Examining Torture Survivors
Danish Medical Group, Amnesty International

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Examining Torture Survivors

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Examining Torture Survivors

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This book contains a collection of re-edited articles and guidelines. Originally, they were presented as lectures at a seminar held by the Danish Medical Group of Amnesty International in September 1987. The main part of the authors are members of the Danish Medical Group.

This collection of articles and guidelines is an attempt to illustrate a number of aspects of the medical examination of torture victims. It also touches on our experiences concerning the initial procedures of the examination, and on the later processing of the material.

The empirical material which is described stems from the examinations performed by the Danish Medical Group throughout the last 15 years. Our experience shows that examinations of torture victims can be divided into three types:

a. Victims referred to or sought up by the Danish Medical Group as part of the exposure to torture of a group with the same nationality or of a number of individuals from a well-defined geographic area who have been examined successively.

b. Individuals who approach the Medical Group with a wish to give a report and to be examined following torture subjection.

c. Refugees who as a part of their application for asylum and in concert with the Danish authorities are referred to the Medical Group in order to have an examination of subjected torture included in the overall argumentation for the obtaining of asylum.

As already mentioned, the material which forms the basis of this collection of articles stems from a systematic registration of information obtained at examinations of torture victims. In principle, the working methods of the Danish Medical Group are the same as those applied in other medical tasks and clinical work. However, they offer a number of difficulties, partly of a technical character and partly in relation to attitude.

For obvious reasons it is difficult to obtain documentation of the immediate, clinical picture of the torture. However, in cases of liberation or escape it is sometimes possible to obtain knowledge of the acute, external signs of torture.

Thus, the examinations are mainly based on retrospective information. This means that the torture subjection of those examined may well and often have taken place up to several years earlier. At the time of the examination changes are demonstrated and information is procured which can be pieced together as components of a pattern of malfunction which can often be directly derived from the torture.

The torturers use a technique which gives as few visible sequelae as possible in order to be able to deny the carrying out of torture. Furthermore, the authorities often argue that the victims lie or exaggerate, that it is probably just an isolated case, or that, reluctantly, a single police officer or warder has forgotten himself.

Seen on this background, it is essential that medical examinations of groups of torture victims and not only of isolated cases have been performed, and that the method of examination is systematic and uniform, and, furthermore, that the examiners are familiar with the method, and that it has been sufficiently tested. In practice, this is done by using a protocol which contains detailed, anamnestic sets of information which take account of previous state of health, medical treatments and hospital admittances, if any, circumstances in connection with the torture, particularly in relation to its carrying out and duration, prison conditions and duration of imprisonment.

At the examination symptoms and signs should be carefully looked for. The examination should in particular be oriented towards neurological findings. At all examinations performed by the Danish Medical Group two doctors have always been present, sometimes also a dentist.

However, the difficulties which lie in not being able to perform immediate examinations are not the only difficulties encountered. An examination at a later time can also cause problems, e.g. language barriers and/or the presence of an interpreter, problems of understanding, and insufficient background knowledge of another culture.

Finally, circumstances such as expatriation and the fact that an emotional trauma may be at a distance may have caused other variables to occur. This may cause a psychological processing, or a development derived from the primary symptoms may have occurred. Finally, time-related, intercurrent diseases may be present.

In the processing of collected, clinical material it is therefore necessary to be aware of such veiling causes in recent components of symptoms towards the immediate symptoms and signs of the torture period.

It is some of these problems and special conditions in relation to the examination of torture victims which this collection of articles and guidelines attempts to illustrate.

Henrik Marcussen, 1991
CONTENTS

PREFACE............................................................................................................. 3

ADMINISTRATIVE CONCEPTS
Pre-Asylum Procedures and the Medical Report as “Evidence”, with special Reference to Denmark
by Jakob Gammelgaard .............................................................................. 5
Organizing and Planning a Mission
by Jørgen Kelstrup ..................................................................................... 8
The Forensic Mission
by Jørgen Laie Thomsen ............................................................................. 10
Medical Ethical Standards for Prison Conditions, Missions, and Refugee Work
by Karin Helweg-Larsen ............................................................................. 12

PLANNING AND PRACTICAL MATTERS
Interviewing Technique and Writing a Report
by Ole Vedel Rasmussen ............................................................................ 14
Draft for Torture Report ............................................................................ 16
The Ethics and Techniques of Interpreting
by Vibeke Pentz-Møller ............................................................................. 17
How to Present Lectures on the Work of the Medical Group
by Frede Bro-Rasmussen ............................................................................ 20

THE TORTURE VICTIM
Psychiatric Examination of Torture Victims
by Marianne Kastrup .................................................................................. 22
The Neurological Evaluation of Torture Victims
by Marianne Juhler .................................................................................... 25
Skin Changes after Torture
by Lis Danielsen .......................................................................................... 27
The Rheumatological Examination of Torture Victims
by Bente Danneskiold-Samsøe and Grethe Skyllv ........................................ 33
Gynaecological Sequelae of Torture
by Aase Rubbe ............................................................................................. 36
Odontological Treatment of Torture Victims
by Peter Jerlang ............................................................................................ 38
Traumatology and Different Types of Physical Torture
by Ole Vedel Rasmussen ............................................................................ 41
The Torture Victim. Deficiencies and Stress
by Henrik Marcussen .................................................................................. 43
Psychosomatic Disorders in Torture Victims
by Henrik Marcussen .................................................................................. 45

THE WRITING OF REPORTS WITH A VIEW TO ASYLUM APPLICATION
The Writing of Medical Reports with Special Reference to the Legal Evaluation
by Hans Petter Hougen .............................................................................. 47
Medical Reports in Asylum Cases
by Poul Søgaard .......................................................................................... 49

PLANNING OF STUDIES OF TORTURE VICTIMS
The Controlled Study of Torture Victims
by Hans Draminsky Petersen ...................................................................... 51

TREATMENT OF TORTURE VICTIMS
Rehabilitation of Torture Victims: Principles for Treatment and Follow-up Research
by Inge Genefke, Inge Lunde, Jørgen Ortmann and Bent Sørensen ................. 57

LIST OF AUTHORS ......................................................................................... 60

TORTURE Supplementum No. 1, 1992
Pre-Asylum Procedures
The Medical Report as “Evidence”, with special Reference to Denmark

By Jakob Gammelgaard

Survey
Pre-Asylum procedures will differ according to the class of asylum seekers involved. So far, spontaneous refugees, who arrive at the Danish border and seek asylum there, have constituted the largest class. Persons arriving in Denmark as refugees, for instance under an agreement made with the UNHCR, constitute another class. Characteristic of this class of refugees is that their need for protection has already been determined before entry. The third class of asylum seekers emerged in connection with the revision of the Danish Aliens Act in 1986. This act introduced a new provision which stipulated that persons not being able to obtain entry for lack of visa, may apply for asylum to a Danish diplomatic representation in their country of residence. The Pre-Asylum phase for persons residing in a third country is often very difficult. There are many such applications, and the period during which the application is being considered in Denmark is often as long as in the case of spontaneous refugees.

In this article I shall confine myself to dealing with the asylum procedure and assessment of evidence relating to spontaneous refugees.

Description of the Danish refugee administration
The most important authorities involved in the asylum procedure are the Central Police Unit, the Directorate for Aliens, the Refugee Appeals Board, the Danish Refugee Council and the Danish Red Cross.

The Aliens Authorities (The Central Police Unit) are responsible for the reception, registration, interrogation and return of asylum seekers. The unit cannot make any decision in relation to the asylum application and, as such, it acts as dispatch office in relation to the Directorate for Aliens. Furthermore, the police will, at the request of the Directorate for Aliens, carry out interrogations as a basis for the consideration of asylum applications.

The Directorate for Aliens is a civil authority under the Ministry of Justice. It is the authority responsible in all questions pertaining to the stay of foreigners in Denmark, including refugees. The Directorate makes the first decision in refugee cases, and a refusal can normally be brought before the Refugee Appeals Board. The asylum seeker is required to assist in throwing light on his case, for instance by accepting interrogation or by providing evidence. However, it is the duty of the Directorate to procure the necessary background information and to ensure that all data necessary for making a decision have been procured.

The Refugee Appeals Board is a court-like body, which makes the second and final decision in refugee cases. The Board has 42 members, and the chairman and vice-chairmen shall be judges. Decisions are made in the Full Board, consisting of 7 persons, or in a number of "Small Boards", consisting of three persons. Usually, proceedings in the individual cases are oral, and the asylum seeker is given the opportunity of presenting his case. As already stated, the Board's decision is final, i.e. it cannot be appealed to a higher authority. If the asylum seeker receives a final refusal, he has the right to remain in the country until he receives a written notification of the Board's decision. He must then leave the country at once.

The Danish Refugee Council is a private umbrella organization. Its most important duty is to administer public resources allocated to the Council's integration programme for persons granted refugee status.

The Danish Red Cross is not a decision-making authority in the asylum procedure, but has made an agreement with the Directorate for Aliens and the Ministry of Justice concerning the running of refugee centres and various other social tasks relating to spontaneous refugees while staying in Denmark.

Finally, the parliamentary ombudsman has in many cases treated complaints from asylum seekers concerning the Refugee Appeals Board's treatment of their case.

Assessment of evidence in refugee cases
Decisions in refugee cases made by the Directorate for Aliens and the Refugee Appeals Board are legal decisions and are as such bound by the limits defined by law and subject to certain general rules concerning case insight and competence. Certain pieces of evidence will naturally carry more weight than others. Testimony under oath carries more weight than mere statements, and certain sources, for instance medical or police reports, will be assigned greater importance than others because of their established or institutional credibility.

Establishing the underlying causes for an asylum application can prove extremely difficult. A person trained in the assessment of asylum applications and with a profound knowledge of the country of origin or with experience from a large number of similar cases may not find it difficult to make an exact judgment in the individual cases, but there will always be borderline cases in which this is difficult.
On the assumption that it will often be difficult to decide which circumstances should be made the basis of the case, it is obvious that the assessment of evidence becomes somewhat irrelevant. In the absence of appropriate evidence the Refugee Appeals Board will therefore have to fall back on considerations of the asylum seeker's credibility. An assessment of credibility will furthermore depend on the asylum seeker's supplementary explanations and statements from third parties, and subjective considerations may be hard to avoid.

Assessment of credibility is of decisive importance in refugee cases. The assessment is based on the consistency and coherence of the asylum seeker's testimony and the consistency of the testimony with general knowledge about conditions in the country of origin. Invariably, the eloquence of the asylum seeker, his personal appearance, cultural background, etc. are important subjective factors, too.

Apart from the assessment of credibility a decision whether to grant asylum or not will also be based on an assessment of whether the asylum seeker on return to his home country will risk persecution to an extent allowing him to be recognized as having a need for protection according to the asylum law.

**Medical reports as evidence**

It is in the light of the Refugee Appeals Board's normal procedure in connection with the assessment of evidence that medical reports on alleged torture can be seen as "evidence". The medical report is of course only evidence in the sense that it is an evidence of torture; however, there are certain factors which make a medical report exceptional when asylum cases are considered.

Before I discuss these factors, it may be useful to have a brief look at the importance of torture in the consideration of asylum applications.

The Convention on the Status of Refugees does not state torture as a ground for asylum. It only deals with persecution in general. However, there is no doubt that torture is one of the strongest indications of individual and concrete persecution which is the main condition for obtaining asylum. The delimitation of the concept of torture can be of certain importance. To the extent that they can offer an indication of whether injury was deliberately induced or formed part of an arbitrary action, other factors concerning the torture subjection, such as its severity, are also important. The authority carrying out the torture also plays a part, for instance whether it is a governmental body, the extent of its powers to impose punishment and the extent to which it will use its powers. If the authority in question is a non-governmental body, an assessment will be made of the extent to which the state will be able to offer protection against further abuse. These considerations all form part of an assessment of the intention of governments to persecute (or protect) the person in question.

A medical report on torture assists in substantiating an often unconfirmed explanation and, as such, it is part of the attempt to map out the facts of the case. That torture has taken place only plays an indirect role when considering the right to asylum. What is to be decided is whether it is likely that the applicant in question will be persecuted (e.g. tortured) again if he returns to his home country.

As mentioned earlier, a medical report often plays a prominent part among the other "pieces of evidence" in an asylum case because it gives an objective and impartial presentation of an explanation which can only seldom be verified in another way.

Apart from offering a substantiation of a statement of torture, a medical report can be included in the assessment of credibility in other ways, too. In most cases - except when new explanations are given - the applicant will, at an early stage, have made a statement on detentions, torture and imprisonment to the police or private citizens. The information given in the medical report will therefore be compared with earlier explanations with a view to assessing consistency - whether the applicant has altered or elaborated on his earlier explanation, or whether there are any contradictions and why. Moreover, the applicant will usually be questioned again when his case is heard before the Appeals Board. Dependent on the individual case, aspects from the anamnestic part of the medical report will be made the subject of questioning and credibility assessment.

**Impartial experts or pressure group**

The asylum worker or the member of the Refugee Appeals Board who receive a medical report will read it carefully, expecting it to clarify the circumstances of the case, or at least establish the risk of persecution on which a lawyer will be able to build his case. "Weak" conclusions in the report will be detected and may be turned against the asylum seeker, while others will argue that previous torture subjection of the applicant cannot be precluded. Many "thin" cases have been won on account of the medical report because the Board was afraid to disregard the contents and conclusions of the report. In other, more obvious cases, the medical report will form part of a number of documents all pointing in the same direction. The medical report will not be decisive of the outcome of these cases. Conversely, there will be cases in which the medical report cannot be used as evidence, either because the explanation rendered in the report is conclusively contradicted by other explanations in the case, or because the torture described, when seen from an overall assessment of the case, is not of such a character that it can establish a risk of persecution soliciting protection. This may be the case, for instance if the torture incident took place several years ago, and the applicant has been able to remain openly in his country in the intervening years, has been regularly employed, participated in meetings, has been able to leave and return to the country or other instances indicating that the authorities have shown no particular interest in his doings and whereabouts. In such cases the medical report is an objective presentation of an incidence of persecution in the applicant's life. It will form part of the facts of the case, but will be dismissed as having no present relevance for the consideration of the asylum application. The objectivity of the report is unchallenged. However, if, in a situation like this, the report argues that the examinee needs protection, and if this finding is based on torture subjection, at best it will be received as an insufficiently substantiated argumentation which bases its presentation on conditions forming part of the facts of the case, but leaving out circumstances of relevance to the consideration asylum application. Apart from this somewhat complex example there is usually a vast area in which medical findings clash with legal discretion.

In Danish administrative practice it is seldom seen that interest groups act directly as spokesmen of individual persons in relation to the authorities. Rather, this is
done by associations of private persons or organizations looking after more general interests, for instance social, financial, or political interests. The pressure which these groups can exert is therefore to point out certain considerations which the authorities should include in the decision procedures. In this connection it would therefore be more natural to link professional expertise with the conduct of special interests.

The boundary between acting as experts and acting as a pressure group is sharp, and requirements for professionalism equally high, not least in politically sensitive areas such as refugee cases. The medical establishment of torture subjection and the assessment of need for protection are two qualitatively different assessments. A legal assessment of the need for protection which is primarily built on a medical assessment of an individual’s physical and mental condition as a result of an established torture subjection would be poorly applied jurisprudence. Likewise, a medical assessment of torture which is primarily built on a legal presentation of rules of law concerning the protection of individuals against encroachment on personal rights would be poorly applied medical science.
Organizing and Planning a Mission

By Jørgen Kelstrup

Objectives
AI medical groups have experience from many missions to a number of countries, including Greece, Spain, Chile and other South American countries, the Middle East, and Northern Ireland.

There are different types of missions, and it is essential to know from the start which type is under discussion:

a. Missions including a medical delegate. The objective may be discussions with local doctors and officials, and evaluation of medical material. In principle, detailed examinations of victims should not be undertaken.

b. Mixed missions. As above, but including detailed examinations for part of the time. At least two doctors should participate, preferably from different medical specialities. They should come from the same country to facilitate the preparation of reports.

c. Purely medical missions, the purpose being detailed examinations. Always two medical delegates.

d. Specific medical missions, for instance forensic missions (see Jørgen Lange Thomsen's article on this subject, p. 10).

Contact with the researcher/research department
Some researchers have had prior experience of missions with a medical component, while others have had none. It is safest to assume that a given researcher has only little experience of such missions, and may therefore know very little about doctors' working methods and in particular about what a doctor can contribute to a mission. Working with a researcher may therefore include an educational element. At the same time it is essential to be aware of the fact that the researcher is a full-time employee and official. If the researcher participates in the mission, he will usually be responsible for contact with the IS. It is important to remember that there is always one IEC member who is politically responsible for a given mission, and that it may be of great help to contact this member.

Fields of activity
The various fields of activity should be clearly defined before departure, usually during the initial talks about the mission, followed by final agreement in connection with the briefing (see below). Apart from a researcher and doctor(s), a mission may include a lawyer or an interpreter. The function of each delegate should be clearly defined from the outset, so that time is not wasted during a mission discussing each delegate's expectations as to his or her functions. However, unexpected situations may easily arise during a mission, necessitating a different assignment of tasks.

Time schedule
A golden rule is that the preparation of the report will take four times as long as the actual mission. Before consenting to going on a mission, one must therefore be prepared to undertake considerable work after the completion of an often very stressful mission. Writing the report can be exhausting, physically and mentally.

Briefing
Amnesty's international secretariat (IS) is in London. It is divided into several departments, e.g. Research, Press and Publications, Documentation, Campaign and Membership (including Medical Office), the Legal Office and the Secretary-General's Office.

Briefing prior to a mission almost always takes place at the IS in London. It is a very important element in the preparation of a mission, and it is vital to make the most of the opportunity by asking all the relevant questions. It will probably always prove advantageous to be in contact with the Medical Office.

Language and selection of interpreter
The examinee may talk slang or speak a dialect which it may be impossible to interpret correctly unless the language is totally mastered. Although working with an interpreter is time-consuming and onerous, and although problems of finding an impartial interpreter may occur, it is extremely important that no detailed examinations are performed without an interpreter unless one really masters the language in question.

Presence of other people
With detailed examinations, only the doctors and possibly an interpreter should be present. On the few occasions when the researcher or other delegates have been present, problems have occurred, because laymen and medical doctors often interpret statements differently. The presence of a friend or family member should also be discouraged during the detailed examination, since it may inhibit the examinee's willingness to speak. Other delegates will often be present at non-detailed examinations or talks with local doctors or authorities.

Letter of accreditation
Delegates participating in an official Amnesty mission will receive a letter, often signed by the Secretary General of Amnesty, confirming their status as delegates. In this connection it should be mentioned that it is the principle of AI always to let a given government know that a mission is being sent to its country. In principle, secret missions do not exist.
Insurance
For Scandinavians the yellow Sickness Insurance Certificate applies only to tourist journeys in Europe and the Mediterranean countries. This certificate therefore would never cover participation in missions. For other journeys within the EEC, a form (Form E 111) that secures the provision of free treatment, also to non-tourists, is available from the local social security office. In all other cases no public insurance is provided. As a rule AI will take out an insurance on behalf of the mission delegates. A sensible thing to do, however, would be to find out what the terms of the insurance are, also with a view to discovering whether insurance against death and disablement is included in the policy taken out. Delegates should also make sure that their personal insurance policies are valid even in countries with a lot of unrest. A certificate stating in English that the delegate is a medical doctor should also be obtained (available from the National Board of Health).

Local contacts
The contact with local authorities, etc. will often be handled by the researcher. It is essential to realize that there may be political/religious differences between the local contacts and the individuals to be examined.

Publication
A regular mission report will be published by the IS, in some cases forming part of a report relating to a particular country. The IS is responsible for the editing, and this may cause problems in relation to the material and terminology to which medical delegates assign importance. Here it is important that the medical delegate can answer for his/her section of the report. Should the IS not want to publish a given material, it may be published by the local national section, subject to the approval of the section and the IS. Unless both parties give their approval, the material cannot come out as an Amnesty International publication.

Special problems
I am thinking particularly of problems with taking photos. The available camera may be able to take excellent pictures, but if it is a bit old the results depend very much on the person using it. It is advisable to get thorough instructions to be sure of bringing back usable pictures. It should, of course, be decided in advance whether to have slides or prints made from the film.

Visa
A visa is required for entering certain countries, and relevant information can be obtained from the local embassy. Please observe that delegates may have different passports and that, consequently, different visa requirements may apply. The choice of itinerary may also influence visa requirements.

Financing and foreign currency.
The IS will usually provide foreign currency, but expenses have later to be accounted for and receipts provided. However, the delegates may provide their own foreign currency by means of traveller’s cheques or credit cards. The extension of credit cards varies from one country to the other, and in Europe postal cheques or Eurocheques work admirably.

References
1. Rules to be observed by all persons charged with attending trials or carrying out other missions on behalf of Amnesty International. IEC, January 1976.
2. Mission procedures and controls. ACT 01/02/77
4. 1979 ICM Referred Resolution 18: AI Missions. ORG 52/01/80.
Introduction
The following is an account of some of the tasks which a forensic scientist may be sent out to perform, including the legal basis of such missions. By way of introduction it should be noted that the organisation, objectives, and guidelines of forensic missions do not differ from other AI missions with a medical component.

What can be expected of a forensic scientist?
People have different conceptions of the work of a forensic scientist. These conceptions come from TV programmes, novels, private experiences (deaths in the family, etc.) and only in the rarest cases from actual knowledge of our various fields of activity. However, everybody seems to know that the forensic scientist is a “documentarian”. He deals with facts and attempts to document causalities.

Objectivity, and independence of religious, ethnic, political and other affiliations constitute another set of common forensic features. These fully comply with the guidelines for working within AI.

There are different branches of forensic medicine, and each can provide a specific task in relation to missions: forensic pathology, forensic psychiatry, genetics, toxicology, odontology, forensic anthropology, etc.

Forensic activities
Typically, the forensic pathologist is used to investigate deaths, for instance in prison, when allegations of abuse in the form of torture and/or extrajudicial executions have been raised against the authorities (1). Most forensic pathologists will also be trained to investigate the sequelae of physical violence in the living and can therefore be useful in cases concerning living torture victims.

The forensic psychiatrist will be able to assess and evaluate the sequelae of psychological torture (see below).

The forensic geneticist may substantiate or render probable the kinship between abducted children and their parents or grandparents, as for example has been done in Argentina.

The forensic toxicologist will be able to detect results of pharmacological torture (e.g. forced administration of psychotropic drugs), the forensic odontologist can detect sequelae of violence to the teeth, and together with the forensic anthropologist he can be used for purposes of identification (victims in mass graves, etc.).

The legal basis for forensic missions
It has not yet been definitively established to whom a dead body belongs. However, there is some precedent that the family has right to the body, and this is probably common belief. Before going abroad to investigate the death of a person, it is essential to find out which declarations and conventions are recognized by the country in question. The laws of the country should also be studied. Most countries have signed one or more declarations, for instance those dealing with human rights under the auspices of the United Nations, and it can be useful to refer to this. The legislation of most countries provides that the authorities shall conduct thorough investigations into any suspicious deaths, including deaths of people in custody, and these laws may also be useful in this connection.

As a foreigner it may be difficult to obtain permission to investigate deaths. In most cases this will require a request or permission from the relatives or the authorities, and as a rule AI will seek the formal consent of the authorities before sending a delegate to a particular country. The authorities often have something to hide, but they would hesitate to refuse a request from AI since this may injure their reputation.

However, the authorities who have something to hide may try to obstruct the work of the forensic expert. They may give permission for a partial autopsy, e.g. to involve only certain parts of the body, and no samples to be taken, etc. In this connection it is of great importance that a group of lawyers and forensic pathologists from Minnesota have elaborated a “Model Autopsy Report” (2). This report describes in great detail the prerequisites for an adequate forensic autopsy, and it could deal with reluctant authorities who attempt to limit the extent of an examination. The report is still under debate, but it is to be hoped that it will receive international recognition, for example through the UN.

In many cases the task of the visiting forensic scientist will not be to perform the actual work, but to attend and make observations, for instance at autopsies performed by local doctors. This is what AI would usually prefer, but it is important to realize that many countries will have only few or no forensic scientists, and it can be embarrassing, if not dangerous, for a local doctor to work in connection with a case in which the authorities are suspected of abuse.

Examples of forensic missions
The following is a description of examples of forensic missions, not all of which have taken place under the auspices of AI.

At the beginning of the 1980s AI became aware of forensic scientists as a professional group. The first real mission was the visit by an American forensic pathologist to El Salvador in 1983. Until 1983 approx. 40,000 extrajudicial executions had occurred in connection with...
the civil war. Many of the killings were committed by paramilitary “death squads”, who wanted to scare the population, and the corpses would often be dumped in public places. It was extremely easy for the American forensic pathologist to see that the forensic facilities and procedures which are necessary in a civilized society did not exist at all. No interest was shown in the recording of causes of death, autopsies were rare, as were efforts to find the killers. Only when pressure was brought from abroad, for instance when Americans were killed, did the authorities make weak attempts to resolve the killings. The AI report (3) gave an excellent illustration of the very basic shortcomings which in this case formed part of the basis for gross human rights violations.

A mission with a Danish forensic delegate was sent to Togo in West Africa in 1985. A high-ranking officer had died while under house arrest, and murder was suspected. The officer was considered a potential rival of the almost autocratic President. The forensic scientist was to be present at the autopsy, and, since it was possibly a case of poisoning, he had brought equipment to take samples for later toxicological testing in Denmark. Immediately on arrival in Togo, the AI delegation was summoned to a meeting with the President, who announced that the deceased’s family had objected to an autopsy. Presumably convinced that he would receive a positive reply, the President asked the forensic scientist if the wishes of the family were not paramount in deciding for or against an autopsy in Denmark also. He was subsequently informed that, if a crime was suspected, a court order permitting an autopsy would be applied for. It was later discovered that Togolese law makes similar provisions (4). The AI delegation was then introduced to the deceased’s relatives and was encouraged to try to convince them of the desirability of an autopsy. This was probably a manoeuvre designed to place AI in an unfavourable light: “AI puts pressure on the bereaved”, etc., and no attempts to do so were made. Another argument in favour of refraining from persuasion was that according to the terms of reference of the mission the delegates were sent as observers and were not expected to play an active role in any activities.

These decisions were endorsed by the regular and mandatory calls to AI in London.

A group of forensic scientists went to the Philippines in December 1986. Since the transfer of power, the new government has wanted to train local forensic scientists. The group mainly gave lectures on traumatology. One of the members was a forensic anthropologist, and his teaching included the exhumation of unidentified victims of extrajudicial executions, buried in anonymous graves along highways, etc. Furthermore, two members of the group attended a local doctor’s autopsy of a man who had been shot dead by the military. It was a very crude examination, which confirmed the need for a strengthening of forensic medicine in the Philippines.

In a wider sense, participation in national and international meetings also forms part of forensic missions. It is important to inform the international medical community about the human rights issue. This issue is increasingly discussed at forensic meetings, and my impression is that forensic scientists throughout the world have become increasingly aware of it in recent years.

References
Medical Ethical Standards
Prison Conditions, Missions, and Refugee Work

By Karin Helweg-Larsen

Prison conditions
The common standards for the treatment of detainees and prisoners are universal principles of human rights. The Universal Declaration of Human Rights was adopted by the UN in 1948. The fundamental idea of the Declaration is that all human beings are born free and equal in dignity and rights; that everyone has the right to life, liberty and security of person, to equality before the law without discrimination, to a fair and public trial, to be presumed innocent until proved guilty, to freedom of movement, to freedom of thought, conscience and religion, to freedom of opinion and expression, to form and to join unions, organizations, and associations. Unlike the UN Declaration of Human Rights, the 1950 Council of Europe Convention on Human Rights and Fundamental Freedoms (ECHR) has been ratified, i.e. the countries which have ratified the Convention are legally bound by it.

The declarations on human rights include the provision that everyone has the right to be presumed innocent until proved guilty. However, in most countries opposite considerations are involved, on the one hand the legal rights of the individual, on the other hand society's interest in enforcing the law, securing that the offence is cleared up, if possible. This seems to necessitate granting certain powers to the legal system, including the police and the courts. These powers may include infringement of the rights of individuals who are innocent in principle if it takes place in a situation in which the case has not yet been tried, guilt has not been proved and sentence not passed.

Solitary confinement during custody, during which the prisoner is wholly or partly excluded from the company of others in the interest of the clearing up and the adjudication of the offence with which the prisoner in custody is charged, may be in contravention of the European Convention on Human Rights. Article 3 states that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. It seems that prolonged solitary confinement during custody may result in severe mental problems of the kind which is seen in connection with the acute mental stress syndrome - i.e. reduced concentration, depression, and loss of identity. Hence, solitary confinement during custody causes problems for the medical officer attached to a prison institution.

Principles of human rights in connection with solitary confinement during custody are especially important for doctors working within the prison system. Studies have shown that 60% of all confessions made during custody were made in order to escape solitary confinement, and in ¼ of the cases the confession was later withdrawn. My reason for emphasising solitary confinement during custody in this outline of medical ethical standards for prison conditions is that, in Denmark, it probably constitutes the most urgent problem in connection with prisoners and human rights.

In 1955 the UN adopted the Standard Minimum Rules for the Treatment of Prisoners. They were followed by the Council of Europe's Standard Minimum Rules for Prisoners. Articles 22 to 26 deal with the duties of the medical officer. At least one qualified medical officer who should have some knowledge of psychiatry shall be attached to every prison. Sick prisoners shall be offered specialist treatment, and they shall have the opportunity of being transferred to civil hospitals, if necessary. The services of a qualified dental officer shall be available to every prisoner. If a female prisoner is pregnant, pre-natal and post-natal medical counselling shall be offered, and arrangements shall be made wherever practicable for the child to be born in a hospital outside the prison. The medical officer shall see and examine every prisoner as soon as possible after his admission with a view to treatment or special care, if necessary. The medical officer shall daily see all sick prisoners and all prisoners at risk of being sick (probably including prisoners held in solitary confinement). The medical officer shall report to the prison director any unfavourable health conditions and advise him upon the food, hygiene, sanitation, the prisoners’ immediate surroundings and opportunity for physical activities.

Thus, the medical officer attached to a prison institution has many duties. My own experience from Danish prison institutions in the provinces tells me that medical ethical standards are not always fully complied with. E.g. the medical officer’s duty to advise the prison administration is not always carried out in practice. In many Danish prison institutions there is inadequate access to physical activities, and the immediate surroundings are not suitable. It is known from the Red Cross and Amnesty International, among others, that prison conditions in numerous countries are far below the standards which satisfy human rights conventions and the UN Standard Minimum Rules for the Treatment of Prisoners. It is also known that either there are no medical officers in these prisons or the medical officers are not
granted - or do not exploit - the opportunity of objecting against inhuman prison conditions.

In June 1987 the *UN Declaration on the Protection of all Persons from Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* was ratified. This makes it legally binding for the countries which have ratified it. This means that it is possible to take legal proceedings against foreign individuals staying in a country which has ratified the convention, and that these countries can proceed against individuals or systems which violate the convention, including violations in connection with the treatment of prisoners.

**Standards concerning missions**
The relationship between doctor and patient is based on respect for the individual, as first set out in the *Hippocratic Oath*. In 1948 the World Medical Association (WMA) adopted the Declaration of Geneva in which the following fundamental principle is expressed: “I will maintain the utmost respect for human life from its beginning even under threat and I will not use my medical knowledge contrary to the laws of humanity”.

When performing mission work abroad, e.g. when examining torture victims, re-evaluating autopsies, studying prison conditions, a doctor may find himself in a situation in which he is confronted with a colleague’s violation of the WMA Declaration or in which he finds that a medical examination (e.g. a medico-legal autopsy) has not sought/managed to uncover questions concerning a possible violation of human rights. He then finds himself in a foreign country in a situation in which he, supported by the WMA Declaration, feels morally obliged to criticize a colleague. In many countries medical ethical standard rules apply which state that a member of the medical profession must not undertake practices which conflict with common medical ethics or which in any other way may weaken the population's confidence in doctors and their work. However, concerning inter-collegiate relations it is stated that doubt as to a doctor’s treatment and qualifications may create a feeling of insecurity in the patients, and therefore a member should not put forward uncalled-for criticism of medical practices performed by another doctor. In general, such medical ethical standard rules should be seen in terms of professional protection, meaning that it is probably up to the individual doctor participating in a mission abroad to determine at which level and how he can make a public statement about medical standards in the mission country.

**Standards concerning refugee work**
The standards which must apply to refugee work are the same as the above-mentioned, viz. The WMA Declaration of Geneva together with the World Psychiatric Association’s Declaration of Hawaii on the abuse of psychiatry and the WMA Declaration of Tokyo.

The fundamental principle for doctors must be to react against human rights violations and to contribute to an optimal professional standard, in this context especially in connection with refugees who during the pre-asylum phase seem to enjoy considerably less legal protection than the citizens of the country in question.

**References**
Interviewing Technique and Writing a Report

By Ole Vedel Rasmussen

The interviewing and examination of a torture victim by the method used in Denmark may take as long as 7 hours in difficult cases. The procedure makes heavy demands on the examiners and the interpreter and, not least, on the examinee, who often develops a headache or has to go out for a breath of fresh air during the examination. It is my belief that the surroundings in which the examination takes place are very important, and perhaps the medical group has not paid enough attention to this aspect. Higher priority should be given in our examinations to being seated comfortably in bright and pleasant surroundings, contrasting with the horrible torture situation which the victim is re-living. It is also important to provide coffee or tea, fruit or biscuits. Hence, it is recommended that the examiners arrive at the place of examination before the interpreter and the torture victim to make the necessary arrangements, and to consider where and how those present at the examination should sit, since this is also a matter of great importance. I believe that the best contact with the victim is achieved if the interviewer faces him. The interpreter should be seated to the right, i.e. between the victim and the interviewer, and the other doctor opposite the interpreter, also between the victim and the interviewer. This makes it possible - provided the interpreter is competent - to maintain eye contact with the victim during the interview, and the interpreter will then act as a bridge between the victim and the interviewer.

At the beginning of the interview, after a cup of coffee, the examiners should try to develop a relaxed atmosphere and inspire mutual trust. A torture victim will, naturally, be nervous about what is going to happen, and because of the presence of two doctors and a third person who are going to hear about everything he has endured. It is important for the examiners to take time in introducing both themselves and Amnesty International, and that the interpreter is given time to introduce himself. The examiners should also inform the examinee as to what prior knowledge they have of his case, and what relevant material they have in their possession. He should also be told that if questions are asked which he does not want to answer, he is completely free to refuse. Finally, it should be made clear that the report will only be forwarded to the person at whose request the examination is being made. Provided that the examination is being undertaken in connection with an asylum application, the identity of the torture victim should be established at the beginning of the interview. The examinee should be offered anonymity if the examination is not undertaken with a view to obtaining asylum, as for instance if it was part of a mission in a foreign country or if it was of interest, for example to Amnesty International, in obtaining documentation on torture in a given country. Anonymity in these cases should entail not only omitting the victim's name, but also distorting the truth as to time of arrest, age, profession, etc.

Who should be present at the examination?

I have so far assumed that two doctors and an interpreter were present, together with the victim. This is ideal. The presence of friends or relatives of the examinee, whether compatriots or maybe Danish friends, should be discouraged, since it is often detrimental to the examination. If a researcher from the International Secretariat in London is part of a mission, my experience is that he should not be present throughout the entire interview, but that he should leave after the questions about the arrest, charge, and torture, i.e. before the more purely medical aspects of the case are discussed.

It is important to select an interpreter whom the examinee can trust, but on the other hand they should not be too intimately connected, i.e. the interpreter should not be a relative or close friend, such as a friend from a resistance group. In my experience, the best results are obtained when the interpreter has medical knowledge of some kind.

Where should the examination take place?

I have already mentioned the importance of a bright and pleasant examination room. To choose a neutral place is also important, and the best would be the Amnesty office. It is an advantage to have easy access to a telephone, for instance to tell relevant people that an examination was lasting longer than expected. Missions abroad create a security problem and it would be best if the examination was performed at a place where many people come and go, since this would make it more difficult to observe and identify the persons being examined. I have only little experience of examinations in prisons, but in such cases it is imperative to insist on being left alone with the prisoner.

The interview

The two examining doctors should divide the work between them so that one is responsible for the interviewing, the other for taking notes. The latter should also be responsible for the writing of the report. He should interrupt the interviewer as little as possible. This could be done by saving supplementary questions till later in the examination. The reporter should help to ensure that all relevant aspects are covered.
The interview should start with questions about the victim's health prior to the arrest, previous hospitalizations, if any, and any relevant traumas. By starting with these questions the interview will take on a medical character which may contribute to increased confidence.

After noting this information, together with an outline of arrests and periods in prison, questions should be put about the victim's education, profession, and family background.

The examinee should then be asked to give a brief account of his arrest, detention, and, if relevant, his leaving of the country of origin and arrival in Denmark. It may be useful if the interviewer himself records this information. This will enable him to revert to it later and explain to the examinee which period needs further elucidation. On research missions it has been very helpful to use a small questionnaire to record information on name, profession, age, family status, arrests and charges, together with various chronological facts about episodes in prison. It has also been useful to provide the interpreter with a short list of the questions to be dealt with during the interview.

If prison conditions are being investigated in an interview, it is as well to find out how many places of detention the victim has been in. It would be a mistake to spend two hours detailing everything about the first place of detention, only to discover that the victim had been in ten others since.

In the description of the alleged torture it is best if the torture victim can speak freely about what happened from arrest to release. However, not everyone can give such a description without help from the interviewer. Some are extremely detailed in their testimony, but to interrupt on grounds of irrelevance may make the examinee lose the thread of his story, leading to further detailed time-consuming accounts. Some examinees give a thorough description of what others have been through, and in that case it is, of course important to stress that only self-experienced events are of interest. When the torture victim has completed his testimony, if necessary assisted by supplementary questions, it may be necessary to fill in some gaps. It is of particular importance to understand fully how the alleged torture was carried out. Some essential details must be established, for instance about clothing during the torture, including the wearing of shoes, blindfolding, handcuffing, etc. Occasionally, it may be necessary to ask the victim to demonstrate the position he is describing. After one has interviewed and examined several people who have been subjected to the same type of torture, perhaps from the same country or even the same prison, one may tend to deal superficially with a description of the torture. This should be avoided because it is this description which allows assessment of whether the examinee has in fact been exposed to the alleged torture.

During the collection of information about the types of torture it is important to include both the quality and the amount of the torture, how many times it occurred, whether the examinee was subjected to this or that type of torture, for how many days, the strength of the blows, etc.

Questions should then be put systematically about symptoms from the different organ systems at and immediately after the torture. Several types of torture result in rather specific acute symptoms, and it is important to compare one's knowledge of these with the victim's statements. One must also find out whether the victim was subjected to any type of torture other than those mentioned. Doubtful statements, such as receiving no food or water for five days, must be challenged, though not necessarily immediately. They can be reverted to later by asking, in the instance cited, if there had been absolutely no access to water. The reply may be that there was a chance of getting a little water during visits to the toilet. Often it is the reporter who later asks such supplementary questions.

The symptoms at the time of examination, which may be several years after the torture, should then be described in the same systematic way. Sexual symptoms are often omitted in reports, probably because it may be difficult to ask the necessary questions. However, if such questions are introduced immediately after questions about urinary symptoms, they will often present little difficulty and embarrassment.

I shall not go into details about the physical examination, except to say that the interviewer should do it and the reporter should record it. If the examinee and the interpreter are of opposite sexes, it may be necessary to ask the interpreter to leave the room during the examination. Both positive and negative findings should be noted.

Writing the report

This should follow the guidelines laid out in the "Draft for Torture Report". Several of us have found it useful to stay on an hour or so after the examination in order to dictate the report. This is also a good time to go through any points of doubt.

The report should end with a conclusion, which should consider 1) whether there is consistency between the alleged torture form and the subsequent acute symptoms; 2) whether objective findings which can be related to the alleged torture are present; 3) whether the alleged torture is consistent with Amnesty International reports from the country in question.

Should there be inconsistencies, they should be recorded. My opinion is also that in such cases the examiners should conclude that the claims of torture put forward by the examinee cannot be substantiated by the findings of the examination.

Although it is beyond the scope of this paper, I should like to conclude by recommending that, during research missions, the examiners and the researcher agree each day on the torture to which the examinee has been subjected, the duration of detentions, etc. It would be useful to design a protocol for recording these aspects.
1. Date of examination:
   Examiners:
   Interpreter:
   Report by:
   Prisoner's name/No.:
   Age: Sex:
   Occupation:
   Others present:

2. **Brief presentation of prisoner:**
   A very brief summary of the course of events to give an immediate impression of the case and the length of time the prisoner has spent in this country.

3. **Background:**
   Including social conditions, family.

4. **Previous diseases and state of health before the arrest:**
   Ordinary history-taking as for a medical record.

5. **Arrest and charge:**

6. **Conditions in prison:**
   In the event of different prisons or cells, describe each separately:
   - Size, number of prisoners, type of prisoners.
   - Conditions in cell:
     - Size
     - Number of prisoners in cell
     - Lighting
     - Temperature
     - Sanitation
     - Food
     - Furnishing
     - Sanitary conditions
     - Access to medical aid, visits, warders, informers

7. **Interrogation and torture:**
   Itemized classification and detailed description of torture methods.

8. **Symptoms after torture:**
   Detailed description of visible changes on the body as well as subjective sensations. State, if possible, the duration of each symptom.

9. **Knowledge of other torture methods:**

10. **State of health in other respects during stay in prison:**

11. **Family Conditions:**

12. **Trial, sentence, further course:**

13. **Present symptoms and signs:**

14. **Brief summary and conclusion of physical examination:**
The Ethics and Techniques of Interpreting

By Vibeke Pentz-Møller

Interpreting when interviewing and examining torture victims
Interpreting for individuals who have been exposed to torture demands more of the interpreter than sound general interpreting ethics and techniques.

This paper is, the refore, divided into two main sections:
1. Interpreting in general: competence, preparation, the actual interpretation, the interpreter as a convey or of culture, professional secrecy.
2. Interpreting for torture victims: understanding of the issues of torture, special guidelines for the interpreter, cooperation with the medical doctor, opportunity for a brief conversation with the doctor before and after the interview/examination.

Interpreting in general
It goes without saying that an interpreter, before accepting an assignment, must find out whether he is competent for the job, whether he can master the relevant terminology and usage, whether he is capable of interpreting for many hour on end, perhaps several days in a row, should the assignment so require, and whether he is mentally fit to cope with emotionally stressful tasks. As it is an inviolable principle for an interpreter to remain neutral, interpreters should never accept an assignment if their impartiality can be questioned.

The interpreter should prepare himself by finding out for whom he is going to interpret, and on which subject, in order to check the terminology beforehand. Interpreting involves not only straight translation, but also the conveying of nuances between two or more individuals. Due to culturally-conditioned differences in social standards, it is essential prior to the interpretation to know the nationalities of the parties and, if possible, their social environments, educational statuses, whether they are from the country or the town, etc.

The actual interpretation should to the greatest possible extent be carried out in such a way that the parties can communicate as if they were speaking the same language. Many professional interpreters master consecutive as well as simultaneous interpretation, and the choice of method then depends on the specific situation and the parties involved.

With consecutive interpretation, the parties should confine themselves to a few sentences at a time, partly to avoid putting too much strain on the interpreter's memory, thus forcing him to spend more time on remembering than on translating, and partly to avoid disrupting the parties' sense of direct communication if they have to remain silent while long passages are being translated. The physical position of the interpreter is also important for good communication, and this is best decided by common agreement.

The interpreter should translate everything, conveying as far as possible all the linguistic nuances and idioms, but he should be aware of the fact that, if translated directly, some expressions and turns of phrase may not make much sense to the other party, and sometimes the wrong meaning may be conveyed. In this connection the interpreter must apply his knowledge of culturally-conditioned differences, also in relation to sense of humour and irony, and as far as possible communicate a message corresponding to the one intended.

It is not the interpreter's task to assess whether part of what is being said is uninteresting or superfluous, and he should not act as a buffer, taking the sting out of deliberately insulting statements. They must be translated literally, though not always word-for-word, if the parties are to get the correct impression of each other and of the situation. Strongly emotional expressions should therefore not be modified. This means, among other things, that the interpreter should speak in the first person whenever the parties do so. Situations may arise in which, subject to the agreement of the parties, it will be fully justified for the interpreter to give a résumé of what has been said. However, it is an inviolable principle that the interpreter should not distort or put his own construction on anything, but should remain loyal to what is said, as well as to the spirit of it, and should render it in a language which is easily understood by the listener. However, it should be stressed that, in interpretation as opposed to written translation, it is more essential to convey the meaning rather than to translate word-for-word.

The interpreter's absolute impartiality should not be mistaken for indifference. A good interpreter is not a passive tool, but a human being who plays an active part by constantly making sure that both he himself and the parties fully understand the message. If he is in doubt about the meaning of a statement, he should inquire in order to avoid subsequent misunderstandings. It is not always understood that interpreting is physically and mentally demanding, and that the interpreter, while doing his job, should not undertake other things as well, e.g. the preparation of minutes.

It is part of the interpreter's duty to possess understanding of the social structure, culture, family patterns, and general living conditions in the country whose language he interprets. Without sufficient knowledge in these areas the interpreter cannot perform his work satisfactorily since he, apart from being the purely verbal communicator, is also the intermediate link which con-
veys the non-verbal, culturally-conditioned signals which are often not immediately intelligible to individuals from different cultures. The two parties who are to speak together may assign different importance to essential elements such as religion, the relationship between the generations and between man and woman, courtesy standards, taboos, to mention a few, and it is the interpreter's task to give the correct weight to these concepts.

All parties should understand from the start that the interpreter is bound by professional secrecy. Without it, the building up of trust would be difficult, and open frank communication between the parties might be impossible.

**Interpreting for torture victims**

Apart from sound general interpreting ethics and techniques an interpreter should, in order to do justice to the work with torture victims, have acquired a clear knowledge of the concept of torture in advance; he should be fully aware that all torture is not only traumatic for the victim, but also totally unacceptable from an ethical point of view.

Interpreters who are new to the work and who do not have personal understanding of the issues of torture will have to read the relevant reports and literature. Such material is now abundantly available in several languages, and it would be beneficial if the doctors and dentists who request the service of interpreters would inform them about relevant material. Video cassettes and films on torture and torture methods, on rehabilitation of torture victims, and on the training of trainers may also supplement and widen the interpreter's understanding of the victim's perception of his own situation and of his reactions during interviews and examinations. No matter how many years of experience an interpreter has, he will never acquire complete knowledge of any field, but must continue to keep himself up to date with current developments in the various fields in which he works. He must also at all times be conscious of his professional and personal responsibility. Problems in this connection relate to professional secrecy/loyalty/impartiality: what if a patient for instance says one thing during the interview/examination and something else in another interpreting situation, or when he and the interpreter are alone? If the services of an interpreter were not required, he could express himself freely to different people, but should this privilege be reserved for people who speak the same language? If the interpreter finds that contradictory statements from the torture victim may prevent an optimal assessment and evaluation of his situation, mutual trust between the interpreter and the examining doctor is of decisive importance in order that the interpreter, when in doubt, may mention such contradictions to the doctor without being afraid that it may be "interpreted" as a breach of his professional secrecy.

Acting as an interpreter for torture victims demands greater attention on behalf of the interpreter than do most other interpreting situations, and it may be difficult to maintain the necessary balance between involvement and impartiality.

It is essential to be sympathetic towards the torture victim and his situation, but it is important, and difficult, to avoid the rather obvious pitfall of regarding people who have been exposed to torture as patients who need consoling.

As interpreters we must recognize that the sequelae from which the victim suffers today should be regarded as a normal human being's reactions to an extremely abnormal situation. The interpreter should know that sequelae to torture and prolonged isolation often take the form of reduced concentration, memory, and sense of time and a reduced ability to express experiences in a chronologically correct order; otherwise, he may often think that he misheard something. Should something in the victim's testimony appear contradictory, it is up to the doctor to clear it up. The interpreter should translate what the victim says. He should never interfere in the interview and never make personal comments. The knowledge which the interpreter should acquire about the objectives and effects of torture will allow him to understand or anticipate strong reactions in a torture victim in situations which might not affect a non-tortured individual. Waiting for the doctor, the form of the interview, instruments and gadgets in the room, the way in which the victim is to sit or lie down, the examination itself - all these factors can remind him of the interrogation and torture sessions he has gone through, thus giving anxiety. Again, cooperation between doctor and interpreter is absolutely necessary.

It is important that the doctor or dentist explains what he is going to do, even in a completely painless examination, and that the examinee can ask questions at any time and request a pause. The interpreter must know the words that describe the most frequently used methods of torture in his own language as well as in the foreign language, and he should know what they mean so that he need not ask the doctor or victim when they are mentioned. The interpreter should also know that, for instance, the preparations for taking an ECG or an EEG closely resemble those leading to electrical torture. The interpreter may in other instances, in cooperation with the doctor, but without taking an active part, contribute to mitigating the victim's fear of examinations which may cause him to relive memories of the torture.

In connection with cooperation, a few things should be mentioned of which a doctor using an interpreter for the first time may not be aware. When it is not possible to interpret simultaneously, for instance if the victim during the interview speaks incoherently or is searching for words, the interpreter should be allowed time to complete the translation. The doctor should listen to and look at the victim, even though he does not understand the language, so that he does not make unintentional interruptions.

Communication will be more successful if the doctor addresses the victim directly, i.e. he should avoid saying "Would you ask him if...", "Tell him to...". A person living in exile will often understand bits of the foreign language, and it may create a sense of distance to use the third person. For the same reason the doctor should not make any side remarks such as "don't translate this" to the interpreter. During the interview all three parties should be seated so that they can see each other without having to turn around - "triangular seating". Throughout, the interpreter should keep eye contact with the victim so that he may detect his non-verbal expressions and draw the doctor's attention to his reactions.

The interpreter must have prior knowledge of the victim's background and present situation, and he must read the report, if available, on the victim. If not available, he should be briefed by the doctor.

The inviolable principle that the interpreter must
remain neutral also implies that he should take great care not to “steal the picture”; rather, he should act as a catalyst; however, it may prove difficult, under strong emotional influence, to maintain the balance between sympathetic understanding of the situation and distance from the communicating parties. By virtue of his education and work a doctor is familiar with maintaining this balance, but in general an interpreter is not. When acting as an interpreter for torture victims, he should develop this ability; good working relations between the doctor and the interpreter will support the interpreter in this and contribute to optimal interpreting conditions.

The neutral attitude, the balance, should also be maintained whenever the interpreter is alone with the torture victim, e.g. during periods of waiting. He must then avoid talking about or commenting on the interview/examination, and he should not ask the patient about his torture experiences. Should the patient mention those subjects himself, the interpreter should, of course, listen attentively but at the same time attempt to lead the conversation in another direction.

Another matter which forms part of the cooperation between doctor and interpreter is that, after very emotionally stressful interviews and examinations, the interpreter should be given the opportunity of talking, if only briefly, with the doctor. The interpreter can then get psychological support, if needed, to combat his own strong reactions which he has no professional basis for understanding.

The aforementioned guidelines for the ethics and techniques of interpreting are basic principles in all aspects of interpretation and are followed by interpreters throughout the world. To become a translator and interpreter, including a thorough theoretical background, takes approx. six years in Denmark. When refugees come from countries without interpreter training, it is often necessary to use nationals from those countries as makeshift interpreters, and it may be difficult to assess their worth. They may do an excellent job, for instance when they have the proper linguistic ability, knowledge of cultural differences, ethical attitude, personal involvement, impartiality, etc. However, their use may have a negative effect, for instance if the interpreter comes from the same country as the victim, but holds different political views, if he has a poor Danish vocabulary, if he has earlier only acted as an interpreter for his family and friends, or has not acted at all. He will then often summarize or put his own interpretation on what has been said, or maybe provide a word-for-word translation.

This may give rise to misunderstandings, create uncertainty and render it difficult, maybe even impossible, to develop the mutual trust which is a prerequisite for the interview and examination of a torture victim. If a qualified or experienced interpreter is not available, the doctor should, if possible together with a qualified interpreter, conduct a “job interview” with the makeshift interpreter before the first session.

The age and sex of the interpreter are not normally important, though they can be in some cultures. The doctor and the interpreter must again cooperate to find out in which instances those factors are significant.

Apart from the foregoing, certain other conditions are essential in the treatment of torture victims, throughout which a patient should preferably have the same interpreter.

It is not ideal to have to use the services of an interpreter when interviewing and examining torture victims, but for most Danish doctors it is necessary. So that we can best train new interpreters, I think it would be an advantage to have feedback from those doctors, the users, who have worked with all sorts of interpreters.
How to Present Lectures on the Work of the Medical Group

By Frede Bro-Rasmussen

An important duty for the members of the medical group is to pass on information about Amnesty International (AI) and the work of the medical group, aspects that are closely linked.

Information may be passed on orally or in writing - two distinctly different tasks.

In the following I shall confine myself to oral communication of information, based on my general experiences as a speaker under the auspices of AI and/or the medical group. I shall add some practical hints and "rules-of-thumb" which may prove valuable for the less experienced speaker in connection with the preparation, planning and delivery of a talk.

Traditionally, when preparing to address a scientific meeting, as in writing a paper, a well-established sequence is used: title - introduction - introductory summary - material and methods - results - discussion - conclusion/summary. This practical outline can always be modified according to the particular target group and the purpose of the talk or paper.

Only in the rarest of cases will the talk involve the presentation of results of medical examinations. Public attention has been focused on the medical group and its work to such an extent that its members have been in great demand as speakers on AI in general, on human rights, on the formation of the medical group and its work, and more particularly on torture, on the prevention and abolition of torture, on torturers, on the death penalty, on violence in society, etc. The audience will see the speaker as a representative of AI as well as of the medical group, and, irrespective of the initial approach (the title of the paper or lecture), the audience will, if not earlier then at least during the closing question time, embark on AI and human rights and various aspects of the work of the medical group. It is therefore as well to be prepared for the questions.

The same talk will not of course suit all occasions, and the content must be tailored to the time available (e.g. 10-60 min) and the target group - schoolchildren of various grades, parishioners, social workers, police officers at different levels, Lions Club members, AI members or potential members, medical students or doctors, to name a few gatherings I have addressed.

Presenting the results of an investigation of torture methods and their sequelae to colleagues is very different from presenting them to a group of elderly female parishioners. In both instances the audience must be convinced (Aristotle: "The art of speaking is the art of persuasion") - the doctors of the value, use, and perspective of professional examinations of torture victims, the parishioners of the value and use of supporting the cause for which AI and the medical group work. In the first instance the speaker should appeal to objectivity and reason, in the other to conscience, imagination, and feelings.

In fact, it is often easier to catch the audience's attention by appealing to its imagination and feelings rather than to its reason. This is best done by referring to something concrete, for instance a "telling" picture or comparison from everyday life, a slide showing a torture victim (the audience finds it easier to identify with one single or a few torture victims than with a group) or something similar, instead of using abstract expressions. If one's thoughts and feelings can complement a slide, they will be remembered, relived and preserved more easily.

The Alpha and Omega in the preparation of a talk is constantly to keep its aim, and the audience in mind.

Many talks have little impact. The audience may not be able to follow the speaker because of his poor speaking technique or bad lay-out of the subject-matter. There may be constant small distractions which may deflect the concentration from the main message. This can be avoided if certain basic "rules-of-thumb" are observed in planning, structuring, and giving the talk.

The title of the talk

Much thought must be given to the title. At congresses, it must catch the attention so that participants do not go to the lecture next-door; in a community set-up it must be able to compete with television, cinemas, etc. It should not promise more than the talk contains. It is a good idea to start the title with the most important word and to include important keywords. Empty words should be avoided - it is better to have a subtitle.

Introduction

To begin with the speaker should say that he is happy to have been invited, perhaps introduce himself and say under which auspices he is there.

Introductory summary

The talk should be introduced by explaining the importance of the subject and why it might be of special interest to the assembled audience. Do this briefly. Some speakers, particularly at scientific meetings, start by showing a summary on a slide (cf. Summary in scientific articles).
Speaking technique
a. To hold the attention, one must avoid monotonous reading of a script and try to have frequent eye contact with the audience.
b. Speak clearly and slowly at about 100 - 120 words per minute (a sheet of A4 with double spacing contains approx. 30 lines of 10 words each). Reckon about 50 words per slide if the accompanying text is not written in the manuscript.
c. Use a language which can be understood by the uninitiated. It is easiest to address an audience with the same interests, i.e. which "speaks the same language". It demands great skill to say what one is doing in simple words which are understood by everybody. Most speakers overestimate an audience's knowledge. If the speaker uses slang, abbreviations, and various words and concepts which are not understood by the audience, he will lose their interest - this is immediately apparent because of inattentiveness and increased noise in the room.
d. Use personal names only if they really are necessary for the proper understanding of the subject. Names are difficult to remember - not more than 3 should be mentioned in a 10-minute talk, and not more than 6 in a 45-minute talk. If there is an opportunity to refer to somebody present in the room, do so, and you will be remembered.
e. An audience can only grasp 2 or 3 important points at the most in a talk lasting from 10 to 45 minutes. This is considerably less than most speakers imagine, but experience confirms the importance of this. It is a great help if the important points are shown on a slide or a blackboard.
f. The time allotted for speaking should be complied with. If the speaker cannot get his message through in 10 minutes, it is unlikely that he will be able to do so in 45 minutes. It is better to finish earlier than later. The impression of the chairman's efforts to stop the speaker should not be the final - and sole - result of the speech. Indicate at a few places in the margin roughly how long you should have taken.

Conclusion/summary
The conclusion constitutes an important part of the talk; it should serve a purpose and contain a message and not just consist of empty clichés added on. Highlight the positive and play down the negative. This can be done in several ways, for instance by way of a well-chosen quotation, a pat on the shoulder to the audience (this pays!), a call for action (support the work of the medical group, support A1), etc. A scientific paper may end with a summary, preferably identical to the introductory summary (do not forget an extra copy of the slide), containing the 2 or 3 important points in 2 or 3 short and clear sentences, thereby emphasizing the essence of the talk.

Visual aids
a. Slides serve the purpose of illustrating a paper. They give (should give!) a clear and intelligible presentation of summary, results, main points, case histories, etc. They can also stimulate the overall view, understanding, feelings, emotions, imagination and memory. But slides should be selected and presented with care. Only use 6 slides at the most during a 10-minute talk, and about 30 at the most during a 45-minute talk. In magazine articles, which can incidentally never be used as lectures, drawings and tables may contain a considerable amount of detailed information which the reader can revert to and spend the necessary time on. This an audience cannot do. With talks it is a question of illustration rather than documentation, and figures and graphs are better than numbers and tables. However, tables are better than nothing. Limit the use of important numbers on the slides (4 per slide at the most as a rule-of-thumb). Be careful when showing pictures of torture victims - blood and gore may not bother medical doctors, and young people may want to see more, but some will not be able to face it. Use professional assistance when making the figures, graphs, and slides. A slide can be inserted into the projector in 8 different ways, but only one is correct. The operator will be blamed if it comes upside-down, but the responsibility is the speaker's. Mark the slides clearly with a name and a number, so that the operator can read them. Indicate in the margin of the manuscript when the slides are to be shown. Remove fingerprints and the like from the slides before use.
b. Films. If films are to be shown, inform the organizers well in advance about projector requirements (8/16mm films, silent/sound films, magnetic/optic light) and duration. The operator should be given time to run a test, so make sure the film is available well in advance (and do not count on everything being all right, anyway!!)
c. Blackboard and posters should be readable for the entire audience - go to the back of the room to check that this is so before giving the talk.

Before and after the talk
The inevitable nervousness and restlessness before giving a talk is best allayed by making certain that the technical facilities are in order (they seldom are in community centres and parish halls), where they are positioned, and how they are operated. Be happy for questions after the talk, they are a sign of understanding and interest.

Do not leave manuscript, spectacles, cigarettes and the like on the rostrum, remember to take the slides with you, also the last one in the projector. Seek out any aggressive questioners afterwards, they often turn out to be kind and interested people - A1 will gain support, or get a new member.

Let it be a consolation for the inexperienced speaker that only few people are natural-born speakers. There is no need to despair. Practice makes perfect. It is a good idea to rehearse with a tape recorder. This will reveal without mercy deficiencies in articulation, speed, etc. Find a small audience similar to the audience expected to attend the actual delivery; if these guineapigs can follow and understand the lecture, you are ready to approach the rostrum.
Psychiatric Examination of Torture Victims

By Marianne Kastrup

Before examining a torture victim it is essential to recognize the underlying motivation for the infliction of torture. There has previously been general agreement that a major objective of torture infliction was the extraction of information from the victim.

However, seen on the basis of the experience and documentation obtained from the Danish Medical Group’s work with torture victims, it becomes increasingly clear that a major objective of torture infliction is to disintegrate the torture victim’s identity, both personal and in relation to society. During torture, the victim’s physical, intrapsychic and interpsychic (social) identity is attacked. The aim is to confuse the victim’s identity, and this can be done by blindfolding the victim, thus causing confusion and disorientation as to time and place. Isolation and sensory deprivation will lead to a failing physical perception, and repeated humiliations and lack of opportunity of personal hygiene and the like will break down the victim’s self-esteem. Furthermore, attempts to destroy the victim’s relations to his primary group and members of his family will often have been made, for instance by means of false denunciations or threats of torture, and this will further weaken the victim’s perception of his own identity. At the time of the examination the sense of a changed identity may have become intensified because of the problems occurring in connection with the exile situation and the social changes associated with it.

Consequently, the person you meet at the examination may very well display signs of severe identity disturbance.

Types of psychological torture.

Psychological torture can take many forms. As previously mentioned an essential objective is to break down the identity of the victim and render him helpless and exhausted. Sensory deprivation involves the withholding of stimuli from the environment. The deprivation may take many forms, and the victim will normally be subjected to a variety of simultaneous deprivations, for instance if the victim is blindfolded and placed in a small, closed room. During such deprivation the victim will experience cognitive disturbances, increasing confusion and disorientation as to time and place, reduced power of concentration and, often, hallucinations.

In contrast to the sensory deprivation with its absence of stimuli, the torture may also involve the imposition of a flood of stimuli of a stressful character. The torture may take the form of meticulous supervision of the victim, and any breaking of the rules, however insignificant, will lead to punishment.

Repeated humiliation is frequent; the victim is verbally abused or humiliated by being forced to do things which he would never have done previously.

Mock executions and threats of arrest and torture of friends and relatives, or the direct witnessing of the torture of other closely-related persons, constitute a particularly unpleasant and effective form of psychic torture.

The torturers’ methods of addressing and communicating with the victim may assume the character of psychological torture. This may for instance happen when the “double-bind” technique, in which the victim is presented with contradictory messages, is applied. During interrogation the victim is confronted with what seems to be impossible choices since, irrespective of the choice made, the consequence will be inevitable and the same.

Finally, compulsory treatment with various kinds of psychotropic drugs, having either a sedative or a hallucinogenic effect, is a common method of psychological torture.

Information on premorbid psyche

A medical examination of a torture victim should always contain information on the mental condition of the examinee before the first arrest. This should include information about previous treatment of psychological problems or mental disorders, previous prescription and use of psychotropic drugs and sedatives, and previous drug and alcohol abuse, as well as an assessment and evaluation of the premorbid personality.

More precisely, the examination should include information about any previous contact with own general practitioner on account of psychic problems, contact with a psychologist or specialist, and any admissions to institutions for psychiatric treatment.

Apart from this, the victim should be asked questions relating to contact problems, loneliness, behaviour patterns in stress situations, lack of concentration, memory disturbances, fatigue, pattern of emotional response, vulnerability, suspiciousness, frequent changes of mood, etc.

In general, it can be said that torture victims are strong personalities who have made an active effort to combat repression in their country of origin. They will, therefore, only rarely have suffered from significant premorbid mental problems. However, this does not imply that information about premorbid psyche is irrelevant, since a description of the premorbid personality may
often help to understand the victim's behaviour pattern after the torture.

**Early mental sequelae of torture**

A description of the victim's state of health immediately following the torture (from a few hours to a few days after the torture) should include information not only about the physical problems, but also about the mental condition of the victim. Ideally, each torture session should be considered separately, ending with a history of problems resulting from the recent torture session.

Was it ever necessary during the imprisonment to refer the victim for medical treatment because of the mental problems? If so, what treatment was prescribed?

Did the victim experience any visual, auditory or sensory hallucinations in connection with the torture? (ask about impressions and sensations which were not real).

Did the victim experience any illusions? (ask about ideas and sense impressions which seemed peculiar and which the victim realized were not real).

It is often difficult for the victim to give a factual description and elucidation of the experiences because torturers often take advantage of the victim's inability to distinguish between fact and fantasy. One example is the playing of cassette recordings outside the victim's cell. The victim will often be in doubt as to whether or not the sound impressions are real.

Did the victim ever lose his sense of locality, causing doubt as to time and place?

Did the victim experience any fear and anxiety, and did any anxiety attacks occur, either of an immediate character or in the form of a more permanent anxiety?

Did the anxiety ever assume such dimensions that it became uncontrollable and resulted in genuine panic attacks?

Did the victim feel sad, resigned and depressed in connection with the torture sessions? Were the symptoms so pronounced that the victim felt an urge to go to sleep never to wake up again, or to die during the torture session? Did the victim genuinely consider taking his own life, had it been possible, and were there any real suicide attempts? Or perhaps the reaction took the form of restlessness, maybe of a manic character, instead of sadness and resignation.

Did the victim feel intense rage and aggressiveness towards his torturers, and did episodes occur during which this aggressiveness could not be controlled?

Did the victim suffer from excessive fatigue, exhaustion and a feeling of not being able to cope?

How did the victim sleep, were there problems with falling asleep, interrupted sleep or waking up early? Were there recurrent nightmares, and did they tend to be of the same nature?

**Late sequelae of torture**

The information about the early sequelae of torture should be supplemented with that about the mental problems occurring in the period immediately following the torture up to the present. Information about any treatment of psychic problems given by general practitioners, specialists or psychologists should also be collected, and the victim should be asked to report whether he has been in contact with psychiatrists, either in a consulting room or as an in-patient. If psychiatric treatment was received, the time at which it took place should be noted together with the name of any institutions of admission, and the treatment given. What symptoms were decisive in referring the victim for treatment? Did any psychotic phenomena occur such as depression, mania, paranoid delusions or hallucinations? Were the main complaints of a neurotic character, e.g. with anxiety attacks, hypochondriac complaints, phobic symptoms, compulsive ideas and actions? Did the victim have an alcohol or drug problem?

Apart from this rather exact information, the victim should be asked if he feels that his personality has changed from what it was before.

How can the mood of the victim be described? Has he suffered from depression, and if so, for how long and to what extent? Does he find it more difficult now than before to cope with daily problems? Has he gone through periods when he felt that life was not worth living, and was his desire to die so strong that he considered or attempted suicide?

The level of energy should be clarified. Does he feel exhausted and tire easily, and does this represent a change compared with his habitual condition?

Has he suffered sleep problems, and were they particularly related to falling asleep, recurrent interruption of sleep or waking up early? Is the sleep disturbed by nightmares, are they recurrent and of a certain nature? Has his sleeping pattern changed?

Has he ever had psychotic experiences in terms of visual, auditory or sensory hallucinations, paranoid delusions, mental disturbance, disorientation? If so, in what way and for how long did they occur?

Has the victim experienced difficulties in contact with friends, family or social contacts, and have there been any changes compared with before?

To what extent is the victim capable of handling stress situations, tackling unpleasant confrontations or unexpected episodes?

How does the victim react when exposed to teasing or when feeling angry? Have lability and irritability heightened following his arrest and torture, and does he feel that he has become more sulky and morose or that he overreacts to trifles?

How does his reaction to other people affect him, does he feel more vulnerable, or does he find it more difficult to express his feelings? How does he cope with criticism put forward by others? Is he more suspicious now?

**Present symptoms**

The last part of the psychiatric examination consists of a description of the victim's present mental condition. This should include the same questions as stated under the sections on early and late sequelae of torture. In the present situation the condition of the victim during the few days prior to the examination should be emphasized. Is he being treated at present by a general practitioner or a psychologist/psychiatrist because of his psychic or psychological problems? For how long has he been receiving treatment, and what is the nature of the treatment? Have any psychotropic drugs been prescribed?

How does the victim describe his present state of mind? Does he feel sad, disheartened, resigned, depressed? Does he want to die, and has this in fact given rise to suicidal thoughts?

Is he presently haunted by hallucinatory experiences, and are they of a visual, auditory or sensory character? Does he think that he is being persecuted, monitored?

Does he display signs of anxiety, and does he suffer genuine anxiety attacks, perhaps amounting to panic?
Does he worry unduly about his physical health, and is he afraid that he might suffer from a severe disease?

Does he exhibit signs of suffering from compulsion and obsession?

Has he signs of increased susceptibility to fatigue and lack of energy to cope with daily doings?

Has he any sleep problems, and, if so, of what kind? Does he have nightmares? What do they consist of?

How does the victim describe his relations to friends, spouse or social environment? Does he feel incapable of establishing lasting emotional relationships? Does he complain of loneliness?

How does he react in stress situations or when unexpected, unpleasant situations arise? Does he tend to get suspicious or to misinterpret what is going on?

Does he easily feel susceptible to irritability and aggressiveness? Does he see himself as vulnerable, over-reacting, sensitive?

Are the present symptoms new? How long have they been present? Does the victim view them as alien to his personality?

The examination

The examination includes an assessment and evaluation of the victim's mental health status. An attempt should be made to assess the intellectual level of functioning. Is the examinee cooperative? Does he appear to be collected, well-structured? Are there any signs of incoherent thought processes? How can the contact to him be described, formally as well as emotionally? Does he seem suspicious, guarded, reluctant to give information, or does he seem reasonably confident? Does he exhibit any signs of tension, anxiety, motor disturbances, or restlessness during the examination? The mood of the victim should be described - is it low and to what extent? Does he display any signs of suicidal impulses? Does he seem hysteric, elevated? Is he capable of controlling his aggressiveness or do bursts of rage occur? Does he reveal any signs of paranoid delusions or of suffering from hallucinations? Finally, the examination may include a description of the examiner's overall impression of the victim.

Communication

The examiner should recognize that any contact with a torture victim can be therapeutically applied, even if the contact is only brief. It is essential for the victim to experience a sense of understanding and to feel that his case is progressing. In this connection, detailed information and advice may be of minor importance; the essential element is to be able to communicate the notion that his case is being taken care of.

Although the major purpose of the examination is to collect information about the previous and present condition of the victim, he should also be given the opportunity to talk about his feelings, problems and worries, and it can be very useful to assure him that the symptoms bothering him now can later be alleviated by therapy. In many instances the victim did not give a detailed account of his situation during prior contacts with the authorities. Fear of reprisals cause many victims to remain silent. Others are afraid of being considered weak, or are afraid that any signs of weakness may be used against them. Therefore, it may be difficult and will often require some experience to make a victim show as much trust and openness as it will take to speak freely. To encourage this situation the atmosphere during the examination should be one of mutual trust and respect. It is vital that it does not assume the character of an interrogation, in spite of the many exact data which the victim is requested to give. A climate of empathy and genuine understanding and concern for the difficult position of the victim are necessary elements for an optimal interview. It is important to recognize that the victim may find it difficult to transcend the threshold of giving a detailed testimony of the most personal matters to several examiners, previously unknown to him.

During the interview the examiner should exhibit an ability to show empathy and to listen - also to matters unspoken. Attempts should be made to trace what the victim has in mind, and questions should be adjusted accordingly. To ensure the necessary trust, questions should be encouragingly and kindly put, clear and intelligible. Too many questions in a short time should be avoided, and it is particularly important to avoid using a tone which may gassociations with previous interrogations. The creation of a trusting atmosphere may be further promoted by means of a few encouraging remarks or non-verbal expressions of understanding and encouragement.

It is important that the contact between the examiner and the victim is increasingly strengthened during the examination. This can be done at the start by showing respect for and acceptance of the victim, inspiring him with the necessary trust, and then proceeding to disclose problem areas and to procure the necessary information.
The Neurological Evaluation of Torture Victims

By Marianne Juhler

The justification for a neurological evaluation of a torture victim is to be found, partly in the neurologists traditional interest in sequelae of severe stress (e.g. the so-called KZ-syndrome), partly in the torture anamnesis which often includes potentially brain-damaging situations.

Apart from the diffuse stress reaction and psychological suffering which torture inflicts on the victim, there may be acute as well as chronic symptoms and findings from the organs at which the torture was directed.

Many torture survivors have been exposed to situations which are potentially brain damaging, such as:
1. direct cranial trauma, with or without subsequent unconsciousness;
2. anoxic episodes caused by submersion or airway obstruction until the stage of fainting; and
3. electric torture with convulsions and consequently insufficient respiration. The neuropsychological examination rarely confirms suspicion of organic brain damage. Clinical/neurological examination, CT scan of the brain, and EEG are almost always normal.

Furthermore, many victims have been exposed to beating on the back, and, evidently, suspension by the arms, fractures of the extremities and beating traumas can result in injuries to the spinal marrow, the roots of the spinal nerves, and the peripheral nerves.

Symptoms
The complaints years after the torture could suggest dementia. There are great difficulties with adaptation in the asylum country and with learning a new language. Complaints of irritability, testiness or emotional exhaustion can also be typical. There are complaints of sleep disorders, intolerance to alcohol, difficulties in concentrating, and poor memory. In spite of the poor memory, a very good memory of the torture is often found, even relating to details. Another frequent complaint pertaining to the neurological field is that of back pain, often located to the loin. The pain is seldom characterized by typical radicular symptoms from the legs, even though elements are often found which could resemble radiation from the neural roots.

A thorough clinical neurological examination is sufficient to disprove the presence of the suspected polyneuropathy, as is spontaneous subsidence of symptoms along with the patient's mental improvement through psychotherapy. Generally speaking, problems which remain after significant mental improvement should be reconsidered medically.

Symptoms from the motor system mainly fall into two categories: 1) joint symptoms from overstretching by e.g. tight confinement or suspension; 2) muscular pain related to tension by general stress. Low back pain is a common symptom. During imprisonment many torture survivors have been subjected to beating on the back or forced to heavy labour. Both may lead to back problems. A large minority of torture survivors with back problems have symptoms which indicate lumbar root compression. The objective examination sometimes produces findings which support that suspicion (reflex differences, minor sensory changes, pain-related reduction of muscle power). "Hard findings" consistent with intervertebral disc herniation (actual paresis, dermatom sensory changes) are rare.

Symptoms from the eyes are most frequently uncharacteristic visual disorders (previously called cerebral asthenopia). Furthermore, there may be visual disorders which are often related to severe headache.

There are also symptoms from the eyes which are specifically related to torture methods, e.g. chronic irritation and conjunctivitis following submersion in contaminated water, direct eye lesions, and cataract which in some cases must be suspected to be traumatically induced.

Symptoms from ears/hearing are almost always directly related to the torture method. Repeated beatings on the ears result in damage to the middle ear with subsequent conduction disorders. Labyrinth damage and all degrees of nerve deafness are also seen as direct sequelae of head trauma.

Signs
It is often mentioned (and rightly so) that psychological mechanisms are the major matter in post-torture symptoms. However, only a minority of the survivors perceive their problem to be mainly or entirely of a psychological nature. The majority experience and present their situation as a somatic disease. It is important to understand that the somatic complaint picture, irrespective of any organic basis or not, is an important (perhaps the only) access for initial treatment. The torture survivor has a right to have his situation taken seriously, and a somatic complaint which is listened to and which results in a formal medical examination may be the gateway to confidence.
The preparation for examination consists of giving the patient an understanding of the purpose of the examination, the technical procedure, the applied equipment, and of any expected after-effects. When the result of the examination is available, it is important to inform the patient of the result and any consequences thereof. When the outcome of an examination is completely normal, it is also important that the patient is told so by the doctor, since the fear of suffering from a disease thus may be removed.

Radiological examinations (myelography and/or CT scanning), if they are performed, mostly show normal conditions or minor changes which do not suggest that improvement should be sought surgically. Back problems with or without radicular symptoms will in most cases be fully amenable to physiotherapy or other conservative treatment, perhaps supported by medication therapy for a short period.

It is important to diagnose even minor hearing impairment and to establish contact to an otologist for a correct diagnosis and treatment, being e.g. reconstructive middle ear surgery or a hearing aid recommendation. In contrast to neuro-radiological findings, oto-neurological findings often indicate damage to the labyrinth.

Prior to any diagnostic procedure, it should be reconsidered whether it is really necessary to carry out the contemplated examination. In general, it is unwise to subject patients to diagnostic procedures if the same information can be obtained in a way which is simpler and less straining for the patient. In particular, this applies to torture survivors who, due to their torture experience may, suffer from pronounced fear of procedures and medical equipment. For the same reason, it is important to "institutionalize" the examination and treatment as little as possible. It will promote trust and thereby cooperation and diagnostic yield of examinations if they can take place in an atmosphere and in surroundings which are as non-technical as possible.

In conclusion, it could be said that, even if the anamnesis and the complaint picture suggest a suspicion of actual neurogenic damage, this only rarely (fortunately) prove to be true. The neuro-psychological complaint picture could be termed a "pseudo-dementia", the basis of which is the chronic psychological stress with repression, sense of guilt and insufficiency, etc., which does not leave many psychological "reserves" to tackle new tasks. Complaints of pain located to the back and the extremities are very often myogenically conditioned. Concerted action of a medical, psychotherapeutic, physiotherapeutic and social character is a logical procedure in examinations and treatment. The medical and physiotherapeutic contact is often the first contact - not least because the complaints are primarily presented as purely somatic.

References
Skin Changes after Torture

By Lis Danielsen

Torture leaves many types of change in the skin. Their main significance is that they can be used diagnostically to support an allegation of torture. They rarely inconvenience the patient, but can sometimes be of cosmetic importance since they may add to the changed sense of identity induced by the torture.

The following method of examining and assessing skin changes following torture will primarily be aimed at the diagnostic possibilities afforded by the examination.

The history should include: 1) information on skin disease prior to the torture; 2) as detailed an account as possible of the origin of the skin lesions, with particular respect to the shape and size of applied instruments (if any) and the type of energy transferred to the skin, e.g. electrical energy, heat energy; 3) description of the appearance and duration of acute lesions and information on the localization of any permanent changes.

The physical examination should include: 1) examination of the entire skin to detect signs of generalized skin disease; 2) description of the localization, symmetry, shape, size and colour of the scars and their demarcation and level in relation to the surrounding skin; 3) photographing of the scars; 4) punch biopsy (if necessary).

Important considerations when drawing conclusions from the examination are: 1) an attempt to compare the details stated about the origin of the lesions with the objective findings, 2) possible differential diagnoses in relation to non-torture-related skin changes.

The examining doctor must be familiar with the characteristic skin changes that follow the most frequently applied types of torture, and with their differential diagnoses.

Torture sequelae located to the skin

Torture sequelae located to the skin may be:

1. Scars resulting from direct physical injuries.
2. The occurrence of new, or aggravation of existing skin diseases, provoked by physical or psychological trauma.

Most of these sequelae resolve soon after the torture. Permanent changes in the skin due to blunt trauma are infrequent, uncharacteristic, and usually without diagnostic significance.

An exception is flogging, which may leave long, straight or curved linear scars in asymmetric patterns (Fig. 1). The scars are depigmented and often hypopigmented, surrounded by narrow, hyperpigmented stripes (Fig. 2). The only differential diagnosis is plant dermatis, but this is dominated by hyperpigmentation and shorter scars (Fig. 3).

By contrast, symmetrical, atrophic, depigmented linear changes, which are sometimes claimed to be torture sequelae, represent striae distensae (Fig. 4) and are not normally related to torture.

Another sequel of blunt violence which may be used diagnostically is a linear zone extending circularly around the femur, and which is claimed to have occurred after the application of tight cords (Fig. 5). The zone contains few hairs or hair follicles, probably a form of cicatricial alopecia. No differential diagnosis in the form of a spontaneous skin disease exists, and it is difficult to imagine any trauma of this nature occurring in everyday life.

Sharp violence often leaves permanent scars, but they are often uncharacteristic and without substantial diagnostic significance.

An exception is razor blade lesions, which are 5-10 mm long, 1 mm wide, linear, often depigmented and macular scars (Fig. 6). If pepper is applied to the open wounds, they may become hypertrophic (Fig. 7). An asymmetric pattern and different sizes of scars (Fig. 8) are probably significant in the diagnosis of torture changes. A possible differential diagnosis is ritual tattooing with scars, though little is known about this. In Africa it is performed with razor blades and subsequent application of ashes in order to produce a regular and aesthetically beautiful pattern (Fig. 9).

Burning is the form of torture that most frequently leaves permanent changes in the skin. Sometimes, they may be of diagnostic value.

Cigarette burns often leave 5-10 mm large, circular and macular scars with a depigmented centre and a hyperpigmented, relatively indistinct periphery (Fig. 10). The burning away of tattoos with cigarettes has also been reported in relation to torture (Fig. 11). The characteristic shape of the resulting scar and any tattoo remnants will help in the diagnosis. Surgically removed tattoos constitute a differential diagnosis, but dermabrasions and excisions usually produce rectangular and striped scars.

Burning via the transfer of larger amounts of energy to the skin than that used when stubbing a cigarette on the skin often produces markedly atrophic scars. They are sharply demarcated with narrow hypertrophic or hyperpigmented marginal zones. This may for instance be seen after burning with a gas lighter (Fig. 12) or an electrically heated metal rod (Figs. 13 and 14). It is difficult to imagine any differential diagnosis if many scars result. Spontaneously occurring inflammatory processes would probably lack the characteristic marginal zone and only rarely exhibit such a pronounced loss of tissue.
When the nail matrix is burnt, subsequent growth produces striped, thin, deformed nails, sometimes broken up in longitudinal segments. If the nail is also pulled off, an overgrowth of tissue may occur from the proximal nail fold, resulting in the formation of pterygium (Fig. 15). Changes in the nail caused by lichen planus constitute the only relevant differential diagnosis, but they will usually be accompanied by a widespread skin affection. Fungus infections, on the other hand, are characterized by thickened, yellowish, crumbling nails, (Fig. 16) different from the above changes.

Electrical torture often leaves scars on the skin. “Picana”, performed with pointed electrodes, may give distinct lesions, 1-2 mm wide.

Immediately following “picana”, clusters of such lesions covered by reddish-brown crusts may be observed, usually without the surrounding inflammation seen after burns (Figs. 17 and 18). Some of the lesions leave scars appearing as clusters of hyperpigmented macules without any sequelae resulting from inflammatory reactions in the periphery (Fig. 19). Insect bites might constitute a differential diagnosis, but these are often accompanied by inflammatory reactions in the periphery and are unlikely to leave cicatization.

An example of skin diseases being psychologically provoked by torture may be the concomitant occurrence of an urticarial eruption. Physically provoked skin diseases may be the development of psoriasis or lichen planus in the traumatized area, as a “Köbner-reaction” (Fig. 20). However, such skin changes have little diagnostic significance in relation to torture.

**Conclusion**

The diagnostic value of macroscopic changes in the skin is often limited. While few and uncharacteristic scars can support the allegation of torture only to a limited extent, characteristic changes may, on the other hand, offer substantial evidence, particularly if they occur in large numbers.

**COMMENT:**

The 20 illustrations of skin changes after torture inserted in the middle of this issue of TORTURE are available as slides and can be obtained by sending a request to:

The Danish Medical Group
Amnesty International
Dyrkøb 3
DK-1166 Copenhagen K

Price: £ 8
Fig. 1.: Long, straight or curved, linear scars in an asymmetric pattern on the back, 6 months after flogging. The scars are depigmented, hypertrophic and surrounded by thin, hyperpigmented stripes.

Fig. 2.: Straight and curved linear scars, 6 months after flogging. The scars are depigmented, hypertrophic and surrounded by thin, hyperpigmented stripes.

Fig. 3.: Plant dermatitis with short, hyperpigmented scars.

Fig. 4.: Symmetrical, atrophic, depigmented, linear changes on the back, allegedly occurring 2 years after beating and scalding. The patient had similar changes in both axial regions. It is a case of striae distensae without relation to torture.

Fig. 5.: Linear zone, extending circularly around the leg, 6 years after hour-long application of tight cords. It is probably a case of cicatricial alopecia, caused by the torture.
Fig. 6.: Numerous 5-10 mm long, 1 mm wide, linear, depigmented and macular scars, 3 years after torture with razor blades.

Fig. 9.: African ritual scar-tattoos in a regular and aesthetically beautiful pattern made by razor blades and the application of ashes (Søren Nancke-Krogh: Kunsten på kroppen (Art on the Body), Copenhagen, 1985).

Figs. 7 and 8.: Numerous 5-15 mm long, 1-3 mm wide, linear and irregular scars on each side of the neck, 2 years after torture in Africa with razor blades and the application of pepper to the open wounds. The scars are asymmetrically localized and irregular in shape and size.

Fig. 10.: Approx. 5-10 mm large, circular and macular scars with a depigmented centre and a hyperpigmented, relatively indistinct periphery, 4 weeks after burning with a cigarette (Aa. R. Kjersgaard and I. K. Geneke, Ugeskr. Læg 1977:139,1057).
Fig. 11.: Heart-shaped scar consisting of closely set depigmented patches measuring a few mm across, surrounded by hyperpigmentation and containing tattoo remnants 4 years after the burning away of the tattoo with two packets of cigarettes during torture.

Fig. 12.: Circular, atrophic scars with a narrow hypertrophic marginal zone 10 years after burning with a gas lighter.

Figs. 13 and 14.: Circular and oval scars with an atrophic centre and a narrow hypertrophic or hyperpigmented marginal zone 1 year after burning with an electrically heated circular metal rod the size of a cigarette. The patient had 35 such scars (L. Danielsen and Ph. Berger, Acta Dermatovener, Stockholm 1981:61,43).

Fig. 15.: Striped, deformed toe nails, the left big toe nail divided into 3 slightly curved longitudinal segments with overgrowth of tissue from the proximal nail fold resulting in the formation of pterygium, 2 years after injury to the nail matrix caused by the pulling off of toe nails and burning with charcoal embers.
Fig. 16.: Thickened, yellowish toe nail caused by mycosis.

Fig. 19.: One mm wide, macular, hyperpigmented scars, 4 weeks after "picana". There is no marked marginal zone (Aa. R. Kjersgaard and I. K. Genefke, Ugeskr. Laeg 1977:139,1057)

Fig. 20.: Lichen planus (verified by biopsy) on the front of the shin, 12 years after kicks during torture, possibly a "Köbner-reaction" to this.

Figs. 17 and 18.: 1-2 mm large lesions with reddish-brown crusts and red stripes a few hours after "picana". The lesions on the legs are without surrounding inflammation, but slight surrounding inflammation can be seen in the lesions on the abdomen (Ole Vedel Rasmussen, doctoral thesis).
The Rheumatological Examination of Torture Victims

Rheumatological Diseases in Torture Victims, and their Treatment

By Bente Danneskiold-Samsøe and Grethe Skyll

Rheumatology is defined as diseases in the motorsystem, i.e. diseases in the bones, joints and muscles.

As is the case with the ordinary medical examination, the anamnesis and the physical examination of torture victims are necessary prerequisites in order to make the correct diagnosis.

It should be natural for a doctor to show respect for the individual patient and his dignity as a human being. This is particularly necessary if the patient is a torture victim.

The questions which the doctor put and his body language can greatly influence the course and outcome of the examination. In the rheumatological specialty, as in other specialties, this applies not least to the examination situation. Great care must be shown and repetitions avoided during painful examinations, and this also applies when anamnestic information is collected.

Though the patient record will contain information relating to the patient's nationality, psychosocial and family background, and his torture subjection, the rheumatologist should ask questions relating to this. It may be relevant to seek amplification of certain pieces of information, including the torture, since this is a concurrent factor for the diagnosis and hence also for the specific rheumatological examination and subsequent treatment. Thus the anamnesis must often be supplemented with specific questions about torture sequelae in the motor system.

The rheumatological examination

The background for the rheumatological examination is the direct or indirect injury inferred on the torture victim's motor system - his own body. The injuries - and hence the scars on the soul - occurred during the torture may be brought to mind again during a (painful) examination. Great care should be taken when applying procedures which may resemble those applied during torture, for instance when examining:

1. Mobility of the joints of the spine and the extremities;
2. Palpation of fibrositis;
3. Reflexes, sensibility, sense of vibration, etc.;
4. Palpation of joints, tendons, tendon attachments.

It is necessary to maintain eye contact both during the anamnesis and the physical examination. Placing yourself behind the patient should therefore be avoided. The interpreter will have to assist you when examining the back of the victim.

It is our experience that, contrary to custom, it may have a reassuring effect if you during the inspection put your hand on the shoulder of the patient and talk to him.

As is the case in all clinics, rheumatological diagnostics is based on symptoms and signs.

Symptoms

The torture victim's description of diseases and symptoms should take the form of conversation. A flood of questions may remind the victim of an interrogation situation. It is important for us to know which symptoms the torture victims had before the torture in order to separate the symptomatology connected to the torture from other symptoms. The description of pain is important to find out whether it is a matter of direct pain, projected (radicular) pain, referred pain, pain with no apparent pathological basis, psychogenic pain, or, unfortunately, maybe phantom limb pain. Often the pain is located to specific areas which have been exposed to torture, and often the pain is combined with headache, insomnias, nightmares, bruxism, tachycardia attacks, and anxiety attacks. Furthermore, one should be aware that, apart from diseases related to the torture, victims can develop diseases like everybody else, but their reactions may be different from what is usually seen.

It is important to be able to use different kinds of body language because of cultural differences. Both body pain language and verbal pain language are often different from the ones we know from our daily practice.

Signs

The general physical and mental condition of the torture victim should be noted. The general motor function in connection with daily activities should be analyzed. Striking defects should be noted. A complete rheumatological examination is very time-consuming. Often you must give priority to certain parts of the examination at the expense of others, dependent on the anamnesis. The part about the torture description is particularly important.

In broad lines, the following examinations should be given priority:

The inspection of walking function is particularly important if the torture victim has been exposed to falanga.
Gait analysis, including examination of columna cervicallis and thoracolumbals. Bends in the sagittal as well as the frontal plane should be examined. The pelvic inclination and the mobility of the entire spine should be examined in both planes. The muscular volume should be assessed, and it should be noted whether the musculature is relaxed or tense. Muscular atrophy following various traumas should be noted. Facet joints should be examined with a view to determining facet syndrome.

Palpation of the striped musculature should be made in order to establish regional fibrositis and coating on the tendons, synovial bursas and sheaths, joints and ligaments. Palpation of the occipital and lumbar muscles and the muscles of the back should be made while the person is lying down, perhaps sitting with regard to the occipital musculature. Changes in texture, the size of the changes, and tenderness of the "relaxed" muscles should be noted on an anatomic plane for registration of a so-called "fibrositis index".

Joint mobility should be examined with a view to establishing the presence of hyper/hypomobility of the individual joints. Furthermore, you should look for dyyarthritis, crepitation located to the tendons or the synovial bursas. Deformity of the bones, instability, contractures, amputations. The muscle strength, isometric as well as isokinetic (dynamic) should be examined by means of a grading from 0 to 5, or you may use a more rough grading from normal - slightly reduced - to markedly reduced muscle strength.

As can be seen, the examination does not differ much from the rheumatological examination of ordinary patients. However, it is very important to stress that the examination should take specific account of the torture to which the victim has been exposed. For instance, it is natural to make a thorough examination of the planta if it is a case of falanga. In case of suspension, it is natural to pay specific attention to the joints which have been strained.

The examination must not give the impression that the victim is being ordered about; it should take place in a calm and trusting atmosphere.

Rheumatological diagnoses in relation to type of torture.

**Type of torture**

Diagnoses related to the motor system are now available from a prospective study of 29 torture victims (1). 8 women and 21 men participated in this study. Almost all of them had been exposed to psychological torture, notably isolation. Proportionately more women than men had been exposed to sexual humiliations.

As for physical torture, almost all the victims had been beaten more or less systematically all over the body. This type of torture constituted 25% of all the types of torture carried out.

Electrical torture was the second most common type of physical torture, and, finally, falanga and suspension, each constituting 10%.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>The different types of psychological torture to which the victims were exposed.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of</td>
</tr>
<tr>
<td></td>
<td>men</td>
</tr>
<tr>
<td>The psychological torture</td>
<td>20</td>
</tr>
<tr>
<td>Isolation</td>
<td>11</td>
</tr>
<tr>
<td>Skin executions</td>
<td>4</td>
</tr>
<tr>
<td>Sexual humiliations</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 3</th>
<th>The different types of physical torture to which the victims were exposed.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of</td>
</tr>
<tr>
<td></td>
<td>Men</td>
</tr>
<tr>
<td>The physical torture</td>
<td>20</td>
</tr>
<tr>
<td>Beatings all over the body</td>
<td>19</td>
</tr>
<tr>
<td>Unsystematically</td>
<td>8</td>
</tr>
<tr>
<td>Systematically</td>
<td>10</td>
</tr>
<tr>
<td>Suspension</td>
<td>5</td>
</tr>
<tr>
<td>Electrical torture (incl. picana)</td>
<td>14</td>
</tr>
<tr>
<td>Pharmalogical torture</td>
<td>1</td>
</tr>
<tr>
<td>Water torture</td>
<td>8</td>
</tr>
<tr>
<td>Starvation</td>
<td>5</td>
</tr>
<tr>
<td>Burdening</td>
<td>2</td>
</tr>
<tr>
<td>Dental torture</td>
<td>3</td>
</tr>
<tr>
<td>Mutilation</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>78</td>
</tr>
</tbody>
</table>

Almost all the victims had been exposed to a large number of different types of torture, which makes it difficult to establish a direct connection between the individual types of torture and the state of ill-health of the victims.

However, it seems that falanga is the cause of fasciitis plantaris pedis.

**Diagnoses**

Fibrositis syndrome was diagnosed in 83% of the examinees. Abnormal joint mobility was observed in 66%. 66% also suffered from headaches. Furthermore, a broad spectrum of diagnoses of a more or less serious character and related to the motor system was observed.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Nationality of torture victims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>number of</td>
</tr>
<tr>
<td></td>
<td>men</td>
</tr>
<tr>
<td>Iran</td>
<td>2</td>
</tr>
<tr>
<td>Iraq</td>
<td>5</td>
</tr>
<tr>
<td>Turkey</td>
<td>5</td>
</tr>
<tr>
<td>Uruguay</td>
<td>4</td>
</tr>
<tr>
<td>Chile</td>
<td>3</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>1</td>
</tr>
<tr>
<td>Eritrea</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 4

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>number of men</th>
<th>women</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Artralgia and osteoarthrosis</td>
<td>2</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Abnormal joint mobility</td>
<td>12</td>
<td>7</td>
<td>66</td>
</tr>
<tr>
<td>Subluxatio carpo-metacarpalis 1 dxt</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Fracture of the spine, thorax, or nasi</td>
<td>3</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Fracture of the extremities</td>
<td>2</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Tendinitis</td>
<td>5</td>
<td>1</td>
<td>21</td>
</tr>
<tr>
<td>Fasciitis plantaris pedis</td>
<td>4</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Hyperkyphosis tharacalis</td>
<td>3</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Regional muscle pain</td>
<td>11</td>
<td>4</td>
<td>52</td>
</tr>
<tr>
<td>Fibrositis syndrome</td>
<td>17</td>
<td>7</td>
<td>83</td>
</tr>
<tr>
<td>Cephalalgia</td>
<td>14</td>
<td>5</td>
<td>66</td>
</tr>
<tr>
<td>Bruxism</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Hemiparesis after torture</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Infections after torture</td>
<td>2</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Prolapsus disci i.v. Lumb.</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

Apart from these diagnoses, 24 victims suffered from disturbed sleep (83%).

Connection between torture and diagnosis

There seems to be a connection between falanga and fasciitis plantaris pedis (2). As could be expected, this connection is most obvious in the severest cases.

It is not known whether the frequently seen abnormal joint mobility is a result of suspension in different positions. This would demand more detailed descriptions of the torture than those available, but case reports draw the attention to specific abnormal mobility patterns of the extremities after suspension. However, in particular the facet syndrome (3) is frequently seen, and it is often interpreted as cardially provoked pain, gastritis or other thorax-related pain (4).

It is uncertain whether the fibrositis syndrome (5,6) forms part of the sequelae which comprise sleep disturbances (7,8) and mental symptoms. Maybe the muscles has been damaged by the often daily exposure to beating for long periods of time. It is known from traumas of another character that an excretion of the oxygen-transporting myoglobine into the blood can occur so that the myoglobine will be present in very high concentrations. In extremely severe cases myoglobinuria resulting in kidney failure can be observed.

Only rarely can these severe cases be diagnosed since they concern an acute condition. However, it is not known whether the torture results in a chronic change in the striped musculature, as is seen in connection with the fibrositis syndrome. Here, rubber band-like changes occur along the muscle fibre (9).

Treatment

Please see the article on “Rehabilitation of torture victims”.

Results of treatment

So far the clinical experience has been that physiotherapy alleviates the victims' symptoms; in certain cases it has even had a curative effect. In the afore-mentioned prospective study 22% of the victims examined have completed treatment. All except one obtained a reduction in the “fibrositis index”. This indicates that the “chronic” myogenic changes found in torture victims are reversible. The study is based on a quantification of the fibrositis (10,11). In the same way a quantification of changes in the case of fasciitis plantaris pedis could be expected. The importance of clinical changes and the effect of treatment can also be seen indirectly from the study.

References

By Aase Rabbe

Torture, including sexual torture, inflicts physical and psychological injuries on men and women. Their reproductive functions may be injured, and in particular the sexual functions of both sexes may be affected.

Female torture victims may present particular problems for the examiner in the form of sexological as well as more common gynaecological sequelae - whether or not the torture included sexual violence or direct injury to the genitals.

Torture
The most severe physical injuries in the lower abdomen will almost exclusively result from violence of a sexual character.

Blows, kicks or other blunt violence to the abdomen, including the lower abdomen, will rarely damage the relatively well-protected internal female genitalia organs. Physical violence to this region will in general be direct violence to the external genitals, electrical torture, brutal rape, or the insertion of objects into the vagina, and violence of this character must be classified as sexual.

Sequelae of torture
Physical sequelae
Sexual violence often results in severe anogenital tears, which in turn lead to constricting lesions from secondary infection and scar formation.

Infections that are known to be sexually communicable, e.g. gonorrhoea, lues, and chlamydia infection, can certainly be observed after rape during torture. To these should now be added the possibility of acquiring AIDS.

Hormonal sequelae
Hormonal disturbances will not result from trauma to the lower abdomen since the ovaries are well protected. Whether trauma to the head can cause such disturbances is uncertain. If it can, it would be in the form of traumatic hypothalamic/ituitary insufficiency, but this is very rare.

Though protected anatomically, the ovaries are highly sensitive to external factors, possibly through these factors' influence on the woman's mental condition. The hormonal function of the ovaries is influenced by disturbances in the hypothalamic/pituitary/gonadal system. Psychological factors work through the hypothalamus.

A number of factors account for the occurrence of the ovarian dysfunction. The previous functional condition of the ovaries is important. Certain "built-in" changes in the ovaries and adrenal glands render the function unstable, and indications of this will often have manifested themselves earlier in the form of bleeding disturbances. All things considered, ovarian function is more vulnerable in young women than in older women of fertile age.

Apart from physical, psychological, and sexual violence, with their attendant fear and anxiety, loss of weight, which need not be extreme, can affect ovarian function. Loss of weight may be a result of insufficient food or substandard, polluted food, which can cause gastrointestinal distress and loathing of food or psychologically conditioned loss of appetite. The latter will usually form part of a complex of psychological disturbances which affect the hormonal functions, particularly in predisposed women.

Above all, ovarian dysfunction gives bleeding disturbances. There may be irregular, possibly frequent and prolonged menstruation. However, especially in the above-mentioned predisposed women and in cases of loss of weight, there is more likely to be oligomenorrhoea, developing into amenorrhoea.

If those women were to be examined during the period of dysfunction, ovulatory function would probably be irregular or absent, whereas the oestrogenic level would probably be normal. However, in the case of prolonged depression of ovarian function, perhaps accompanied by loss of weight, a hypo-oestrogenic condition may occur, and with a low basic temperature, changes in hair and skin, hypoplasia of breasts and uterus.

The described conditions will not lead to changes in the pituitary hormones, but the LH-peak will disappear. Serum concentrations of FSH will not increase.

Sexual sequelae
Numerous examinations have revealed affected sexual functions following torture in both men and women. Women will not experience problems to the same extent as men in connection with the performance of the sexual act. However, a symptom such as dyspareunia, which is a frequent symptom, makes intercourse difficult. Reduced libido, developing into fear of sex and absent orgasm, may be the result, not only of sexual violence and humiliation, but of the often prolonged state of fear in which torture in general leaves many victims.

Pregnant female prisoners constitute a particularly exposed group. Miscarriage may easily be a consequence of physical violence, especially of the lower abdomen. Anxiety for the safety of the infant makes it even more difficult for these women, and the fact that many children in prison have vanished without trace proves that the anxiety is not unfounded.

Particularly specific psychological problems may arise if pregnancy occurs as a result of rape during torture. In such cases the woman will often deny her pregnancy and wish for it to be interrupted. Particularly tragic is the disowning of the child after a full-term pregnancy since the child will be victimized to the same extent as the mother.
The gynaecological examination

The gynaecological examination of female torture victims demands extreme care and particular consideration for any anxiety-related reactions from the examinee. It is obvious that the examination may revive memories of torture events, including sexual molestation and humiliations, so that the examination may be painful even though everything may be found normal. It will usually have a soothing effect if the examiner continuously explains what he/she is doing during the examination, what he/she is looking or feeling for, and what he/she is finding.

Abnormal findings include sequelae of sharp violence in the vulvovaginal region, e.g. scar formation with deformation and perhaps vaginal constriction. The examinee will often complain of tenderness of the internal female genitals although they may appear to be normal. As an isolated finding such tenderness cannot automatically be accepted as an indication of gynaecological disease. By contrast, tenderness of the musculotendinous structures on the pelvis wall, often located to the region of the psoas and piriformis muscles and the floor of the pelvis, may be seen as a genuine indication of organic changes in the motor system resulting from anatomical changes in the back, pelvis or lower extremities, or muscular strains and tensions, which are extremely common in victims formerly exposed to torture. It is not a gynaecological disease, but it can be observed at the gynaecological examination. Such muscular changes often provoke pain which can be mistaken for a gynaecological disease, e.g. lower abdominal pain and dyspareunia, and it is important to establish the correct cause of the pain so that the correct treatment can be given.

Evidence of sequelae of torture inflicted on the genitals is very hard to obtain. The subject is taboo for women of many cultures. The mere description of sexual torture subjection will be painful to most women, partly because of the humiliation involved. Even the examining doctors have often found it difficult to interview women about sexual torture and shed sufficient light on this aspect of torture. To the torturers, however, it is in no way taboo, and the extent of sexual torture and its often far-reaching consequences make it an important subject within the torture spectrum.
Odontological Treatment of Torture Victims

By Peter Jerlang

In the middle of the 1970s the Danish medical group of Amnesty International began to examine the many torture victims arriving in Denmark. It turned out that part of the torture carried out had been directed at the head and the oral cavity. It was therefore natural that dentists were included in the examination and treatment of torture victims.

The torture types we found comprised all forms of severe violence to the head and face, and more specialized torture, such as electrical torture, with electrodes were attached to the face, lips, gums, teeth or tongue.

In a previous study of torture findings in 39 persons (1) conditions were found which do not differ much from the findings of a more recent study (2). This study comprised torture victims from 6 different countries.

The torture involved the following:

Blows to the head and face with clenched fists (39); blows to the head and face with instruments (11); kicks to the head and face (18); teeth deliberately loosened (1); teeth extracted (1); electrical torture to the teeth (8); electrical torture to the gums, lips or tongue (11); electrical torture to the face or back of the neck (11): submari­n­ino (13).

Symptoms and signs

When summing up the sequelae of torture in these 39 per­sons, the following result emerge:

- One or more teeth loosened because of beating: 7
- Teeth knocked out during the torture: 2
- Teeth lost later as a direct consequence of beating or loosening: 7
- Tooth fractures because of beating or as a consequence of deliberate action by the torturers:
  - Enamel fracture: 4
  - Enamel/dentine fracture, uncomplicated: 4
  - Fracture complicated: 1
  - Left roots: 3
  - Hypersensitive teeth: 1
  - Necrotic pulp: 3
  - Spontaneous headache: 14
  - Provoked headache: 13
  - Pain in the jaw-joint: 3
  - Pain when opening the mouth: 2
  - Reduced mobility of the lower jaw: 2
  - Deviation of the lower joint when opening the mouth: 1
  - Caries: 14
  - Toothache: 4
  - Need for root treatment: 6
  - Symptoms of gingivitis: 5
  - Signs of gingivitis: 19
  - Marginal paradontal pouches over 3 mm: 17
  - Negative papillae: 7

The picture of symptoms immediately after the torture and the signs found at the time of examination differ since several years had often passed since the torture. The more acute pain-causing cases had often been treated in the intervening period, i.e. traumatized teeth had either been extracted or treated in some way.

Among other things, it could be mentioned that most of the persons who had been subjected to submarino developed inflammation of the oral cavity, including tenderness, swelling, bleeding and fissures in the mucous membranes of the mouth.

Accessory dental complaints

Almost all the victims examined throughout the years suffer from tender masticatory muscles and headache. It is possible to ascertain that headache, together with depressions, states of anxiety, irritability, sleep disturbances, nightmares and impaired power of concentra­tion, forms part of the picture of symptoms found in almost all torture victims.

The mental condition, the somatic sufferings, and the exile situation with its social, family and language problems cause the victims to live in a state of extreme mental stress. In most victims this state results in a highly increased psychomotor activity which inevitably manifests itself in various forms of parafunctions in the masticatory system, such as dental pressure or teeth grinding.

It could almost be said that the teeth become the mirror of the soul.

Therefore, it is not surprising that the frequency of headache caused by tension is much higher than the one found in a normal group of patients.

The victims have seldom suffered from headache or other symptoms relating to bite functions before the detention and torture. Therefore, a connection between the mental state and the pronounced symptoms of head­ache is very likely.

Theories of the origin of facial pain

As mentioned earlier, one of the more general symp­toms among torture victims is that of facial pain and myogenic headache. The frequency of these symptoms is three times as high among persons in this group than among persons in a Danish normal group. Headache can be a direct result of head traumas, but often it is a functionally determined headache resulting from tension. At the same time, pain in the muscles of the neck, globulus sensation, the supportive musculature of the head, the occipital muscles, and the muscles of the pectoral girdle is found. The mental crisis which the victim undergoes probably accounts for the headache resulting from tension which most victims experience. The crisis is a result both of the previous torture experiences and of the exile situation forced on the victims. This stress condition intensifies the psychomotor activity which results in the emergence of various parafunctions such as dental pressure, teeth grinding and tongue pressure. The para­functions both occur during the day, e.g. in anxiety pro­
voking situations or during concentrated work, and during the night when the increased psychomotor activity causes hyperactivity in the masticatory system. This is particularly so during nightmares. This state is termed bruxism. Bruxism implies a contact between the teeth in the upper and lower jaws. Often the lower jaw is set in an extreme position during the development of vigorous muscle activity. During this activity facets of attrition occur on the teeth. They are often delimitated and shiny.

If this state is allowed to continue, pathological conditions in the connective tissue of the muscles in the form of fibrositis, traction periostosis and damage to the teeth and jaw joints will soon occur. If this condition is not disrupted, experience shows that a self-increasing vicious circle is created. The chronic muscular pain will result in depression or increase an already existing depressive state of mind. The heavy muscle activity may result in large or small dental fractures and gradual changes in the occlusal contact conditions. These conditions will cause irritability of the neuromuscular control mechanisms, and this will further stimulate the parafunctional objectional habits. Furthermore, experience shows that this chronic state of pain may cause a change in the reactionary pattern of the organism during stress influences.

In these patients a higher concentration of catechol amine and of 17-hydroxysteroids than the one seen in healthy patients has been found. Moreover, it has been shown that these pain-suffering patients react to stress situations by tightening their masticatory muscles far more than normal patient would do in a similar situation.

If the parafunctions continue during a long period without treatment, the jaw joints will often be damaged because the upper part of the lateral pterygoid muscle, which inserts itself in the anterior part of the disc of the joint, is particularly active during teeth grinding. This hyperactivity will gradually cause an anterior or lateral dislocation of the disc with loading of the soft posterior part of the disc. This causes pain and swelling. The patient will experience the luxation as a snapping of the jaw-joint. The snap usually takes place at the end of the opening movement when the disc slips into place at the top side of the condyle. The disc will be correctly positioned during the closing movement, but at the end of the closing movement, it will be dislocated anteriorly again. A return snap will occur which will often not be audible to the patient. When the disc is not in its right position between the condyle and the fossa, the distance between the condyle and the fossa will be reduced. This will cause a disturbance of the normal occlusal position. This position may be stabilized by intrusion of the posterior molars. However, supra-contacts at lateral movements will occur, and they will worsen the existing parafunction. If the situation continues, lasting and degenerative changes in the jaw-joints will occur. If treatment is initiated at an early time, a reposision of the discus can be obtained, and regenerative scar formation will take place. An arthrosis will usually stabilize itself and become relatively symptomless if the parafunction stops. However, heavy pain and reduction of mobility will often occur later.

**Examination of bite function**

Most of the torture victims examined by us do not relate their headache to dental pressure or teeth grinding. It is therefore important always to include an examination of the bite function as an essential part in an odontological examination.

The examination contains the following elements:

- The **yawning movement** should be symmetrical up to a distance of 40 mm between the edges of the incisor teeth in the upper and lower jaws. A smaller distance, or an asymmetrical opening movement could indicate an anteriorly displaced discus; however, this could also relate to a muscular condition.

- **Jaw-joints.** Palpation of the movement of the condyles and the discus should be made. Both lateral and dorsal palpation should be made.

- **Examination of the muscles.** All masticulatory muscles should be palpated, if possible, bilateral palpation. If any painful areas are found, they should be marked in a diagram with a special marking of the subjective pain areas. The localization of the pain-causing fibrositis provides a clear guide to understanding how the lower joint is positioned during bruxism. For instance, if fibrositis is found in the masseter muscles of both sides, in the anterior right part of the temporal muscle, and in the right lateral pterygoid muscle, it is likely that the patient performs his bruxism with his lower jaw positioned anteriorly to the left.

In order to establish this hypothesis the teeth should be examined with a view to finding bruxer facets where such contact may occur.

Then a **provocation test** should be made. Here the patient finds the hypothetical position in which the attrition facets fit together, and he presses his teeth firmly together for some minutes. If known facial pain occurs, the test is positive.

Finally, the **occlusal contact conditions** should be examined, and also whether there are non-interfered gliding possibilities during protrusion, laterotrusion, mediotrusion and retrusion.

**Short on treatment**

The actual dental treatment will not be dealt with here, but it should be mentioned that it should be carried out together with an applied general treatment.

**General treatment**

Psychotherapy to reduce mental strain. Physiotherapy. Medicamentation.

**Dental treatment**


**Preparation of dental treatment**

All the persons examined had a distinct wish to undergo dental treatment, especially treatment based on regeneration, because it is extremely important to the victims to appear whole again. The oral cavity seems to have great psychological importance.

The often long periods of detention under poor sanitary conditions and the poor prison food increase the already pronounced need for treatment which is found among the victims (3).

The prerequisite for a successful treatment is a profound knowledge of the victim's background, torture record, imprisonment and present situation. It is important to build up slowly a relationship of trust. This is often difficult because of the language problems since
this means that communication often takes place via an interpreter. In such a situation it is very important to direct the attention solely at the victim and more or less ignore the interpreter. Body language must be used. At the same time a poor knowledge of the victim’s cultural background can be a problem, especially in the interpretation of the victim’s reactions.

The first contact should never take place in the consultation room, and never with the victim placed in the dental chair. If the victim is placed in the chair, with instruments and two persons bowed over him, the victim will feel fixed and deprived of control. He will experience such a situation very much like an earlier torture experience. In fact, dental treatment will often be experienced as a crisis which can easily trigger off violent reactions on account of the earlier crisis experiences.

In severe cases it may therefore be necessary to prepare the dental treatment in cooperation with the psychologist, who, with a good result, can practise programmes of relaxation to be used in the dental chair. It may be an advantage if the psychologist participates during the initial treatments until the necessary contact and trust is established.

It is important never to let a torture victim wait for treatment because this waiting may trigger off anxiety reactions which can easily destroy an already established trust relationship.

References
1) Bølling P. Tandtortur. Tandlægebladet, October 1978; 82: 571-574. (Summary in English).
Physical torture mainly comprises beating, different methods of suspension, electrical torture, and specific types of torture, e.g. the bathtub (bañera).

Beating: This implies blunt trauma, and it is worth noting that penetrating injuries are rare.

Beating can be categorized according to the way it is carried out, e.g. with the flat of the hand, clenched fists, by kicking, or beating with an instrument, for instance a truncheon.

The force and approximate number of the different beatings must be noted, and the number of persons simultaneously involved in carrying out the torture. It should also be noted whether the victim was clothed and wearing shoes, which may have provided protection.

Finally, the position of the victim during the torture should be noted. For instance, suspension may have been combined with beating, or the victim may have been immobilized, for example by being pressed into a tyre and then beaten on the soles of the feet.

Let us now consider the different regions of the body to which beating can be applied:

The head: beating with a hard instrument may cause concussion and fractures of the skull. As in normal clinical work, it is important in the assessment of possible brain damage to take a detailed history to determine amnesia, loss of consciousness, projectile vomiting, etc. Blows to the head may give rise to the post-concussion syndrome if the trauma was of such a degree that cerebral contusion occurred. The syndrome is characterized by a number of symptoms including headache, fatigue, poor concentration, impaired memory, vertigo, irritability, anxiety, and intolerance to alcohol. It is not surprising that victims who became unconscious from head trauma later complain of symptoms which might indicate organic brain damage.

Nose fractures, surprisingly, are infrequent in torture victims. This may be due to the fact that a torture victim cannot fight back - he is defenceless and will try to turn his head away from the aggressor. Victims are not aggressive and, consequently, the nose is probably spared.

Blows to the ears in the form of telephone torture, i.e. hitting the ears simultaneously with the flats of the hand, may give rise to ear drum lesions. These probably result from shock waves caused by the beating and may be compared with the lesions following blasts. Examinations in Belfast (1) have shown that blast lesions produce tinnitus and deafness, lasting only a few hours in the mildest cases, but persisting after severe blasts. Perforation of the drum has often been seen after telephone torture, mainly in the lowest five sixths. The injuries range from linear tears to small holes or subtotal defects. Injuries to the auditory ossicles have also been observed. High-frequency sounds in particular are impaired, while normal hearing is preserved for speech frequencies. Spontaneous improvement of hearing has been noted up to six months after the blasts.

Thoracic injuries: The most frequent thoracic injuries are fractures of the ribs. Haemothorax and pneumothorax have been reported in several instances. Extremely severe intrathoracic injuries have only been recorded in autopsies of torture victims, and it should be stressed that torture produces blunt rather than penetrating thoracic trauma.

This also applies to abdominal trauma. It is rare to hear of torture victims having survived blunt abdominal trauma that resulted in rupture of the spleen or contusion of the liver. Amnesty International reports from Kenya (2) and China (3) describe deaths caused by severe intra-abdominal bleeding after torture.

Blows to the kidneys may produce haematuria. Traumatic haematuria usually clears after a few days and does not give permanent damage.

I would also like to mention haemoglobinuria following trauma. It is well known that long-distance running, e.g. the marathon, can produce haemoglobinuria. The condition is also described as footstrike haemolysis (4) and involves damage to the red blood cells with the excretion of haemoglobin by the kidneys. Falanga victims often report haemoglobinuria after torture.

Torture by falanga deserves particular attention because it is one of the few torture forms which has occasioned more thorough investigations. Bro-Rasmussen has thus undertaken a valuable anatomical study of the foot, and he has been able to document the existence of closed compartments in the foot in which the muscles are located (5). A closed compartment syndrome in the foot was first described in torture victims, later in other people (6). The anatomical studies also showed that swelling induced by the injection of fluid into the closed muscle compartment was most pronounced medially at the ankle. Ischaemic lesions of the toes have been reported after falanga, supporting the theory of a closed compartment syndrome (7).

Bones: The occurrence of fracture in various examinations of torture victims ranges from 4% to 27%. The frequency of fractures in a survey of 200 examinees was 13% (8). Most of the fractures were radiologically veri-
fied. Most frequent were fractures of the rib after beating (10 persons), followed by fractures of the foot after falanga (5 persons). It may be noted that, although evidence of fractures can usually be seen by X-ray long after they have healed, a negative X-ray does not exclude earlier fracture, especially if it healed in an anatomically correct position in a young person. However, only few studies on this have been undertaken.

Trauma to the genital region: Haematuria is common in men after trauma to the urethra. It often occurs after the insertion of an instrument, for example in electrical torture.

Atrophy of the testis as a result of trauma is I think more frequent than reported because of insufficient examination of the torture victims. In a survey of 161 male torture survivors atrophy of the testis was seen in six (4%), all allegedly caused by kicking of the genital region (8).

I shall now briefly return to some special forms of torture which lead to specific symptoms:

Bañera, in which the head of the victim is forced under water. This is often very polluted, and its aspiration might be suspected of leading to pneumonia. However, examinations of relatively recently tortured victims in Spain did not establish evidence of objective changes in the lungs (9).

Suspension by the wrists may give peripheral nerve injuries. Handcuffs mainly damage the superficial part of the radial nerve due to its superficial position over triceps (10). However, handcuffing has also resulted in injuries of the median and ulnar nerves (11,12).

The parrot perch causes pain particularly in the wrist, the back of the lower leg, and in the radial part of the forearm. These parts carry the whole weight of the body during suspension.

The motorcycle causes intense pain in the knees, intensified when they are pressed down, and most intense when they are pressed down and rotated.

The operating table, in which the upper part of the victim’s supine body hangs over the edge of the table, causes intense pain in the spine, particularly in the lumbar region.

Forced standing in the same position for long periods, e.g. within a chalk circle, can cause swelling of the lower leg, to such an extent that skin blisters have even been seen.

I have described only the most frequently practiced special types of torture, and I should like to finish by stressing the importance of knowing in detail how a torture was carried out, its quality and amount. It is also important that we have detailed descriptions of acute and longer-lasting symptoms that are related to specific torture forms. Such descriptions might well substantiate individual allegations of specific types of torture. As in all medical work, correct treatment depends on correct diagnosis, which in turn depends on a correct interpretation of symptoms and signs.

References
5. Bro-Rasmussen F, Rasmussen OV. Falanga Torture. Are the sequelae of falanga torture due to the closed compartment syndrome in the feet and is this a common clinical picture? Ugeskr Læg 1978;140:3197-201.
The Torture Victim

Deficiencies and Stress

By Henrik Marcussen

Torture is a multifactorial matter. It causes physical and psychological lesions, both acute and long-term. Intellectual, emotional and sensory functions are deeply affected. Most likely, integrating functions are affected as well, e.g. physiological reflex mechanisms and the immune system.

We know about this from studies of torture victims. However, it is difficult to assess these various function disturbances specifically. The direct connection between these and the torture and prison life has to be proved. Detention involves much more than the carrying out of the torture itself, for instance isolation, lack of legal protection, psychological insecurity, various forms of deprivation, inhibition of development, long-term physical influences and an understimulated existence.

However, we cannot demonstrate this connection solely by using the total of our knowledge gathered through studies of torture victims (1). There are too many variable and simultaneously strenuous factors. Among the torture victims in a group, various circumstances are present, such as expatriation, isolation from the family, lack of access to education, and change of culture. Therefore, in a number of studies we have attempted to look at certain groups in isolation, as selected and homogenous with regard to a number of common external circumstances. For instance reports from geographically delimited areas with an identical refugee-situation. An ideal example is the study from Greece (2), in which the external influences were moderate. Thus, those examined did not have refugee status, they were socially re-established and had a good reputation.

They had been united with their families, and they could immediately continue their education or occupation.

Below I have attempted to systematize the deficiencies that we often find when going through reports.

The physical deficiencies register a number of factors which secure normal physiological activity, e.g. behaviour and activity of motion, assimilation of food, and sensory function. The psychological deficiencies are more difficult to classify immediately. They are in particular characterized by a permanent activity alertness, isolation and insecurity on behalf of oneself and others. Finally, a number of conditions are mentioned that can be attributed to the miserable physical surroundings, including neglect of natural and acquired needs. This classification should not be taken too literally. Several of the physical and neglect-induced deficiencies could for example be perceived as psychological stress factors.

Stress can be physiologically defined as a state of deficient biochemical adaptation or homeostasis of the hypothalamic centres and of the function of the subordinate endocrine glands. The concept also covers a heavy and prolonged drain on biological and psychological resources, comprising a number of integrating functions such as endocrine, neuro-endocrine, neuro-transmissionary, and immune-biochemical functions, and prostaglandine synthesis. There is a more or less reliable experimental basis for this. Moreover, stress has been explained as “factors in the surroundings, disturbing individual balance and causing emotional tension, thereby promoting ill-health” (3).

Clinical arguments for the influence of stress

The following will deal with some clinical results from a number of comprehensive systematical studies of persons exposed to stress. Often, it is practically impossible to differentiate between deficiencies and stress, as laid...
out in the above table.

In Eitinger and Strøm's study of mortality and morbidity after excessive stress (3), an increased ratio was shown for neoplastic diseases in 4,574 former KZ-prisoners during a period of 25 years. The increased ratio was 1.08. The total mortality for all groups of diseases, however, was a little lower in the ex-prisoners than in the controls. However, it was higher among 50- to 60-year-old people, and for a number of well-defined diseases such as coronary occlusions and infections the ratio was also higher.

Morbidity was studied in detail in 498 ex-KZ-prisoners and matched controls. This comparison showed a significantly higher incidence among ex-prisoners of neuroses, alcohol and drug abuse, gastric disorders and diseases of the muscles/joints. The group was socially less stable and displayed a pattern of adaptation of the problems of the urbanized population in spite of an equal urban/rural distribution.

The conclusion of the study was that the group, selected from survivors of captivity, showed a reduced resistance to both disease and a reduced ability to adapt to changes in the surroundings.

A study of Danish convoy-sailors (4) showed that these suffered from constant alertness in the form of tension, also during sleep. They were forced into a passive anxiety anticipation without normal reactions such as escape or attack. Psychological deficiency was shown in 30 out of 32 with asthenic, intellectual and emotional/affective symptoms in the nature of organic psycho-syndrome. For instance, 22 out of 30 were found to suffer from nightmares accompanied by sweating, restlessness and shouting, as well as a reduced tolerance towards violent events, for instance war movies and unspecified experiences of anxiety and nervous attacks. In a follow-up study of 492 American prisoners of war 9 years after World War II, the morbidity was 7 times higher than among the controls (5).

The diseases affect almost all organ-systems. A study of Hong Kong veterans (formerly in Japanese captivity), compared with controls (their 100 brothers) who had served in the Canadian Army, but had not been prisoners of war, showed that the ex-prisoners earned lower wages, showed less leadership ability, had more personal problems, neuro-diseases and psychosomatic and organ-related disorders. (6).

In a prospective study of 2,500 American sailors, the sailors were divided into a high-risk and a low-risk group following an anamnestic interview. At a later examination it turned out that both groups had responded with a rise in morbidity in connection with extreme stress, but the high-risk group started at a higher morbidity level. (7).

The conclusion of these studies is that continuing and increased stress has an influence on morbidity, and on mortality, provided that there is a differentiation between groups of diseases. A higher risk of infectious diseases and poor adaptation is found. Even minor additional stress situations will worsen an already unstable balance and can lead to manifest disease. This can happen at any time and e.g. explain why no specific “dangerous” period of life was found in the Norwegian study. The studies also show that former, prolonged, continuing stress exposure does not decrease over the years.

In the above-mentioned study of Greek torture victims from the Junta-period (2) we found factors which were consistent with this conclusion. However, it must be emphasized that actual concluding studies of this kind are few.

Experimental arguments for the influence of stress

A number of experiments have shown a connection between life-events and suppression of the human immune response. In particular, this connection has been explored within the field of depression.

Stress causes a rise in antibody-titres of vira that are intracellularly latent, e.g. Herpes simplex I DNA. The mechanism is a reduced cell-mediated surveillance which renders viral DNA capable of living (8).

The natural K-cell activity (the ability to destroy various tumor-cell levels in vitro immediately) was found to be reduced in persons with a high stress level and with no relation to factors that might influence this, e.g. medicamental treatment. Loneliness (social isolation) and examination situations were positively associated to the phenomenon. Other studies have shown that a stressful event can modify an immune response (8).

A connection has been shown between the production of lymphocytes and hormone receptors. This indicates that a two-way-system exists between the brain and the immune system with hormones as messengers (8). Experimental arguments in favour of a irreversibly augmented ageing ratio have been observed in mice that have been exposed to stress, and tissue cultivation has shown changes in the cell-duplication corresponding to what is normally found only in older individuals. To sum up these experiments, it could be said that the biological clock “ticks too fast” (9).

The conclusion of these few examples is that the organism may be under the influence of factors that normally stabilize a homeostatic balance. When this/these factors are acted upon e.g. by a rise in sympathetic tone or the like, or when the mediators of this system are acted on, then disturbances of the homeostatic balance can occur, resulting in conditions which may be reflected by the afore-mentioned clinical observations.

References

Psychosomatic Disorders in Torture Victims

By Henrik Marcussen

Psychosomatic disorders, like several other ill-defined and inexactively delimited conditions, have a series of names:
Psycho-physiological, autonomic, and vegetative nervous system disorders. This suggests a connection with the stress-adaption theory of Cannon and Seyle.
The American Psychiatric Association's diagnostic and statistical manual III of 1980 has characterized these conditions as "psychological factors affecting physical conditions" (1).
Thus the range of the problem is wide and still difficult to define. There are some essential characteristics which show that:
a. there is no correlation between psychosomatic disorders resulting from acute stress, and emotional dysfunction;
b. typically, the persons affected will change the reactions of the organ as time passes by so that an actual target organ may be difficult to find;
c. there is no essential difference in the psychopathology of psychosomatic persons and the one of healthy persons; and

d. there is a strong correlation between chronic physical diseases of any kind and premorbid psychopathology.

Item d) has ethiological significance. This will not be elaborated on here, apart from mentioning that knowledge of "type a behaviour" suggests a pathogenic factor. Research into life-events, which is based on the theory that adaptation exhaustion produces stress and thus illness, is supported by a study of events and traumatic experiences in a series of well-defined known diseases and among control persons (2).

From these assumptions and with knowledge about a series of deficiencies, mentioned in the previous article, some of the requirements are justified for later disturbances which can be called psychosomatic. The list of psychosomatic disorders is extremely comprehensive, depending on the definition. Here, these conditions are limited to gastro-intestinal disorders, cardio-vascular symptoms, arthralgia and back problems, headache and hypertensive, and it should be born in mind that these conditions often correspond to organ affection of non-psychosomatic pathogenesis.

In the study made by Eitinger and Strøm, covering 498 surviving Norwegian KZ-prisoners and matched controls (3), there was a significant difference, with a higher frequency among the ex-prisoners of the following: tuberculosis, neuroses and nervous complaints, alcohol and drug abuse, gastric disorders and diseases located to the connective tissue. Among these categories of diseases the following are selected as possibly psychosomatic from the authors' extensive diagnosis register:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Ex-prisoners</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headache, dizziness and sleep disturbances</td>
<td>51 (10.2%)</td>
<td>21 (4.2%)</td>
</tr>
<tr>
<td>Uncharacteristic symptoms located to the resp.</td>
<td>7 (1.4%)</td>
<td>1 (0.2%)</td>
</tr>
<tr>
<td>System and dyspnoea</td>
<td>59 (11.8%)</td>
<td>25 (5.0%)</td>
</tr>
<tr>
<td>Uncharacteristic symptoms located to the gastro-intestinal functions and dyspepsia</td>
<td>3 (0.6%)</td>
<td>1 (0.2%)</td>
</tr>
<tr>
<td>Uncharacteristic symptoms located to the cardio-vascular function</td>
<td>59 (11.8%)</td>
<td>23 (4.6%)</td>
</tr>
<tr>
<td>Rheumatism-myalgia</td>
<td>13 (2.6%)</td>
<td>3 (0.6%)</td>
</tr>
</tbody>
</table>

Some studies regarding especially gastro-intestinal symptoms should be mentioned because these symptoms are numerically better supported, and they could be important for the understanding of prison-life.

When controlling 120 former KZ-prisoners in 1958, Hermann and Thygesen (4) found that 23% had gastric dyspepsia, 14% had verified ulcus D/V, and 57% had periodic diarrhoea.

Thygesen et al. (5) examined 572 members of the resistance movement in 1970. They found that among these 2% had ulcus and dyspepsia before imprisonment, less than 1% during imprisonment, and 7% in 1967.

Paul (6) examined 2,000 former German prisoners of war. 29.6% of these had disorders located to the stomach and/or the intestines.

Our own study of 135 torture victims showed that 22% had cardio-pulmonary symptoms, 36% headaches and 32% gastro-symptoms (7). This material is invalidated by the lack of controls and by its multiple origin.

The studies mentioned above reflects the conflict situation as inducing a mental trauma, or as a sustained state of stress as the basis for a series of overrepresenting injuries.

In Amnesty International's material on 135 torture victims, the gastro-intestinal symptoms broke out after the period of torture. They were both periodic and permanent, described as similar to the symptoms of ulcer.
dyspepsia, like epigastric regurgitation pain, with food-related oppression and irritable colon of the hypermotoric type as the most common.

These disorders are composed of a complexity of symptoms, and it is not permissive to relate them solely to the torture. However, they could be related to the stress mechanism as such. Here, the torture - and also the physical conditions in the prison and the psychological effects of those - must be seen as major causes.

However, it is possible to imagine other causes or co-causes, such as starvation or limited supply of fluid in connection with heavy physical exhaustion. This typically takes place during the first period of imprisonment.

The low contents of protein and fibres in the prison diet and insufficient exercise are factors with pathogenic importance concerning the development of irritable colon. Protein and fluid restriction leads to insufficiency of salivation and digestion.

It should be mentioned that the dental reports included in the studies stressed these conditions as being responsible for a strikingly worse state of the teeth than was to be expected in a corresponding background population (8).

References
When doctors are to write a report on the basis of an interview with and a medical examination of a torture victim, the vast majority will do this with the ordinary patient record in mind. This will, necessarily, affect the wording and structure of the report, and since doctors, like other professional groups, are prone to using technical terms, most reports contain a lot of Latin medical terms.

These are terms which have precise meanings to doctors, but to laypersons most of these terms will be all double-dutch (especially if their native language is not English). Of course it is tempting to write: “stet. c. et p: i.a.” But why not write “stethoscopy of heart and lungs shows normal conditions”? The excellent word “scar” is just as adequate as “cicatrice”. You cannot take it for granted that laypersons will understand words like “lateral” and “medial”. How does the outsider handle terms like Babinski’s reflex and, even worse, “dysdiadochokinesia”? All the above examples have been taken from reports chosen at random, reports which have all been presented before the Danish Refugee Appeals Board.

Doctors have often been accused of not speaking a language comprehensible to the patients. Lawyers make the same complaint. Even though other professions (e.g. lawyers, economists, and computer people) may be prone to using their special terms as well, we as doctors ought to contribute to the general understanding by using a language which everybody understands. Furthermore, it should be emphasized that the credibility of the report is not increased by using technical terms. Lawyers, as well as other non-medical persons, are more likely to be irritated when they cannot understand all terms.

How the report should be structured is described elsewhere in this book. I shall now dwell on the lawyers’ and the refugee authorities’ evaluation of the separate sections of the report.

Introduction and background
Do not transcribe the police report. Take your time to ask the interviewed person yourself and then write down what you find out, even if this might not be fully consistent with other documents in your possession.

Previous state of health

Be brief.

Arrest and torture
This is an important section which will be closely read. Therefore, it is very important that your description is exact. This does not imply, however, that you should be sparing in words.

Symptoms after the torture
Be brief, write down only strictly relevant things.

Present symptoms
This is a very important section, so be exact here, too. For instance, “headache almost daily, mostly localized to the temple regions, often accompanied by nausea” and “headache when reading, is only able to read for about five minutes” are much more descriptive wordings than just “headache”. “Contemplates suicide” is a piece of information, indeed, but “contemplates suicide when thinking of expulsion” says more about the essentials of the problem.

Medical examination
This section is also carefully read, and therefore it is very important to use ordinary language instead of Latin medical language. There are ordinary terms for nearly all medical terms. If you insist on using some specific professional terms for some reason, then, please, in parentheses after the common expression for the same thing. If you cannot remember this common term, you will find that it is not illegal to have a look in a clinical dictionary. In case you, despite of all efforts, have not succeeded in finding a common, adequate term, it might do, however, to insert the word “so-called” (e.g., “a so-called drainage tube”).

Conclusion
This is by far the most important section of the report. Like the other sections, it has to be concise, but do not make it too brief. It should contain a summary of the previous sections, and it is important to stress the descriptions of types of torture, present symptoms and signs, so that these descriptions will form the basis for the conclusion. It goes without saying that you should not bring forward new information in the conclusion. The conclusion should be positive; the following conclusion, for instance, is not particularly suitable: “On the existing basis nothing speaks against the correctness of
what has been stated”. A much better wording would be: There is consistency between what has been stated and the findings at the examination”. It would be even better to write: “The described symptoms immediately after the torture, the symptoms at the time of examination, and the signs (if any) found at the examination are consistent with the alleged torture”.

It should be possible to grade the conclusion, e.g. by distinguishing between “consistency with” and “full consistency with”. If you find that there is consistency, you may conclude by writing that “the explanation of the examined person is coherent, and there does not seem to be any reasons to question it.”

If you do not think that there is consistency, you should write something like: “At the examination nothing came to light which elucidates the matter any further”. Do not, neither directly or indirectly, write that the examined person has been lying.

Many people would like to include standard terms in the conclusion. This wish is difficult to comply with, since the individual cases may differ greatly, but the main points are to be concise, positive (no double negations!), and not too brief since this may water down the conclusion to the degree of insignificance.

As a general rule: be objective, and do not write more than you can answer for. Remember that often the report is a legal document, but it is not to be seen as a piece of evidence presented by one of the litigants.
Medical Reports in Asylum Cases

By Poul Søgaard

As a member of the Danish Refugee Appeals Board I have several times taken part in hearings of asylum cases at which a medical report prepared by doctors attached to Amnesty International's Danish medical group has been presented.

Normally, the Board attaches great weight to these reports when considering asylum cases. In some instances the reports have probably been decisive of the outcome. Of course, the reason for this is the tradition of credibility, thoroughness, and independence which, combined with medical professionalism, the Board associates with the name of Amnesty International.

The comments in this paper should, first and foremost, be seen as coming from a “user” of the reports.

The role of the Danish Refugee Appeals Board
The Board makes the final decision in asylum cases. The decisions of the Board cannot be brought before a court of law. However, a complaint can be submitted to the parliamentary ombudsman, who cannot alter the decision, but who may criticize the procedure. Normally, this will result in a new hearing. This may also happen if new essential information is produced after the decision of the Board.

The medical report
In cases in which the asylum seeker alleges that he has been subjected to torture, it is often of great importance to have this allegation investigated in the form of a medical examination. The asylum seeker’s lawyer will often be the one who takes the initiative in having a medical examination carried out and the subsequent medical report presented to the Board.

The strength of the medical report is that it is founded on a thorough interview and an examination performed by experienced doctors whose professional expertise guarantees the value of the report.

Because of the Amnesty doctors’ specific knowledge of torture types and torture sequelae, great weight should be attached to medical reports made by doctors from Amnesty International's medical groups.

The lawyer should not include the medical report in his pleading since this may give the members of the Board reason to question the objectivity of the conclusion of the report.

The contents of the medical report
In my opinion the medical report should contain the following elements:

- the asylum seeker’s explanation of the torture and circumstances in connection with the carrying out of the torture
- the asylum seeker’s explanation of the torture sequelae, including the present state of health
- a description of the signs found at the medical examination
- an assessment of the consistency between the signs and the asylum seeker's explanation of the torture and its sequelae
- if necessary, a note about how the explanation of the torture and the signs tally with Amnesty International’s general knowledge of the use of torture in the country in question.

The report should not, however, say anything about the asylum seeker’s credibility in general or render explanations of matters which have no connection with the torture (apart, though, from necessary background information). The Refugee Appeals Board will assess the credibility itself, and the asylum seeker’s general explanation is given in the questionnaire, the police report, through the lawyer, and before the Board.

The medical report should not say anything about the risk connected with sending the asylum seeker back to his native country. The Board is to assess this risk on the basis of the asylum seeker's explanation compared with general background information from, among others, the Ministry of Foreign Affairs, the Danish Refugee Council, and Amnesty International. An exception can be made, however, in cases in which a need for treatment cannot be fulfilled if the asylum seeker is sent back to his native country, and in which the health of the asylum seeker will be endangered because of this.

As for the writing of the medical report, I concur with Hans Petter Hougen’s paper on this subject.

The influence of the medical report on asylum decisions
As previously mentioned, the contents of the medical report may have decisive importance in the individual asylum case. If the report does not support the asylum seeker’s explanation of having been subjected to torture, the asylum seeker’s credibility and his chance of being granted asylum will be weakened. In such cases the lawyer will probably choose not to present the report to the Board. If, on the other hand, the report supports the asylum seeker’s explanation, his chances of obtaining asylum will grow. You should, however, be aware of the fact that asylum seekers do not automatically have a
right to asylum because they have been subjected to torture in their native countries. For instance, if the torture and a possible confinement took place several years ago, and the asylum seeker has been able to live comparatively free in his native country during the intervening years, he will often find it difficult to convince the Refugee Appeals Board that he, when leaving his native country, was actually persecuted or that he, if coming back, will risk persecution to an extent which fulfils conditions for obtaining asylum.

But as a general rule, the existence of a medical report contributes to secure the best possible basis for decision-making in asylum cases, and this must be in everybody's interest.
The Controlled Study of Torture Victims

By Hans Draminsky Petersen

Introduction
Over the past ten years a number of studies has been published on the health of torture victims. Some are case reports (1-2), in other works from Amnesty International (AI) the examining doctors have attempted to evaluate the credibility of the victim's statements on the basis of each victim's description of the torture experience and post-torture symptoms and on the basis of the results of an objective examination (3-5). The health problems of torture victims have been described in uncontrolled studies (6-11). Only in later years have controlled cross-sectional studies of groups of torture victims been done to illustrate the effects of torture on health (12-14), and one attempt has been made to initiate a longitudinal study (12). However, research in this area involves a number of problems. In this article some of these problems and areas not yet analysed will be discussed.

Exposure
The following describes the types of exposure to which many torture victims and potential control persons are subjected.

Torture
The torture exposure is extremely complex, (3-15), a large number of physical and psychical methods are used simultaneously or successively. In step with the stabilisation of the repressive regimes (e.g. Chile), torture methods seem to become more sophisticated (16), and there is evidence that health professionals have participated in the planning of torture programmes (17). In many parts of the world identical torture methods are used, and this has led to the assumption that there is an international exchange of experience with a view to making torture more efficient (18) and difficult to document. Thus it is common that the torture leaves no physical scars on the victim. Where scars occur they are usually uncharacteristic as those left by everyday traumas (12).

Sophisticated psychological methods of torture have previously been thoroughly described (19, 20). They fulfil the requirement that no visible traces of torture be left on the victim. An example of this is the “impossible choice” (20) which may cause late symptoms like impaired self-esteem, a feeling of guilt and shame, and a tendency to avoid contact with others.

The objective of torture is, besides extracting confessions and information, to destroy troublesome individuals, break up opposition groups, frighten those closest to the person in question. An indication that the torture has achieved its purpose may be that the victim will refrain from seeking medical assistance as a result of this mental condition caused by torture and perhaps also refrain from participating in studies of a scientific or documentary nature.

Attempts have been made to quantify torture, but this has proved difficult. The few viable means of quantifying the severity of torture are the number of days spent in an institution where torture is used, loss of weight during the period of torture, and the number of incidents of unconsciousness during the torture period (22). These standards mostly reflect the physical torture, but it is common experience that the mental torture is felt to be at least as heavy a strain. To this should be added that the individual victim’s experience and interpretation of suffered maltreatment, his/her resistance to stress and threshold for developing late effects probably differ very much.

Also the understanding and support which the torture victim is met with from friends, family, fellow workers and others are important factors in the restitution and rehabilitation, i.e. symptomatology in the post-torture period. Finally, the impact of other forms of exposure as mentioned below is only partly known, and the interaction of exposures is unknown. In the light of this, the determination of isolated correlations between the severity of torture and the occurrence/intensity of subsequent symptoms seems to be of no value. A correlative assessment on group level presupposes a complex stratification.

A few torture methods may be assumed to cause certain symptoms. The operating table (described in (12)) may e.g. cause back pain. Sexual abuse of women may cause sexual disturbances (9) and falanga has been described to cause closed compartment syndrome of the foot (23). However, the torture victim usually displays a large number of non-specific psychical and somatic symptoms (10) of which the psychical are the more prominent.

Other forms of exposure
In the period leading up to the arrest, some torture victims have been wanted by the authorities or have lived in constant fear of being arrested. The fact of being wanted by authorities who use torture must be regarded as a stress factor by itself (24-25), causing mental symptoms qualitatively similar to those known in torture victims.
Detention by the police and imprisonment in a regime using torture must be a stress factor at least as severe as being wanted. In an arbitrary regime the prisoner lives in constant ignorance of the length of the detention and whether he/she is going to be maltreated. Detention under such circumstances can probably be compared to the situation of hostages taken by armed groups.

Most often, exile is characterized by the involuntary and sudden loss of family, friends, cultural patterns, the ability to communicate with the local population and the authorities, loss of home, property and occupation. Exile differs from migration in many ways: losses are more complete, involuntary and sudden. As opposed to migration, exile may often be characterized as the flight from an immediate, short-term threat to a receiving country selected by chance. The refugee’s influence on choice of receiving country and his/her knowledge and conception of the conditions there may be very limited. The possibility of preparing mentally for migration often does not exist. Several of these factors must be assumed to affect the mental health (26).

A contributory stress factor is probably the pre-asylum period during which the refugee is in a state of uncertainty as to whether he/she may be expelled to his/her native country and face the risk of being treated as a renegade by a repressive regime. This has been described previously (27, 14).

In the case of children, imprisonment and torture of one or both parents have been described to increase the incidence of a number of mental disorders (28). The psychological symptoms of these children are probably due to the sudden, violent separation from the parents as well as the subsequent unharmonic life with parents who have suffered mental damage from imprisonment and torture. The adult spouse of the torture victim is probably in a similar situation. Fear and uncertainty as to the fate of the detained spouse and the subsequent life with a person who is mentally characterized by sleep disturbances, nightmares, fear and depression, suspicion, a tendency to withdraw and/or non-specific emotional attacks on the adults and children he/she lives with must be a stress factor by itself (29).

The tortured population. Risk groups

According to AI torture is used in more than 90 countries today (30). Usually, the torture takes place during the period following the arrest and until the detainee is tried before a judge (or released direct from the police). In countries with severe social unrest/civil war these most likely to be subjected to torture with the object of extracting information are persons with established connections to violent groups. The authorities may further be interested in fighting various activities deemed to have a direct or indirect connection with violent groups. Persons who participate in certain demonstrations, meetings etc. face the risk of more or less arbitrary arrest and maltreatment. It is probably very rare that the authorities obtain valuable information from the torture of persons from such risk groups, but the knowledge that torture is used against such groups will spread and have an intimidating effect. The following example from Spain illustrates that torture is used on broad sections of a population. The information originates from a Spanish newspaper and has been collected by a local human rights group (31):

In a Spanish province with a population of around 2.5 million people, 1,157 arrests were made in 1983 under the anti-terrorist law. 853 persons were released direct from the police or guardia civil without trial. Most of the others were released unconditionally or provisionally by a court order. According to AI (30) those who are primarily subjected to torture in Spain are people detained under the anti-terrorist law. The above figures clearly show that the authorities did not even have sufficient proof to remand in custody the majority of these people at risk of being subjected to torture.

II-l-founded arrests as the above may, of course, also be pure mistakes or based on information extracted through torture of other persons. It should not be forgotten that an effective torture apparatus may procure all sorts of information and confessions, true or false, from a very large number of victims.

The examined population. Selection factors

Today, the use of torture is against the law in almost all countries. Mention in the press of human rights violations entails the risk of loss of political prestige and support. Torture is therefore used secretly and is probably not systematically recorded. Thus it is not possible to analyse which section of the torture victim population is dealt with by scientific or documentary studies, but a high degree of selection must be assumed. The contact network from examiner group to the local population is all-important in this selection. If the contact network consists of e.g. general practitioners, psychologists and other professionals, the study will to a large extent be comprised of “sick” torture victims whose contact originates in a desire to be treated. If the contact network is made up of civil rights groups, political parties or lawyers, the examinees consist to a large extent of politically active persons who want to fight the authorities’ repression and who are largely “healthy”, i.e. not suffering to any degree which would prevent them from participating, cf. above. The possibility exists that persons who have not been subjected to torture allow themselves to be included in the study in order to discredit the regime through false testimonies.

The factors which tend to select persons from participation in studies are death during torture, long prison sentences and emigration. It must also be assumed that persons suffering from very severe mental torture sequelae, e.g. extreme anxiety, withdrawal tendencies perhaps combined with a sense of guilt and low self-esteem will not be inclined to participate in a study. These victims represent that part of the spectrum which has been subjected to the severest exposure and suffers the severest sequelae.

Exiled persons may present special features. One group is made up of wanted persons who have escaped arrest. It is possible that this group comprises a number of persons who, as a consequence of the after-effects of torture, have abandoned all struggle and ambition in their own country. Others have chosen exile as a temporary residence serving as the basis for a continued political fight. The exiles probably include persons who attempt through false claims of torture to obtain a residence permit and social benefits in an affluent receiving country. A further group of exiles may be persons who, while serving prison sentences for criminal political activities, have been given asylum through the diplomatic intervention of the receiving country (e.g. certain South American immigrants in Denmark). The authorities would probably not release prisoners who continued to display a will to organized opposition during their imperi-
sonment and accordingly this group must be assumed to consist of relatively severely affected persons.

In the receiving country some torture victims will be referred to a medical examination for torture related injuries through the local health system. In other cases, the lawyer refers a person seeking asylum to a medical examination with a view to supporting a claim of torture and thus facilitating the granting of asylum. Such persons have often passed through the local health system without any torture related damage having been detected, and they may belong to a less severely affected group of torture victims.

In published material (e.g. 4, 6-13) the majority of torture victims is male (at least 75%) aged 20-40 years. The description of the professional status of the examinees is often imperfect, among other things because some have been forced to live underground for some time, have discontinued an education or lost their job as a result of the political activities or imprisonment (9). Overall, the torture victims seem to represent broad sections of the population, with some over-representation of persons with a higher education in some studies (12) probably as a result of the way the contact was established between examiners and victims, i.e. a form of selection. None of the studies published so far gives any reason to assume that torture victims differ materially from the background population, nor with respect to e.g. intelligence or alcohol consumption.

The control groups
The ideal control group consists of persons who are comparable with the examinees in terms of age, sex and social status, health, consumption of alcohol and drugs before the exposure to torture. If the objective is to analyse torture as an independent exposure factor, the control group should consist of non-tortured persons who have experienced the same degree of imprisonment/detention and political persecution before and after arrest as the examinees. Such a group of persons hardly exists. In practice, the following additional difficulties will be encountered:

Persons who have been imprisoned may have been subjected to even fairly severe maltreatment/torture without themselves regarding what happened during their arrest as torture. A person may consciously withhold information of torture for fear or reprisals if the results of the study comes into the hands of the authorities. In the controlled study such persons will be incorrectly classified.

A more important objection to the above design is that there will be a high level of noise, i.e. symptoms caused by exposure to the liminated exposure factors persecution and imprisonment. This will drown out the effect of the measured exposure = torture because the symptoms occurring after these forms of exposure, after exile and after torture are practically identical. A close matching as described above may partly explain why in a controlled study of torture victims (13) hardly any correlation between exposure to torture and health effects was found. A less complete matching makes it impossible to specify the influence of each type of exposure on the overall health effect.

In studies of exiles it may be justified to attempt matching on cultural background, i.e. in practice often nationality. This reduces the size of the populations substantially. The exiled population may well consist of around one fourth to one third in the age group 20-50 years, being the expatriates proper who have been subjected to torture. The great majority of this group is male. A slightly smaller group is comprised of spouses of the first group. A large number of the remaining persons are children of the former groups.

A population of limited size (13) where the examinees are mainly men and the control group largely consists of women, presents a great risk that the control group is made up of the spouses of the examinees. This leads to confounding because, as mentioned above, living with a torture victim must be regarded as a sort of exposure by itself. Differences in health effects between the examinees and the control group are neutralized.

In studies of torture victims living in exile the most important major social factor which should be controlled is asylum status (14). In addition, links to the labour market, family situation and adaptation in the receiving country, in terms of e.g. command of the language, must be assumed to influence a person's well-being/health.

Health assessment
The number of symptoms (13), the existence of symptom complexes (22) and scoring systems (12, 14) have been used to assess the health of torture victims. Population studies (32) show that a very large part of a middle-aged population frequently suffers from symptoms of a banal character. Therefore, a scoring system was designed so that symptoms occurring occasionally did not warrant recording and that the existence of one symptom only would not lead to scoring (12). As the torture victim is affected by numerous somatic and especially psychical symptoms (10,22), the psychical symptoms were awarded a higher scoring potential than somatic. However, none of the above-mentioned health assessment systems have been tested as to validity. Moreover, the elements of these systems may not be suitable for distinguishing between different levels of ill-health. This may be one reason why the effect of an additional exposure (e.g. torture) is difficult to detect in people already subjected to other forms of exposure (e.g. exile and pre-asylum). For this reason and for the use in evaluation of changes in health over time, e.g. in intervention studies, a rating scale for impairment of health in torture victims is needed.

The recording of symptoms may be supplemented by a rating system, e.g. as follows: 0 = absent, 1 = the symptom is present, but does not hinder normal activities, 2 = the presence of the symptom prevents normal activities to some degree, 3 = the presence of the symptom leads to discontinuation of normal activities. Torture victims, however, display numerous symptoms and it may be impossible to point to one as the cause of a reduced ability to function. As yet, there are no standardized systems allowing a rated recording of individual symptoms in torture victims with numerous symptoms.

An isolated rating of objective somatic findings has not been attempted in practice. Most often, the findings are quite non-specific scars and marks on the skin (12). Only very few cases describe scars which are so characteristic that it is practically torture that is the primary cause (33). More severe physical injuries to other organic systems are also rarely described. Bone injuries have been seen after falanga torture (34), and cerebral atrophy established through CT scanning has been described in young torture victims (35). Unobtrusive objective changes may result in a severe reduction of the ability to function physically, e.g. because of pain. A meaningful
rating of objective torture sequelae therefore has to include an evaluation of impairment of functioning, due to the particular sequelae. Rating of objective psychical findings is used together with anamnestic information in the evaluation of the severity of mental disorders (36) in patients with an established psychiatric diagnosis. It is a condition for using such measuring tools that the examinee does not feel that he/she is under pressure which will often be the case, e.g. for a torture victim seeking asylum. It is doubtful whether such methods are viable in the examination of torture victims whose psychiatric condition cannot easily be classified, and whose physical condition may often have an organic foundation.

An evaluation of the overall health effect, e.g. based on social function including performance at work and in the home, is often made difficult because of the torture victim's complex situation. It may e.g. be characterized by continued repression with limited scope for activity, unemployment, exile and language difficulties. So far, established methods of health assessment, e.g. the sickness impact profile (37) or the Cornell index (38) have not been used for torture victims.

Considering the complexity of the situation of torture victims, it is necessary to evaluate the validity of such methods before they are generally used. Instead of assessing the validity of existing methods, a rating system is being drawn up to evaluate the health of torture victims. Self-reported health defects will be compared with the objective findings and with the examinee's own assessment of the overall health.

**Dropout problems in the cohort study**

Participation in a study of torture made in the country using torture entails the risk of being identified by the authorities as a potential political opponent, i.e. member of a risk group. This fact may discourage some persons from participating and as time goes by examiners as well as examinees may revise their interpretation of the risk involved with the result that the second part of the study cannot be made.

The studies are carried out in relatively unstable societies where the political climate is subject to sudden and marked changes. To ensure the safety of the participants it must be endeavoured to carry out the studies whithout attracting the attention of the authorities. The examiners do not, of course, have access to public records and they therefore have limited possibilities of tracing persons who have changed their address in the period of the study. Being members of a risk group, some torture victims will be re-arrested in the observation period and again subjected to torture. The follow-up examination thus gives a clinical picture which is a mixture of acute, sub-acute and chronic torture sequelae. As stated above, the risk of renewed arrest is considered an independent stress factor whose effect on the health cannot be distinguished from the effects of torture unless the control persons also belong to a risk group. If so, some control persons will be eliminated because they have been arrested and tortured in the observation period.

A study of torture victims in a receiving country will also involve high dropout rates because some applications for asylum are turned down and because there is a substantial geographical mobility in the receiving country in the first years following immigration.

In the light of the above it is difficult to stipulate a required study material size, a predictably large dropout problem calls for a substantial material. On the other hand, the only controlled cross-sectional study made so far in the country of torture (12) indicates that there are very marked differences in health status between control persons and torture victims examined shortly after the torture. In conjunction with the fact that torture sequelae seem to be chronic (10, 22) this indicates that data from a limited material may answer the questions raised by the study.

**Ethical aspects**

The general experience is that torture victims who describe the maltreatment they have suffered will experience increased psychical difficulties in the following days and nights. So far, this problem has not been considered an ethical aspect which could prevent studies from being carried out. And it is possible that participation in projects aiming at providing knowledge of torture for use in the rehabilitation of torture victims and eventually by doing away with torture may enhance the victims' self-esteem. Studies made in certain receiving countries may have the result that the participant is referred to specialist therapy if severe torture related problems are detected.

A more serious problem in the local communities is that the authorities may classify all participants in a project as potential political opponents who will thus find themselves in a risk group. It must therefore be attempted to carry out the study without informing others than potential participants. All participants must be informed of the potential risk involved in participating and be completely free to opt out. To restrict information about the project as far as possible potential members of the control group must be subjected to selection before being asked to participate. On the other hand, participation in a medical project in cooperation with doctors from abroad could well offer a certain protection against harassment, since this could soon become known outside the country. The final decision on the ethical justification of a project must be made in the light of a local analysis of the risk involved for the participants set against the possibility of keeping the project secret and the value of the potential knowledge gained from the project.

Intervention studies may be carried out in areas which offer specialist therapy for torture victims. There is, however, general international agreement that a controlled design: treatment plus observation versus observation is unethical. In any case, it should be attempted to fit the torture victim and his/her family into society, teach the exile the language of the receiving country and find a qualified job. Such initiatives combined with basic psychological support are tantamount to treatment. Accordingly it is not possible to find a completely untreated control group unless a design is realized which is asymmetrical in time, cf. below.

**Some potential applications of the prospective design**

Based on noise/signal considerations, the best place to carry out a prospective study designed to illustrate the health effects of torture is probably the area where the torture takes place as this eliminates the effect of two major forms of exposure: exile and pre-asylum and sources of confounding due to restricted possibilities of selecting controls may be avoided. If the area does not offer systematic treatment and the study is consequently ethi-
4) Are there special characteristics in the social and treatment environment of persons who do not develop chronic sequelae?

The answer to questions 1 and 2 is, in theory, of relevance for claims for compensation made by torture victims (after the political environment has changed).

The answer to questions 3 and 4 may provide guidelines for the future research relating to treatment priorities and strategies.

An impression of the interaction of the individual types of exposure may be obtained by examining, in an asylum country which does not offer specialist therapy in the pre-asylum phase, a group of torture victims who seek asylum and controls also seeking asylum. After asylum has been granted, a re-examination by longitudinal comparison will illustrate the health effect of the pre-asylum period, and a group comparison will give an impression of the interaction of the various exposure factors (i.e. pre-asylum and torture). The results of such a study may be used as an argument for reducing the time involved in dealing with requests for asylum.

As mentioned previously, a traditionally designed study to assess treatment effects cannot be carried out for ethical reasons. However, in certain countries with many local torture victims where new rehabilitation centres are being set up it is possible that torture victims will seek assistance at varying intervals after the torture. Persons who receive treatment a long time after the torture was suffered may form a control group for persons who undergo treatment soon after the torture. Allowing for conditions of life from the torture experience until treatment starts, a comparison of two groups of tortured persons may be made at a fixed point in time after the torture, one group treated, the other untreated. No-one is deprived of treatment for scientific reasons.

Validity and reliability

Generally, the torture victim's own description of torture and the subsequent health effect together with the (often very few) visible physical signs and discrete psychical findings are the only basis for judging the validity of the statement. It is conceivable that individuals and groups may give false statements about torture to discredit a regime or for personal gain: compensation, pension, asylum or secondary neurotic gain. The judgment of the validity of each individual statement is therefore essential and is made by comparing different categories of anamnestic data with each other and relating them to any objective findings (3-5). Further, identical statements of torture from a number of persons who have been detained by the same police force may enhance the group's credibility. Individual statements may be compared with other data from the region, e.g. information from Amnesty International.

Just as the examinees, the examiners may have a political interest in discrediting a local regime, and in some cases it will be advantageous to involve foreign doctors to a certain extent. It is not possible to effect blind studies. A certain examiner bias must therefore be anticipated.

Published studies mention in a few cases that the credibility of the examinees might be doubted (4, 14). Usually in the sense that the statements are deemed to be exaggerated. On the other hand, in a group of Greeks examined ten years after the torture and after the repressive regime was abolished no case of accident neurosis was found (10). In another study (9) the examinees stressed that torture victims seem to be reluctant and ashamed to describe their experience to others.

It must be assumed that particularly examinations of torture victims with complex symptom constellations offer considerable scope for inter-observer variation. Relevant factors are the sensitivity of the examiner and a possible interpreter to hints and body language of the interviewee, and the degree of confidence the interviewee has in the examiner and the interpreter. The interview must be professional and it must be made clear to the interviewee that the examiner is familiar with torture techniques and the problems of torture victims and that he/she may relate even bizarre details and humiliations, confident that they will not be misunderstood. In the light of all this a great inter-observer variation must be considered. The simpler the variable measured, the higher the degree of reproducibility may be expected. The use of simple variables are not inconsistent with detailed interviews which in their entirety may be used to evaluate the credibility of the total statement.

COMMENT:
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Rehabilitation of Torture Victims: Principles for Treatment and Follow-up Research

By Inge Genefke, Inge Lunde, Jørgen Ortmann and Bent Sørensen

In 1973 Amnesty International (AI) appealed to the medical profession to combat torture worldwide and to help relieve its effects. AI's first medical group was established in Denmark in 1974. Its primary task was, through systematic examinations, to determine whether or not torture had taken place in a given case.

During the next few years the medical group performed a series of examinations and studies of Chilean torture victims living in exile in Denmark and Greek torture victims living in Greece. The studies proved that there were early as well as late sequelae of torture. The studies also revealed that there were no significant differences in the sequelae of the two population groups, indicating perhaps that the sequelae of torture overshadow the problems of being exiled (1).

These very severe sequelae clearly required treatment, and this naturally raised the question of treatment and rehabilitation. In 1978, AI held a seminar on the Violations of Human Rights - Torture and the Medical profession (2). In this connection an international group was set up to work out a proposal for the best way in which to treat and rehabilitate victims of torture. On the initiative of this group a seminar was arranged in 1979 (3). The major conclusion of the seminar was that a special treatment and rehabilitation centre for torture victims should be established. At a meeting in 1980 at the AI international secretariat in London it was decided to ask the Danish members of the rehabilitation group to undertake the task of establishing the first centre for the treatment of torture victims, with location in Copenhagen. It was also made clear that the scope and authority of AI did not extend to treatment and rehabilitation activities.

The four Danish doctors who were members of the international rehabilitation group constituted themselves as a local group for the purpose of establishing a rehabilitation centre. On October 30, 1982, the private and independent institution, the Rehabilitation and Research Centre for Torture Victims (RCT), was established on paper. Torture has been with us from time immemorial. The intention was to punish people, to beat out confessions, to obtain information, or to convert or reform people. Torture is still devised to achieve these aims, but today the main purpose is the breakdown of the individual. The purpose of subjecting people to this type of torture is, first, to neutralize an active opponent of the regime and, second, to release this former active opponent in his or her broken down condition as a deterrent and warning to others who might be in opposition to the rulers.

People who have been subjected to torture directly designed to break down their identity cannot, with the special nature of the sequelae, be treated within the general framework of the health services; even in countries with a highly developed, free health service, treatment is not practicable.

Torture: methods and sequelae

According to the 1975 Tokyo Declaration of the World Medical Association, torture is defined as: “the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.” Torture has been defined by other organizations also, including the UN and AI.

Torture may be divided into physical or mental types. Generally speaking, torture already starts in the home at the time of the arrest. Brutal policemen or soldiers break into the home and smash the furniture to pieces, beat up and perhaps rape the wife in front of the husband and children. The children are beaten up, and their pets killed while they are watching. The father is perhaps beaten unconscious.

The first few days after their arrest, the torture victims are typically exposed to reckless unsystematic violence. They are beaten up. They are, of course, not allowed to go to the toilet; they do not get any food or drink. They may be stripped. They are humiliated and scorned. Women are left standing for hours or days with menstrual blood running down their legs while being called slobs, pigs, or other degrading names.

Development of models for treatment

Beginning in 1979-1980 the treatment of torture victims was started at the University Hospital (Rigshospitalet) in Copenhagen. From 1980 to 1982 a model was developed for the treatment of torture victims. The fundamental principles of this treatment, which is the basis for the RCT's treatment today, are:
1) that procedures which may remind the patient of the torture to which he or she was exposed should be avoided as far as possible;
2) that treatment should be both physical and mental, with physiotherapy as an important element of the physical treatment;
3) that the physical treatment and psychotherapy should run parallel with each other;
4) that the treatment should include not only the individual torture victim, but also his or her entire family;
5) that the social conditions should be included as a factor, and that personal social counselling should form part of the treatment.

**The RCT today**
As mentioned earlier, the RCT is an independent, private institution with just under half of its costs covered by the Danish Government and the other half funded by various private donations and contributions. The independence enjoyed by not being a government institution, but still acknowledged by government grants, makes the torture victims more confident when they visit the centre. The key to successful treatment is the patients’ feeling of safety and confidence.

**Registration and examination programme**
A torture victim who has been transferred to our centre will first be asked to come to a detailed interview. If the person is a torture victim and eligible for treatment, he or she will undergo our standard examination programme.

The standard programme consists of:
1) a detailed examination by a psychotherapist. This often stretches over three sessions, each of a duration of 2-3 hours. A few psychological tests are included;
2) a clinical examination, including a neurological examination;
3) an examination by a social worker;
4) an examination by a specialist in rheumatology;
5) a dental examination;
6) an examination by a nurse, including ECG, urine test, and various blood tests;
7) an examination of the spouse;
8) an examination of the children.

As mentioned earlier it is extremely important as far as possible to avoid any procedures that may resemble torture.

A simple and painless examination such as an ECG may produce an extreme anxiety reaction in someone who was once exposed to electric torture. It goes without saying that a gynecological examination of a woman who was subjected to sexual torture may be extremely anxiety provoking. Even waiting time may remind the torture victims of the hours that he or she was kept waiting for the torture to begin, so that waiting time is in itself a type of mental torture.

**Treatment at the RCT**
The treatment at the RCT is interdisciplinary with a standard treatment programme consisting of psychotherapy, physiotherapy, general somatic treatment, and social counselling, plus treatment of spouse and/or children as required (5,6,7). The following is a brief outline of the various treatments, the psychotherapeutic treatment being described in more detail.

**General somatic treatment:**

Nursing:
To a large extent nursing consists of personal counselling, support, and information. Above all, very thorough information is given about the various somatic examinations and treatments. The nurse also accompanies the patient to all somatic examinations, she is present in connection with full anesthetization and surgery, and she is in the recovery room when the patient comes round after surgery, etc. An important part of the nurse’s work is instructing the patient about diet and nutrition. Moreover, nursing naturally includes the traditional activities of dispensing and administering drugs and medicine, etc.

**Dental treatment:**
Many torture victims have had their teeth broken or pulled out; some have had their jawbones crushed. Lack of oral hygiene in the prison may have caused dental caries or parodontosis.

**Social counselling:**

**Physiotherapy:**
Physiotherapy focuses on specific physical injuries in the motor system. Physiotherapy includes body awareness treatment, the objective of which is the reacceptance by the torture victim of his or her body since most torture victims tend to dissociate themselves from their bodies, which have suffered so much during torture.

**Psychotherapy:**
Psychotherapy normally starts with 1 1/2 hours twice a week. Interpreters are used for the majority of sessions. The point of departure for psychotherapy is the torture to which the person has been exposed. We seek to make the patient recall and describe all details of the torture. We try to make him understand the purpose of torture, to recognize that all responsibility and guilt must rightly be placed with the torturers, that torture victims cannot be held responsible for what they said or did during torture. In torture situations a victim is faced with a series of impossible choices, leading to other people being confined and tortured no matter what the torture victim replies to the interrogator’s question.

We encourage the torture victim to express suppressed feelings of anger, grief, hatred and rage feelings experienced during torture, but which had to be hidden. We encourage the victim to see the torture as a thing of the past - for him to forget it is impossible. During this process we try to restore the identity of the person and make him focus on the future (5).

**Treatment of spouses:**
If a wife or husband has asked for an interview and examination, the necessary treatment is initiated.

**Treatment of children of torture victims:**
Children are a vulnerable group and the RCT has chosen to give high priority to the examination and treatment of children. Often these children suffer from psychic disturbances.

**Research methodology at the RCT**
We have sought to follow these treatment principles from the start, but the necessary means have not been available until a few years ago. On the basis of a preliminary evaluation (8) it seems that treatment according to
the principles is effective. 90% of the torture victims which underwent full treatment improved substantially or recovered completely. However, only a prospective, systematic study of the course of treatment will be able to offer a sufficient evaluation of the effectiveness of this method of treatment.

If possible, the value of a treatment method compared to non-treatment or another treatment is assessed by making a clinical controlled study based on blinded randomization of the material, dividing it into a treatment group and a control group. Such a study requires the briefed consent of all parties participating.

Torture victims differ from “ordinary” patients in that they do not suffer from a disease in the classic sense. Nor have they been exposed to an accident. In a sense they are not patients at all. They have been subjected to a systematic destruction of their physical and mental health, a destruction induced on them by other people, and it is this systematic, destructive influence which leaves its mark on their present functions. Furthermore, torture victims are refugees, often from cultures fundamentally different from our own - and the refugees differ among themselves in cultural background. If we were to let the torture victims form part of a clinical controlled, randomized study, they would not understand why, let alone accept it. From our earlier examination experience in AI’s Danish medical group we know of the mistrust and anxiety which often prevent torture victims from consulting their doctor even for a simple medical examination. They will rather live in solitude with all their problems than expose themselves to something uncertain and perhaps dangerous. From our experience gained from treatment at the RCT the same can be concluded: shyness and reluctance as to treatment until a trusting contact has been established. We would never be able to establish such contact if at the first interview with the victim we informed him about the clinical controlled study, about the principle of arbitrary distribution of patients into control groups and treatment groups, and tried to obtain his consent. To torture victims such a proposal would be a direct insult in line with the degrading and inhuman treatment to which they had been exposed during the torture itself.

Because of the above reasons we have had to refrain from using the clinical controlled, randomized study. We would not be able to obtain consent from a fair number of individuals, and the attempt alone to obtain consent must be said to be unethical towards this group of patients. Hence, the method is not applicable here. Fortunately, there are other methods available to evaluate the results of a given treatment. But the use of other methods also offers difficulties in connection with this group of people. As a basis for an evaluation of the treatment results it is necessary to describe typical sequences of diseases and to make the descriptions uniform and systematic. However, even a systematic examination is a strain on many torture victims - a strain which the victims themselves often compare with torture and interrogation. This is so in spite of the efforts made by the examiners to avoid a method of examination which may resemble torture and interrogation.

There are other problems: language problems/the use of an interpreter - and everything which this involves. Moreover, the group of torture victims treated at the RCT is very heterogenous and comprises many different cultures. It is therefore very doubtful whether they are comparable group by group. Furthermore, all torture victims in many countries find themselves in a special situation: exile - and everything which this involves. That alone sets bounds for the victims’ possibilities for functioning in their usual surroundings and trade or profession. Again, this makes it difficult to evaluate the results of the treatment.

References
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What to do

Information for authors writing articles to TORTURE

TORTURE is grateful for small news items as well as articles on everything connected to torture and the fight against it. However, it is advisable to contact the editor before writing the article!


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The Rehabilitation and Research Centre for Torture Victims is an independent, humanitarian, non-political organization established in 1982 to help victims of torture and to contribute to the prevention of torture. Its main objectives are to rehabilitate persons who have been subjected to torture, to rehabilitate their families, to instruct Danish health professionals in the examination and treatment of persons who have been subjected to torture, and to carry on research into the nature, the extent and the consequences of torture.

The International Rehabilitation Council for Torture Victims is a private non-profit foundation, created in 1988 by the RCT. The objectives of the foundation are, on an international basis, to support research into all aspects of torture, to support education and training of health professionals and of other relevant personnel in the medical, social, legal and ethical aspects of torture, and to serve as an international clearing house for information about torture activities.