. The breathing should be natural.

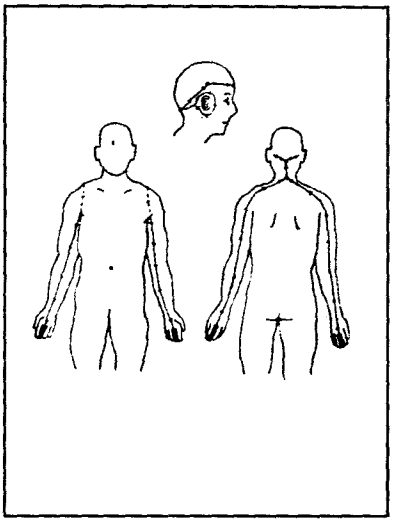


Instructions

1. With the mouth gently closed, move the tongue in circles lightly touching the inside of the mouth with the tongue. Begin by moving the tongue from the floor of the mouth up the left side to the roof of the mouth, down the right side. Do this nine times.

As the tongue turns, simultaneously imagine and guide the

qi starting from the *dantian* (area two inches below the navel) to make circles around the navel from left to right approximately the size of a saucer, circling also nine times. When the tongue is at the roof of the mouth, the *qi* should be above the navel.



Qi follows thought. As one thinks of the *qi* moving, the *qi* will naturally follow. For beginners, it is helpful to trace the circular movement around the navel with the finger. Later, trace the circles without actually touching the body. End the nine turns at the *dantian.*

2. Then, guide the *qi* up to the *shanzhong* (heart point). If you do not feel anything at first, that is fine. Just bring your awareness to the points indicated. From the heart point, guide the *qi* back down to the *dantian.*

From the *dantian,* split the *qi* into two to move down along the inner part of the thighs, knees, calves, passing under the ankle bone to the outside corners of the big toes. Then imagine the *qi* moving to the *yonquan* (center of the soles of the feet), and up the back of the legs to merge at the tip of the tail bone. Guide the *qi* up along the spinal column to the *dazhui* (seventh cervical vertebra, the bone at the base of the neck).

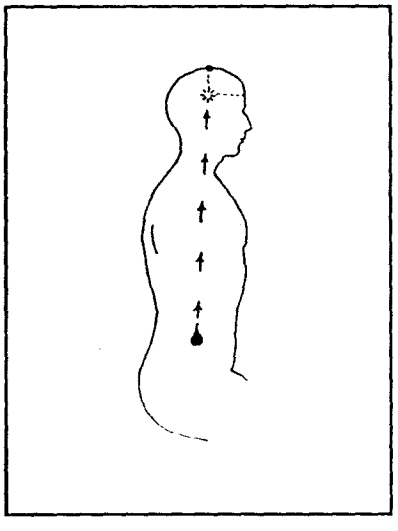
3. From the *dazhui,* split the *qi* into two again moving it towards and through the shoulders, out the underarm down the inner side of the arms, the crook of the elbows, the hands towards the *zhongchong* (tips of the middle fingers). Then move the *qi* over the fingertips to the back of the hands, up past the el-

bows, the upper arms, towards the shoulders, to merge again at the *dazhui.*

From the *dazhui,* bring the *qi* up to the *feng-fu* (hollow at the base of the skull). From the *feng-fu,* split the *qi* moving it to and around the ears and then back to the *feng-fu.* Beginners may omit this step.

4. Then guide the *qi* through the head to the *ni-wuan* (point located in the head which is the intersection of lines drawn from the *yin-tang* - the point between the eyebrows and the *baihui* - the center of the crown of the head). now bring the *qi* to the *ming-tang* (area just behind the center of the eyebrows) and allow to remain there a few seconds. Then swallow and imagine the *qi* moving back down to the *dantian* along the *Ren Mai,* the center meridian.

This completes the cycle. Repeat from the beginning and do this cycle nine times.



Points to remember

a. This exercise should be done in a relaxed and unhurried manner. Try to empty the mind.

b. For beginners, if it is difficult to do the nine turns around the mouth and the *dantian* simultaneously then begin by practicing them separately.

c. Moving the *qi* around the ears, may be omitted by beginners. However, it is more beneficial to do this step.

d. The parctice of **Jiu Zhuan Zhen Dan** clears the meridians and cures

chronic diseases. It is safe to do this even when one is pregnant or during one's monthly period. No limitations to one's diet are required although alcohol consumption should be moderate.

e. This exercise is for balancing the *yin* and the *yang*, and for better circulation of the blood and *qi*. For those with depleted energy, this practice energizes.

f. One may feel vibrations or sometimes feel light, as though floating. This indicates the body is healing itself. Falling asleep during practice may happen. Upon waking up, simply begin again.

g. Always finish the exercise with the *qi* in the *dantian*.

h. If during practice one forgets where the *qi* is, do not be feel frustrated. Simply begin again.

i. Coordinate breathing with the movements of the *qi*. As the *qi* moves upward, inhale; as the *qi* moves downward, exhale. Coordination comes more naturally after one has practiced this for some time.

KUAN YIN STANDING QIGONG



Preparation

Stand with feet about shoulder width apart. Follow the preparation instructions. Hands come together in front of the dantian. Left hand is over right with palms facing up, tips of thumbs touching (**Fig. 1**).

FIRST MOVEMENT
Boat Rowing in the Stream of Air

1. Slowly bring the weight of your body slightly forward, gradually bending, knees, hips moving back. At the same time, gradually lift the arms forward and upward in an arc, to the level of the chest, moving them to about shoulder width apart. Keep the hands relaxed and the elbows slightly bent. Bend the torso forward to about 30 to 45 degrees (**Fig. 2**).



2. Gradually straighten the legs, pushing the body up. At the same time, move the arms back to starting position, gently pushing down with the palms. Then straighten the wrists naturally when the arms reach the sides of the body (**Fig. 3**).


Fig. 3

3. Bend the knees and the body again while lifting the arms as in Step 1. The head may gradually turn left or right while doing this. Then straighten the body as in Step 2, bringing the head back to starting position. Repeat many times.

Points to Remember:

a. Use the momentum of the body to lead arms forward and backward, imagining the *qi* moving from the *dantian* to the shoulders, to the elbows and hands, and then back.

b. When bending forward, the hips move back naturally while inhaling. When straightening back, the pelvis leads by going forward and up while exhaling. The breathing and movements must be coordinated, the pace and extent of movements, comfortable and natural.


Fig. 1

c. Smile and be in a joyful state while moving.

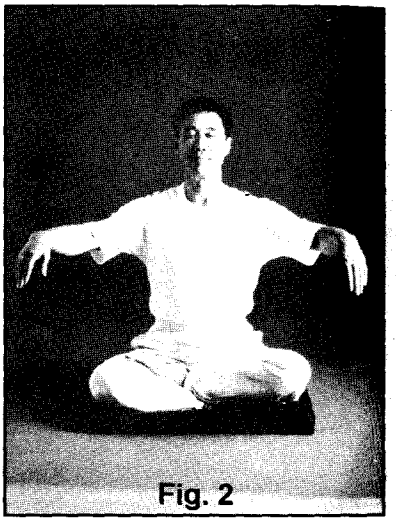
d. Do this movement many times.

JESUS SITTING QIGONG

Preparation:

Assume the sitting position following instructions and preparation . Do the **Zhongtian Movement** . Then bring the hands to rest lightly on the knees (**Fig. 1**). Hold this position briefly. Si-

multaneously lift the arms as in **Fig. 2** and bring the palms together in front of the chest (**Fig. 3**). Hold this position for some time.


Fig. 2

FIRST MOVEMENT
Love Descends On Me

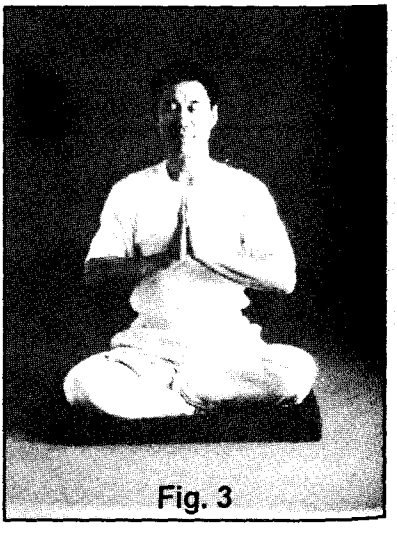
1. Gradually lift the elbows, while keeping the fingertips together as in (**Fig. 4**).

2. Gently raise the arms and as they reach the top of the head, open them out to the sides until they end at shoulder level. Palms are facing up while the elbows are slightly bent (**Fig. 5**). Hold the position for some time.

Points To Remember:

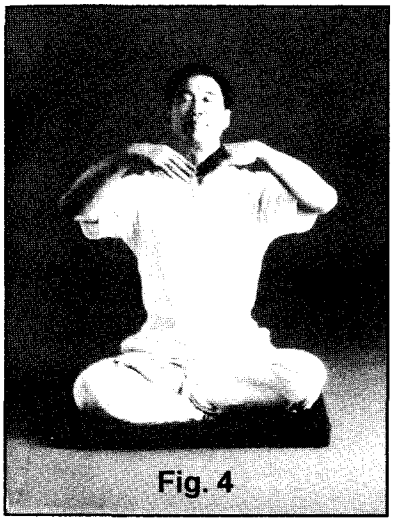
a. The arm movement in **Fig. 4** should be continuous.

b. If the shoulders are relaxed, this position can be held for an extended period of time without tiring.


Fig. 3

SECOND MOVEMENT
Unraveling the Heart

Gradually move the hands upward and inward toward each other letting the arms drop slightly so that the hands end up in front of the chest about head-width apart (**Fig. 6**). Hold this position for some time.


Fig. 4

Points To Remember:

a. Keep the shoulder relaxed while leaving some space between the arms and torso.

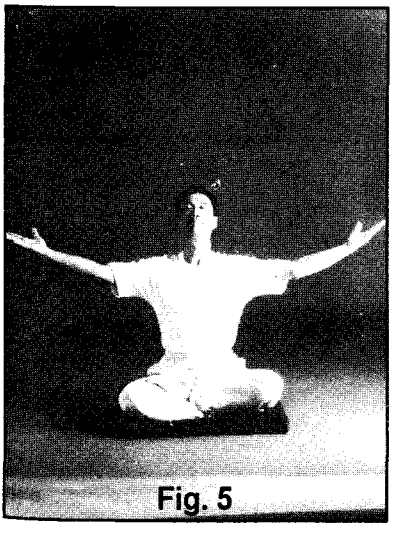
b. Do not bend or flex the wrists.

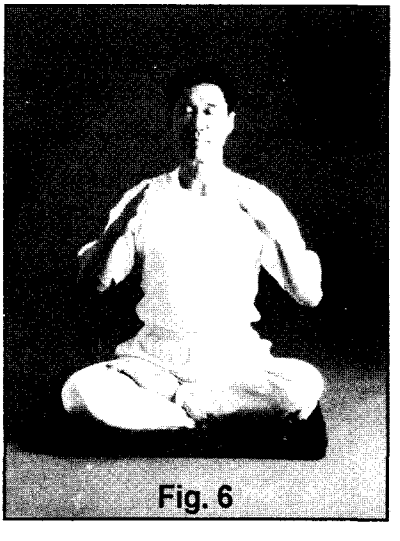
c. Fingers should be spread apart but relaxed.

THIRD MOVEMENT
Supreme Truth

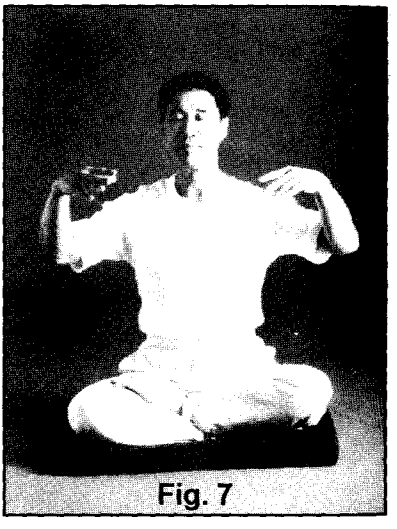
1. While inhaling, relax the wrists and gradually move the hands slightly out to the sides (**Fig. 7**).

2. While exhaling move the hands slightly out to the sides and down towards the abdomen. The palms are facing the dantian (**Fig. 8**).


Fig. 5


Fig. 6

3. While inhaling, let the hands hang limp and move them upward along the center of the torso (*Ren Mai*), at the same time keeping the back of the forefinger and middle finger slightly touching each other (**Fig. 9**).

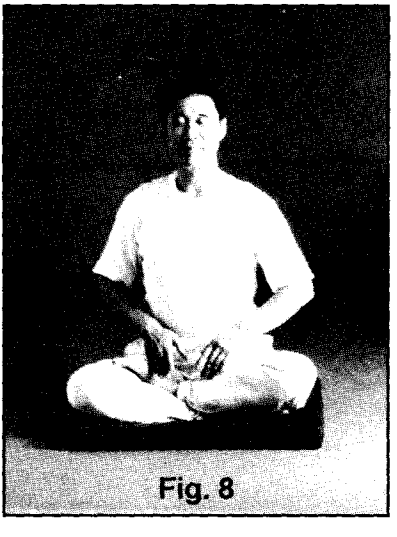

Fig. 7

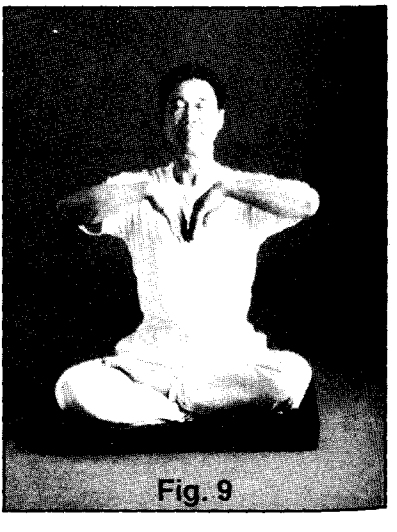
4. While continuing to inhale, move the hands above the head and extend the fingers upward turning the palm to face each other with fingertips touching and pointing up (**Fig. 10**).

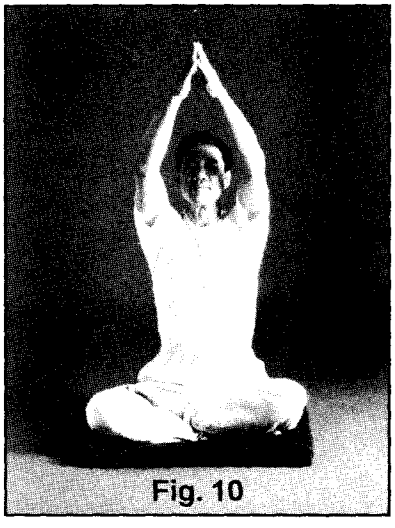
5. While exhaling, gradually bring the palms together while the hands move down to rest in front of the chest (**Fig. 11**). Hold this position for some time.

Points To Remember:

Movements should be fluid and the breathing natural.


Fig. 8


Fig. 9

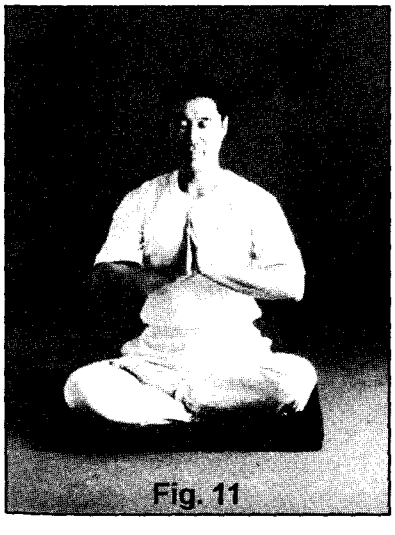

Fig. 10

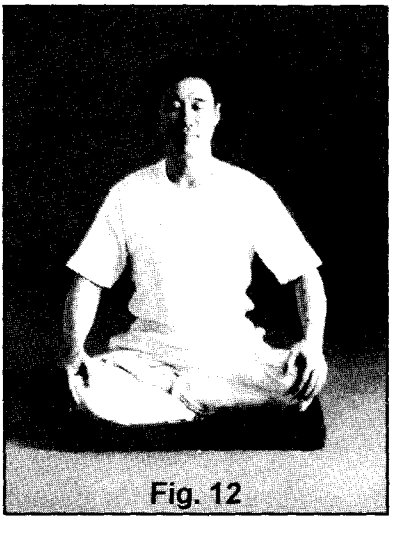
The Closing Movement:

Gradually move the hands apart and bring them down resting palms on the knees (**Fig. 12**). To conclude, do the **Zhongtian Movement**.

Zhongtian Movement

This movement symbolizes the cleaning of the hands and the face. It must be done at the beginning and at the end of every *qigong* practice. When done at the begining, it is a prayer for help and guidance in doing the practice and when done at the end, it is a prayer of thanks for the help and guidance received.

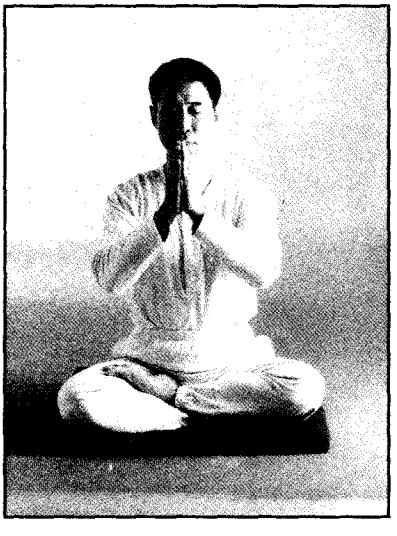

Fig. 11


Fig. 12

When several different forms of *qigong* are practiced consecutively, it is not necessary to do the movement at the beginning and end of each form. Do it only at the beginning of the first form and at the end of the last form.

The Zhongtian Movement can be done in either a sitting or standing position. It is performed as follows:

Raise both hands and bring them together with palms facing each other as shown in **Fig. 1.** The hands are very slightly cupped with the thumbs slightly apart with the tips of the other fingers as well as outer edges of the hands touching. Blow into the space between the palms.



After blowing, separate the hands, moving the right hand down to a little below the navel while simultaneously moving the left hand up to sweep the front of the face from the chin to the forehead.

Keeping the right hand in its position just below the navel, continue to move the left hand, sweeping it downward in front of the face and the torso until it comes to rest on the palm the of right hand.

The arms are bent slightly at the elbows and the upper arms are held a little apart from the side to the torso. The palms of the hands are facing up and the tips of the thumbs are touching forming a heart-shaped

hollow space. This is the starting position of the hands when practicing the different forms of *qigong*.

(Editor's Note: The exercises are edited excepts from *A Return to Wholeness* by Master Gong Chang and Master Li Jun Feng, published by the International Sheng Zhen Society, 1996.) □



Research Issues in the Care of Torture Survivors

"While we have been talking about treatment in this seminar, it should not be our only concern."

Dr. June Pagaduan Lopez

Research Issues in the Care of Torture Survivors

JUNE PAGADUAN LOPEZ

WHILE we have been talking about treatment in this seminar, it should not be our only concern. Our work with torture survivors has yielded so much information waiting to be recorded and studied in a systematic way.

Research on torture entails learning from those who have gone ahead of us. Having been in this work for 13 years, we are very proud to say that our university-based program, the Psychosocial Trauma and Human Rights Program (PST) has begun to systematize our in-

Dr. June Pagaduan Lopez is associate professor of psychiatry and the program director of the Psychosocial Trauma and Human Rights Program of the University of the Philippines.

formation. The program gives us the opportunity to conduct research on torture in as simple a way within the limits of our resources.

Research is prevention

Why is research on torture important? Why is research something that we have to do and not be afraid of doing?

When we want to prevent something we first have to educate ourselves about it. By understanding the phenomenon, we equip ourselves with ways of minimizing, if not completely eliminating the problem. In the case of torture, understanding the factors that promote its practice would help us advocate and recommend policies as well as plans action for its prevention.

Setting up a center or a program for torture survivors may be more difficult than starting an investigation on the situation.

Reasearch is collaboration, collaboration is protection

At PST, we welcome collaborative research and we have the facility for it because of the University setting and our strong linkages with both government and non-government organizations locally and internationally. These linkages have brought us not only a certain level of credibility but protection as well.

For example, an international and local campaign launched by MAG and the IRCT network for the release of Dr. Aurora Parong (a medical colleague who joined in organizing the Medical Action Group during Martial Law in the Philippines) led to her release after 18 months of unjust detention.

Similarly, a resolution passed by the American Association for the Advancement of Sciences (AAAS) decrying in 1987 the chilling effect of a public "red-baiting" and "red-labelling" against Filipino health professionals advocating human rights served to stop the practice. (Prof. Richard Claude and Eric Stone of the AAAS involved me in a documentation project that resulted in the publication of "Human Rights and Health Professionals in the Philippines" in 1987.)

Aside from clinical approaches, we are also interested in alternative or indigenous intervention methods such as yoga or *qi gong.*

Research agenda

So what is our research agenda on torture? What are the possible areas for collaborative research?

The first is on *monitoring the incidence of torture.* Monitoring torture in our respective countries is a partnership. For instance, if access to information is a problem in your country, you can contact us and we will send you whatever information we have that you need. We can also send you information that we have about your country.

The second is *documentation of cases.* If anyone of us encounters one or two torture victims, we must document their stories. We owe it to them, to society and to history. There is no other way. As health professionals, we have our own system of recording. It is just a matter of writing down the story as it is.

The third is *evaluation of interventions for rehabilitation.* Aside from clinical approaches, we are also interested in alternative or indigenous intervention methods such as yoga or *qi gong.* These may not be easy to do but we should try and see the difference between the more mainstream western methods and the alternative or indigenous methods.

The fourth is *monitoring the involvement of health professionals.* This is a sensitive area of research. That is why we included in this seminar topics such as monitoring of prisons, prison visits and the medical-ethical roles and responsibilities of health professionals. We hope that the books brought here by Dr. Fleur Fisher, such as *Medicine Betrayed* by the British Medical Association, will be helpful guides to monitoring the positive or harmful involvement of health professionals. This is not just about the direct or indirect participation of health professionals in torture but also about the participation of health professionals in the promotion of human rights.

We can consider the workshops in this seminar as a research endeavor. The sharing that results from this rare opportunity to come together is a rich material for research.

The fifth area is *establishing the problems and needs for education and prevention.* We may want to conduct a series of activities that will let us identify and prioritize concerns.

And finally, *identification of the problems and needs of caregivers.* This has been very much articulated by various speakers.

We can consider the workshops in this seminar as a research endeavor. The sharing that results from this rare opportunity to come together is a rich material for research. Every paper, every book, every magazine that is circulated in meetings on this work is research material.

Finally, we have to reflect on what has happened these past few days. How have we been affected and how have we reacted to all the information – new painful information?

As an initial reflection, I wish to share this poem with you. Please spend five minutes to reflect on this poem outside before you go to your workshop rooms.

I wonder how many of you have appreciated this place? How many of us have been walking, slowly appreciating the trees, and the flowers here? This is an oasis and I am thrilled that we found this place in the heart of Bangkok's asphalt jungle. Because I was so tired after this morning's session, I decided to walk slowly to lunch. Only then did I realize that I have not absorbed this place. In the same spirit that Master Li has asked us to empty our minds, I ask you now to fill your minds with the beauty of this place.

In order to be at peace
It is necessary to feel a sense of history
That you are both part
of what has come before
and part of what is yet to come.

Being thus surrounded
You are not alone
And the sense of urgency
that pervades the present
is put in perspective.

Do not
frivolously use the time that is yours to spend
Cherish it.
that each day may bring new growth inside and
awareness
Use this growth not selfishly
but rather in service of what maybe
in the future tide of time

Never allow a day to pass
that did not add to what was understood
before

Let each day be a stone
on the path of growth

Do not rest
until what was intended has been done
But remember
go as slowly as is necessary
in order to sustain a steady pace
Do not expend energy in waste.

Finally
Do not allow the illusory urgencies of the
immediate
to distract you
from your vision of the eternal. □



Workshop Highlights

Workshop Highlights

THIS four-day seminar-workshop was held in Bangkok, Thailand on October 2 to 5, 1996 as a Human Rights Education Program for Health Professionals in the Asian region. It was supported by the United Nation's Voluntary Fund for Torture Victims and DANIDA through the International Center for the Rehabilitation of Torture Victims (IRCT). Organized by the Psychosocial Trauma and Human Rights Program of the University of the Philippines-Center for Integrative and Development Studies (UP-CIDS-PST), the seminar-workshop provided a forum for discussing ethical responsibilities of medical and other health practitioners concerning the incidence, practice and participation of health workers in torture and the care of survivors.

In the workshops, the participants shared personal and country experiences; identified problems and assessed the needs particularly of women, children and indigenous peoples who are most vulnerable; and de-

fined research and ethical concerns. Three workshop groups were organized, each one headed by a facilitator. Each group nominated a rapporteur who documented and presented the discussions during the plenary sessions.

The seminar participants came from Bhutan, Cambodia, China, Sri Lanka, Bangladesh, Indonesia, Thailand, India, Nepal, New Zealand and the Philippines.

Workshop I, which focused on the sociopolitical conditions and human rights situations in the countries represented were shared, it was noted that caregivers themselves are "wounded and traumatized" by the situations they confront. In general, they are restrained from expressing and evaluating the political conditions in their own countries. The participants were encouraged to share what they wanted or were ready to share.

Concern was raised regarding people from developed countries who wish to support health professionals working in developing countries but whose assessment of the situation is sometimes naive. This sometimes puts people in developing countries in danger. Doubts were raised as to the potential help or support to be expected from national medical associations. Many of these associations have links to the government or big drug companies.

In response to this concern, a participant from a developing country noted that health professionals have no choice "but to continue living in a repressive system" and "have a meaningful life only doing what they have to do." They may show courage not only because they want to do something but also because "international friends were there to protect them." As regards the medical associations, it was observed that they are just repressed and may be as victimized as the health professionals in developing countries.

Some consensus evolved on ways in which various international groups can help increase the feeling among health practitioners in developing countries of relative safety. These groups may possibly be waiting for an expression of concern to come from indigenous groups in the developing countries before coming in to provide resources, conduct collaborative research, monitor conditions, and then expose to the international media the conditions that prevail.

It is also useful for health professionals to organize activities in their countries and let themselves be known by the diplomatic or expatriate community who may be able to provide protection or safe haven.

In the discussion on caring for caregivers, a framework/instrument was tested wherein the caregivers could look at themselves and how their work or attendant circumstances affect them. By using the instrument,

one can see where the person came from, where he/she is now, and where he/she would like to go. This is important for planning any kind of intervention because the caregiver is given a tool to highlight the survivor's potentials, positive aspects and limitations. In this way, the caregiver facilitates the return of the survivor's sense of hopefulness.

Ethical concerns were raised regarding the "half-baked and insensitive" use of such an instrument, especially if done in public and by a person without adequate training and experience. It was clarified that for public case discussions there must be consent as well as an atmosphere of respect, and appreciation of the survivor's story. The participants also took exception to the use of videos and photographs. There was consensus that one must consider the right to privacy and the overall health interest of the survivor. It is important to obtain the consent of people before using documents or materials in which they are identified. These people should also understand how the materials will be used, who will see them, who will have access to them, and when they would be destroyed.

Regarding research concerns, participants expressed interest in knowing what is happening in the different areas of the Asian region. The health professionals felt a need to know each other and each other's problems both for their regional as well as global significance.

A particular problem is how to conduct research for areas that are remote and without research facilities. For example, how to get some research-related materials on such difficult issues as psychological problems of amputees. There are groups, such as the PST, the IRCT, the PHR, the BMA and the AAAS who are willing to play a networking role in this regard.

With respect to communication among health professionals in the region, the medium, which is usually English, can be a problem. People may find great difficulty in expressing very emotional issues outside of their own language or may be hesitant to join group discussions because of their inability to be fluent in English.

In Workshop II, the problems and needs of victims/survivors of human rights abuse and political violence were identified. Strategies, resources and activities to deal with these problems and needs were also explored by the three workshop groups.

The concerns of the various countries represented cover a wide range. These are: injured soldiers, poverty, street children, beggars, refugee camps (particularly the young people in those camps), political violence, torture perpetrated by the police, child-trafficking, political instability, illiteracy, social structures, domestic violence, child abuse, and repression.

The needs of victims and survivors include: basic education for children; provision of jobs and food; vocational training; adequate shelter; funds for putting up small businesses; repatriation of political refugees; conduct of human rights awareness programs, particularly on torture and rape; establishment of treatment and rehabilitation centers for torture survivors; legal aid; empowering women by making them self-sufficient; and training for caregivers on assessment, treatment and research related to trauma and violence.

The strategies suggested consist of two levels, the personal and institutional. The personal level concerns the caregivers themselves. For instance, they may not have the confidence to provide whatever survivors demand or expect. They feel a lack of knowledge and skills on how to take care of torture victims. Hence, there was a clamor for more training activities as well as for support groups. Opportunities to talk about caregiving needs and problems among themselves were underscored in order to minimize, if not, prevent burn out.

The workshops stressed that caregivers must do their job as medical and health professionals in the best way they can. They must educate themselves and the others around them on torture-related issues. While doing this job well, they can document cases and sys-

tematize the information which can be shared with other people who can serve as support groups. This can contribute to the development of the field of mental health in countries like China, Sri Lanka and Cambodia. Caregivers should also develop survival strategies which are culturally appropriate to the specific challenges they face.

On the institutional aspects the following strategies were enumerated: (1) coordination and cooperation at the regional level by focusing the work of a regional council or secretariat among the organizations working in the Asia/Pacific region; (2) establishment or improvement of information dissemination through publications; (3) collaboration with allied groups and organizations; (4) networking with local and international non-government organizations dealing with human rights; (5) making public the activities of health professionals through different media, including the Internet; and "politically correct" ways of publishing important information; (6) and working through the government system while not "losing our human rights stance."

On resources: local manpower and financial resources are needed, along with international support. This international network is not only important for the development of skills and human resources but also for the protection of caregivers in their respective countries.

In summary, there is a broad spectrum of problems that surround the phenomenon of torture which cannot be ignored. There are short-term and long-term solutions, the latter referring to the elimination of the root problems of torture. There is also a clamor for more coordination and collaboration as well as improved dissemination of information. Logistical support is much needed, along with the continuous building of a strong network that will protect the caregivers as well as enable them to develop their own programs in each country and in the Asian region. Basic training and research initiatives are also activities worth undertaking. □

Appendices

Appendix

A

Actual Seminar Workshop Program

Day 1

October 1, 1996

6: 00 p.m. Welcoming Ceremony

- Opening remarks
  June Pagaduan Lopez, *PST Program Director*
- Welcome remarks from the sponsoring agency
  Inge Genefke, *IRCT Medical Director*
- Introduction of the keynote speakers
  Elizabeth Protacio-Marcelino, *PST Research Director*
- Keynote address
  Vithoon Eungprabhanta, *Advisor of the Health Law* Seminar of Mahidol University
  Hon. Khun Wittaya Keawparadai, *chairperson,* House Committee on Justice and Human Rights
- Closing Remarks, **Elizabeth Protacio-Marcelino**
- Dinner and cultural presentation by Thai dancers

Day 2

October 2, 1996

8:30 a.m.	Continuing Registration of Participants
9:00	Introduction of Participants
9:15	Objectives and Overview of the Seminar
9:30	Torture Today *Dr. Inge Genefke*
10:30	Break
10:45	International Covenants and International Humanitarian Laws Regarding Torture *Dr. Bent Sorensen*
11:45	Open Forum
12:15	Lunch
1:30	Energizer
2:00	The Role of Health Professionals in Promoting Human Rights *Prof. Erik Holst*
3:00	Open Forum
3:30	Break
3:45	Guidelines for Prison Monitoring *Dr. Bent Sorensen*
4:45	Open Forum
5:15	Qi gong Exercises *Master Li Jun Feng*

Day 3

October 3, 1996

8:30 a.m.	Detection and Management of Physical Sequelae of Torture *Dr. Bhogendra Sharma* *Dr. Veli Lok*
9:30	Open forum
10:00	Break
10:15	Psychological Sequelae of Torture, Assessment, and Management *Dr. June Pagaduan Lopez*
11:15	Open Forum
12:00	Lunch
1:00	Energizer
1:30	Medicolegal Investigations and Torture *Ms. Kari Hanibal* *Dr. Robert Kirshner* Presentor: *Dr. Richard Pierre Claude*
2:30	Open Forum
3:00	Break
3:15	Ethical Issues Regarding the Involvement of Health Professionals in Torture *Dr. Fleur Fisher*
4:00	Workshop 1 - Needs Assessment
6:00	Cultural Night

Day 4

October 4, 1996

8:30	Workshop I (Plenary)
10:00	Break
10:15	Special Concerns: Torture of Women and Children *Dr. Elizabeth Protacio Marcelino* *Ms. Amihan Abueva* *Ms. Rebecca Samson Gaddi*
11:45	Open Forum
12:15	Lunch
1:30	Energizer
2:00	Caring for Survivors: The Holistic Approach *Ms. Palesa Mahlangu*
3:00	Break
3:30	Introduction to Care for Caregiver *Dr. June Pagaduan Lopez*
5:00	Plenary
6:00	Qi gong Exercises *Master Li Jun Feng*

Day 5

October 5, 1996

9:00 a.m.	Care for Caregivers *Dr. June Pagaduan Lopez*
12:30	Research Issues in the Care of Torture Survivors: Ethics and Methodology *Dr. June Pagaduan Lopez*
12:30	Lunch
1:30	Workshop 2,3 and 4 (Integrated)
3:30	Plenary
4:30	Evaluation and Closing
6:30	Farewell Dinner

Appendix

B

Workshop Guidelines

Participants will be divided into three workshops (A, B, C). Each workshop will be headed by a facilitator to be assigned by the organizers and a rappoteur to be nominated by the workshop participants. The panel rapporteur will document the discussions in the workshop, make a workshop report and present this during the plenary sessions after each workshop. All workshop reports should be submitted preferably on the same day or early the next morning to the secretariat. The following are the guidelines for the discussions in the workshops.

WORKSHOP 1

Sharing and leveling of experience

1. To share the socio-political conditions and human rights situations in their own countries.

2. To share experiences, views and opinions on the participants encounter/exposure to victims/ survivors of human rights violations and other forms of political violence.

3. To look at the involvement and roles played by health professionals in helping the victims/survivors.

WORKSHOP2

Problems and needs assessment

1. To identify problems, needs and priorities of caring for victims/survivors of human rights abuse and political violence with emphasis on vulnerable groups (women, children, indigenous peoples).

2. To identify possible responses and solutions to these problems.

3. To identify the problems and needs of the participants themselves, as caregivers, and find possible answers and solutions to these

WORKSHOP 3

Research and ethical concerns

1. To identify areas of common concern and come up with a possible research agenda for cooperation, coordination and implementation in the region.

2. To identify ethical issues that need to urgently addressed and proposed possible actions on this regard.

WORKSHOP 4
Planning and programming

1. To recommend strategies, resources and activities to be included in a plan of action.

Appendix

C

Circles of Life

JUNE PAGADUAN LOPEZ, M.D.
LITO MISA, PH.D.*

The following questions will help you reflect on the impact/effect of a traumatic experience on you. Please answer them as accurately as you can remembering that there are no right and wrong answers and that your actual personal experiences are more important than your ideal or theoretical thoughts about the experience.

Think of a traumatic experience in your life and answer the following questions:

A

1. What were your thoughts and feelings about this experience?

2. How did your behavior change after this experience?

3. How would you describe yourself before and after this experience?

B

1. How did this experience affect your most important relationship with your environment at work, at home, and in your community?

2. How did this experience change your relationship with your environment at work, at home and in your community?

* *candidate*

C

1. What are the affects of this experience on your peace of mind?

2. What would you like to have for your peace of mind after this experience?

D

1. What helped you handle/cope with this experience?

2. How were your personal and external resources affected by the experience?

3. What were the obstacles to your full recovery?

4. What personal potentials would you like to develop to help you cope further?

5. What external resources would you like to develop to help you cope further?

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Psychosocial trauma is an injury caused by an event, man-made or natural, which results in temporary or permanent mental, emotional, spiritual, or moral dysfuntion or maladjustment and which impairs a person's capacity to resume a healthy and meaningful life.

Over the years professionals and development workers in human rights advocacy who have been servicing the psychosocial needs of survivors of violence have accumulated a large amount of experiences. Their efforts which can provide a deeper understanding of psychsocial trauma, are now being documented by the Program on Psychosocial Trauma (PST) of the University of the Philippines Center for Integrative and Development Studies. But the insights from such psychosocial interventions need scientific validation.

To achieve this and more, the PST conducts interdisciplinary research and education on psychosocial trauma through joint efforts among non-government organizations (NGOs) and the academe. The NGOs provide services, while the academe complements the NGOs' field experiences by conceptualizing these into appropriate frameworks. These studies are aimed at mainstreaming of the care of psychosocial trauma survivors, which is the guiding principle of the program.

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