Physical and Psychological Effects of Politically Motivated Torture of Chilean Refugees

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Preface and Acknowledgements

The discussion about politically motivated torture has become more prominent since the establishment of Guantanamo as a detention center, the revelation of the abuses that took place in Abu Ghraib, and the torture experienced by Canadian citizens in Syria.

This working paper is intended to assist those professionals who consider it important to have particular knowledge about the process and dynamics of torture when helping people affected by it.

The information presented here was collected in the early 1980s from 15 people who were tortured in Chile. I thank them for sharing their horrific experiences and for the fact that, despite the brutality they suffered, they were able to transmit to me hope and optimism.

Miguel Sanchez
Introduction

The available research on torture is consistent in stating that the effects of torture are serious, both physically and psychologically. Among refugees, victims of torture are considered a subpopulation presenting a special risk for mental disorder (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees-CTF, 1988), and their rehabilitation presents a great challenge to mental health workers (Ahearn, 2000). Indeed, untreated psychological or physical trauma has been identified as one condition that prevents refugees from moving from disablement to rehabilitation (Center for the Treatment of Refugees and Immigrants-CEPAR, 2003).

Professionals working to alleviate the effects of torture note that to understand the consequences of torture and to facilitate recovery, it is essential to have precise information about the methods of torture (Kosteljanetz and Aalund, 1981) and the process of torture itself (Berdichevsky, 2003). Berdichevsky also notes certain factors that will either increase vulnerability to the possibility of long-term effects or produce greater resilience. Some of these factors are related to the process of torture; that is, the form and degree of torture and the circumstances under which the torture took place. According to the Canadian Centre for Victims of Torture-CCVT (2004), the form and severity of torture is a very significant factor affecting treatment outcomes. Basoglu (2001) reports that a cluster of symptoms experienced by torture victims are related to a long duration of torture, which may imply greater severity of illness caused by more severe trauma.

The purpose of this paper is to provide information on the methods, the extent and the effects of torture, based on my research with 15 Chilean refugees to Canada. I obtained the data from this sample population, which is not readily accessible to most researchers, while doing undergraduate work in 1985.

As noted, victims of torture are a subpopulation among refugees presenting a special risk for mental health disorders. Many Canadian refugees face the task of resettling, meeting their basic needs and adjusting to a new reality, while haunted by their earlier traumatic experiences. These experiences are largely unknown to social workers and other professionals working in human services and/or health-related fields.

Background

Torture, imprisonment and exile are not new political phenomena. They have been prominent components of political repression since ancient times. In general, the objective of political repression, regardless of place and time, has been the annihilation of a political response through the psychological terrorization of the population (Barudy and Paez, 1979). In terms of process, political repression has been said to have as its ultimate aim the destruction of people’s political and affective links, their futures and their social plans, or the facilitation of the old, or the establishment of new, political rules (Dominguez and Westein, 1985).

Although prohibited under the International Covenant on Civil and Political Rights of 1966, which came into effect on March 23, 1976, torture is still very prevalent as a means of political repression. Every year, Amnesty International reports the torture or ill treatment of prisoners around the world. It is estimated that between 100 and 120 of the world’s governments regularly employ torture (Simalchick, 2002; Center for Multicultural Human Services-CMHS, 2003; The Bellevue/ NYU Survivors of Torture Program, 2003).
Imprisonment and exile also exist as methods of political repression. It may be that because these methods do not explicitly involve the brutal physical attacks inherent to torture, they are not given the same prominence in the literature. Instead, imprisonment and exile are treated as the continuation of a destructive process initiated by torture (Fishman and Ross, 1990; Gonsalves, 1990).

**Definition of Torture**

There are many definitions of torture. Generally they are similar, their differences confined to the set of criterion used to determine what actually constitutes such an act. For the purpose of this paper, I use the definition adopted by a convention of professionals working with Latin America torture victims. The convention, held in Buenos Aires in 1985, states:

Torture is the intentional application – by public functionaries or other persons in the exercise of public office – of methods and techniques that provoke pain, suffering, and physical, psychic and moral terror with the purpose of making a person or third parties yield, break down and become submissive. The intent of torture is to rob a person of his or her identity, or his or her political conviction, in order to obtain information or confession of acts supposedly committed. Torture relies on punishment and coercion in an attempt to impose an alien ideology on a person and convert the subject into a being without personality, thoughts, feelings or will of their own. (LADOC, p. 8. My translation)

**Physical Effects**

Research has found that, as a direct consequence of torture, victims often suffer from devastating medical problems requiring both immediate and long-term attention (Stover and Nightingale, eds., 1985, p. 58; CMHS, 2003). For instance, torture victims are affected by gastrointestinal symptoms, including periodic or permanent ulcer-like dyspeptic symptoms, regurgitation pains in the epigastrium and oppression after eating. The most commonly reported symptom is an irritable spastic colon. Rasmussen and Marcussen (undated) suggest that these kinds of physical effects belong to a “symptom spectrum” in which stress may play a significant role. They further note that, because patients with these symptoms also complain of difficulties of a psychiatric nature, their gastrointestinal symptoms ought to be viewed as psychosomatic.

Several studies have described numerous other physical effects of torture. These can include: headaches; dizziness; loss of sensation and other neurological symptoms; pain in the feet, back, muscles or joints; hearing loss; teeth and gum disease; damage to heart, kidneys, lungs, spine, ears and eyes; scarring; broken or poorly healed bones; gynecological problems; and an abundance of localized disorders (Simalchick, 2002; Bellevue/NYU Program, 2003; CMHS, 2003). Studies using computer tomographic scanning reveal evidence of brain atrophy in some torture victims. The results suggest a common pathologic substratum for the torture syndrome and the post-concussion syndrome, or PCS (Kosteljanetz and Aalund, 1981).

**Psychological Effects**

Some research indicates that psychological damage appears to be the worst sequelae of torture. Based on their medical study, Cathcart, Bergen and Knazan wrote, “The victims, particularly the younger ones, were emotionally labile. All exhibited psychological disturbances; most still had nightmares and crying episodes, and there is no way of knowing how long these will persist” (1979, p.18).
Ahearn (2000) concludes that, due to the psychological impact of violence and war, the mental health needs of refugees and displaced persons are massive and their problems will continue for a generation or more. However serious, the full extent of the impact of torture on refugees’ mental health is relatively unknown (Manshreda et al., 1998).

The most common psychological and emotional symptoms of torture are fear, anxiety, sleep disturbances, depression, loss of concentration, emotional irritability, anger, aggressiveness, impulsiveness, severe headaches, lability, introversion, fatigue, hypersensitivity to noise, emotional numbness, sexual dysfunction and difficulty maintaining close relationships. Victims of torture may also suffer from guilt, shame, difficulty trusting, social withdrawal, low self-esteem, attempts to avoid reminders of the trauma, hyper-alertness to danger, memory disturbances, learning problems, phobias and flashbacks. Specific mental health problems include various depressive and anxiety disorders and post-traumatic stress disorder, or PTSD (Cathcart et al., 1979; Cam, Nielsen and Rasmussen, 1977; Kosteljanetz and Aalund, 1981; Simalchick, 2002; Bellevue/NYU Program, 2003; CMHS, 2003).

The long-term effects of torture include a variety of acute medical symptoms such as gastrointestinal disorders, lumbar spine abnormalities, skin lesions and hearing deficits. These problems, along with pronounced mental symptoms such as severe headaches, insomnia and nightmares, constitute an entity named the torture syndrome (Cam et al., 1977; Kosteljanetz and Aalund, 1981; Elsass, 1997). As noted above, some authors consider these symptoms to be constituents of PTSD.

Gerrity, Keane and Tuma (2001) summarize the debate regarding the approaches for conceptualizing the consequences of torture and related violence and trauma as follows:

Most groups, including survivors of torture, mental health researchers, and therapists, agree that the PTSD diagnosis can be a useful tool for describing the suffering and symptoms of survivors of torture and trauma, for gauging the extent and severity of traumatic experiences, and for planning and delivering clinical interventions….Researchers and clinicians have also proposed a number of other trauma related clinical syndromes, including survivor syndrome, torture syndrome, prisoner of war syndrome, concentration camp syndrome, vicarious traumatization syndrome and gross stress reaction syndrome. (p. 8)

It is clear that the effects of torture are serious, and no matter what conceptual approach one chooses, there is a need for more discussion about them. The lack of information about the methods of torture has direct repercussions on the effectiveness of professionals who treat torture victims. These professionals require more precise information about the methods and process of torture to determine appropriate treatment and to assist in the recovery process. This paper may contribute to the literature that is available in this area.

Research Method

The data for my research study were obtained through 15 personal interviews with former political prisoners from Chile. At the time of the research in 1985, the study participants were living in exile – one in the United States and the others in various Canadian cities. They had left Chile after the September 11, 1973 coup d’etat in which the democratically elected socialist government of Salvador Allende was violently overthrown.

The individuals were chosen for the study on the basis of their disposition to participate and their experience of detention and torture in their country of origin. All participants were male, ranging in age from their late 20s through early 40s. All but one had been in exile for more than seven years. All
but four had been detained and tortured immediately or soon after the Chilean coup in 1973. Those four, unlike the other respondents, had spent at least a year (in one case, more than five years) clandestinely, either hiding or actively working against the military government.

For the purpose of this paper, I have reduced the number of subject areas that were originally studied to two main topics: 1) the forms and degree of torture and 2) characteristic coping mechanisms and the physical and psychological effects of torture. Analysis proceeds by identifying the commonalities in the experiences of the respondent and by noting exceptional responses.

**Forms and Degree of Torture**

**Physical Torture**

As has been noted, Kosteljanetz and Aalud (1981) and Berdichevsky (2003) indicate that to understand the consequences of torture it is essential to have precise information about the methods applied.

Physical torture was applied to all but one of the participants in this study. The particular forms of physical torture they experienced included beatings, electric shocks, suffocation, suspension in mid air, forced positions, cigarette burns and exposure to the cold.

Fourteen respondents received beatings. These consisted of punches, kicks, strikes with rifle butts and blows to the head, including the use of “the telephone” in which the victim’s ears were hit simultaneously with open hands.

The extent of the brutality may be assessed from the recollections of two respondents:

- The beating was endless, my entire body was numb. (Respondent 3)
- As a result of the blow, I flew about five meters. When I landed, my leg was jumping out of control, I couldn’t walk. I couldn’t breathe. (Respondent 7)

Fourteen respondents were subjected to electrical shocks. Two respondents experienced a particular method of electrocution known as the parrilla. With this method, the victim, who is usually naked, is placed on a metallic bed frame and electrodes are applied on different parts of the body, including the genitals, ears, arms and temples. In some cases, the electricity used was taken directly from electrical outlets, which, in Chile, carry a charge of 220 volts. Respondent 10 had a piece of metal pushed into his anus and an electrical current then applied.

Suffocation-asphyxiation as a means of torture has been reported in several forms, including techniques such as the “wet submarino”\(^1\) and the “dry submarino,”\(^2\) and detailed in other studies (e.g., Manshreda et al., 1998). One participant in this study experienced the dry submarine and three others were subjected to the wet submarino.

Respondent 2 described another suffocation technique not experienced by any of the other study participants and not reported in previous studies:

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\(^1\) The person’s head is submersed in water for long periods.

\(^2\) A plastic bag is placed over the person’s head, depriving the person of air.
I was sitting and totally immobilized. Behind me there was a person whom I never saw...This person would pull the string and keep the pressure constant on my neck. The string would cut off the air inflow and, more importantly, cut off the blood flow to the brain because of the pressure on the artery. Then they posed the questions and if my answers were unsatisfactory to them, he pulled the string tighter, thus causing an enormous desperation. But the desperation was even greater when he released the pressure. I could then feel my blood pounding on its way up to my head.

Unfortunately, this then-new method of suffocation is now used in other parts of the world. For instance, an asphyxiation technique suffered by Maher Arar, a Syrian-born Canadian citizen tortured in Syria between 2001 and 2002, closely resembles the asphyxiation technique reported by Respondent 2. An important reason for presenting this 1985 data is that they seem to confirm reports that torturers consistently attempt to refine their methods (see, for instance, Rasmussen and Marcussen, undated; Domovitch, Berger, Waver, Etlin and Marshall, 1984; Simalchik, 2002).

The data also allow us to conclude that the methods of torture used in Chile were consistently applied throughout the country: The study included people who were tortured in the north, centre and south of Chile.

The study found that the most common forms of physical torture included electrocution and beatings. This is a finding consistent with those of previous studies. At least two respondents also reported physical exhaustion, exposure to the cold and/or burns by lit cigarettes. Six respondents experienced suspension in mid air and forced positions.

It is possible to state that the torture sessions themselves followed a more or less consistent pattern. According to Respondent 2, the process of torture is best understood in three main parts. In the first, which he called the softening part, the torturers use various beating and humiliation techniques. The second – the interrogation phase – occurs when the torturers apply electric currents and other systematic techniques, such as the submarino and mid-air suspension, intentionally designed to elicit a response from the victim. In the third part of the torture process, which he called the farewell phase, indiscriminate beatings are given as reprisals for the victim’s lack of cooperation with the interrogators.

**Psychological Torture**

A discussion of the physical aspects of torture does not, by itself, allow us to gain a complete picture of the respondents’ experiences. It is necessary to understand their experiences from a psychological perspective as well. This may then facilitate a fuller understanding of the symptoms which were present at the time of the interviews.

Other studies such as those of Allodi (1985) and Kosteljanetz and Aalud (1981) suggest that any method of physical torture also constitutes a form of psychological torture. The organization, Advocates for Survivors of Torture and Trauma (2006), notes that the distinction between physical and psychological methods of torture is an artificial one because both methods are intended to destroy the sufferer’s sense of safety, autonomy and personal and physical integrity. Basoglu (2007) indicates that both physical and psychological methods of torture have similar mental effects.

All of the study participants said that they were subjected to psychological torture. This included witnessing and hearing the torture and killing of other prisoners, sham executions, death threats, threats to relatives and friends, sensory deprivation, sleep deprivation, food deprivation, solitary
confinement, verbal abuse, forced nakedness, continuous exposure to dark, forced eating of excrement, surveillance at work, job firings and the prevention from continuing studies after imprisonment.

Ninety percent of the study participants reported sensory deprivation, most often through blindfolding. The length of time that they were subjected to this kind of torture varied from one week to three months. Forty to sixty percent of the participants reported verbal abuse, solitary confinement, forced nakedness, threats to relatives and the loss of jobs or studies after imprisonment. In some cases, their torture lasted for a few days; in others, for two to three weeks and, in at least two instances, for three months.

Five respondents were subjected to sham executions, witnessing the torture or death of other prisoners and sleep and/or food deprivation. Those who were forced to witness or listen to the torture of other prisoners stated that the experience was the most traumatic of all. Similarly, the respondents exposed to sham executions claimed that that technique had a great psychological impact on them.

Continuous exposure to the dark as a psychological method of torture was applied to only one respondent. Another respondent was forced to eat excrement. In contrast, almost all of the respondents were subjected to a particular technique which they called “the good and bad guy.” Allodi (1985) refers to this technique as an occasional indulgence-fluctuation in the interrogator’s attitude. It is applied following a session of torture and after the prisoner is left alone for a while. A conciliatory interrogator is then introduced to persuade the victim to relay required information so that the “bad guys” will cease the mistreatment. Usually this officer offers a cigarette, candy or coffee in an attempt to gain the confidence of the prisoner. The response of the study participants to this technique was similar in that they doubted “…that among all of the bestiality there could be an angel in this inferno” (Respondent 2). While doubting the good intentions of the conciliatory officer, most of the respondents also indicated that they were impressed in the beginning with the torturers’ change of attitude.

**Coping Mechanisms and the Effects of Torture**

All study respondents had relied on some sort of coping mechanism during torture. Based on their descriptions, it appears that the coping technique used was related to the specific type and degree of torture experienced. For the most common forms of physical torture (i.e., electric shocks and beatings), the respondents often adopted similar coping mechanisms. For example, Respondent 4 recalled that his main aim when being subject to electricity was “to stand the flow as long as I could. I knew it had to end…The yelling helped me to mitigate the pain.” Respondent 3 stated that he followed the advice of a friend who had said, “… when electric shocks are applied, it helps not to get desperate and to shout as much as you can. During beatings, it is important not to resist the blows…”

The victims’ reactions to torture can be separated into two main categories: 1) the immediate reaction and 2) the long-term effects. Within each of these categories, the reactions may be further separated into the predominantly physical and the predominantly psychological.

In terms of the immediate effects of torture, Respondent 2 provided a description that demonstrated both physical and psychological reactions. Although it was difficult for him to recreate his feelings during the torture, he stated that after the first session when his legs had been broken:

My mind wasn’t working properly. I didn’t know if I was awake or dreaming, I didn’t know if the pain was real or imaginary…Then, after these five days I went into a deep depression and decided to commit suicide. I attempted suicide twice.
Respondent 1 emphasized the physical reactions to torture more than any of the other respondents:

I felt very tired and in permanent need of sleep. I felt the desire to become violent against the soldiers. It wasn’t pain in my head, but an intolerable sound in my head. Two whistles seemed to come out of my ears, with the intensity increasing to a point it seemed that my head was about to explode. I had respiratory problems; whenever I breathed, I felt internal pain. It seemed that I needed more air, but I couldn’t breathe any deeper.

When describing his reaction to a second torture session, this respondent recalled having “…great difficulty with walking, and my talking was incomprehensible. My arms and head ached a lot. I vomited for about two hours.”

Although the immediate reactions to torture differed on the whole, there were several similarities. For example, Respondent 3, in agreement with Respondent 2 who had attempted suicide, recalled, “The other feeling that I experienced during torture was that of self-destruction. I felt the need to be killed to end the torture.”

Additionally, most of the respondents reported that they entered a state of passivity immediately after being tortured. In this state, they felt impotent and powerless and were fearful about or uncertain of what was to come. However, two respondents reported different reactions: Respondent 5 described his response to his beatings as one of great rebellion: “There were times when they were beating me that I shouted to them, ‘Keep beating me son of a bitch.’ Whenever I could, I spit at them.” Yet, like the other respondents, he too “felt great impotence as a result of being beaten, and for having my hands tied.”

What were the long-term effects of torture on the study participants? Are they consistent with those found in other studies of torture victims? To answer, Allodi’s categorization of the long-term effects of torture was employed in the analysis to follow.

In the category of the physical long-term effects, three respondents had scars or burns on their bodies. As a result of his beatings, one respondent was left with three fractured bones and a deviated spine. The fractures healed naturally while he was in prison, but they still bother him when the weather changes. The spine deviation required corrective surgery, which was done in Canada.

In the psychosomatic category, almost the entire group reported pains, headaches, nightmares and night panic. Common themes in the respondents’ nightmares were those of escaping from uniformed men and being shot. Respondent 10 stated that he had frequent nightmares, sometimes nightly.

Four of the respondents had recently experienced severe physical problems. With the exception of one case, no clear organic cause of those problems had been found. In this regard, Respondent 1 stated that, during 1976-1977,

I started to faint regularly. Doctors, neurologists, and psychiatrists did scans, took x-rays and several tests to find a reason for the fainting, and couldn’t find any organic cause. The fainting disappeared. A year ago [1984], a series of

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3 Allodi’s categorization includes the physical, the psychosomatic, the affective and the intellectual and mental long-term effects of torture.
complications appeared; for example, heart arrests. The doctors found I had a
deficiency, but it is not the kind to cause the cardiac problems that I’ve been
experiencing.

Respondent 3 said:

Some time ago I was treated for a tumor in my head. There was no clear cause
according to the doctors… I have to say that I received several blows on my head.
In 1980, I suddenly fainted, lost some of my side vision and was sweating cold.
After being treated, the doctor told me that the tumor had disappeared.

Respondent 6 suffered from acute headaches which had begun about four years before the interview.
He claimed that their severity had reached the point where “I have to make sure there is a safe place
where I can lay for about an hour because I inject myself with a drug substance that knocks me out in
about two minutes.”

Were these respondents affected by post-concussion syndrome as defined by Rasmussen et al., (1977)
and cited by Kosteljanetz and Aalund (1981)? A definitive answer to this question could not be given
in the context of this study. However, based on the respondents’ testimonies, the evidence suggests
that given their past medical history, the physical problems they were experiencing at the time of the
interview were likely a result of the torture they had endured.

Using Allodis’ category of affective long-term effects, this study found that eight of the 15
respondents suffered from periodic depression. Four respondents stated that nightmares usually
preceded their depression. However, none of the respondents reporting self-destructive thoughts
during their detention had attempted or contemplated suicide since their release.

Five participants reported anxiety. Two respondents experienced severe sexual dysfunction. One of
them said, “I think that the worst effect…is the sexual problem caused by premature ejaculation”
(Respondent 5).

Respondent 12 was the only participant to indicate that he did not face psychological problems
stemming from his experience. However, he mentioned that when he is in his apartment and hears the
sounds of keys and someone walking in the hall, he automatically stops what he is doing until he
realizes that he is in Canada and not in his prison cell.

Within the category of intellectual and mental long-term effects, the only specified issue for the
respondents was “confusion,” which they had experienced during torture, during imprisonment and
well into exile. The confusion that they spoke of related to their uncertainty about the future.

It is important to note that all of the respondents believed that torture has long-term effects, and that
one who is tortured changes forever. These beliefs may influence the way each respondent thought
about past experiences and the effects they experience today.

After their torture sessions, 12 respondents remained in prison for periods ranging between two and
five years. The other three respondents were tortured while in detention that lasted from five to 30
days; two of them then left Chile as exiles and one was sentenced to internal exile (i.e., sent to live in
remote villages or towns within the country) twice, for a total of six months.
Limitations of the Study and Suggestions for Further Research

At the time of the interviews, 14 of the 15 study respondents belonged to organizations for exiles. The main objective of these organizations was to promote solidarity with what the respondents called the cause of democracy in Chile. The study findings may not apply to victims of torture who either lacked the support of such a cohesive group or did not share the same high degree of ideological conviction as the respondents in this study. Further research may be structured to control for group support in particular. It is unlikely, however, that many political exiles will lack at least fairly strong political views, and it may be difficult to assess how ideological attitudes affect the response to torture while in exile.

In terms of the physical effects of torture, this study suggests that there are at least two possible loci of causality for the severe headaches affecting at least five participants. One possibility is what some authors refer to as the post-concussion syndrome. In such cases, testing should be done to detect brain damage that may have resulted from beatings. The other possibility requires determining the extent to which physical effects are expressions of psychological damage. A particular example is the case of Respondent 7 whose problems with severe chest pain began three or four years before the interview. His doctor advised that the pain could be a symptom of angina, but that he could find no organic cause. The respondent recalled that after he had been dealt a severe blow to the chest the torturer had advised him that he was one of a few prisoners to survive. The torturer then “sentenced” the respondent by saying that, even though he had escaped death, no one receiving that kind of strike lived more than ten years. Incidentally, ten years had passed before the respondent began to experience the physical symptoms for which his doctor could find no organic cause.

A significant element to consider when pursuing the psychological basis of physical symptoms is the time factor. Five participants indicated that their headaches had become more than a nuisance approximately two to four years before this study. At that time and at the time of the interviews, the Canadian media reported frequently on Chilean demonstrations calling for an end to the military regime.

More precise questions and more in-depth content analysis are needed to further reveal a link between physical and psychological effects. Precise questioning may also result in greater clarity regarding the appropriateness of the different approaches used to conceptualize the consequences of torture and related violence and trauma.

In addition to providing researchers with information on the torture experienced by a group of Chilean refugees, a practical contribution of this study is to demonstrate the importance of informing Canadian health and immigration officials of the existence of refugees who have been tortured, and to urge that their needs be identified and properly attended to. Merely allowing refugees to exist safely in another country does not lessen the trauma they may have suffered. Canada must do more than add to its population if these refugees are to know the country as a true sanctuary from the barbarity they have endured.
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