Welcome to this first number of the Journal on Rehabilitation of Torture Victims and Prevention of Torture. This Journal will replace the Newsletter, which dealt with the same subjects. So what is the difference? Well, there will be more about research, treatment, and rehabilitation of torture victims, as well as campaigns against the torturers - and all this requires more and better information.

The editorial board of the Journal consists of doctors with many years of experience in research into and treatment of torture victims. It is the board's special wish to enlarge the coverage of the worldwide activities in this field.

It is very important for researchers, therapists, and other persons with a special interest in the treatment of torture victims and in the fight against torture to be able to count on all-round and relevant information in a journal.

The Journal has its roots in Denmark, where the world's first international centre for the treatment of torture victims was established. The aim of the Journal is, however, to become as international as possible. It should therefore appeal to all who are working in rehabilitation and research, and stimulate them to contact us for the communication of their knowledge and results.

The international community (the United Nations, the Council of Europe, etc.) is directly involved in the fight against torture, and the pressure on the many nations in the world that continue to practice torture is very strong at the moment. However, only few countries have completely renounced these terrible methods of punishment and of creating fear. Many private forces will therefore have to continue to put pressure on the dictators, just as many specialists in the democratic part of the world will have to help the legions of victims of torture.

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PREVENTION IS BETTER THAN CURE

In the ancient Roman Empire they did a lot of thinking, of which we occasionally are reminded. For instance Juvenal posted the question "Quis costudiet ipsos costudes?"

It was not until many thousand years later, more precisely in the later part of the twentieth century, that a good answer was given to the question of who are to control the controllers: International safeguard mechanisms.

United Nations initiated the long, and lately fruitful process of defining and guaranteeing the international Human Rights. Some would say: Of most importance in theory! The Council of Europe succeeded just five years after the United Nations Charter was agreed upon to create the European Convention on Human Rights. Both organisations, however, have strongly influenced governments and have alleviated the sufferings of people.

But paper is patient, and many words have been printed on it - without improving the suppressive lot of millions of people. Yet endeavours did not stop with declarations, covenants and conventions - non-governmental organisations performed grand campaigns, and independant bodies, approved by the governments, were established in the late 1980s to supervise the grand designs to guarantee the human values.

One of these new international bodies with a force that is still to be seen is the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). It is so young that only this year it published its first general report covering November 1989-December 1990. Its seventeen members are carrying through a brand-new task of visiting prisons and police stations with a view to prevent torture.

The CPT always looks into the general conditions of detention. It examines not only whether abuses take place but try as well to spot indicators pointing to possible future abuses: Space available, toilet facilities, medical care, safeguards against ill-treatment, access to lawyer etc. More detailed standards are needed in this respect, the Committee observes in its first report.

To demonstrate impartiality and neutrality, the countries which the CPT intended to visit in its first year, 1990, were drawn by lots, and places of detention in Austria, Denmark, England, Malta and Turkey were visited. The respected international inspectors have had their first and nearly often bitter experiences with the controllers of the controllers of the controllers - the press. National authorities at the police stations and prisons were alarmed that some newspapers carried articles disclosing confidential and not always correct informations. The European Commit-

tee was not to blame. The subject simply attracted the press on the alert.

Not all comments, however, were unwelcome: The day the CPT started their visit to England, The Times in an editorial requested the government to publish CPT's report in due time. The CPT still awaits an answer from the United Kingdom, but the CPT has had the great satisfaction that Austria, which was the first state to be visited, from May 20-27, 1990, and which received CPT's report in November 1990, in its answer has informed, that the Austrian government would like to see the CPT report published.

Amnesty International strongly criticized Austria in a report of 1990 for having molested 128 people in police stations since 1984. From CPT's report and Austria's answer appears that CPT's suggestions for a considerably better registration and surveillance system in police stations have been met by the Austrian government, consequently the cases described in Amnesty's report are unlikely to occur in future. A number of other proposals put forward by the CPT have also been met, whereas other suggestions need more time for preparation. It is quite obvious, that CPT's suggestions have been received in a positive spirit and that this has led to important improvements.

There was no sign of torture as such in Austria, but the CPT recommended that the government change procedures in the police stations to prevent ill-treatment of the detained, adding that adequate professional training of police officers is required.

The first government to publish its report, however, was the Danish government in September 1991. The CPT likewise did not find any torture in Denmark, nor did it register any ill-treatment. However, the comprehensive study (45 pages on Austria against 75 pages on Denmark) included various suggestions to improve conditions in detention centres and prisons. The CPT asked to be kept informed of the findings in two cases concerning foreigners (both Africans) who were ill-treated when trying to enter Copenhagen. On the whole, the Committee expressed a positive opinion of the Danish establishments visited (hygiene, training opportunities, libraries for prisoners etc. were adequate).

Gradually the Committee is developing its own "measuring rods" through comparison of various systems of detention. After a while the Committee might set up general criteria for the treatment of those deprived of their liberty. One should not be surprised that these standards some day are made public. It would be a useful guideline for the democracies. A piece of advice to any government wanting to prevent rather than be forced to cure the consequences of torture.
Physiotherapists from the Whole World to Fight Against Torture

The World Congress for Physiotherapists (WCPT) in July/August 1991, approved a resolution against torture - completely in line with the UN's Convention against Torture of 1984.

All 41 delegates at The World Congress for Physiotherapists, held in London in July and August 1991 voted for a resolution against torture, proposed by the Chairman, Inger Brøndsted, Denmark.

The chairman reasoned that a resolution of this kind would direct the attention of physiotherapists to the problem and show the world that physiotherapists are working actively to fight this form of humiliating and inhuman punishment.

- It is the privilege of the physiotherapist to practice his/her profession in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity, said Inger Brøndsted.

She also mentioned that for the purpose of the declaration, torture was 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".

The declaration says:

1. The physiotherapist shall not countenance, condone or participate in the practice of torture of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.

2. The physiotherapist shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

3. The physiotherapist shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment are used or threatened.

4. The physiotherapist's fundamental role is to alleviate the distress of his or her fellow men, and no motive whether personal, collective or political shall prevail against this higher purpose.

5. The World Confederation for Physical Therapists will support, and should encourage the international community, the national physiotherapists associations and fellow physiotherapists to support the physiotherapist and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

6. It is appropriate that education and information regarding the prevention and prohibition of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment should be included in the undergraduate and postgraduate training of physiotherapists.

Keeping balance - mentally as well as physically - is part of the physiotherapeutic rehabilitation (constructed session).
Kuwait gets first centre for treatment of torture Victims in the Middle East

Two Danish psychologists went to Kuwait in September 1991 on a one year contract to help to set up the centre.

The Kuwaiti government has announced that it fully supports the establishment and running of a rehabilitation centre in close cooperation with the Danish Rehabilitation and Research Centre for Torture Victims (RCT) in Copenhagen.

The Danish psychologists, Allan and Mia Stehr, RCT, will train Kuwaiti doctors, psychologists, and physiotherapists in the special types of treatment required by victims of torture. Nobody knows for certain how many people were tortured during the 6 months' occupation of Kuwait by Iraq, but a qualified estimate puts the number at 15,000 out of the 600,000 people who stayed in Kuwait between August 1990, when the Gulf war started, and January 1991, when the Iraquis started to leave Kuwait.

The authorities and doctors obviously have in mind the victims of the Iraqi occupation forces, though this is not stated directly in the proposal. The Kuwaitis were exposed to all kinds of torture which Iraq is notorious for using on its own citizens: parts of the body were placed on live electric plates of all sorts, people were forced to swear by touching an electric Koran, various tools (files, awls, crowbars, etc.) were used to cause disfigurations.

The Kuwaiti hospital director, Abdulrahman Al-Asfour, visited the RCT in Copenhagen in June 1991 and gave the first positive signals. Preparations have since been made for the foundation of the centre in Kuwait City. The Kuwaiti authorities have decided to adapt a building for the purpose, and all Kuwaiti citizens who were in the country during the Iraqi occupation will be offered a screening examination.

Since the oil state has well-trained health personnel at its disposal, as well as large economic resources, the Danish delegates will only be concerned with training. The victims have a common background, and therefore group therapy can be organized, in contrast to many other places in the world where the torture victims are also refugees in a foreign country.

Kuwait is prepared to cover the costs of the stay of the two Danes, as well as the running costs of the new centre. The Danes will also be asked to make the Kuwaiti population aware of the special treatment that will be available for victims of torture. It is here mainly a question of underlining that it is not humiliating to be mentally ill or under stress from previous torture, and of convincing the Kuwaitis that, if necessary, they should contact the health authorities for relevant outpatient treatment.

«If this continues... for you».
The Kuwaiti official buildings have been heavily molested by the occupation forces.
Chile’s Efforts to give Adequate Treatment to Torture Victims

Denmark is among the democratic countries that have given a helping hand to the new democracies which have emerged from dictatorships during the past decade.

The Danish government, like other governments, not only supports developing countries because of their weak economies, but also in order to further democracy in the widest sense.

For that reason, Denmark decided in 1990 to give 1.3 m. Danish kroner (0.22 m. $) to the running of CINTRAS (Centro de Investigacion del Stress), which was established in Santiago in 1986.

The centre was originally supported by the Danish Rehabilitation and Research Centre for Torture Victims (RCT) with 375,000 Danish kroner (65,000 m. $), and the continuous Danish support - today 70% of its annual budget - has created several ties between Denmark and Chile. Danish doctors have visited Chile more than once, and Chileans have visited the RCT in Copenhagen.

In an attempt to involve and train health staff outside the capital, CINTRAS arranged a seminar in January 1991 in the town of Linares, 400 km south of the capital, Santiago. 150 doctors and psychologists from all over the country took part and listened to lectures on the treatment of torture victims. Many participants had travelled hundreds of kilometers to attend. Musculoskeletal injuries, medical ethics, ergotherapy, group therapy, - many subjects were dealt with, and many experiences were exchanged. The need for treatment in the rural population in Chile is considerable, and it is therefore very important to train therapists all over this large country.

The idea of creating the Santiago Centre came from a Chilean torture victim who was treated in Denmark. Like the RCT in Copenhagen, the Chilean Centre developed gradually. The Chilean refugee in Copenhagen knew about small centres in Chile that had given psychological treatment in the middle of the 1980s. He thought they could be extended, when supplied with the experiences from RCT.

The official Danish International Development Agency (DANIDA), together with private organizations and church committees in Chile, provided the basis for the opening of the centre in January 1986. Victims of political suppression, prisoners and ex-prisoners are among the clients who have been helped there.

The important question today is whether the new government under President Patricio Aylwin - who succeeded the dictator Augusto Pinochet in January 1990 - can take over some financial responsibilities for the rehabilitation of the many victims of the former regime, says the Danish doctor Ole Vedel Rasmussen, a surgical specialist. He visited CINTRAS earlier this year together with Bente Danneskiold-Samsøe, MD, specialist in rheumatology. They were both impressed by the work done under the leadership of Dr. Mario Vidal, himself a refugee abroad for two years.

- CINTRAS has acquired more self-confidence, he explained. We have initiated cooperation with other organizations which deal with victims of the suppression that lasted for 16 years in Chile. We organized seminars quite freely in 1990, and in the preparatory stages we had the new experience of cooperating with representatives from the Ministry of Health.

- CINTRAS is in need of more physiotherapists. There is only one in Santiago, and many torture victims have severe physical injuries that need special treatment, relates Bente Danneskiold-Samsøe. Many have been exposed to falanga and require ultrasound treatment. Many have severe psychological barriers that only specially trained psychotherapists can help to overcome.

Fortunately, CINTRAS has now opened satellite centres in different parts of the country. Until recently many Chileans had to travel hundreds of kilometers, up to 400, to reach CINTRAS for treatment. A total of one million people out of a population of 13 million suffered directly or indirectly during the bloody repression which Pinochet's military dictatorship represented.

Unfortunately, torture is still practised at Chilean police stations and prisons. There are still about 200 political prisoners in the country, and about 40 people have been tortured since March 1990. Seven people have died under strange circumstances. Six of the 40 are under treatment at CINTRAS.

Three case stories

Pedro Marin, MD, has been in prison for four years because he had treated patients who were injured after a coup d'état against Pinochet in 1987. The military demanded a 23-year prison sentence, but his case is still pending. That also holds for a nurse who helped Dr. Marin with the treatment of wounded people. Bente Danneskiold-Samsøe visited Dr. Marin in the prison, Carcel Pública, situated in the poor district of Santiago. Accompanied by another Dane and a Chilean, she had a long talk with the prisoner. Dr.
Marin stressed that the Chilean Doctors’ Association had not done enough for its members. It has not publicly protested against the doctor torturers who still practise, nor has it shown willingness to fight for imprisoned members.

Another example concerns a man and a woman who were imprisoned at the same time in 1987. The small family, husband and wife and two small children, was caught without warning during the night. During the arrest, the parents were beaten severely while daughter and son (4 and 7 years old respectively) looked on.

In the prison, the torturers told the husband that they knew very well that his wife had been worse than he, since she was more politically active. If he would only inform against her he would be set free – a form of bait. They did not persuade the husband to give in. There after they let him see how the other looked on. The husband was imprisoned for a year and a half and was released one year before his wife. The situation in January 1991 was that both were free, but on condition that they presented themselves once a week at an office: that meant the loss of almost a whole working day per week. If new information (“proofs”) should emerge, they can be imprisoned without further notice. They both suffer severe sequelae from torture.

The man had been beaten on his head with butts and has a broken bone in his left inner ear so that his hearing is diminished. This was diagnosed by the physiotherapist because he has not yet been able to afford an examination by an ear specialist. There is no money for x-ray examinations either; he was previously told by the prison doctor that he had broken two ribs. Furthermore it is difficult for him to keep his balance and thus to cope with his job as an electrician, particularly on high scaffolding. His present subjective complaints are pains in his left arm, and lower back pain during and after physical work. He has severe sleep disturbance and strange sensations in his hands and feet, in which he notices no feelings of pain or temperature changes.

His wife has not yet been examined by a doctor after the imprisonment, but according to the husband she has become not only quick-tempered and psychologically unstable, but also insane. They have become afraid of each other. When the husband came out of prison, their house was completely stripped, and their neighbour said that the military/police came around a couple of months after their arrest and asked where they lived or had moved to. The police pretended to know nothing. The neighbours said that the house was stripped completely.

The last story concerns a small family consisting of a grandmother Felicia, her daughter Susanne, and Susanne’s 4-year-old boy, Paulido. Susanne was arrested because she lived very close to a house in which weapons were found. At the arrest she was pregnant, and later she gave birth to Paulido in prison. When he was 3 months old, he was removed to the care of his grandmother, Felicia. The child’s father had disappeared to Argentina, and nothing is known about him.

Felicia became politically involved because of the arrest of Susanne and started to take part in the demonstrations with the aim of getting her out of prison. Little by little Paulido began to look on his grandmother as his real mother, and his relationship with Susanne became less close. Susanne was released from prison between Christmas and the New Year 1990, and she received psychotherapy from CINTRAS. Treatment was started in the prison 3 months before her release. The present situation is that Felicia, who used to be happy and was expectantly awaiting the release of her daughter, is about to give up everything.

It is very difficult to make the three function together. Susanne has changed completely from being a caring mother and daughter to being careless and unhygienic, as well as physically aggressive towards her son. It is as if she no longer has any form of love for her family. The imprisonment seems to have had an effect far beyond the sphere of the imprisoned individual.

A substantial number of refugees arriving in Australia are the victims of torture and other forms of organized violence. In this article, the authors provide an overview of the broad range of physical and emotional disabilities that arise from these experiences, examine the special difficulties in identifying and assessing patients at the primary health care level, and offer an approach to counselling for survivors and their families.

Authors.


This paper reports a retrospective study of the frequency, severity, modalities and mental health consequences of torture in 28 Latin American refugee women in Toronto. The data on these women and a comparison group of male torture victims were retrieved from case records in a hospital outpatient clinic. The results support the hypotheses implicit in the scanty literature available that the frequency and effects of torture in women differ from those found in men. In female victims, as in their male counterparts, the severity of the torture was related to the degree of their political involvement. However, torture was more frequently sexual, and its consequences more often affected the women's sexual adaptation.

Authors.


A model for time-limited group treatment of exiled survivors of torture is presented and the importance of placing such traumatic experiences in a sociopolitical context is emphasized. The model is illustrated by descriptions of work with a group made up of Central and South American refugees. Therapeutic techniques are proposed that focus on symptoms of torture-related post-traumatic stress disorder, allowing group members to attain gradual psychological reorganization.

Authors.


The countertransferential reactions of psychotherapists working in a threatening environment with victims of political repression are described. Via case studies based on clinical consultation and direct testimony, this paper examines the effects on Chilean therapists living and working in that country. It is suggested that these clinical observations may have application to therapeutic work with victims in other stressful settings.

Authors.


Interviews with 32 Chilean refugees elicited descriptive findings on the effects of detention and torture and subsequent exile in the U.S. It is suggested that exile for this group constitutes a continuation rather than a cessation of their suffering. Marital problems, economic hardship, and loneliness are recounted by the adults, while teachers and parents report adjustment and behavioral difficulties among the child-

ren. The influence of sociopolitical factors on these outcomes is discussed.

Authors.

This paper presents the main issues in the diagnosis and treatment of psychiatric sequelae in torture victims. The concept of post traumatic stress disorder is used to organize literature on psychiatric casualties resulting from massive psychic trauma, e.g., the Nazi Holocaust, the Vietnam and Israeli wars, and the current world epidemic of torture. Torture is a unique human made stressor resulting in category-specific diagnostic symptoms. Medical assessment can be complemented with photographs, x-rays, electroencephalograms, and sleep studies. Individual psychotherapy and group techniques focus on the issues of denial and trust, loss, survivor guilt, and reparation. Programs of psychological and social rehabilitation and treatment with benzodiazepines, tricyclic antidepressants, and other compounds are reviewed. Future research needs include the conceptualization of the trauma of torture and its sequelae in broader terms, the application of standardized measurements to facilitate international comparisons, and the testing of various approaches to intervention in an experimental design. An ethical physician must resist the pressures of totalitarian governments to assume neutrality in the presence of human rights violations affecting his/her patients.

Author.


This is a retrospective study on the effects of torture on Latin American refugee women in Toronto. Thirty-six cases of female torture victims are reviewed. The cases are divided in 2 groups, according to whether they experienced physical and psychological torture or only psychological assaults. Both groups are compared in terms of demographic characteristics, social and/or political involvement prior to the traumatic experiences, symptoms for which they sought psychiatric intervention and recovery rates. The symptoms presented by all women are consistent with those described in the literature for torture victims, regardless of their sex. The main findings are that women who experienced direct physical and psychological...
Interpretation as Part of the Rehabilitation

The use of interpreters in the rehabilitation of people who have been subjected to torture is a relatively new idea and there is practically no literature on the subject.

By Vibeke Pentz-Møller* and Anders Hermansen**

Our knowledge of interpretation work has been accumulated through many years of work for Amnesty International and the RCT (Rehabilitation and Research Centre for Torture Victims) in Copenhagen, where we are now working as interpreters for Latin American torture victims and their families. In this connection the RCT's own training of interpreters has enabled us to exchange useful views and experience with professional medical staff, social workers and interpreters from other parts of the world whose languages and cultures are far more alien to a Northern European than those of Spanish-speaking countries.

For clarity 'he' is used for the client, and 'she' for the interpreter in this article, which has been divided into two main parts.

In this issue of TORTURE we'll bring the first part, the second part will appear in the next TORTURE.

In later issues of TORTURE some of the problems concerning interpretation in other cultural contexts will be discussed.


Interpretation in general, including competence, preparation, interpretation sessions, different interpretation methods, professional discretion and the communication of cultural differences.

Part II: Interpretation during psychotherapy and the interpreter's needs.

Part I

Competence of the Interpreter

Before accepting an assignment, the interpreter must ascertain that she is competent, i.e. has sufficient command of the necessary terminology and language usage, and must thereafter decide whether she is up to the job.

One of the first principles for an interpreter is to remain impartial.

Preparation

The interpreter should then prepare for the job by familiarising herself with who the client is, the circumstances of the case and whether or not it is necessary to brush up any relevant terminology, or perhaps to learn new. An important aspect of an interpreter's work is to keep up to date on social problems, culture and religion, both in her own country and in the countries whose language the interpreter is working with, since language undergoes a continuous process of development parallel with society as a whole.

Interpretation Sessions

The interpreter is the link enabling two or more people to communicate as though they were speaking the same language. By interpretation is meant communication not only of language but also of cultures. In other words, all messages must be interpreted and fine shades of meaning and idiomatic expressions conveyed as far as possible. It is not for the interpreter to assess whether anything the parties have said is uninteresting or superfluous, and the interpreter should also convey emotional including hard and offending expressions in unweakened form. In terms of language, one of the results of this is that the interpreter speaks in the first person whenever the person speaking does so.

It is a fundamental principle that the interpreter never conceals, distorts, construes or infers what is said, but is loyal both to what is uttered, and to the spirit in which it is said and interprets each utterance in a language which is clear and intelligible to the recipient. We would emphasise that contrary to written translations, it is always more important to convey the message than to use a specific formulation of language. The interpreter's impartiality should thus not be mistaken for indifference: a good interpreter is not merely an empty vessel translating backwards and forwards, but a person who is actively involved in the communication by making sure that she on the one hand and the parties on the other understand the underlying message in what is actually said.
Interpreting is always a physically and mentally exacting process and the interpreter, therefore, does not undertake any other function for the duration of the assignment.

**Interpretation Methods**

Many professional interpreters master both consecutive interpretation (i.e. subsequent reproduction of short or long statements) and simultaneous interpretation. Normally the choice of method will depend on the concrete situation and on the parties involved. Simultaneous interpretation requires that the interpreter is familiar with the subject and that the person speaking does so articulately and at a controlled speed. For easy communication, consecutive interpretation requires the persons speaking to say only a few sentences at a time, thus avoiding two problems:

1) unnecessary strain on the interpreter's memory because she uses more energy on remembering what is said than on interpreting and
2) interruption of the direct communication between the parties when they have to sit passively and wait for the interpretation of long statements. Efficient communication also depends on the physical position of the interpreter.

**Professional Discretion**

All interpreting is based on a relationship of trust, and an interpreter respects a pledge of professional secrecy and discretion, a fact which should be made clear to all parties.

**Interpretation in General for Torture Victims**

The above is a review of general interpretation principles. We will now focus on the special aspects of interpretation when an interpreter is working with torture victims.

To satisfy the requirements of rehabilitation work the interpreter must in advance decide upon her attitude towards torture. She must be aware that not only is torture a traumatic experience for the victim but also completely and utterly unacceptable from an ethical point of view.

It is important for the interpreter to avoid the pitfall of perceiving people who have been subjected to torture as patients who are to be "comforted" and "helped". We must help emphasise to the client that his sequelae are the reactions of any normal human being to an extremely abnormal situation.

Overall the interpreter must be aware of her professional and personal responsibility. It is essential that she feels empathy towards the client and his situation but this should not lead her to intervene in the treatment without the consent of the therapist and not to enter into any obligations in relation to the client without consulting one or more of the professionals. Otherwise the client may become too dependent on the interpreter.

The interpreter should cooperate with all the staff at the centre where she works, not only with the therapists and professionals for whom she is interpreting.

Political refugees may be confronted with special difficulties in the early stages of treatment. Whether consciously or unconsciously their attitude towards the recipient community and its institutions is often negative; the refugees feel guilty or embarrassed at being suspicious of and in opposition to the person they have asked for help.

A relationship of trust and confidence between the people involved in the treatment is absolutely vital for the client to feel so safe that he dare voice and analyse his problems. Spending time with the client, therapist and other staff before and after interviews will help create a positive atmosphere.
Professional Skills
In rehabilitation work the interpreter should master the general terminology of the five main areas mentioned below:

a) Anatomy, physiology and pathology

b) Psychology and psychiatry. For some languages interpretation is facilitated if the doctor or therapist uses the Greek or Latin terms for diseases, organs, symptoms etc.

c) Forms of torture. A torture victim will often shrink back from relating the harrowing experiences of the past. In order not to overexert the client by asking him for detailed, elaborate explanations, it is necessary for the interpreter to be familiar with many of the most frequently applied methods of torture in her own and in the client's language and to know what they consist of. The interpreter should also be aware that new methods of torture are continuously being introduced in various parts of the world.
d) Social services. As rehabilitation also comprises the client's social situation in the country of exile, the interpreter should be broadly familiar with the structure of the social services of the country and the main rules regarding benefits and procedures. In this respect, the situation will often be very different from that of the client's homeland.

It goes without saying that a mere word-for-word translation of terms, will be inadequate. Frequently a "direct", correct translation will make no sense at all to the client and may intensify his feeling of being alien and may even completely undermine his positive attitude. The interpreter must often act as a catalyst, i.e. explain the meaning of a term rather than just translate it. If a thorough explanation is required, the interpreter should point this out to the social worker. The general principle for interpreters only to translate what is said is still applicable in theory but must often be modified to suit the specific requirements of a given situation.

Preparation
New interpreters who are not familiar with torture and torture-related problems will have to study reports and literature on the subject. A wide selection of such literature is now available in several languages, and ideally such material should be at hand at the rehabilitation centre in all languages in which interpretation is carried out. Another thing which is extremely useful to new interpreters is watching films and videos about torture, the training of torturers (especially the film Your Neighbour's Son) and rehabilitation of torture victims. The last item should portray the treatment of a victim and include his own account of his situation and the favourable results of treatment should be made visible through the pictures. The insight which the interpreter gains from this is important because it will confirm and further her understanding of the client's situation and reactions.

In rehabilitation work it is of immense importance for the interpreter to keep up with latest research findings, new specialised areas and methods of treatment. She must do this partly on her own initiative and partly through attending symposia and seminars etc. held by the professionals attached to the rehabilitation centre, and not least by studying relevant literature. Moreover, the relationship of trust and confidence with the clients will be encouraged if the interpreter feels "at home" at the rehabilitation centre, and keeps herself familiar with all developments, guidelines for treatment, administrative routines and so on at the centre.

Communication and Cultural Differences
As mentioned earlier it is part of the interpreter's job to possess a knowledge of the community, culture, family patterns and lifestyle of the country or countries whose language she masters.

If her knowledge is insufficient, she will not be able to perform her job satisfactorily since she is to communicate not only the purely verbal communication but also any non-verbal signals rooted in the differences of culture wherever these are neither common nor immediately intelligible. Another aspect, which the interpreter should bear in mind, is that verbal utterances which can on the face of it be translated word-for-word will, if such is attempted, often be received in a way the speaker had not intended.

Basic elements of everyday life, such as family feeling, relationships between the generations, notions of physical and mental illness and the possibility of recovery may be looked upon in completely different
ways. The sense of community, responsibility towards family members, the man-woman relationship, the relationship between young and old, concepts of disgrace, honour, religion and faith may be much more significant in other cultures than in those of our western countries and it is for the interpreter to ensure that the right importance and dimension are given to these aspects during an interview. This does not mean that the interpreter should act as a buffer for instance to soften insulting utterances, which will have to be interpreted in accordance with their face value if the parties are to get an accurate picture of each other and of the situation. Neither is it just a question of being expert in finding the precise phrase or proverb which expresses the speaker's thoughts perfectly - very few can live up to such expectations.

A direct translation of what is said supported by a more detailed explanation may very likely turn out to be the best way of conveying the meaning of what has been said.

Guidelines Before and After Interviews and Consultations

If possible, the interpreter should arrive in good time (15 minutes) before an interview. This is of particular importance if the client is new so that the interpreter and the client get a chance to tune in to each other and build up a relationship of trust. A point to remember here is that the interpreter is not a therapist and that such conversations should concentrate on "neutral" subjects. The interpreter must under no circumstances encourage the client to recount his experiences of torture etc. If the client touches upon itself, the interpreter should listen attentively, of course, but should seek to turn the conversation away from the subject.

When a session starts the interpreter and the client should enter the room together and they should leave together. A follow-up conversation between the therapist and the interpreter should take place.

After an interview the interpreter and the client should not discuss the matters that were raised during the interview.

Interpreting outside the Centre

Even if the rehabilitation centre has professional and specially trained staff within the various areas of treatment, the client and his family may from time to time have to be sent for specialist examinations and treatment outside the physical setting of the centre, for interviews with social workers and case workers in the local municipality, to schools etc. The interpreter must be briefed beforehand and must know what to do when she accompanies a client alone to such interviews or examinations.

The interpreter's job is, as we have said before, to pass on what the professionals and the clients say to each other and not to interpolate personal comments or explanations during the assignment. However, the exceptions to this rule are the situations where the client is not accompanied by a therapist or other professional from the centre.

In connection with somatic examinations and treatments, the interpreter should be aware of things that may remind the client of his torture. The interpreter may on her own initiative draw attention to these.

On visits to the social authorities etc. the interpreter may support the client by intervening to make sure that all essential points and details are explained and understood. However, she must not take over the conversation on the client's behalf, acting as his "guardian", but just draw attention to things which may have been forgotten or inadequately explained, enabling the client himself to formulate his own questions and wishes for interpretation. This to emphasize that the very purpose of rehabilitation is to restore the client's feeling of self-respect and assurance necessary to enable him to cope with his own life. If after the interview the interpreter finds that all points have not been attended to and emphasised appropriately, she must report back to the centre to decide what steps should be taken.

Interpretation in Practice

Some clients find it difficult to learn another language. Others learn quickly. This means that many of the clients understand and speak Danish well enough to handle many situations, but all the same many clients prefer to have an interpreter with them, perhaps because they find it difficult to express themselves clearly and precisely.

In such cases the interpreter should suggest that the professional speaks in his own language while the interpreter will translate single words or passages, when she feels that perhaps the client does not catch the full meaning of what has been said.

The professional may speak or understand some of the client's language. If so, it should be made quite clear that the professional never interferes with the interpreter's choice of word or forms of expression unless this is to avoid mistakes.

As far as the physical position of the interpreter is concerned the interpreter should be seated so that she can see the people she is interpreting for. During consultation or therapy the interpreter should preferably be seated between the client and the therapist. If she is seated next to one of them or closer to one of them this may shift the balance between the two parties.

To be continued
violence more frequently had persistence of symptoms than women who experienced only psychological violence.

Author.


Human rights and health care under apartheid in South Africa were studied. Human rights violations, such as detention without charge or trial, assault and torture in police custody, and restriction orders, have had devastating effects on the health of persons experiencing them. These violations have occurred in the context of a deliberate policy of discriminatory health care favoring the white minority over the black majority. South Africa's medical societies have had mixed responses to the health problems raised by human rights violations and inequities in the health care system. The acceleration of health care for all and prevention of human rights violations depend on ending apartheid and discrimination and greater government attention to these problems.

Author.


The death of the well-known black leader, Steve Biko, in detention in South Africa in 1977 has continued to generate debate in the international medical literature. The three doctors who examined him during his terminal illness made a diagnosis of brain injury while in detention. The inquest into his death provided a rare insight into the manner in which state doctors function in relation to the police of a repressive regime. This article documents the relevant testimony from the inquest and explores the reasons for the doctor's mismanagement of Biko. It is suggested that failures in the doctors' judgement were a result of complex influences including the effects of their own social conditioning, the risk of habituation by state doctors to degrading prison conditions, the inroads that Apartheid has made into medical practice, the possibility of reprisal if state doctors oppose the wishes of the police, and more speculatively, the possibility that the doctors' obedience and passivity were exploited by the Security Police who wished to absolve themselves from responsibility of Biko's injuries. Most importantly, it is argued that the repeated failure of the major medical organizations in South Africa to provide clear guidance and leadership to state-employed doctors increases the risk that individual doctors will continue to succumb to hierarchical pressures to condone acts of state-sanctioned violence against detainees.

Author.


Political persecution, state terrorism, torture, political assassinations, kidnapping and forced exile have become common occurrences in many parts of the world. Several researchers have tried to determine the impact of these situations on the mental health of those affected. At the same time, different types of aid programmes have been developed to prevent and treat the effects of violence on mental health. In this article we present clinical materials collected for 10 years by the Latin American Collective of Psychosocial Work (Collectivo Latinoamericano de Trabajo Psicosocial (Colat)), a medical-psychosocial assistance programme for political refugees. The programme was under the academic supervision of the Catholic Universities of Leuven (KUL, ULC), Belgium. The concept of identity is the central theme of a model which tries to understand and explain the suffering of exiles. We try to identify and expose the mechanisms of political violence that have traumatized an individual's self-esteem and disordered his familial and social bonds. In the second part of this article, the central ideas which support the medical-psychosocial practice of the programme are presented. This programme seeks to heal the damage caused by repression and exile through the active participation of those affected. Only in a context of communal action is it possible to develop a therapy to promote an individual recovery. It is in this sense that the strategic goal of the programme is to permit elaboration of the suffering at an individual, familial and group level, and to facilitate group dynamics which can trigger the potential of the exiles to transform the conditions of violence that originated and maintain their pain.

Author.

Petersen HD. The controlled study of torture victims. Epidemiological considerations and some future aspects. Scandinavian Journal of Social Medicine 1989; 17(1): 13-20. Sequence to torture have only been described in recent years. Only few controlled and no longitudinal studies have been made. Such studies are encumbered with many difficulties. Torture victims included in documentary and scientific studies have been selected on several levels. Certain forms of exposure e.g. torture and exile, which often occur simultaneously, may cause identical clinical pictures. Thus, some of the health effects of torture may be concealed in controlled studies in which matching is very close. Small populations present a considerable risk of confounding. So far, only simple methods have been used to assess the health of torture victims quantitatively. The validity of these methods is not known. In the future, methods used for health assessment of torture victims should be evaluated. Longitudinal studies may disclose characteristics for victims with specific prognostic features and may thereby be helpful when setting priorities and choosing strategies for treatment.

Author.


The health consequences of organized violence are well documented (increasing from many parts of the world). We review experiences reported from Latin-America based on literature, contact with human rights organizations and participation in conferences in (Santiago de) Chile and Costa Rica, with special focus on: the destructive psychosocial influence of a repressive society; the development of torture methods; the development of therapeutic methods; the serious psychological implications of "impunity". In Central America joint strategies have been developed for preventive and therapeutic work connected to the effects of war-traumas and terror. Psychiatrists and psychologists from Western countries involved in treatment of refugees in exile can mutually benefit from the experiences of colleagues who have dealt with the problems in countries where prosecution and oppression have taken place. Within this framework professionals are challenged to take a firm stand against human right violations.

Author.
First Rehabilitation Centre in Russia

How the “Compassion Programme” helps old age Victims of Stalinism

By Dr. Marina Berkovskaya * and Alexey Korotaev**

Political repression in the USSR began just after the October Revolution in 1917. It was particularly pronounced and widespread during the period of Stalinism in the 1930-50s.

The exact number of victims is still unknown, but according to Alexander I. Solzhenitsyn about 100 million perished, including the victims of political repression, collectivization and deportation of whole nations during World War II. People repressed without any real guilt were sentenced to prison or concentration camp terms of 5-25 years. Labelled “enemies of the people” they gave false confessions after suffering through all kinds of physical and psychological torture. We can hardly add anything new to the many recollections about these tortures 1). But today’s treatment of the “enemies” of past times is new.

After the investigation, the torture continued in prisons, concentration camps, exile. All the prisoners suffered from malnutrition, hard exhaustive labour, extreme climatic conditions and somatic diseases without medical help. For the whole period of repression the prisoners were subjected to humiliation, inhuman and degrading treatment and acts of violence.

Close relatives of prisoners were also repressed in a direct or indirect way. They were labelled “relatives of enemies of the people”. Even if they were not arrested after the arrest of their parents, spouse, children, siblings and so on, the conditions of their life became unbearable. They were doomed to miserable lodgings, hard and unqualified work, and were virtually forbidden to continue their education at colleges and universities. The younger children of the arrested “enemies of the people” were sent to special orphanages that resembled prisons.

Thus considering all the evidence we can say that victims of Stalinist repression in the USSR are a unique group of torture survivors according to the definition of torture which is found in the WMA Declaration of Tokyo: “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.”

The Compassion Programme Activity

Approximately 4,000 victims of the Stalinist repression now live in Moscow. More than 2,500 of them are linked with the Memorial Society, which was founded as a social movement in 1988. Its aim is to research the history of the political terror in the USSR, and to keep alive the memory of its victims, and to help those of them who are still alive.

The idea was conceived to supplement the rather inefficient (especially if the patients are old and alone) state health service with a specialized system of medical and social help. Such a system requires significant resources which can only be received from charitable endowments. But charity in the USSR is a very young and weak movement in 1988. Its aim is to research the history of the political terror in the USSR, and to keep alive the memory of its victims, and to help those of them who are still alive.

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The experience gained during the clinic. Therapist from the National programme's existence shows that such a complex system (two psychiatrists and one psychologist) in the various departments of the Moscow General Hospital No. 15, 20 of our patients receive permanent nursing help at their homes. The experience gained during the programme's existence shows that our patients differ from the majority of clients at rehabilitation centres in other countries. We deal with a unique group of torture survivors which has no analogue in the world. The main features of its members are:
- age: 60-80 years and older
- the long duration of the period of stress
- the long-lasting an far-reaching consequences of torture.

The hard and long repression and overlong stressful period of life led to the creation of the whole complex of psycho-somatic disturbances enforced by the age pathology and the extremely unfavourable living conditions. These features require the organization of a special non-standard system of medical and social care for this group of patients. This system as we see it must contain two main elements. First it is a continuation and enhancement of the existing system of income help to our patients. Second, the creation of the Rehabilitation Centre as such. It must be affiliated with some established general hospitals and realize the following functions:
- hospitalization and treatment of patients with serious illnesses,
- psychotherapeutic help and psychological support,
- intramural psychological and somatic rehabilitation of the patients, especially if they are very old or alone for several months.
We think that only such a complex system can render all necessary help to our group of torture survivors. But the realization of this plan strongly depends on the programme's ability to raise enough funds from Soviet and foreign donors.

Research Projects
Along with its practical activities the Compassion programme undertakes some research related to the medical and socio-psychological problems of torture survivors. The first research project Psychogeriatric aspects of delayed consequences of the strong psychogenies was initiated in April 1990. The project is carried out by a group of researchers from the National Centre of Mental Health (leading specialist, Dr. Natalia M. Mikhailova), and funded by ENIO. The preliminary results were reported at the training seminar at the RCT (Copenhagen, April 15-22, 1991).

In the beginning of 1991 within the framework of the Compassion programme was initiated another research project Correlation between the types of repression and the current psycho-somatic status of torture victims.

We are collecting the following data during the medical examination of our patients: history of direct or indirect repression, length of repression, evidence of torture, type of somatic diseases, time of onset of disease, personal features of the patients. The social-demographic characteristics of the patients are also recorded.

We suppose that the analysis of these data will enable us first to develop practical recommendations for differential therapy and complex help to our group of torture survivors and second to show a possible correlation between the frequency of occurrence of some somatic disorders and the type of previous repression.

The first attempt to process the data showed the necessity for data formalization and the addition of auxiliary criteria, because only the computerized form of data representation can cover such heterogeneous and diverse information. The specialized computer database for this project is now being developed.

References

1) The salient work of Alexander Solzhenitsyn The Gulag Archipelago, which we strongly recommend to all interested, is the best compendium of data, pertinent to the topic.

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How Electrical Torture can be Scientifically Proved

The organization Anti Torture Research has done it

By

Lis Danielsen, M.D.*
and Ole Aalund,
D.V.M. († 1991)

Since its foundation in 1978, Anti-Torture Research (ATR) has been actively carrying out the provisions of the ATR constitution. These stipulate that ATR should act as sponsor, initiator, and coordinator for biomedical research in the broadest sense of the term in all medical and scientific fields related to the effects of torture. The ATR list of publications includes two doctoral theses (1, 2). The main activity of ATR has so far been to study the skin after exposure to electricity, with the aim of developing diagnostic means for revealing the use of electrical torture.

Experimentally induced electrical skin lesion

The thesis “Electrically induced dermal changes. A morphological study of porcine skin after transfer of low-moderate amounts of electrical energy” has recently been published (2). The results of this study have proved useful. Thus, in a case of homicide, ATR was able to demonstrate that the lesions produced in electrically exposed skin sites of fully anaesthetized pigs were similarly present in human skin. A summary of skin changes following exposure to electricity is given below.

Vesicular nuclei (1, 3). The lesions following electrical injury appeared in small superficial and conical segments, probably areas with low resistance to an electrical current. The segments were necrotic. Within the cathode area following exposure to direct current (DC), and in the lesions following exposure to alternating current (AC, 50 HZ and 8000 Hz) the segments contained large multilocular “vesicular nuclei” with clear nucleoplasm and clumps of chromatin. Since basic solutions were able to produce similar changes in the nuclei, and since “vesicular nuclei” were never observed in the anode areas, in burns, or in 100,000 Hz AC lesions they are presumably a result of electrolysis in the tissue during exposure to the electrical current.

Vesicular nuclei were produced by low to moderate amounts of energy and could be observed in areas with no visible alterations in the skin. However, they disappeared a few days after the injury.

Collagen calcification (2,4). A characteristic pattern of deposition of calcium salts was observed on collagen fibres in the dermis a few days after exposure to AC or DC, the deposits in the latter situation being present in the cathode area. The segmental necrotic lesions of the skin were surrounded by an inflammatory zone of demarcation. From day 2 after exposure, small foci of calcified collagen and elastic fibres were present within viable tissue in a narrow zone encircling the necrotic lesions, at some distance from the inflammatory zone and the regenerated epidermis. During the following days, the calcified foci increased in number and size as calcification also took place in the collagen and elastic fibres within the viable tissue situated superficially to those calcified initially. At day 7, calcified collagen fibres had reached the regenerated epidermis. Calcified collagen fibres were still present in the cathode area 2 months after the injury, even though a transepidermal elimination of fragments of calcified collagen fibres was observed 3 weeks after the injury.

Collagen calcification was induced by low to moderate amounts of energy at the cathode and occasionally by 50 Hz AC. Collagen calcification was never observed in anode areas or in burns.

Within the necrotic areas that followed exposure to all the types of energy used, deposits of calcium salts were seen in cells of sweat glands and vessel walls. In electrically induced lesions, these deposits probably resulted from concomitantly induced inflammatory reactions.
mitantly generated heat. They could easily be differentiated from collagen calcification.

Conclusion: Segmental lesions were typical of electrical injury. "Vesicular nuclei" were pathognomonic for injuries after exposure to electricity and basic solutions. The characteristic calcification pattern of collagen fibres was highly indicative of electrical injury.

Observations in Human Skin

Recently, we observed deposition of calcium salts on collagen fibres in human skin from a case of suspected homicide (5), the pattern being identical with that described above. A previously healthy 5-year-old girl was found unresponsive in her home and was taken to the emergency department where cardiopulmonary resuscitation was successful. She remained in coma for one week and was then declared brain dead. At admission, it had been noted that she had injuries in the skin of her chest and left arm.

A morphological examination revealed that the skin lesions were segmental, with necrosis and inflammation. Some of the lesions were superficial, others deep. Deposits of calcium salts distinctly located to collagen fibres were observed:

1) below the regenerating epidermis is at the periphery of two skin lesions of the chest wall,
2) in the lower part of the dermis at the periphery of a skin lesion on the left arm, and
3) within connective tissue adjacent to elastic arteries and peripheral nerves from the thoracic cavity.

The pattern of the calcification that was distinctly located to collagen fibres and situated both superficially and deeply in the skin in a zone of viable tissue close to necrotic tissue is characteristic for lesions induced via exposure to AC, and for cathode lesions after exposure to DC as observed in pig skin. The deep necrotic lesions in the present case suggest the effect of severe concomitant heat, a condition that is more characteristic for AC than for DC exposure. The segmental appearance of the lesions is typical for both AC and DC injuries. Even though there have been reports of deposition of calcium salts on collagen fibres after application of calcium salts in high concentration to the skin in man, the collagen calcification in the pattern observed in the present case is probably associated diagnostically with electrical injury.

References


News in Brief

Election of two members of the Anti-Torture Committee

In the Council of Europe the Committee of Ministers has elected Mrs. Pirkko Anneli Lahti as a new member (in respect of Finland) of the Committee set up under the European Convention for the prevention of torture and inhuman or degrading treatment or punishment.

Mrs. Lahti is a psychologist and the Executive Director of the Finnish Association for Mental Health.

The committee of Ministers has also re-elected Mr. Petros Michaelides as the member of the Committee in respect of Cyprus.

Mr. Michaelides is an Ambassador and a former Minister of Justice. He was first elected to the Committee in September 1989.

The members of the Committee, who come from the 20 states which have ratified the Convention (one member from each state), are empowered to visit places of detention and to make recommendations to the public authorities with a view to strengthening, if necessary, the protection of persons deprived of their liberty from torture and inhuman or degrading treatment or punishment.

The committee consists of medical doctors, psychiatrists, professors of law or lawyers, judges, prison governor and politicians.
Bone scintigraphy as clue to previous torture

From Lancet 1991; 337: 846-47

SIR, - Torture is used by certain branches of government in various countries, and Turkey, unfortunately, is one of them. Officially it is denied or seen as an isolated act of individuals. However, when we formed a medical investigation committee and announced it, the flood of applications left the strong impression that torture is a routine practice by Turkish police. A questionnaire distributed under the supervision of the prison authorities revealed that 73% of prisoners had been tortured while in police custody (1), and an international survey (2) came up with a similar figure. The most frequent method is falanga, beating the soles of the feet (3). Most victims are too frightened to report this maltreatment and the occasional hero who is may find that his claim does not convince a court because he had been released from prison long after the physical signs of torture had disappeared. Any objective sign of torture that persists would be very valuable. We have investigated alleged torture cases using techniques such as ultrasound, computerised axial tomography (CAT), and bone scintigraphy; the latter has emerged as a promising test.

A 35-year-old woman was arrested for suspicion of involvement in a kidnapping. She was heavily beaten for about 2 days and released a week later because she was found to be innocent. Subsequently, she required extended psychiatric inpatient care. 1 week after the incident, clinical examination and the CAT scan revealed soft-tissue oedema of the feet, and there was increased activity in the first and second metatarsal bones of the left foot on bone scintigraphy with technetium-99m (figure). Conventional radiography was normal with no signs of bone fracture. This patient has been followed up for 12 months now and bone scintigraphy has been persistently positive in thirteen scans done every 2-4 weeks. She is still under psychiatric treatment.

A 41-year-old woman was interrogated by the police for about 24 hours about some missing jewels. When examined a week later, she said that she had been beaten (falanga), kicked, and hit. She had multiple bruising and the soles of the feet were tender. Whole-body bone scintigraphy 10 days after the incident revealed increased activity at the 9th thoracic vertebra, 9th left rib, 10th left costovertebral junction, and first metatarsal of the right foot (figure). Radiography and a CAT scan disclosed only L5-S1 spondylolisthesis and soft tissue...
oedema of the feet. 1 month later scintigraphy still indicated increased activity in the left 9th and right 10 ribs, and these findings were still present at 5 months.

A 35-year-old man beaten by the police 2 days earlier with falanga and on the hands had CT evidence of soft tissue oedema of the feet but scintigraphy revealed increased activity in the second and the third metacarpals of the right hand only. A 27-year-old man beaten in the same incident had oedema of the feet, bruising, and cigarette burns. A CT scan of the feet disclosed soft-tissue oedema with no bone injury; scintigraphy showed hyperactivity at the first metatarsal bone of the left foot. These two patients did not attend for follow-up.

Bone scintigraphy is a sensitive indicator of trauma (4,5). It may reveal small fractures missed by conventional radiographs. A positive scintigraph may remain positive for over 5 months (6). Since our patients did not have fractures corresponding to the active scintigraphic site the scans may be revealing periosteal damage caused by the beatings.

These observations have been forwarded to the International Rehabilitation and Research Centre for Torture Victims (RCT), and the project will continue as a joint effort by RCT and the Human Rights Foundation of Turkey in three large Turkish cities. We hope that the project will fall short of its aim of one hundred patients.

References


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Patient 2, ribs: on admission (left), and 5 months later.
Forthcoming Conferences and Seminars

Holland, Amsterdam, November 1st, 1991
The Johannes Wier Foundation: Symposium on Health and Human Rights in Eastern Europe.
Further information: Johannes Wier Foundation for health and human rights
P.O. Box 1551
3800 BN Amersfoort
Netherlands
Tel. 31-33-726 749
Fax. 31-33-653 161

Theresa Swinehart
Grensen 18
N-0159 Oslo 1
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Tel. (47-2) 42 13 60
Fax. (47-2) 42 25 42

Israel, Jerusalem, November 4-7, 1991
The Society for Medicine and Law in Israel:
3rd International Congress on Psychiatry, Law and Ethics.
Further information: Congress Secretariat:
Stier Group Ltd.
190A Ben Yehuda St.,
Tel Aviv
Israel
Tel. 03-224153
Fax. 03-247782, 03-224151

Italy, Roma, November 18-19, 1991
WPA - International Conference, Social Psychiatry Meeting: Power and Mental Health.
Further information: Conference Secretariat
SC Studio Congressi
Via F. Ferrara No. 40
I-00191 Roma
Italy
Fax. 6 32 86 897

Norge, Oslo, November 4-15, 1991
Norwegian Institute of Human Rights:
Seminar on democratic institutions (CSCE Parallel Activities).
Further information: The Norwegian Institute of Human Right
Contact: Bjørn Engesland or

Royal Society of Medicine: The Nature of Human Response to Abnormally Stressful Experiences.
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Egypt, Cairo, January 16-18, 1992
World Psychiatric Association: Regional Symposium.
Further information: Egyptian Psychiatric Association
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