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The issue of torture receives wide coverage in the media, and it is not difficult to obtain further information about it, for example on the Internet. The article on page 23-25 of this issue describes some of the problems associated with news coverage of torture. It is a particularly broad topic, comprising a wide variety of views, attitudes, and more or less sound work. Well-researched biomedical literature about torture started tentatively after the Second World War with studies from the Nordic countries of concentration camp victims and war-sailors, and with studies of American and Canadian war veterans. The last 15 years have seen a vast increase in this literature.

Despite this increase, scientific, biomedical databases have a limited number of key words describing torture. This illustrates the fact that the issue is often described in connection with other fields – such as psychiatry, psychology, social medicine, and political, legal, and human rights issues – not so often as an issue in its own right. For this reason, it is often necessary to search for literature on torture within a wide field of related issues. Journals of particular interest in this connection are: the "Health and Human Rights" section of the Lancet, the British Medical Journal, the American Journal of Psychiatry, the American Journal of Social Psychiatry, the Journal of Traumatic Stress, and other journals within the fields of psychiatry, the social sciences, and public health.

In 1988 the forerunner to Torture was published. It was called "Newsletter", and it included information and issues of interest to health professionals and others with an interest in the work of the RCT and the IRCT. The Newsletter was published quarterly, perhaps in slight contrast to the element of "news" expected in a newsletter. This, together with a need to have a publication specifically designed for articles about torture, was the rationale for the IRCT publishing Torture in 1991. Torture replaced the Newsletter and contained research, documentation, and information. Another reason for establishing a more comprehensive journal than the Newsletter was the increase in the number of rehabilitation centres with which the IRCT cooperated. It was important to have a forum where information about courses, meetings, and conferences could be shared.

This was the background for the creation of the journal Torture 10 years ago. In the intervening years, the journal has progressed to contain sections for investigations and results, documentation and background, as well as news for health professionals, human rights defenders, and others.

The conditions under which Torture is produced differ from those of most other biomedical journals. Firstly, the target group is highly diversified, including scientific libraries, health care personnel and other groups involved in the work against torture, as well as people and organizations in regions where torture and other human rights violations actually take place.

The aim is to present a broad and comprehensive coverage of the issue of torture, the contexts in which it is practised, and the variety in rehabilitation experiences. This includes accounts from countries which receive torture victims as refugees and countries where torture takes place. The editorial demands on articles received from the former countries adhere to general standards and uniform requirements for biomedical journals. However, it may in some cases be difficult to place the same strict demands on authors from countries with limited resources for training in scientific research and presentation. It has been the policy of the Editorial Board to give priority to important documentation from such countries rather than to insist on standardized requirements. The alternative would be that such documentation would not receive appropriate attention. This policy means that there are further demands placed on the process of editing and language editing. Another aspect to take into account when publishing sensitive material is the need to pay additional attention to ethical considerations – over and above those stated in the Helsinki Declaration of 1975 (revised in 1983). It may for example be necessary to disguise the place of origin and personal identities, perhaps even the identity of the author.

Ten years have gone by since Torture was launched, and many of the original intentions have been fulfilled. This does not mean that the development process is finished now. The progress in communications technology, among other things, has opened for new perspectives. We do not attempt to look ten years into the future, but immediate plans include placing future issues of the journal as well as selected articles from earlier volumes of the journal on the IRCT website. Furthermore, we will work to establish clearer guidelines with regard to copyright issues, and we expect to accentuate the need for manuscripts to live up to uniform requirements and recommendations from referees.

These plans should be seen as part of an effort to maintain the position of Torture in scientific contexts and to promote the journal as an important forum for original and specialized information about torture.

H.M.
The prevalence of disorders due to organized violence and torture in Mashonaland Central Province, Zimbabwe

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Abstract
• Background – The prevalence of disorders due to organized violence and torture is not well understood in the African setting. In Zimbabwe, preliminary studies have indicated that such disorders may be a significant proportion of the morbidity due to psychological disorders in primary care settings.
• Objective – To determine whether psychological disorders due to torture or organized violence are prevalent in rural health centres and hospital outpatient departments.
• Design – Prescriptive screening of consecutive patients.
• Setting – Adults aged 16 years or more, who were not acutely ill, attending rural health centres and hospital outpatient departments.
• Measures – 425 patients were given the Self-Reporting Questionnaire (SRQ-8). Those scoring 4 or more were administered the Present Health Status Questionnaire and the History of Violence Form.
• Results – The results show a high frequency of disorders due to torture and organized violence: about 13% of general morbidity and 42% of total psychological morbidity. A wide variety of different forms of torture were reported, with physical assaults and psychological abuse being the most common forms of impact torture and psychological torture respectively. Witnessing of torture was also commonly reported. There were few statistically significant relationships observed between the measures of disorder and the forms of torture reported, but there were differences between the two samples in the frequency of torture experienced.
• Conclusions – The results indicate that disorders due to torture and organized violence are common in the primary care and outpatient setting, and that prescriptive screening seems the only approach at present to improving detection of these disorders. Chronicity may be a factor complicating the measurement of disorders due to torture.

Background
Most work on survivors of violence and torture has either been done on Western populations, especially on war veterans, or on survivors who are either refugees or forced immigrants in host countries. Many studies of torture survivors have demonstrated high rates of Post-Traumatic Stress Disorder (PTSD) in these persons. Psychological disorder is also found in groups exposed to war and other related trauma. In all of these studies, there is a consistent clustering of symptoms, which include the following: depression, anxiety, sleep disorders, fatigue, recurring nightmares, irritability, ruminations, isolation, and startle reactions.

In Africa and other Third World settings, clinical or epidemiological studies of the health consequences of organized violence are rare, although there is a large literature commenting upon such effects, especially the effects upon children. There are a few clinical studies, which generally support the conclusions of the Western work, but few epidemiological studies. A study in Palestine indicated that 40% of the community sample reported seven or more PTSD symptoms, whilst studies from Nepal, Sri Lanka, and South Africa have shown very high rates of PTSD in civilian populations. Work from Zimbabwe has similarly indicated that disorders due to organized violence are prevalent, but this data was derived from clinic referrals rather than from epidemiological study. Epidemiological studies of Mozambican refugees resident in Zimbabwe have also indicated that disorders due to organized violence are common. However, these studies did not specifically examine for torture.

This paper reports upon an epidemiological investigation of the prevalence of disorders due to torture and organized violence in two administrative districts in Zimbabwe. These districts had reportedly been the recipients of epidemic levels of violence from 1972 to 1980, and torture had been identified as a common form of organized violence by human rights observers at the time.

Objectives
Since previous Zimbabwean studies of the prevalence of psychological disorders indicate that a substantial proportion (20-30%) of primary care morbidity is due to psychological disorders, we attempted to determine what proportion of this morbidity is due to organized violence and torture. The major objective was to determine whether psychological disorders due to torture or organized violence are prevalent in rural health centres and hospital outpatient departments, whilst a secondary objective was to characterize the types of trauma experienced, the types of symptoms complained about, and any relationships between types of trauma and types of symptoms.

Design
Since psychological disorders, apart from acute psychoses or organic disorders, are rarely detected by primary care staff, we adopted a prescriptive screening approach, which has also been recommended by previous Zimbabwean epidemiological studies. Prescriptive screening involves taking consecutive patients attending a health care setting, and conducting a structured and standardized interview with each patient.
The patients for this study were selected among adults attending primary care clinics or hospital outpatient departments. Patients were attending these facilities for medical assistance for various complaints.

Consecutive patients were administered the SRQ-8, a short version of the Self-Reporting Questionnaire (SRQ-20). Patients who scored 4 or more on the SRQ-8 were then administered the Present Health Status Questionnaire (PHSQ), a 22-item questionnaire previously developed by the AMANI Trust.\textsuperscript{18,23} Those who reported an experience of organized violence were additionally administered the History of Violence Questionnaire, a lengthy interview about the effects of torture. The questionnaire was developed by the AMANI Trust and used in earlier studies of torture survivors and war veterans.\textsuperscript{18}

In all, 425 patients were prescriptively screened.

**Setting**

The setting was two Districts in Mashonaland Central Province, an area in the north-east of Zimbabwe that experienced epidemic levels or organized violence and torture in the 1970s. The two Districts, Mount Darwin and Muzarabani, were both frequently mentioned in human rights reports compiled in the 1970s. The patients were selected among adults, aged 16 years or more, who were not acutely ill, attending rural health centres and hospital outpatient departments. Acutely ill patients were returned to the queue, whilst possible candidates for inclusion were seen in private for the interview. Compliance was generally good, although the numbers attending a clinic or an outpatient department varied considerably.

It was intended that sampling be done at all health facilities in both of the Districts, but this proved impossible for time reasons and because of the difficulties of reaching some of the clinics during the very heavy rains at the times of the study. In the end, the outpatient departments of all hospitals were sampled as well as 12 of the Rural Health Centres.

**Measures**

A variety of measures was used. The psychiatric screening instrument, the SRQ-8, is a widely used screening instrument in Zimbabwe. The SRQ-8, as well as the longer SRQ-20, was developed in Zimbabwe.\textsuperscript{24} The cut-off of 4 was used, since the validation work with the SRQ-8 had shown this to be predictive of significant psychological disorder.\textsuperscript{24}

A specially prepared interview was used for the study, which was comprised of the following:

- Demographic information: age, sex, marital status, children, education, employment
- Health status: Present Health Status Questionnaire
- Torture: History of Violence Questionnaire.

All these instruments have been used in previous studies.\textsuperscript{18,25} The Present Health Status Questionnaire (PHSQ) is a 22-item questionnaire covering the common complaints seen in survivors of organized violence and torture. The questionnaire was developed from the questionnaires provided in Rasmussen's monograph on torture,\textsuperscript{26} and used in several previous studies.\textsuperscript{18,25} The History of Violence Questionnaire was similarly developed from Rasmussen's work, and consists of a structured interview covering detention, torture, political activity, violence against other family members and disappearances. It too has been used in several previous studies.

The measures of torture were classified according to the responses on the History of Violence Questionnaire as follows:

- Impact torture: physical assaults (beatings, suspension, electrical shock, burnings, rape, etc.) and deprivation (lack of food or water; solitary confinement, etc.)
- Psychological torture: sensory over-stimulation (continuous lighting, continuous noise, drugs, etc.) and psychological abuse (threats, abuse, non-sexual abuse, etc.)
- Witnessing: witnessing of impact torture (witnessing beatings, suspension, electrical shock, etc.) and witnessing of psychological torture (witnessing of threats, abuse, etc.).

It may seem that there is little distinction between Psychological Torture and Witnessing, but the separation was made to distinguish cases where Psychological Torture was done intentionally and cases where people were intentionally forced to witness torture or inadvertently witnessed torture. The distinction refers to an issue of control: Psychological Torture refers to situations in which individuals could not control the psychological input, since this was being deliberately inflicted, as opposed to situations in which people saw torture occurring - usually in a group setting - but could take some control, by closing their eyes for example. The term "Impact Torture" is self-explanatory and refers to the direct infliction of pain (physical assaults) or suffering (deprivation) upon the body.

The data was entered on a spreadsheet, and tests of means and frequencies were carried out.

**Results**

As can be seen from table 1, the prevalence of psychological disorders in the two districts was generally high (30.6%), but variable across the sites - 35% for Mount Darwin and 25% for Muzarabani - and between the sites, with a range from 12% to 52% across all the sites. The variability was considerably less in Muzarabani than in Mount Darwin, but the differences between cases and non-cases was significant (p=0.001). The prevalence of disorders due to torture and organized violence was similarly high. An earlier study had estimated that disorders due to violence were about 30% of total psychological morbidity,\textsuperscript{18} but the current data suggests that this figure should be revised to about 39% of total psychological morbidity, and about 12% of total morbidity (see figure 1 below). There was a significant difference between the two samples of organized violence and torture (OVT) (p=0.001).

Table 2 summarizes the age and marital status of the sample. As can be seen, the sample was generally older, which would be expected since the torture had occurred during the 1970s, whilst there was an expected trend for there to be fewer single persons in the torture samples. However, the differences observed were not statistically significant (p=0.55). There was a trend for the torture samples to have had less education than the other samples, with a marked tendency for the torture samples to have had no formal education at all. Again, this tendency was not statistically significant (p=0.1).

There were few statistically significant differences between the various clinical measures taken during screening. No differences were found in the mean SRQ-8 scores, nor in most of the differences observed on the Present Health Status Questionnaire (PHSQ). A difference was found between the
Table 1. Prevalence of cases and non-cases in Mount Darwin and Muzarabani Districts, Mashonaland Central Province, Zimbabwe.

| Province, Districts, Mashonaland Central | Cases from 44  
| Mount Darwin District |  
| Mutungagore            | 3 | 5 | 3 | 8 | 37.5  
| Nyumahobogo            | 7 | 2 | 19 | 11.8  
| Chawanda               | 15 | 14 | 7 | 29 | 51.7  
| Dotito                 | 9 | 28 | 2 | 37 | 24.3  
| Mt Darwin              | 26 | 26 | 3 | 52 | 50.0  
| Karanda                | 5 | 17 | 3 | 22 | 22.7  
| Nembire                | 15 | 21 | 8 | 36 | 41.7  
| Kamutsenere            | 11 | 32 | 0 | 43 | 25.6  
| Total                  | 86 | 160 | 28 | 246 | 34.9  

| Muzarabani District |  
| Muzarabani           | 4 | 13 | 2 | 17 | 23.5  
| Hoya                  | 6 | 16 | 5 | 22 | 27.3  
| Machaya               | 10 | 30 | 3 | 40 | 22.5  
| Chadera               | 7 | 20 | 3 | 27 | 25.9  
| David Nelson          | 8 | 15 | 5 | 23 | 34.8  
| Chawaura              | 6 | 23 | 1 | 31 | 19.4  
| St. Alberts           | 3 | 16 | 3 | 19 | 15.8  
| Total                 | 44 | 135 | 22 | 179 | 24.6  

Overall totals 130 295 50 425 30.59

Table 2. Demographic characteristics of all cases (psychological disorder and organized violence) in Mount Darwin and Muzarabani Districts, Mashonaland Central Province, Zimbabwe (n=130).

| Demographic Characteristics | Cases from 98  
| Age (mean; s.dev) | 32.6(14.1) | 35.9(14.3)  
| Marital status |  
| single            | 6.4% | 15.7%  
| married           | 78.7% | 61.4%  
| divorced          | 8.5% | 17.1%  
| widowed           | 6.4% | 5.7%  
| Education |  
| No education      | 27.6% | 24.7%  
| Primary school    | 46.8% | 25.8%  
| Secondary school  | 25.5% | 49.5%  

Table 3. Frequency of torture experienced by cases of organized violence in Mount Darwin and Muzarabani Districts, Mashonaland Central Province, Zimbabwe (n=55).

| Cases from 98  
| Muzarabani | Mount Darwin  
| mean (s.dev) | 2.3 (1.7) | 1.4 (1.3)  
| Deprivation | 1.2 (2.1) | 0.4 (0.8)  
| Impact Torture Total | 3.8 (3.6) | 1.7 (1.9)  

| Sensory overstimulation | 0.5 (1.0) | 0.1 (0.4)  
| Psychological abuse     | 2.6 (1.6) | 2.2 (2.0)  
| Psychological Torture Total | 3.1 (2.3) | 2.2 (2.1)  

| Witnessing abuse         | 2.3 (1.7) | 2.2 (2.3)  
| Witnessing executions    | 0.9 (1.3) | 0.3 (0.6)  
| Witnessing Total         | 3.1 (2.5) | 2.4 (2.7)  

Total Torture 9.9 (7.3) 6.4 (5.9)

Discussion

The overall prevalence rate for psychological disorders (30.6%) was within the range found in most other Zimbabwean studies. There were differences in the rates between the two Districts, and, interestingly, the rate found for Mount Darwin was close to the rate found by a previous study in the same District. Psychological disorders as a whole constitute a significant proportion of primary care morbidity.

Disorders due to torture and organized violence are a significant proportion of this morbidity, as can be seen from figure 1 above. There were differences between the two sites, with a much greater percentage of reported torture in Muzarabani than in Mount Darwin. Two groups on the Physical sub-scale of the PHSQ (OVT=4.9, s.d 2.3; t=3.26, p=0.003).

As regards the frequency of torture types reported (see table 3), most of these differences were highly significant. The Muzarabani group (OVT=4.9, s.d 2.3; t=3.26, p=0.003) reported more Impact Torture (p=0.001), Psychological Torture (p=0.001), Witnessing (p=0.002), and Total Torture (p=0.001).

The relationships between the various measures taken were also examined. Spearman rank correlations were calculated, and there were some interesting relationships between the measures. The PHSQ only showed strong relationships with itself, and all the scales were strongly intercorrelated: PHSQ(Total) correlated with both sub-scales (PHSQ(PSY) r=0.89; p=0.001). All the forms of torture were strongly related, with Impact Torture showing strong relations with Psychological Torture (r=0.93; p=0.001), the Witnessing of Torture (r=0.87; p=0.001), and the total number of torture types experienced (r=0.98; p=0.001). All forms of torture correlated with the total number of torture types, and both psychological torture and witnessing were correlated (r=0.86; p=0.001). The SRQ-8 showed only correlations with the various torture measures, and these were all highly significant (p=0.001).
rabani than in Mount Darwin, but the overall percentage for both Districts is extremely high. Clearly, disorders due to torture and organized violence are a significant proportion of both total primary care morbidity and psychological morbidity in particular. This was similar to a previous finding.¹⁸

Survivors of torture and organized violence are not easily distinguished from other cases of psychological disorder. Survivors are likely to be older and have much less education, but only the former has any clinical significance. There are no obvious differences in the other clinical measures, the SRQ-8 and the PHSQ. Elsewhere it has been observed that a combination of one or more of four common pains (stomach, head, chest/heart, back) is more common in cases of psychological disorder,²⁰ but, in the clinical setting, these symptoms would not at face value distinguish survivors from other psychological cases. Here it is very important to stress that back pains among survivors of torture who have been subjected to various forms of Impact Torture are likely to have a different clinical significance to the same symptom in ordinary psychological disorder.²¹

There were some interesting differences between the two groups of survivors in the frequency and types of torture experienced. The Muzarabani group (OVT98) reported both a greater number of persons suffering from disorders due to torture, and a greater frequency of the various types of torture. This would seem to suggest that the violence was worse in Muzarabani than in Mount Darwin, but this can only be an inference in the absence of independent evidence of the violence at the time.

The relationships between the measures are interesting. The SRQ-8 is strongly correlated with the measures of torture, which suggests that the screen will identify cases of OVT as well as cases of ordinary psychological disorder, but it will not distinguish them. The measure of symptoms, the Present Health Status Questionnaire (PHSQ), does not correlate either with the SRQ-8 or the measures of torture, so this instrument will probably not be useful for distinguishing cases of OVT from cases of ordinary psychological disorder. However, it does seem that cases of OVT report many more symptoms than cases of ordinary psychological disorder. This is important in the light of the many findings on the significance of multiple somatic symptoms in detecting psychological disorder, and the observation that the somatic symptoms reported by cases of OVT represent a mixture of psychological and physical disability. For the present it would seem that survivors of torture can only be distinguished by explicitly asking for a history of OVT subsequent to psychiatric screening. Clearly more work needs to be done on developing instruments for detecting OVT.

The issue of chronicity must also be highlighted. These cases of OVT are all chronic, with the original trauma dating back more than two decades, and this makes for difficulties in clearly concluding that the current symptoms are directly related to the trauma. Disability, severe poverty, and the many life stresses associated with these two factors may easily account for the current disorder, and this emphasizes the need for studies contrasting acute and chronic populations in the field of OVT.

Conclusions
These findings show that disorders due to reported organized violence and torture (OVT) may be very common in the Zimbabwean community: about one adult in 10 reports a history of torture during the 1970s. Few of these survivors are identified by the health care workers, and a previous study conducted in the same district makes no mention of disorders due to violence.²⁸ There is a clear need to train health workers in the detection of psychological disorders, including those due to torture, especially in areas where very high rates of human rights violations have been reported.

The forms of torture reported by these patients agree with previous Zimbabwean reports,¹⁸,²⁵ and also with other international reports. Thus, in areas where there have been epidemic levels of torture and organized violence, multiple somatic complaints may reflect physical disability due to physical injury during torture as well as psychological disorders. Clinicians should be aware of this, and thus thorough examination is called for in such settings. This view is bolstered by the observation that this group reported much higher total numbers of symptoms than other primary care samples.

Chronicity may complicate the clinical picture considerably. There were few relationships between the measures where such relationship might be expected. This was a sample whose reported abuse had taken place at least 17 years previously, and thus the combination of disability, both psychological and physical, and the stresses induced by disability over the years may produce a clinical picture very different to that found in many of the reported studies. Chronicity therefore should become a focus of specific study in the future, and attempts made to determine the differences between acute and chronic reactions to extreme stressors such as torture and organized violence.

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Selected list of publications

received in the IRCT International Documentation Centre


No five fingers are alike: what exiled Kurdish women in therapy told me / Ahlberg, Nora. - Oslo: Solum Forlag, 20000000. - 348 p.

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Plus jamais ca / Enriquez, Eugene. - In: Revenue francaise de psychoanalyse; vol. 64, no. 1. - 20000200. - p. 189-199.


Listening for the sounds of silence: a nursing consideration of caring for the politically tortured / Racine-Welch, Twilla; Welch, Mark. - In: Nursing inquiry; vol. 7, no. 2. - 20000600. - p. 136-141.


Assessment of the psychic sequelae of torture and incarceration (I) – a case study

Ferdinand Haenel, MD, Psychiatrist and Psychotherapist

The number of medico-legal assessment reports on the psychic sequelae of torture requested from me in my capacity as psychiatrist at the Center for the Treatment of Torture Victims in Berlin, Germany, has increased substantially over the past few years. Most of these reports are required for asylum procedures at the administrative courts or for claims for the recognition of late psychic sequelae in former political prisoners of the German Democratic Republic (GDR) submitted to the Social Courts under the so-called “SED Unrechtsbereinigungsgesetz”.

According to today's estimate, 200,000-250,000 persons were detained and tortured for political reasons in the former GDR. Starting in the mid-1950s, political detainees in the GDR were tortured, often more psychologically than physically, while in custody. Deprivation of sleep, long interrogations of varying length and frequency, and the use of fabricated written confessions of family members and partners were some of the methods used. These methods were in practice until 1989 and with time they were increasingly refined to reach the goal of the so-called “Zersetzung der Persönlichkeit” (undermining of the personality).

Currently there may be about 20,000 claims for the recognition of late psychic sequelae in former GDR political prisoners submitted to the Social Courts.

The assessment of the late psychic sequelae in persons imprisoned in the former GDR is particularly difficult to answer when the causative incidents occurred many years, even decades, ago.

It is to be welcomed that the psychic sequelae of extreme traumata have now been included in the two larger diagnostic manuals, the American DSM and the ICD. But it has to be emphasized that Post-Traumatic Stress Disorder (PTSD) and Enduring Personality Change are only two of various other post-traumatic psychic sequelae. Severe depression and/or phobic syndromes, psychosomatic and dissociative disorders can accompany or mask the symptoms of PTSD or Enduring Personality Change.

Persons who had been arrested and tortured in the former GDR and whose psychic trauma sequelae have persisted for decades, report that their nightmares, which used to be frequent, have decreased over the years. However, they frequently complain of depression, intense nervousness, elevated inner arousal, increased irritability with aggressive outbursts, disturbed sleep and concentration. It seems that for them the intrusive symptoms listed in the DSM-IV under Criterion B have receded in comparison to the hyperarousal symptoms listed under Criterion D. They hardly mention the avoidance symptoms under Criterion C. This is because, as a result of strategies that have been developed in their daily lives over many years, these symptoms are no longer experienced as ego-alien, but as ego-syntone and part of their personality. It is therefore of great importance to collect information on these symptoms from third persons, such as relatives or partners. However, even these data may not be sufficient for an exhaustive evaluation, as illustrated by the following case report.

The case of Mr A.

Mr A. was referred to me by the Social Court for assessment in connection with a claim for late mental sequelae after long detention in the Soviet Occupation Zone and former German Democratic Republic. He was 70 years old, retired and seemed relatively fit for his age. He complained of irritability, inner restlessness, and aggressiveness with impulsive outbursts triggered by harmless situations with other people. He reported that the moment people begin to talk about subjects that are even remotely connected with his experiences in prison over 45 years ago, he becomes highly excited and begins to raise his voice and shout, he loses his self-control and becomes unable to think straight. Once he has got into such a state, he becomes even angrier and can only with difficulty be calmed down by those around him.

Arrest and custody

Fifty years ago, three years after the end of the Second World War and shortly after completing his training as a forester in Mecklenburg, Mr A. was arrested by the Soviet occupation authorities for having been involved in war crimes, with which, however, he had demonstrably had nothing to do. He was held in solitary confinement with sleep deprivation for several weeks, during which he was subjected to interrogations lasting several days and nights, to beatings over his entire body, and to repeated humiliations and verbal abuse, including threats to kill him. Finally he had seen no alternative but to sign a record written in Russian – a language that was incomprehensible to him. He had then, after a hearing, been sentenced to eight years’ imprisonment, four of which he spent in the Bautzen prison and four in a conventional prison, until he was finally released in 1956.

Mr A. described his time in custody awaiting trial, the interrogations, and his years in Bautzen prison in a striking manner. His description of the events was frighteningly vivid and impressive, as though they had taken place only yesterday, rather than 45 years ago. Mr A. recalled the names of his fellow prisoners during his initial period of imprisonment in Bautzen prison, and he described the deaths of each, how one after the other had been found dead on their pallets in the morning, having succumbed to either disease or starva-

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A chronic phobic syndrome

At the time Mr. A. had been the youngest and strongest and had survived them all. He also described other vivid memories that haunted him both during his waking hours and in nightmares. The latter, however, were no longer as frequent as they had been in the past. After eight years Mr. A. was released. Some months later he started a job as a forester in Mecklenburg. Four years later he married a woman from the same town, and a year after the wedding, a daughter was born.

Reaction after release

After his release from prison it would have led to further criminal prosecution against Mr. A. if he had talked publically about his detention and the prison conditions. He reported that after his imprisonment the self-confidence, self-assurance, and hopes for the future which he had previously possessed had dissolved, and that he had subsequently been subject to persistent feelings of insecurity, self-doubt and anxiety, a constant awareness that he must not, on any account, do anything wrong. He was regarded as a war criminal and felt guilty, as if he really had been one. Only by above average performance and ensuring that he made absolutely no errors in his work had he been able to compensate for his insecurity. When colleagues had done only half the work they should have, he had demanded of himself that he do twice as much. He had been known for his hard work. This had been a successful way of making himself indispensable. Only this assured him that they would not lock him up again.

His fear and mistrust of other people and his tendency to withdraw and isolate himself had affected his daily life. Since his imprisonment he had been a fearful and mistrustful outsider. Until he retired from work he had lived together with his wife and daughter in a secluded house in the forest. He had usually carried out his work as a forester on his own and outdoors. After his release from prison, his isolated life in his secluded home had for decades seemed to him a routine as a forester working alone outdoors in nature had served as a kind of niche, and his attentive wife and later also his daughter had played an important supporting role. Without realizing it, they both colluded in his avoidance behaviour. They had suffered from his impulsiveness and emotional lability as husband and father, but they had attributed it to his having an innate choleric nature and had anxiously tried to avoid all situations in their daily life that might provoke an emotional outburst. Neither of them had, of course, known him before his time in prison.

As a result of his systematic avoidance behaviour, Mr. A. was no longer aware of his anxiety, nor of the avoidance behaviour itself. Since it had become an integral part of his daily life and self-confidence, he experienced it not as ego-alien, but as ego-syntone. The previous assessor had failed to notice these symptoms, which were highly important for evaluating the degree to which Mr. A.'s working capacity was reduced. The assessor had diagnosed a mild "post-traumatic psychosomatic disorder" and a 10% reduction in working capacity.

On the basis of Mr. A.'s history, his life before he was imprisoned (as a parachutist in the Second World War), and the results of my psychiatric and physical examination – including a cranial CT scan showing normal density of the brain structures without any signs of brain damage due to arteriosclerosis – the only possible diagnosis was that of Enduring Personality Change following extreme traumatization with moderate to severe adjustment problems.

Special problems in the assessment

Assessments of the mental sequelae of trauma vary widely even among psychiatrists in Germany. One might ask how such divergent evaluations come about. One answer to this question is to be found in a number of the symptoms themselves, as illustrated by the following list:

- mistrust, hostility, and alienation from the environment
- a tendency to withdraw and isolate oneself
- shame and guilt
- association of the diagnostic interview with traumatic experiences
- fear of the emotions associated with the traumatic experiences
- fear, anger, and finally hopelessness and resignation about being believed
- disturbed concentration and memory
- ego-syntone symptoms.

Most of the above characteristics are listed as criteria for Post-Traumatic Stress Disorder and Enduring Personality Change. Feelings of shame after sexual torture and survivor guilt should be particularly emphasized because they are not a part of the Definition of PTSD and Enduring Personality Change of DSM-IV and ICD-10.

The decisive difference between the assessment of survivors of torture with mental sequelae and the assessment of persons with other psychiatric disorders is that in survivors of torture it is the symptomatology itself which can hinder exploration and thus lead to errors.

This is by no means a new discovery, but a phenomenon known from studies on psychiatric assessments of the reactive mental sequelae seen in victims of the Nazi concentra-
tion camps (remaining reticent about severely traumatizing experiences because they “cannot be communicated” and “resistance to exploration”). In Germany, the book “Psychiatrie der Verfolgten” (“Psychiatry and Persecution”) by Baeyer et al. is a well-known publication dealing with this issue, and it is amazing that such decisive findings of previous scientific experiences obviously are not taken into account in the current psychiatric practice.

In this article I have described how the reactive mental symptoms themselves can be an obstacle to an objective medico-legal evaluation. In a forthcoming article [to be published in TORTURE 2/2001 – ed.] I will describe how and which assessors’ attitudes towards the survivor of torture and his or her history could also be a hindrance to an objective appraisal.

References

Further reading

The next issue of TORTURE will contain an associated article by Ferdinand Haenel “Assessment of the psychic sequelae of torture and incarceration (II) - assessors’ attitudes and objective appraisal”.

On the development of professional psychotherapy

Thomas Wenzel, MD, Lic Psychiatry, Neurology, Lecturer, Licenced Psychotherapist* & Ingrid Sibitz, Trainee Psychotherapist*

At present, psychotherapy is developing in a more structured way with regard to qualifications and training, but also in a more open way with regard to the dialogue between the different approaches. Psychotherapy has a long-lasting historical connection to trauma and persecution, the latter being frequently in focus – also because of the critical and humanistic basic assumptions embedded in most of its “schools”. Pioneers like Bettelheim and Frankl, themselves survivors of concentration camps and torture, have shaped new approaches to trauma which are independent of the traditional Freudian analytic concepts. In a slow process of learning, psychotherapy has been adapted to multi-layered extreme traumatization sequelae in adults, and to understand and treat indirect trauma sequelae in helpers and in families up to third generation. In many countries this process has only just started. The development of specific techniques such as testimony or Eye-movement Desensitization has been independent from mainstream psychotherapeutic models and underlines this development.

Violence and cultural factors

In many countries social and political group pressures have prevented the acceptance of psychological suffering as a result of social violence. Holocaust survivors in particular have been re-victimized by the uncritical application of biological models denying the reality of psychological trauma and suffering. Post-traumatic stress disorder, a concept that was accepted only during the political backlash of collective trauma related to the Vietnam War, has supported a broad change of attitude and awareness of this process. Still, the
concept is limited by a singular focus that neglects many types of sequelae which are of major importance for the quality of life and social rehabilitation of survivors of torture, even for their inclination to seek help. Awareness of the limitations to the medical and psychopharmacological orientation of research and treatment can be seen as a further result, contrasting with the more complex and refined models used in different psychotherapeutic approaches. The understanding of different cultural factors in trauma, post-traumatic suffering, and rehabilitation is greatly aided by the international networking pioneered by IRCT. Rehabilitation centres have often been major stimulants and agents of change in countries where the public response is characterized by a denial of psychological suffering and its different forms of expression.

Progress for psychotherapy
The unclear financial and professional regulations in many countries have been an obstacle to effective psychotherapy being carried out in the communities. In Europe, a growing umbrella organization for psychotherapy, the European Association for Psychotherapy (EAP) has therefore created a framework for setting Europe-wide standards for psychotherapy training, collaboration between countries and approaches, and - most recently - a European Certificate for Psychotherapy. The quality control permitted by these very strict standards has been the prerequisite not only for a higher level of professionalization, but also for the inclusion into public health care programmes. In countries like Austria it has even led to the passing of laws offering free psychotherapy treatment to victims of violence and crime. Although it is not yet clear whether these laws would also cover the sequelae of violence suffered in another country, acts of violence and threats to refugees in a European host-country are usually covered. An offer of adequate psychotherapy free of charge should be seen as a demonstration of social and political solidarity and respect for the suffering of victims of violence and especially survivors of torture.

Psychotherapy for refugees and transcultural therapies
By creating a special Working Group on Psychotherapy for Refugees and Transcultural Therapies, the EAP has confirmed its dedication to this principle, supporting the efforts of the IRCT in this regard (see also the Zürich Declaration7). Special projects of the Working Group related to treatment of sequelae are: regular meetings, the inclusion of torture sequelae in training curricula, a resource database, a library of research instruments, guidelines for the protection of torture survivors and asylum procedures in Europe, and concrete aid and training projects. In 2001, special symposia and activities are planned for the first time in connection with the UN International Day in Support of Victims of Torture on June 26. The close collaboration among the centres in the IRCT network is of major interest to the Working Group, especially with regard to the inclusion of the specific therapy needs of torture survivors and the lobbying for survivors in post-dictatorial countries. The EAP is developing general training projects for psychotherapy in collaboration with the World Psychiatric Association and other professional organizations in such countries. In post-dictatorial countries there is an especially high number of torture survivors recovering from broad-scale suppression, great suspicion and fear, which in some cases prevents the victims from seeking help.

Good collaboration on an individual basis has been achieved during several war-related crisis situations. We look forward to sharing with psychotherapists and members of related professions working in the IRCT structure their experiences and knowledge regarding transcultural and trauma-treatment related issues.

General information on the EAP and the development of psychotherapy standards is available from the EAP head office in Vienna (see the address below). Information on the activities of the Working Group on Refugees and Transcultural Therapies can be obtained from Thomas Wenzel, who is Chair of the Group.

References
4. Eissler KR. How many murders of his children must a man be able to bear, without symptoms, to be judged "normal". Psyche 1963;17(5):241-91.

Address of the EAP:
European Association for Psychotherapy
Rosenbursenstrasse 8/3/8
A-1010 Vienna
Austria
Phone: +43 1 513 17 29
Fax: +43 1 512 26 04
E-mail: eap.headoffice@magnet.at
http://www.europsyche.org

12
The process of writing a UN report
– a positive outcome in Zambia

Bent Sørensen, Professor, MD, DMSc*

Bent Sørensen describes the steps involved in the reporting system to the UN, using Zambia as an example taken from his own experience. The report was issued in July 2000. The following is a citation from the introductory chapter:

"The Republic of Zambia accede to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment on 5 November 1998. [...]"

The Zambian Government, through the Ministry of Legal Affairs, constituted an Inter-Ministerial Reporting Committee to undertake the task of preparing and producing Zambia’s initial report. The Inter-Ministerial Committee drew its membership from relevant line ministries and government departments, quasi-governmental institutions, non-governmental organizations and the University of Zambia.

The entire drafting process was made possible with the assistance of the Swedish Government trough a grant made to the Zambian Government specifically to assist Zambia meet her reporting obligations under the Convention. Zambia also received technical assistance from the Raoul Wallenberg Institute for Human Rights and Humanitarian Law of the University of Lund in Sweden, which sent a representative at the Induction Workshop, and the National Review Symposium referred to below.

The reporting process began with a five day Induction Workshop under the guidance of Professor Bent Sørensen [...] who discussed the drafting guidelines for the Convention with the participants. At the end of the Workshop, participants prepared a skeleton report which formed the basis for further drafting work.

The Induction Workshop was followed by four provincial workshops held with coordination from the Ministry of Legal Affairs. The purpose was to collect information from the provinces on the situation of torture, cruel, inhuman or degrading treatment or punishment. [...]"

Introduction
In essence the work done in the United Nations (UN) is all related to human rights. Sadly enough this fact is not reflected in the budget of the UN – only 1.8% goes to human rights.

Part of this (a small part, alas) goes to the monitoring system. The UN system has created a substantial number of rules, expressed its opinion in declarations and principles, none of which are legally binding on the State Parties, but hopefully morally binding upon them.

However, the system also contains the six treaty Bodies (table I). These are binding for the State Parties, and consequently it is up to each State to decide if it wishes to ratify or not. However, having ratified the provisions of the Convention should be binding in law – as well as in practice – in the State.

It is said that Vladimir Lenin (anyway: some older persons will know who he was) is the father of the proverb: "Con-

Table 1. The UN system on human rights: treaty bodies with monitoring machinery.

<table>
<thead>
<tr>
<th>No. of States Parties ratified by January 24, 2000</th>
<th>Communications Inspections</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEDAW (Convention on the Elimination of Discrimination against Women)</td>
<td>165</td>
</tr>
<tr>
<td>CERD (International Convention on the Elimination of All Racial Discrimination)</td>
<td>155</td>
</tr>
<tr>
<td>CRC (Convention on the Rights of the Child)</td>
<td>191</td>
</tr>
<tr>
<td>CAT (Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment)</td>
<td>118</td>
</tr>
<tr>
<td>CESC (International Covenant on Economic, Social and Cultural Rights)</td>
<td>142</td>
</tr>
<tr>
<td>CCPR (International Covenant on Civil and Political Rights)</td>
<td>144</td>
</tr>
</tbody>
</table>

Table 1 is a list of the six treaty bodies with monitoring machinery under the UN system.

CEDAW has its headquarters in New York and the Committee meets there. The remaining five are connected to the Office of the High Commissioner for Human Rights in Geneva and normally meet there. The UN has (September 2000) 189 member-states and around five more State Parties can ratify the UN Conventions.

The first column shows the number of State Parties that have ratified the respective Convention.

The second column indicates the three treaty bodies, where the committees can receive individual complaints ("communications"), article 22 for CAT. The State Party shall make a specific ratification for these paragraphs – and remarkably few have done that (41 in the case of CAT). The third column indicates the treaty bodies, which allow a specific investigation, eventually an actual visit to the country in question. This occurs only in the case of CAT pursuant to article 20 of the Convention against Torture. While it is possible to go "in and out" of the article 22 procedure, this is not the case for article 20. When a State Party ratifies the Convention it has to reserve on article 20 if it wishes to avoid its effect. Article 20 cannot be reversed upon at a later date.

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Former member of CAT and CPT (Committee for the Prevention of Torture under the Council of Europe)

TORTURE Volume 11, Number 1 2001
fidence is good, control is better.” The UN, despite the fact that Lenin died approximately 25 years before its creation, followed that advice by creating Committees to supervise and control the State Parties in living up to their duties as described in the different conventions.

One of the basic tools, common to all six treaty bodies, is the system of reports. Initially, i.e. around a year after ratification of the Convention and then every three or four years, the State Party is obliged to forward a report to the Committee describing in detail how the State Party has introduced the provisions of the Convention, article by article, into domestic law and into actual practice.

The Committee against Torture (CAT) (1) has developed the following practical procedure in dealing with the State reports: a delegation from the State Party presents the main contents of their report to the CAT, ideally in 15-20 minutes. The delegation then receives questions from the rapporteur and the co-rapporteur as well as questions from other members of the Committee, if they so wish. The questions are based on the report itself, but also from information given to the CAT members from NGOs and from other UN organs, like UNHCR, WHO, and other treaty bodies.

The day after, in the afternoon (i.e. 30 hours after the questions were raised) the delegation gives its answers. There is a short dialogue. In a closed meeting (the day after again) the CAT members discuss, amend, and adopt the suggested “Conclusions and Recommendations” worked out as draft by the rapporteur and the co-rapporteur. Finally these are given to the State Party in a public meeting and later printed in the Annual Report, which goes to the General Assembly of the UN. Thus the whole procedure, with the exception of drafting the final conclusions and recommendations, takes place in public sessions.

Problems
Naturally the State Party wants to produce a “good report” – and many States even wish to produce a report which reflects the truth. However many problems arise when writing a report.

The very small countries
Around 32 member countries of the UN have less than 1 million inhabitants, and many of these countries also fall into the category of developing countries. In such countries one issue is: do they have qualified personnel to write such a report and if the answer is in the affirmative: is it the right priority for a qualified person to use his/her time in writing such reports? Is writing a report which is going to be presented to 10 “experts” in Geneva really of any benefit to the state of human rights in the country concerned?

In the view of the members of the CAT, the answer to these questions is “yes”. However, the UN-system has realized that the problem exists and has consequently created a method to remedy this.

Point 1. The UN-system has introduced what is called “The Human Rights Core Document”. This document describes the legal system, the population, etc. It is common to all six treaty bodies, thus making it easier for the government to write the reports: the government does not have to repeat everything in each new report.

Point 2. Each of the treaty bodies has produced rather extensive “Guidelines” for reporting.

Point 3. The UN has created a system of training in report writing. This training is given to select persons (normally one or two) from quite a number of countries and the participants are trained in writing reports to all six treaty bodies.

In my humble opinion the results of this last exercise is not satisfactory. Maybe because it deals with too many countries and too many conventions. Perhaps specifically targeted (ONE Convention) training related to only ONE State would have a better chance of success.

The Zambian report to CAT
The Government of Zambia has ratified all six treaty bodies (table 1). In order to get experience, the government decided to choose one of the conventions and work thoroughly on reporting to this. The choice was the Convention against Torture.

The Swedish Embassy in Zambia together with the Raoul Wallenberg Institute in Lund (RWI) offered their assistance and contributed to the exercise with a substantial sum of money, around USD 100,000.

The Inter-Ministerial group
In the beginning of the year 2000 the government created an Inter-Ministerial group with representatives from all areas relevant to the different provisions in the articles of the Convention: Representatives from the Ministries of Foreign Affairs; of Legal Affairs; of the Interior; from the police system; prison system; asylum authorities; prosecutors; judges; universities; and NGOs. Around 30 persons in all. I only missed representatives from the health system.

The Government of Zambia together with the Swedish Embassy and RWI had agreed upon a three-step programme:

1. a training seminar for the Inter-Ministerial group
2. four local seminars in order to spread awareness and collect statistics
3. a final national seminar.

The first national seminar
The RWI was the organizer of the content of the first seminar together with the Zambian Ministry for Legal Affairs. The logistics of the seminar were the responsibility of the same Ministry, and the Swedish Embassy was responsible for the financing.

The first national seminar took place in the beginning of February 2000. The RWI had invited me to participate as resource person regarding torture, the provisions of the Convention, the functioning of CAT, and the art of writing a report.

The first day of the seminar was dedicated to human rights in general and Mr Phillat Matsheza from the Human Rights Research and Documentation Trust of Southern Africa, Zimbabwe, led the day with great competence. On day two the situation regarding torture in Zambia was described and discussed, and torture placed in the context of human rights in Zambia, and problem areas defined. The UN-monitoring system was described in detail (table 1), including the function of CAT in practise, in order to inform the participants before writing the report, which questions the delegation could expect from the rapporteur, co-rapporteur and members of the CAT. Thus facilitating the report writing.

On day three the Convention was discussed article by article. For each of these articles: What were the legal demands to the Country? How does the Country ensure that these laws function in practice in daily life? What is the practice? Remedies when it does not function? Etc.
In conclusion: Zambia has produced very valuable, transparent, relevant, updated and detailed information about police and prison-systems in Zambia, which creates possibilities for immediate intervention.

**The final seminar**

This took place in Lusaka on May 29, 2000 and lasted from 8.30 a.m. to 10.30 p.m.

Around 60 persons participated. Again, persons representing the relevant areas of the Convention were all present: the Ministry of Foreign Affairs and of Legal Affairs, representatives from the police and prison system, judges, universities, and NGOs.

The seminar began with statements from the RWI, from the Swedish Ambassador, Mrs Kristina Svensson, and from the Minister of Legal Affairs, Mr Vincent Malambo (see photo). The latter placed torture in the context of human rights in Zambia and he managed to have all participants understand the importance of the work against torture and the importance of the work done by the participants. He ensured that the government of Zambia was prepared to be heavily engaged in the efforts to eradicate torture in Zambia and live up to all the provisions in the Convention.

The draft report – including annexes – was then dealt with, not only article by article, but also virtually paragraph by paragraph. Comments were included and amendments added.

In the end, the participants adopted the whole report in consensus.

The report was printed and later accepted by the government and forwarded to the UN Mission.

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**Selected list of publications**

received in the IRCT International Documentation Centre


Guidelines for the examination of survivors of torture / Forrest, Duncan (ed.) 2nd ed. - London: Medical Foundation for the Care of Victims of Torture, 20001000. - 57 p.: ill.

Custodial deaths – a two-year study

Jagdish Gargi, MD, Professor and Head*, Ashok Chanana, MD, Assistant Professor* & Gurmanjit Rai, MD, Lecturer*

Abstract
The present post-mortem study was carried out by the Department of Forensic Medicine and Toxicology at the Government Medical College, Amritsar, India, from 1 July 1995 to 30 June 1997. All cases alleged to have died in custody during the preceding two years were included. Less than 1% of all deaths were custodial deaths. Out of 13 reported custodial deaths, nine (69%) had taken place in jail custody. Eight of these (89%) died of natural diseases, and in four cases the cause of death was tuberculosis. In addition to these nine, there were four (31%) cases of police custodial deaths. The majority (58%) of the injuries were abrasions and these mainly (47%) involved the lower limbs. Only 6.25% of the injuries were on the buttocks, and 19% of the injuries were on the upper body and face.

Introduction
Since time immemorial man has been attempting to subjugate his fellow human beings. Over the centuries, with the growth of civilization, there has been an increased use of violence, abuse, and torture to twist and turn people around. Torture remains a global problem of great magnitude. It is the very negation of human dignity and cuts at the heart of the culture of human rights. Torture is an international phenomenon and has long been the concern of the international community, because the problem is universal and the challenge is almost global. No violation of any one of the human rights has been the subject of so many conventions and declarations as "torture". The UN Universal Declaration of Human Rights from 1948, which marked the emergence of a worldwide emphasis on the protection and guarantee of certain basic human rights, stipulates in Article 5 that "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment". Despite the pious declaration the crime continues unabated. People are being brutalized physically and wrecked mentally by various organs of the state and other agencies, to achieve one purpose or the other. Article 21 of the Constitution of India guarantees all persons the fundamental rights to life and personal liberty, but sometimes the organs of the state who are responsible for giving protection to the individual go haywire and they themselves perpetuate the violence – especially against people in their custody, thereby threatening their whole existence. The purpose of torture, also when in custody, is to silence us all, not only those tortured, but the rest of us who may be frightened into passivity. There can be no stable development, economic or political, as long as the government rules through torture with extensive powers vested in the police and other similar organizations. Media reports continue to appear about persons arrested, even upon suspicion, being subjected to humiliation and degrading treatment. The most famous custodial death in recent times in India was of Rajan Pillai. The investigation was carried out by the National Human Rights Commission of India.

Nowadays there are various organizations/bodies at national and international levels to protect and safeguard human rights. Still more and more custodial violence cases are reported in the media, thereby raising awareness among the public.

With the establishment of the National Human Rights Commission (NHRC) in India, it has become mandatory for the authorities to report to the NHRC all cases of custodial deaths within 24 hours. Deaths in custody are taking place for varied reasons, some natural, some unnatural. Although some of these deaths may be due to natural causes, the majority are due to inadequate medical facilities. Sometimes deaths occur in custody due to inadequate safety measures of inmates and negligent behaviour of jail officials while performing their duties, something which could have been prevented.

The forensic pathologist has an important role to play in custodial deaths. By performing the meticulous post-mortem examination and by thoroughly documenting the facts he can bring the true picture of custodial deaths into light. He plays a constructive role in society as he not only treats the sick, but is a social healer as well.

Material and methods
The present study covers the autopsy examinations of custodial deaths carried out during a two-year period in the Mortuary wing of the Department of Forensic Medicine, the Government Medical College, Amritsar. Magistrates conducted the inquest in these cases, and the autopsy examination was video recorded by the board of doctors according to the requirement of the National Human Rights Commission. At the end of the autopsy, the video-recorded cassette was handed over to the investigating agency (along with the post-mortem report) for onward transmission to the NHRC.

Observations
During a two-year period (July 1995 to July 1997) 13 out of 1690 autopsy cases showed custodial deaths (see tables 1 & 2). Nine deaths were of inmates of the Central Jail in Amritsar and Gurdaspur. All except one died of natural diseases. Out of eight natural deaths in jail custody, four died of tuberculosis (see table 3). There was one unnatural death in jail custody (no. 9, table 3), and the cause of death was haemorrhage and shock due to the presence of multiple injuries and the rupture of the urinary bladder as a result of an alleged scuffle between jail inmates.

All of the four police custodial deaths were unnatural (see table 4). In three cases the cause of death was haemorrhage and shock, the last person died due to haemopericardium (cardiac tamponade).

A summary of each case is given below:

* Department of Forensic Medicine and Toxicology
Government Medical College
Amritsar 143001
India
January to December, 1995 ............................................ 388
January to December, 1996 ............................................ 871
January to June, 1997 .................................................... 431
Total .................................................................................. 1690

Table 2. Custodial deaths.

<table>
<thead>
<tr>
<th>Year</th>
<th>Jail</th>
<th>Police Station</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>1996</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>1997</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 3. Custodial deaths in jail.

<table>
<thead>
<tr>
<th>No.</th>
<th>Age (yrs.)</th>
<th>Caste</th>
<th>Cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>65</td>
<td>Muslim</td>
<td>Tuberculosis of the lungs</td>
</tr>
<tr>
<td>2</td>
<td>45</td>
<td>Sikh</td>
<td>Bronchial asthma</td>
</tr>
<tr>
<td>3</td>
<td>38</td>
<td>Sikh</td>
<td>Miliary tuberculosis</td>
</tr>
<tr>
<td>4</td>
<td>35</td>
<td>Sikh</td>
<td>Tuberculosis of the lungs</td>
</tr>
<tr>
<td>5</td>
<td>8 months</td>
<td>Sikh</td>
<td>Malnutrition and dehydration</td>
</tr>
<tr>
<td>6</td>
<td>35</td>
<td>Sikh</td>
<td>Epilepsy</td>
</tr>
<tr>
<td>7</td>
<td>35</td>
<td>Hindu</td>
<td>Chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td>8</td>
<td>20</td>
<td>Sikh</td>
<td>Meningitis caused by tuberculosis</td>
</tr>
<tr>
<td>9</td>
<td>50</td>
<td>Sikh</td>
<td>Haemorrhage and shock</td>
</tr>
</tbody>
</table>

Table 4. Custodial deaths in police stations.

<table>
<thead>
<tr>
<th>No.</th>
<th>Age (yrs.)</th>
<th>Caste</th>
<th>Cause of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>86</td>
<td>Sikh</td>
<td>Cardiac tamponade</td>
</tr>
<tr>
<td>2</td>
<td>50</td>
<td>Hindu</td>
<td>Haemorrhage and shock</td>
</tr>
<tr>
<td>3</td>
<td>30</td>
<td>Sikh</td>
<td>Shock</td>
</tr>
<tr>
<td>4</td>
<td>35</td>
<td>Sikh</td>
<td>Shock</td>
</tr>
</tbody>
</table>

Jail custodial deaths

Case No. 1
A 65-year-old Muslim man was referred to the Medical College Hospital and admitted to the Guru Nanak Dev Hospital on 7 August 1995. He died in hospital on 11 August 1995 and the police alleged that it was a natural death. At the autopsy examination it was found that he had been of poor build and had been poorly nourished and anaemic. Multiple cavities with caseating material were found in the apical region of the right lung. One of the cavities was eroding a blood vessel, leading to the right main bronchus being filled with frothy blood. It was a case of pulmonary tuberculosis.

Case No. 2
A 45-year-old Sikh man died on 17 October 1995 as a result of an alleged attack of asthma. At the autopsy examination the man was found to have been moderately built and moderately nourished. The internal body viscera were congested and there were other findings of asphyxia. The lungs were pale and bulky and were found to be prominent with thickened walls and they contained sticky, opaque mucus. The bronchi were occluded by mucus plug. The basement membranes of the bronchi were thickened. The bronchial walls were infiltrated by inflammatory cells. Emphysematous changes were also present. The pathological impression and cause of death was declared as "bronchial asthma".

Case No. 3
A 38-year-old Sikh man was admitted to the Medical College Hospital on 20 December 1995 with a history of fever for the last four months. Due to increased severity of the disease, he died in hospital on 22 December 1995. At the autopsy examination the man was found to have been moderately built and moderately nourished with findings of cyanosis. The right side of his heart was full of blood. The left was empty. The lungs, stomach, intestines (small), liver, spleen, and kidneys were congested. The histopathological examination revealed findings of tuberculosis in both lungs and liver. The pathological impression and cause of death was declared as "miliary tuberculosis".

Case No. 4
A 35-year-old Hindu male prisoner was reported dead on 28 March 1996. At the autopsy examination he was found to have been emaciated, poorly built and poorly nourished. The internal body viscera were pale. The lungs were pale and revealed multiple circumscribed areas of 1.8 cm in diameter, firm, grey-white to yellowish in appearance, and on cutting a section of the lungs, scattered foci of caseating material was found. Pulmonary tuberculosis was declared as the cause of death.

Case No. 5
An eight-month-old Sikh baby-boy born to a jail inmate in the Hospital of Central Jail, Amritsar, was reported dead on 7 July 1996 due to weakness from birth. The mother of the baby was convicted under section 302 of the Indian Penal Code for the death of her husband. At the autopsy examination the boy was found to be of poor build and poor nourishment. The anterior fontanelle was sunken. The eyeballs were lustreless and sunken. The tongue was dry and coated. The abdomen was markedly distended. The skin was wrinkled with minimal amount of subcutaneous fat. The hair was thin, sparse with scattered portions of pigmentation and de-pigmentation. Calves, shoulders, pectoralis, and thigh muscles were wasting. The nails were thin, flat, and brittle. The cheeks were sunken. The internal body viscera were pale. Fatty change was present in the liver, and "malnutrition and dehydration" was declared the cause of death.

Case No. 6
A 35-year-old Sikh man was found in an unconscious state on 14 July 1996. He was later referred to the Medical College at the Hospital of Amritsar where he was declared dead. This was alleged to be a case of natural disease. At the autopsy examination the man was found to be moderately built and moderately nourished. The internal body viscera were congested. The right side of his heart was full of dark fluid blood, the left was empty. The body did not exhibit any sign of torture or trauma. Viscera were preserved for histopathological examination and chemical analysis, but erateley nourished. The internal body viscera were congested and there were other findings of asphyxia. The lungs were pale and bulky and were found to be prominent with thickened walls and they contained sticky, opaque mucus. The bronchi were occluded by mucus plug. The basement membranes of the bronchi were thickened. The bronchial walls were infiltrated by inflammatory cells. Emphysematous changes were also present. The pathological impression and cause of death was declared as "bronchial asthma".

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>3</td>
</tr>
<tr>
<td>1996</td>
<td>4</td>
</tr>
<tr>
<td>1997</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
</tr>
</tbody>
</table>
no disease or poison was reported. The deceased had a relevant history and asphyxia. There were no signs of disease, trauma or poison. The cause of death was declared as “epilepsy”.

**Case No. 7**

A 35-year-old Hindu man was reported dead on his way to the Medical College Hospital, Amritsar, on 20-21 October 1996. The alleged cause of death mentioned at the inquest was “death due to cardiac arrest”. The autopsy revealed a moderately built and moderately nourished man. The internal body viscera were congested. The viscera were preserved for histopathological examination and chemical analysis. No problem was detected by the chemical examiner whereas the pathologist found evidence of “chronic obstructive pulmonary disease” which was also declared as the cause of death.

**Case No. 8**

On 17 January 1997, a 20-year-old Sikh man was referred to the Medical College Hospital for some ailment. History and clinical examination revealed that he had been suffering from fever for the last three months and had been in a coma for the last 15 days. There was also a history of weakness of the lower limbs. Neck rigidity was detected and Kerning’s sign was positive. The chest examination revealed crepitations and the abdominal examination showed hepatosplenomegaly. It was labelled as a case of “tuberculosis meningitis”. In spite of treatment he died on 19 January 1997. The post-mortem examination was conducted on 21 January 1997 and showed a moderately built and moderately nourished man. Pleurae were adherent to the chest walls. At the examination of the lungs multiple cavities containing whitish caseating material mixed with pus were detected. The spleen had multiple whitish-yellow coloured miliary patches. Similarly, the liver exhibited these lesions. The brain had gummatus lesions in the right cerebrum. These findings were confirmed on histopathological examination and “tuberculosis meningitis” was declared to be the cause of death.

**Case No. 9**

A fifty-year-old Sikh man was reported dead on 21 May 1997 on the jail premises due to illness. At the autopsy examination he was found to have been a well-built and well-nourished man with congested eyeballs. Multiple injuries of various types such as abrasions, lacerations, bruises, and subluxation (teeth) were found on different parts of the body. The internal body viscera were pale. Fluid and clotted blood were found in the peritoneal cavity (900 ml) and in the pelvic cavity (400 ml). The urinary bladder was lacerated. Haemorrhage and shock along with rupture of the bladder was declared as the cause of death.

**Police custodial deaths**

**Case No. 1**

On 21 February 1996 an old Sikh man of 86 years was sleeping in his house in a village of the Majitha Police District, when a police party raided his house at 3:00 am in search of his grandson, who was wanted by the Punjab and Haryana Police on criminal charges. The police searched the house. On not finding the grandson in the house, the police verbally abused and pushed the old man who fell on the floor of the house, and after a few minutes he died. This story was narrated by the daughter of the deceased who witnessed the whole incidence. At the autopsy examination the old man was found to have been moderately built and moderately nourished. The pericardial cavity contained 400 ml of fluid and clotted blood. The anterior surface of the heart was covered with clotted blood. Multiple dark-redish contusions varying in size from 4 x 2.5 cm to 1.8 cm were scattered in an area of 5 x 4 cm on the posterior surface of the heart and in the wall of the left ventricle. A perforation 1 x 0.8 cm with clotted blood was present in the contused area of the left ventricle wall which was communicating with the left ventricular cavity. No external injury was evident. Histopathological examination of the coronaries revealed atherosclerotic changes and narrowing of their lumen. Perforation of the heart leading to haemopericardium was declared as the cause of death.

**Case No. 2**

A 35-year-old Sikh man was taken by the police into custody as he was wanted by the police in a criminal case registered under section 302/148/149 of the Indian Penal Code on 14 July 1996. According to police papers the accused was taken into custody on 24 July 1996 and in the night of 24-25 July 1996 the accused complained of a sudden pain in the abdomen. He was taken to the rural hospital for treatment. From there he was referred to the Medical College Hospital, Amritsar. But he died on the way. The first post-mortem examination was conducted in the sub-division hospital of the area where the doctors reserved the cause of death as the viscera were sent for chemical analysis. But fearing a miscarriage of justice and not satisfied with the result of the post-mortem examination, the attendants, relatives, and friends of the deceased moved an application to the sub-divisional magistrate of the area, who referred the cases to the Government Medical College, Amritsar. A medical board of forensic experts and pathologists was constituted by the Principal. At the autopsy examination, 37 injuries of various types such as abrasions, bruises, and lacerations were found all over the body. Cause of death was declared as “shock due to cumulative effect of injuries”.

**Case No. 3**

A 50-year-old Hindu man was arrested by the police on 11 April 1997 under section 457/380 of the Indian Penal Code. He was reported dead on 12 April on account of a fall from the roof of the police station. At the autopsy examination multiple injuries in the form of abrasions, bruises, and lacerations were detected. The radius, ulna, and humerus of the left upper limb were fractured. Also the talus and calcaneum bones of both feet, and the sacrum bone were fractured. Bruising of the right buttock and infiltration of the blood in the anterior abdominal wall were found. Haemorrhage and shock were declared the cause of death.

**Case No. 4**

A 30-year-old Sikh man was arrested by the police on 16 June 1997 under section 457/380/511 of the Indian Penal Code. He died in police custody on 17 June 1997 and the post-mortem examination was done the same day. At the autopsy examination, multiple injuries in the form of abrasions and bruises were scattered all over the body. Viscera were preserved for chemical analysis and histopathological examination. But no poison or disease was reported and shock was declared as the cause of death.

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Table 5. Pattern and distribution of injuries in custodial deaths.

<table>
<thead>
<tr>
<th>Body parts</th>
<th>Injuries</th>
<th>Abrasion</th>
<th>Bruise</th>
<th>Laceration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head and face</td>
<td></td>
<td>14</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Neck</td>
<td></td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Upper limbs</td>
<td></td>
<td>9</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Chest</td>
<td></td>
<td>3</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td>7</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Scrotum</td>
<td></td>
<td>-</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Lower limbs</td>
<td></td>
<td>22</td>
<td>11</td>
<td>15</td>
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<tr>
<td>Total</td>
<td></td>
<td>59</td>
<td>18</td>
<td>25</td>
</tr>
</tbody>
</table>

Conclusion
All custodial death victims were male and the age range varied from 30 to 86 years except in one case, who was an infant of eight months, lodged in the Central Jail in Amritsar with his mother, who was a jail inmate. The pattern and distribution of injuries in custodial deaths are given in Table 5.

Abrasions constituted 58% of the injuries and a maximum of 47% of the injuries were on the lower limbs (see table 6).

Contrary to common belief that torture injuries in custody are mainly on the buttocks, only 3 (6%) of the injuries in these cases were on the buttocks. There were significant 20 (19%) injuries to the head and face, indicating that torture does not spare even the vital parts of the body, and illustrating the inhuman and degrading approach of the custodians (see Table 7).

Table 6. Pattern and distribution of injuries on lower limbs in custodial deaths.

<table>
<thead>
<tr>
<th>Limb parts</th>
<th>Injuries</th>
<th>Abrasion</th>
<th>Bruise</th>
<th>Laceration</th>
<th>Total no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buttocks</td>
<td></td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Thighs</td>
<td></td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Knees</td>
<td></td>
<td>5</td>
<td>1</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Legs</td>
<td></td>
<td>10</td>
<td>-</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>Ankles</td>
<td></td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Feet and soles</td>
<td></td>
<td>1</td>
<td>2</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>22</td>
<td>11</td>
<td>15</td>
<td>48</td>
</tr>
</tbody>
</table>

Table 7. Frequency of injuries in custodial deaths.

<table>
<thead>
<tr>
<th>Body parts</th>
<th>Injuries (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head and face</td>
<td>20</td>
</tr>
<tr>
<td>Neck</td>
<td>4</td>
</tr>
<tr>
<td>Upper limbs</td>
<td>15</td>
</tr>
<tr>
<td>Chest</td>
<td>6</td>
</tr>
<tr>
<td>Abdomen</td>
<td>7</td>
</tr>
<tr>
<td>Scrotum</td>
<td>2</td>
</tr>
<tr>
<td>Lower limbs</td>
<td>47</td>
</tr>
</tbody>
</table>

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A proposal to revisit the UN torture definition

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Abstract
While dealing with the police or other security agencies of the State, the legal rope must be taut so that any extra plucking on it will produce vibrations forceful enough to alert the law. If the rope were sagging, no level of pulling at it would manage that. This observation is made with respect to the last part of the UN definition of torture in which an awful lot of "extra rope" is inadvertently provided to the investigating agencies worldwide, namely..."it does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions." This provision carries the inherent danger of its misuse because there is no way by which force applied at the time of arrest can be quantified.

Introduction
The UN definition of torture
The following is the full text of the UN definition of torture, finalized in the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment. (Adopted and opened for signature, ratification, and accession by UN General Assembly resolution 36/46 on 10/12/1984. Entered into force on 26 June 1987 in accordance with article 27(1)).:

ARTICLE 1
For the purpose of this Convention, the term "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 him or a third person information or a confession, punishing him for an act he or a third person has committed, or 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 a pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

When police violence escalates
The purpose of torture by people acting in an official capacity is excellently enshrined in the UN definition. The extrapolated result of such activity is to break down the moral and personality of the victim, and thus render him unfit to the cause he had been vehemently espousing earlier.

First contact
The first contact carries a long-lasting impression. It makes or mars the opinion, and no amount of grooming or cajoling later on can significantly alter the impression gained at the inception. This is not a secret. Certain professionals try to make the best use of this natural feeling, like in medicine where the students are taught emergency ethics based on the fact that the patient entering the emergency unit at the hospital, if treated and attended well, will forever eulogize the services provided. If not, no amount of attention and pampering later will reduce his distrust. The community talk of the patient would begin like: "When I went to the emergency unit at one o’clock in the morning, there was no doctor available..." The word thus spreads, and it is amazing how such stories nestle comfortably in the heart of the listeners, so fast and so firmly grounded.

The same goes for the police (or any other security agency of the country). The police manual teaches them the ethics of professionalism, and how a cheerful face can lift a sagging demeanour. Now and then we come across slogans pronouncing the virtues of the police: "The police are your friends", "The police are public servants in the service of humanity", etc. No doubt the intentions are good. However, the police also know that the first contact with the alleged criminal, and any impression created at the meeting, will thereafter dispel any wrongly harboured notion in the victim that the police will be professional when dealing with him.

When the violence leads to death
This duality in the beliefs of the interacting characters only serves to bring out the worst. The police tend to be brutal, the victim resenting. The actual outcome is violence. It is immaterial whether the violence is low or high on some scale, because in such instances the level of violence is immeasurable, and open to question later. There is almost always a generalized beating at the site of arrest because it renders the victim "soft" and exhausted, and amenable for a successful "confession-extracting" session later on. This violence is dangerous because any slight shift in the position of the victim is conceived as a threat to the police. That is the reason why a man died when several hefty police officers converged on a helpless victim with the intention to restrain him. The man was unarmed. The police failed to get up fast, and due to their slow reaction the man suffered traumatic suffocation leading to death. The police were never questioned. Why? Because all this happened during the course of arrest of the victim, and it was implicitly and explicitly implied that the arrest was legally justifiable.

In another instance, a man was shot dead in the vestibule of the building where he lived. The man was trying to establish his identity by opening up his black wallet, but the police thought otherwise. The man was shot a dozen times, leading
to death. It did not take long to determine the innocence of the police officers, in the process sweeping away whatever remnants of guilt that may have lingered in the hearts of the officers.

In the last instance of my endeavour to bead together such incidences, a police officer was never even questioned about what was an obvious trespassing of his powers. An alleged culprit running away was hit at the back of his head by a truncheon. The man suffered skull fractures and died in the hospital. His death was considered to be a minor inconvenience, and do doubt “unavoidable” given the set of circumstances prevailing at the time. It never crossed anyone’s mind that his death was unnecessary and totally “avoidable”.

Restraint techniques
The police are trained in dangerous mechanisms to retrain the individual. They use these methods indiscriminately even when they may not be required. The most notorious are armlocks and neck-holds. There are two types – the “bar arm control” and the “carotid sleeper”. The former is alleged to be the most dangerous. In this the restraining officer’s forearm tugs the anterior part of the neck, blocking the larynx. The “carotid sleeper” utilises the two sides of the arm forming a “V” to compress the lateral sides of the neck. The carotids are effectively blocked producing transient ischaemia. These procedures are legal, but what is not legal is their duration. These procedures cause instant death when used in a fight and with the alarming synthesis of disproportionate force and too long a duration. These procedures may be used for dangerous armed criminals and should only be used sparingly.

This background is necessary to raise the issue of whether it is essential to include “... it does not include pain or suffering arising from, inherent in or incidental to lawful sanctions”, which of course includes arrest, into the UN definition of torture. This part of the text gives wide latitude to the police to handle the alleged offenders in the way they think best. It provides them with an international leeway to wriggle through unfavourable circumstances. The scene of arrest is fraught with dangerous uncertainties. The national laws practically give them unlimited impunity while making an arrest. The feeling of professional brotherhood is strongly present among the police officers at such times. Any glaring discrepancy or discrimination is quickly patched up among themselves. There are no effective eyewitnesses. Social recognition of their act is easily available, particularly if the alleged offender has a criminal record.

Summary
Given the prevalent conditions, I feel it is logically misplaced to include the provision of “... it does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions” within the United Nations’ definition of torture. The definition of torture may best end at “... instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity”. To venture beyond that is not only unnecessary, but it stirs up the entire issue of strategies, thus inviting more problems of variable dimensions from unperceived dark corners. I have urged the UN to rethink this matter and to eliminate the last part of the definition, effectively and permanently. No one questions the right of the police to self-defence. Such events may be judged on the basis of merit alone.

TORTURE WORLWIDE

Torture beyond 2000 – its scenario in society and prevention

Torture is defined as a deliberate form of cruel, inhuman and degrading punishment. It is an act by which pain or suffering, whether physical and/or mental, is intentionally inflicted on a person to obtain information or a confession. Torture is the punishment for an act he/she or a third person has committed or is suspected of having committed. It is one of the most profound human rights abuses and is a worldwide problem. Torture of children and women is performed in many countries for the purpose of putting pressure on their parents or spouse.

In India the most widespread kind of torture is domestic torture, for example torture of workers by their employer. Domestic violence is also due to pressure on women by their husbands or in-laws. Another cause is illiteracy and unemployment among women. Child abuse and child labour are also important causes of torture. In the future torture of children will continue to be widespread due to instability in families and a highly competitive atmosphere.

It is the prime duty of everyone to prevent torture in society, and the medical profession has a dual role of carrying out treatment and prevention. Prevention of torture can be done in various ways:

Set up a human rights cell
The establishment of a human rights cell involving the medical and legal professions, human rights activists, NGOs, and committed social workers is the most important way to limit torture. There should be large numbers of these cells all over the world, and there should be links from the lowest level to the highest level in every country as well as links at the international level for a symmetrical and effective control of torture. This network is essential for effectiveness. At present, there are many international bodies like the United Nations, Amnesty International, the Human Rights Commission, the IRCT, etc.
Improvement of the unhealthy atmosphere in families

The most important way of preventing torture is to improve the unhealthy atmosphere in families because this is the most important cause of the evil of torture. In this millennium there will be more and more attacks on this basic unit due to cutthroat competition leading to great stress at work. In the ever-increasing competition, the person is so involved that he has no time for introspection, for family members, for his social environment, or for downtrodden poor brothers and sisters.

Every individual develops basic characters within the family environment and atmosphere. The social environment is a congolmeration of the environment of families. Society's behaviour and values are important in increasing and decreasing the level of torture. The more the value-based family unit is developed, the lower the level of torture will be.

We therefore have to concentrate on the environment in families. The main problem is that parents are not aware of ways of tackling problems with their children, and therefore they try to suppress their children's ideas. Parents want to pressurize their own experiences and desires onto their children, and the parents do not allow the children to grow according to their own experiences and goals. The parents should act as catalysts in the progress of their children by guiding and not by pressurizing them. This suppression of ideas is the main cause of low confidence and development of a depressed and stressed personality. So we have to attack at this smallest unit of the social set-up. There should be a wide discussion to develop a healthy atmosphere in the home. A single unit household is now mostly comprising of a family consisting of husband, wife and one or two children. It is the prime duty of torture consultants to educate this family unit about the importance of a healthy atmosphere. Families can be educated in various ways:

1. Workshops can be held weekly, fortnightly or monthly at clinics.
2. Group discussions for families at regular intervals.
3. Large seminars for families on an annual basis.
4. Discussions with NGOs and other institutions to evaluate the ways to be adopted by families.
5. Assistance from governmental institutions to educate family units.
6. Discussions about novel ways of cooperation between torture consultants at the state and national level.
7. Assistance from the social institutions to propagate the message to these family units.

Likewise, there should be widespread discussions about these issues. This would guide parents in bringing up their children.

Acknowledgement

I am very thankful to my wife, Dr Vijay Laxmi Bapna, Chief Medical Officer at the Labour Medical Services, Saharanpur, for her guidance.

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TORTURE Volume 11, Number 1 2001

Human rights and investigative journalism

A few years ago, a routine crime story about two men under suspicion for car theft was published in a Tanzanian newspaper. In the article, the journalist describes in great detail the circumstances under which the two men had been arrested and brought to the police station for interrogation. The story then relates what happened afterwards and gives further details on the alleged act of crime. It is mentioned briefly—almost in a casual way—that the two men were escorted to the hospital after the interrogation. No mention is made of why they had to go to hospital immediately after the interrogation.

This story is one of many routine news stories on crime, which can frequently be read in many newspapers around the world. At best they are examples of laid-back journalists who base their stories on easily accessible information provided by the police. At worst they are examples of journalists deliberately backing up police repression.

Media coverage of torture and other human rights violations is scarce and often below standard. This is a fact that can be difficult for victims and for human rights organizations to understand and accept.

Speaking from the point of view of ideal journalistic values it is also difficult to understand. Journalists traditionally identify their profession with the idea of uncovering what is not known publicly and to disclose abuse of power. That is why people in the news media see themselves as the fourth power. Unfortunately, this view is an ideal, a self-perception that too seldom is confirmed in practice.

This article presents some of the characteristics of the media coverage of human rights violations, especially torture, followed by some ideas for ways of making journalism about these matters critical and investigative. Idealistic maybe, but not impossible.

Torture in the media

Although little research on mass media coverage of human rights violations and torture have been carried out, two conclusions can easily be drawn: the coverage is limited and often of low journalistic quality.

In the Northern Hemisphere human rights stories have low priority. A study of three major American newspapers between 1985-93 showed that explicit human rights stories only made up between 0.10-0.40% of total coverage. A study of news coverage in the United Kingdom showed that less than 10% of the coverage dealt with events from countries in the South (where human rights violations most often take place). Of this coverage, only 13% dealt with issues such as human rights and the environment.

We can expect the figures to be even smaller today, given the trend in the American and European media to focus less on international news.

It is difficult to make any firm conclusions about the media coverage in countries in the Southern Hemisphere. Little research has been carried out and published internationally. Still, a 1999 study of newspapers in New Delhi, sponsored by the Indian Medical Association and the International Re-
Many citizens in the North consider human rights violations which happen when the media focuses on the extreme acts of the torture. It is simple too risky to cover. With regard to countries in the North, where torture normally does not happen, the scarce attention can be explained by the fact that many citizens in the North consider human rights violations in far away countries to be of little relevance. This makes such coverage a low priority subject for journalists.

The media has a tendency to reduce torture survivors to torture victims by focusing on the horror of their experiences rather than their ability to survive them. The survivor is victimized and portrayed as a pitiful character. Another characteristic is the sensationalistic reporting which happens when the media focuses on the extreme acts of violence and torture, describing the horrific events in graphic details, instead of writing a balanced report.

An additional factor contributing to the poor quality of reporting on torture is the lack of context in stories. News on torture is event-oriented rather than fact-oriented. The story is rarely presented with the background of what happened and the reasons why it happened. In this way torture is presented as something unavoidable. It is practiced for no reason and it has its own existence, its own life.

It is not uncommon to find news stories that convey the message that in some cases torture is necessary and therefore acceptable. For example, when reporting on police interrogations, news reports may use phrases like “the police had to use drastic measures in the interrogation”. This legitimizes, if not condones, the use of torture.

Finally, there is a widespread tendency to omit reports about the consequences of torture for torture survivors. Although physical damage is exposed, the psychological trauma is often neglected in the news story. Thus, there is no doubt that, from a human rights perspective, the media coverage on torture needs improvement, in quantity as well as in quality.

**Framework for investigative journalism**

One of the definitions of news used by journalists is: “News is what somebody for some reason doesn’t want to be publicly known.” Investigative journalism deals with just that: subjects and events that somebody — most often a person in a position of power — does not want others to know. Other features of investigative journalism: it does not describe daily news, but deals with major events or themes, which are described in detail. The stories are based on a multitude of sources, presenting different perspectives, and facts are well documented. If possible, persons and institutions responsible for a given problem are identified.

Certain conditions must be fulfilled to be able to carry out investigative journalism:

- **Autonomy** from economic powers is an important condition. Neither the owners of mass media nor the advertisers should be able to influence the journalistic work carried out. This is a premise that can be hard to fulfill in a media world that is characterized by commercialization and tough competition for audience ratings and readerships.

- **No pressure** from external power interests. Investigative journalism often discovers facts that make certain people uncomfortable, most often people in power, such as politicians, businessmen, police officers, army personnel or persons involved in organized crime. It is of crucial importance that the media resists all types of pressure from such groups.

- **No personal risk** for the journalist is another necessary condition for journalists to be able to carry out investigative journalism. It should be possible for the journalist to work without risking life and health. Unfortunately, in a number of countries this condition is hard to fulfill. This can be seen from the fact that journalists are often persecuted, tortured, and even killed.

**Sources on torture**

The sources and how they are approached are the basis of investigative journalistic work on torture.

Probably the most important source is the torture survivor. Nevertheless, survivors have to be approached in a very cautious way. Some torture survivors have a strong wish to give public testimony about the atrocities that happened to them, thinking that it will help their case and get their torturer put on trial. Although they often feel a relief after the publication of an article about their case, it can lead to depression when they find out that nothing happens to the perpetrators, or it can even have the consequence that the survivor is persecuted again by the oppressor. This risk is particularly high in countries with a tradition for impunity for human rights violators. The journalist must therefore analyse the situation carefully before using a torture survivor as source on the subject of torture.

Apart from the personal risk, the journalist should also consider whether making a case publicly known can harm the survivor in other ways. Labelling a person as a torture survivor can be the same as labelling him or her as a criminal. This happened in a case in Denmark, where a torture survivor appeared on television with the information that he had been tortured in prison in his country of origin. Subsequently, the survivor was confronted with this fact by his colleagues who had seen the television programme. They had understood that he had been in prison serving time as a common criminal, not as a political prisoner, which he was. This difference was of course significant to the torture survivor.

**Medical reports** are another important source of information. This is a source that is not easy to access. Unfortunately, this is a source that might be difficult to interpret in the right manner because there sometimes is a certain level of collaboration between the police and the medical professionals. Professor Bent Sørensen, former member of the United Nations committee against Torture, once related an example of
this kind: a torture victim had been exposed to a torture method where a 3-4 inch nail was hammered into his forehead. After four days this led to the death of the torture victim. In the death certificate the medical doctor stated the cause of death to be epilepsy. Although this was not incorrect, it was not the whole truth either. Thus, medical reports have to be read cautiously - often with the use of medical expertise - but do indeed contain valuable information about torture.

Legal information is another source of information that often needs expert knowledge. For obvious reasons much of the information on human rights violations is found within the judicial system. Information can be found on the judicial procedures that the authorities might have carried out against a person who has been exposed to torture as part of the interrogation. Information about cases filed against the suspects by the torture survivor, or in case of death, by his or her family can also be found. Along the same lines, reports and cases presented by human rights organizations and institutions might be valuable information for the journalist.

It can often be of value in the journalistic investigation to combine information from these sources with information about the obligations of the State and its authorities as defined in international conventions and agreements. Such obligations are stipulated in agreements such as the Convention against Torture, in country reports presented to the Committee against Torture, and in the Committee's response to these reports.

Police reports and other information from the police force might be of great importance as well. In some countries the police are responsible for torture. This happens for example when torture is used as a method of interrogation during custody. In the eyes of the police, torture is a necessary tool to extract information and confessions and therefore an acceptable and legitimate method of work. This is why the police do not speak of torture, but of "third degree interrogation" or "application of physical pressure" as the anti-terrorist police in Israel have called their technique for interrogating alleged Palestinian terrorists.

For these reasons it is necessary to approach the police with a critical attitude and not take their information at face value. This fact is important to emphasize since journalists often give too much credibility to police information. A practical suggestion made by an Indian journalist to solve this problem is that journalists working with crime stories, who therefore depend very much on good relations to the police, should not also do stories on police brutality and torture. This task is probably better managed by some of their colleagues.

Finally, the media itself can be a source of information about torture and human rights violations. It can be straightforward coverage of violations, or it can be stories like the one from the above-mentioned Tanzanian newspaper that never questioned why the two persons under suspicion for car theft were brought to the hospital right after the police interrogation. Therefore, when using media as a source it can be helpful to look for inconsistencies or lacking information in order to complete the description or to understand the logical coherence of an event.

Future challenges
Investigative and critical journalism on torture is scarce, be it in countries in the North or in the South. The reasons can be many: low priority due to commercial pressure, influence from police, fear for the consequences of speaking out, or pure ignorance. The reasons might be understandable or not, but they all have the same result.

This fact is difficult to accept, knowing that torture takes place in more than one hundred countries around the world, and supposing that this number could be reduced if more acts of torture were spoken about and publicly known. For this reason it is a task for human rights organizations to improve their description of the media coverage of torture and to use their findings to persuade journalists to give higher priority to these atrocities and to apply better journalistic methods. - Indeed a challenge, for human rights organizations and for journalists.

Furthermore, changes are taking place in the way torture is carried out. These changes might make it even more challenging to cover the issue of torture. In a world deeply affected by neo-liberalism, the State loses influence, and an increasing number of functions are being privatized. This includes police and security work that to a certain degree is taken over by the private sector.

One can ask what consequences this will have for the respect for human rights. Where perpetrators traditionally have been identified as authorities under the State, there are reasons to believe that in the future an increased number might be found within the private sector. This is a trend that has not been discussed or covered by the media: yet another challenge to be dealt with by good journalists.

References

Further reading

This article is based on a presentation ("Investigative reporting and human rights") made at a seminar for journalists in Tegucigalpa, Honduras, in October 1999. The seminar was arranged by Dr Juan Almendares, Director of the Centre for the Prevention, Treatment and Rehabilitation of Torture Victims and their Relatives (CPTRT), Honduras.

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Twenty years of humiliation due to "misdeeds" of father


The story of the Oufkirs, a mother and six children from one of Morocco's most powerful families, is more atrocious than the worst fictional horror story. One of the children, now the mature woman Malika, with the assistance of the editor of the French magazine "Elle", Michèle Fitoussi, has given a moving account of the way in which she and her family through 20 fearful years were taken from one desert prison to the other. The book has since been translated into at least 12 languages, including English, German, and Danish.

They were so severely punished by the then king of Morocco, Hassan II, because of something Malika's father, general Mohammed Oufkir did: An attempted coup d'etat in 1972, which (presumably) forced him to commit suicide. Malika, who was adopted by Hassan's father, king Mohammed V, until her 15th year had led an unimaginable life in the wildest luxury, and then she had to experience life in its most unkind form.

The desert - so fascinating to visit for thousands of tourists completely ignorant of the fate of the Oufkir family - provided the lieutenants of the revengeful king with the perfect setting for "crushing the Oufkirs", as he had ordered. Through the ingenuity of Malika and the use of their radio, the family succeeded in keeping in contact, even though the guards (there were always several of them around) tried to separate the members of the family in different small rooms.

There was the heat, there were rats, scorpions, and cockroaches - but the worst was perhaps the perpetual hunger. As she puts it: "Hunger transforms the human being into a monster." And the captives were always hungry! Never did they get milk, butter or fruit, apart from some mouldy dates and occasionally some mouldy oranges. In the spring they ate weed, a kind of dandelion, which was cooked with garlic and olive oil.

Of course they dreamed of fleeing all the time. In the prison in Bir-Jidil, where they spent ten years, they went on hunger strike in order to get their conditions improved, and the mother and a brother tried to kill themselves by cutting their arteries. In January 1987, they started digging a tunnel, and in April Malika with one brother and two sisters succeeded in escaping. Hitchhiking a car they arrived in Casablanca. The details of the flight are more exciting than many detective stories. But it is also an account of courage and inventiveness.

After a family reunion - and much international pressure on the Moroccan king - the Oufkirs were still barred from leaving Morocco for years. Not until 1996 could they leave the country where they had to suffer immensely for something another person had done. Malika was 43 years of age when she arrived in France. Time to begin a new life. Two years later she married.

The book is framed as a novel, the layout will undoubtedly lure many people, disinterested in politics, into reading it. Despite quite a few footnotes, the serious reader may want a bit more information on the political situation in Morocco and the circumstances of the unsuccessful attempt to kill King Hassan. This is however a personal narrative, giving the details of the fate of just one family. It is how the life of Malika Oufkir changed from one kind of unhappiness (in the phoney life at the royal court) to another: as a prisoner for 20 years.
provision of health services irrespective of sex, race, and religious or political observation.

Rather, they used their supposed professional independence and the profession's traditional credibility to defend the profession's against any external accusation of failure to do their duty, claiming to adhere closely to internationally accepted professional standards. And unfortunately they were believed.

The book systematically analyses the various aspects of the interaction between the apartheid policy and the exercise of what should have been professional autonomy. It is a sad story, and so well documented that the reader is left with little optimism as to the ability of the health professions to stand up against similar political pressure.

Maybe the most disturbing evidence is that of a continuation even today of some discriminatory and unethical practices, showing a resistance to change. Also, there is continued reluctance to admit openly the professions' collusion with the apartheid authorities and their failure to support the few courageous colleagues who spoke out against the effect of apartheid in the health services.

By some strange coincidence the nightmare of apartheid in South Africa, which was created in 1948 and began its disintegration in 1990, covers almost exactly the time period during which a number of countries in Central and Eastern Europe were subjugated by ruthless Soviet-imposed Communist governments.

The situation in South Africa - bad as it was - did benefit from a sustained international anti-apartheid campaign coordinated by the United Nations, while the situation in Soviet controlled Eastern Europe was allowed to continue without any action from the UN - thanks to the veto of the USSR in the Security Council.

In both situations it took more than a generation to do away with these social abominations with their travesty of democracy and justice - but finally both systems came to fall - a cause for some optimism for the future of humanity. Many other repressive regimes came and went during this period - and some unfortunately remain - leaving dark memories of abominable human rights violations. But apartheid somehow came to stand as a special case - probably due to its basis in racial discrimination and therefore reminiscent of the fight for the abolition of slavery in a previous century as well as the fight against colonialism which dominated the post-World War II period.

Under both systems, health professionals came under severe pressure to side with the suppressors or at least maintain silence as a condition for exercising their profession, and in both cases the professions were unable to deal successfully with this challenge to their ethical standards.

The role of the medical profession during Nazism in Germany has gradually been exposed, while the full story of the Japanese medical profession during the same period still remains to be told. The sad story of abuse of medical knowledge - especially psychiatry - under Communist dictatorship has been revealed to some extent. But the role of - and often the silence of - physicians in relation to law enforcement abuses and human rights abuses committed during military and paramilitary suppression of political dissent is only slowly accumulating.

This makes the volume now published on the behaviour of the health professions in South Africa under apartheid especially important. It is based on a serious attempt to get the full truth of what happened and to try to understand why it happened. It is supported by evidence from victims and perpetrators as well as from the systems that were supposed to oversee the proper conduct of law enforcement and health care personnel. It should be able to tell us something about why and how things may go wrong, and how - if possible - to prevent future break-down of professional ethical standards.

It should also remind us of what is probably still going on in many countries where populations are at the mercy of suppressive regimes and it should challenge us to consider what we can possibly do to improve professional behaviour in such places.

The book should be compulsory reading for anybody involved in the guidance of health professionals through ethical declarations and codes of conduct as well for those who are entrusted with the training of future generations of health professionals.

Erik Holst, MD, Professor
Former President of RCT
Former Executive Vice President of IRCT

Human rights among prisoners and prison staff in South Africa


The purpose of the manual is to promote awareness of human rights among prisoners and prison staff in South Africa. Prisoners in South Africa have not enjoyed a reputation for humane conditions and treatment of its prisoners. With the introduction of a democratic government, the department of Correctional Services, together with a number of NGOs, has implemented a human rights education and training programme for prisoners and correctional services staff. In the introduction, the authors state:

"This manual, Human Rights for Correctional Services, has two overriding purposes. Firstly, to develop and foster a culture of human
rights among correctional services staff, with the consequence that their working relationships with colleagues and prisoners in their care will be strengthened through mutual respect, understanding and the recognition of each other's right to dignity. Secondly, to create knowledge and understanding of the South African Bill of Rights, with special application to correctional services and international instruments and standards relevant to prisons."

The manual is divided into four modules:
1. Human rights training for Correctional Services Managers
2. Bill of Rights
3. Fundamental Rights in Prisons
4. Human rights and the Correctional Services Act (This last module is only a reference list).

The manual foresees a two-day programme. The book contains many case stories to be discussed in small groups.

The Standard Minimum Rules play an important part of module three.

The book is well written with drawings and case studies. Although it is focusing on the South African situation, it can easily be used in other countries.

I can warmly recommend the book and hope that it will be used in South Africa and elsewhere in order to improve those prison systems, which in so many countries desperately need to change their terribly inhuman conditions.

Ole Vedel Rasmussen, MD, DMSc
Member of the UN Committee against Torture (CAT)
Member of the Council of Europe's Committee for the Prevention of Torture (CPT)
Co-opted member of the IRCT Council

FROM THE MEDICAL LITERATURE

Consequences of violence


This book is based on a seminar held in Madrid in July 1997 under the auspices of Médica del Mundo [Doctors of the World]. As the title indicates, it deals with the mental and social consequences of war and political violence.

Fourteen authors, nearly all psychiatrists, give a detailed account of their experiences, most of which have been gathered in the Latin American context. Each paper is followed by a summary of the discussion that took place at the seminar.

In addition to the Latin American contributions there are articles dealing with the global level by Dr Derek Summerfield and Dr Richard F Mollica. The latter writes in his conclusions: In spite of centuries with violence caused by man, which has generated suffering among millions of people, the identification of the consequences has been ignored, neglected or even denied by the people responsible for rehabilitation.

The book is an attempt to remedy this situation.

Henrik Marcussen, MD, DMSc

Torture and history


Brian Innes is a historian and writer specializing in more dramatic fields such as piracy, espionage, revolutionary movements, and rather occult subjects such as "a catalogue of ghost sightings".

It is characteristic for The history of torture that this approach rubs off on the description of tales and facts about the practice of torture in earlier times.

The account is presented in historical chronology starting with Ancient Greece and finishing with Nazi Germany, followed by an epilogue about the war in Algeria (1954-62). There are detailed descriptions of the inquisition, witch-hunting, and the brutal treatment of slaves – especially in the British colonies. This is followed by a variety of descriptions of instruments, supported by a rich illustrative material.

However, despite having over 100 illustrations, the book does not contribute with new angles or explanations about torture as it is known today. There are only sporadic mention of its extent, and limited analysis of the relationship between social structures, economic conditions, and power structures, all of which are known to be important to the existence of torture. The same is the case for the consequences for the individual and for society, for migration caused by torture, and for the rehabilitation possibilities that we know exist.

When the interpretation of the problem of torture is as one-sided as this – even if the intention has been a clear wish to present the historical aspects – it gives the modern reader a distorted picture of reality when it comes to torture in the world today.

Perhaps the disappointment at The history of torture would have been smaller if the title had been "Torture throughout history".

Henrik Marcussen, MD, DMSc

TORTURE Volume 11, Number 1 2001
AI's anti-torture campaign

On October 18 2000, as part of a global event, Amnesty International launched its Campaign Against Torture in Buenos Aires, Argentina.

Even some months afterwards, it is still worthwhile considering why this important campaign is so necessary.

In preparation for the campaign, AI conducted a survey of its research files on 195 countries and territories covering the period 1997 to mid-2000. It revealed that AI has received reports of torture and ill-treatment inflicted by state agents in over 150 countries since 1997. In more than 70 countries torture or ill-treatment by state officials was widespread and in over 80 countries people reportedly died as a result.

The world has changed immeasurably since AI first began denouncing torture at the height of the Cold War in the 1960s, but torture continues and is not confined to military dictatorships or authoritarian regimes; torture is inflicted in democratic states too. It is also clear that victims of torture are criminal suspects as well as political prisoners, the disadvantaged as well as the disdained, people targeted because of their identity as well as their beliefs. They are women as well as men, children as well as adults.

AI's campaign looks at torture by police, in the context of criminal investigations or the maintenance of public order; torture and ill-treatment in prisons; judicial punishments amounting to torture; and torture in armed conflict. The campaign also looks at other forms of violence in the home to victims and ill-treatment are also illegal under the laws of virtually all countries, although many laws are inadequate. As national standards, even though they are not committed by state officials.

No government may use a state of war, a threat of war, internal political instability or any other public emergency to justify torture. Under the Geneva Conventions, torture is illegal in both internal and international armed conflicts. Torture and ill-treatment are also illegal under the laws of virtually all countries, although many laws are inadequate. One form of torture and ill-treatment which is permitted under national law in some countries is judicial corporal punishment. According to AI's survey, judicial corporal punishments are provided by national law in at least 31 countries today.

The most common forms of judicial corporal punishment include amputation and flogging. Some forms such as amputation and branding are deliberately designed to permanently mutilate the human body. However, all of these punishments can cause a range of long-terms or permanent injuries.

Since 1997 judicial amputations have been carried out in at least seven countries (Afghanistan, Iran, Iraq, Nigeria, Saudi Arabia, Somalia, and Sudan) and judicial floggings in 14 countries.

For further information, please see the AI campaign website: www.stop torture.org.

Gallup International Association Millennium Survey

The Gallup International Association (GIA) Millennium Survey is one of the world's largest public opinion surveys ever made on world opinion. Approximately 50,000 people in 60 countries have been interviewed, representing a total global population of 1.25 billion.

The GIA Millennium Survey covers a wide range of topics such as democracy, environment, human rights, women's rights, religion, crime and "What matters most in life?".

Some of the answers are reproduced below:

Universal human rights?

In most countries around the world, strict observance of human rights seems to be causing substantial difficulties. This is disclosed by the survey. Even in the Western World, which traditionally sees itself as being the champion of human rights, observing the UN Universal Declaration of Human Rights seems to be a problem according to the citizens who live there. The GIA Millennium Survey also shows that in a global context, sexual discrimination is the most common form of discrimination. Generally, that part of the world where dissatisfaction with human rights is least pronounced is Western Europe. And yet, Western Europe should not rest on its laurels, because when looking at Western Europe as one unit, less than one out of three citizens believes that human rights are being fully observed.

Almost two out of three Western Europeans see human rights as being only partly observed. Nevertheless, the citizens of Western Europe are the ones who have the most positive view of their countries' willingness and ability to maintain the observation of human rights. In other parts of the world, the prospect is much bleaker. The severest problems with regard to human rights are found in Latin America. Here, less than one in ten (8%) of citizens believe that human rights are being fully observed. As many as one third (33%) claim that as a rule human rights are not being observed at all, and 56% believe that human rights are only being partially observed.

The country given the poorest testimonial by its citizens is also located in Latin America: in Colombia as many as two thirds (65%) believe that human rights are not being observed at all. Similarly, the citizens of West Africa and Eastern Europe display an extraordinarily low degree of confidence in the observation of human rights in general in their respective countries. The country which displays the highest general degree of satisfaction with the human rights' stand is the Netherlands. Here, practically nobody believes that human rights are not being observed, and as many as 70% of Dutch citizens are of the opinion that human rights in the Netherlands are being fully observed. Second to the Netherlands, we find countries like Luxembourg, Norway, Denmark, and Germany which are all situated at the positive end of the scale.

When interpreting the findings of this survey, which covers countries representing almost 1.5 billion adults around the world, it is important to keep in mind that the respondents in
all cases have been asked to evaluate the situation of their own country. In the (unfortunately substantial number) of countries where a large majority of the population express the opinion that human rights are an issue, however, the survey’s findings give rise to valid cause for concern.

Specific rights
The findings above are based on the survey’s general questions regarding human rights. However, the survey also probed into tangible rights mentioned in the UN Universal Declaration of Human Rights.

Table 1 shows which parts of the world are reported to be the best and the worst observers of human rights in general and torture in particular.

Peoples of the world find UN achievements unsatisfactory
Set up in the wake of World War II to act as a form of global coalition to protect world peace and defend human rights, the United Nations has been a focus of attention for many years and particularly in the last decade, which has witnessed active armed intervention in several countries. Additionally, the United Nations have also taken an active role in providing humanitarian relief to the world’s most needy citizens.

The GIA Millennium Survey asked people how satisfied they were with the achievements of the UN to date. The results are disappointing for the global institution, with less than half of those interviewed finding the results achieved to date by the United Nations satisfactory. Further, less than one in ten citizens (7%) claim UN results are very satisfactory and a similar proportion (9%) find the UN’s record very unsatisfactory.

Most important aims for the UN in the future will be to protect human rights
One of the first acts of the newly formed United Nations in 1948 was to adopt the Universal Declaration of Human Rights, and the survey shows that most people around the globe consider the most important task for the United Nations in the future to be to protect human rights (44%). One third believe that the most important objective in the future for the United Nations is the prevention of war by intervention (36%), and a similar proportion stress giving humanitarian aid in times of natural disasters (34%).

To protect human rights is considered particularly important in West Africa (63%), but is also given high priority in Western Europe (47%) and Latin America, but relatively less support in South East Asia (35%) and Eastern Europe (43%). To give humanitarian aid in times of natural disasters is, perhaps not surprisingly, highest priority in areas where such natural disasters occur — in Africa (53%) and in South East Asia (37%). Where these events are less likely to occur, i.e. in Western Europe and even in Eastern Europe, they are less popular as important objectives for the United Nations in the future.

To protect human rights is directly related to age: the younger you are the more important it seems to be. Among those under 25, almost half (48%) put this as the most important aim, compared with only 36% of those aged over 65. Again, the more highly educated, the more protecting human rights is seen as a key future objective of the United Nations.

What matters most in life?
The response that most frequently came back from almost every corner of the globe was: to have a happy family life and good health.

In most of the Latin American countries participating in the GIA Millennium Survey, living in a country without violence and corruption is ranked as no. 3 or 4. Other countries in which living without corruption and violence comes high on the list are Ghana, Taiwan, and Russia.

When looking at religion, Muslims are clearly those for whom being faithful to one’s religion counts the most — mentioned as one of the two most important things in life by 36% of Muslim respondents.

What matters least in life?
The most popular answers to what matters least (when you are forced to choose) are almost as consensual globally as was the high ranking of family and health. If we do have to choose something that matters less, we choose to give up on being faithful to one’s religion and to have a good standard of living. Actually, the population in 4 of the 60 countries mention being faithful to one’s religion as one of the two least important things in life (from a list including the following: faithful to religion, standard of living, an education, a job, no violence and corruption, no war, freedom, a happy family life, and finally: good health).

Although there are differences, we do agree on most values. There can be no question that the family is at the core of our common values. Having good health and a happy family life are the most sought after values almost everywhere in the world. Also, we want a job so we may provide for ourselves and those we love and then, very importantly, we want to live our lives in freedom, in a country where there is no war. If we are only convinced that we can achieve and sustain a happy family life in freedom, without being afraid of others threatening our family and freedom, the world has little reason to fear another escalation into war.

Table 1. Observation of human rights – part of the world.

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<thead>
<tr>
<th>Human rights in general</th>
<th>Worst part of the world</th>
<th>Best part of the world</th>
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<tr>
<td>Torture</td>
<td>Latin America</td>
<td>Western Europe</td>
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The full report is available on:
http://www.gallup-international.com/surveys1.htm
Instructions to authors

General remarks
The editorial board of TORTURE is grateful for small news items as well as articles dealing with aspects connected to torture, rehabilitation of torture victims, and the fight against torture.

Summary of requirements
We prefer articles, reviews, and other material to be word processed in a PC DOS/Windows format, for example Word Perfect or Word, and the text should be forwarded on a disc or by e-mail (only file attachments in Mime/Base64 format are acceptable) as well as in a printed copy.

Your manuscript should be prepared in correspondence with the uniform requirements for manuscripts submitted to biochemical journals. These requirements – the Vancouver system – are described in detail in Br Med J 1991; 302:338-41 or N Engl J Med 1991; 334: 424-8.

A good illustration (photo, drawing, or table) is always very welcome.

The manuscript should be accompanied by a covering letter with the name, address, telephone and/or fax number, as well as e-mail if available, of the corresponding author. The letter should give any additional information that may be helpful to the editor.

Details of address of the author/authors, qualifications such as MD or PhD, and full professorship are published as a footnote to papers, and this information should be provided on the title page of the manuscript.

The editorial board assumes that the material submitted for publication in TORTURE has not been presented anywhere else for consideration with a view to publication at the same time as an evaluation is being made by the board of TORTURE.

If the material has been published on a previous occasion, please state where and when.

The editors retain the customary right to style and, if necessary, shorten material accepted for publication.

If you want to make a review of a book dealing with aspects concerning torture, please remember to give details about the publisher, number of pages and the price, preferably in USD.

The review should in the shortest possible way give a personal evaluation of the book – a mere description of the contents and some quotations are not sufficient.

The review, which must be max ½ a TORTURE page long, equal to approx. 60 lines of 50 taps, should be given an appropriate title.

References
Should be numbered in the order in which they appear in the text.

ARTICLES IN JOURNAL
Standard journal article
(List all authors, but if the number exceeds six, give six followed by et al.).

FORTHCOMING CONFERENCES AND SEMINARS

Baltimore (Maryland), USA  
18-22 April 2001

Sixth World Congress on Stress, Trauma and Coping:  
“Crisis Intervention: Lessons Learned? Challenges for the Future”

Announcement

Further information:
International Critical Incident Stress Foundation, Inc.  
10176 Baltimore National Pike, Unit 201  
Ellicott City, MD 21042  
USA  
Phone: +1 410 750-9600  
Fax: +1 410 750-9601  
E-mail: scohen@icisf.org  
http://www.icisf.org

Montreal, Canada  
1-6 July 2001

26th International Congress on Law & Mental Health: Mental Health Crisis and Social Change

Pre-Conference: “Fundamental Options in Health Care”

During the Plenary Day on 3 July 2001, leading scholars will actively engage in dialogue on family crisis, law, mental health and society. In the parallel sessions on 4, 5, and 6 July a wide range of multidisciplinary topics in the field of Law and Mental Health will be dealt with.

Further information:
International Academy of Law and Mental Health  
c/o Chaire de psychiatrie legale et d’ethique biomedicale  
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The Editorial Board of TORTURE is pleased to receive conference announcements, calls for papers, and other related information of interest to the readers of the journal.

The Editorial Board also receives short reports about conferences already held.  
These may be published in the section “Conference reports”.

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

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

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

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