TORTURE 1/93
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PSYCHOTHERAPY WITH
TORTURE SURVIVORS
A report of practice from the Rehabilitation and Research Centre for Torture Victims (IRCT), Copenhagen, Denmark. By Peter Vest, MD; Finn Sonnentrup, MD, and Marianne Kasstrup, MD, PhD.

Psychotherapy with Torture Survivors is written by three medical doctors, two psychiatrists and a neurologist, who have examined and treated hundreds of torture survivors. The book describes torture methods which RCT clients have survived, the psychological after-effects of these methods in the survivors, and the psychotherapy offered by RCT. Also included are two case stories, and the personal reflections of two former clients.

It is the hope of the authors that their book will be a practical contribution to the international literature on the rehabilitation and psychotherapy with the torture survivors. Price US$ 20

ERRATA
In the last issue of TORTURE on pp 59-62 the mentioned address of the Center in Minnesota was the old one.
The new address is: 717 East River Road, Minneapolis, Minnesota 55455, USA.
Torture and human rights violations have been close to the everyday life of Turks for many, many years. But the existence of non-governmental organizations with the express goal of fighting for the protection of human rights is new in Turkey. The open debate about these violations in Turkey started only within the last five years.

No matter how deplorable - well, disgraceful - the continuing use of torture in Turkey, it was an achievement that the V International Symposium on Torture and the Medical Profession was held in Istanbul on 22-24 October 1992. The Symposium was arranged by the International Rehabilitation Council for Torture Victims (IRCT) in cooperation with the Human Rights Foundation of Turkey (HRFT) and the Turkish Medical Association.

One could only hope that Turkish Politicians would read carefully the text of the Istanbul Declaration (full text on next page). They would find there the pertinent rules that prohibit torture, together with several principles for proper conduct when dealing with prisoners, as well as the rights of detained and arrested people.

If any of the 200 doctors, psychologists, and others who attended the conference, were nervous lest the Turkish authorities, let us say the police, should interfere, or that some kind of sabotage might be directed at the conscientious and gifted torture fighters, they fretted in vain. Almost everything went according to plan.

No Turkish doctor was barred from attending, and several statements and interventions dealt with the precarious situation that still exists in the country. The mayor of Istanbul received all the participants. More than that, the Prime Minister, Mr. Süleyman Demirel, and the Minister of Health, Mr. Yıldırım Akıncı, explicitly denounced the use of torture exactly at the time of the symposium.

Did that mean anything? At least the will of the Turkish government seems definitely against torture and for establishing safeguards against misuse by local authorities. The country is going to have a new constitution, and it is to be hoped that the internationally recognized definition of torture (as in the 1986 UN Convention Against Torture) will be included.

As has been mentioned earlier in this journal, just finding out what torture is confronts us continuously with problems. Many Turks are routinely beaten at the police stations when detained for any reason, criminal or political, but often the detainees themselves do not consider such ill-treatment as torture. Use of physical force, by parents against their children, by husband against wife, by teacher against student, is, sadly, well known.

That may disturb well-intentioned West Europeans who read reports on Turkey from Amnesty International, the Helsinki Federation, or the Council of Europe. What are we talking about? What kinds of problem are we up against? Are the ministers and civil servants in Ankara completely different people from the people at the police stations? Is the Government without proper power?

Yes and no. Apparently more than just decisions at a higher political level is required. Shortly after the symposium, an Amnesty International report repeated the grim message, that the Government was doing little or nothing to stop the misuse by the security forces, especially in the south-eastern parts of the country. Many medical doctors report threats and intimidation. Former detainees assert that some government-ordered medical examinations take place too long after the event to allow any definitive findings, some examinations are cursory in nature, and some take place in the intimidating presence of police officials.

As for people who have been subjected to torture, they usually only see a state doctor. Many doctors are under great pressure to submit false or misleading medical certificates, -stating that no evidence of torture was found. If they do not comply, they risk transfer to another position, or even dismissal. Some doctors, who did not remain silent when they detected signs of torture in prisoners, have themselves had the grim experience of being tortured because of their courageous opposition to attempts to force them to comply with a system of evil.

The politicians compete in making impressive statements that can only affect naive people who pay more attention to paper than to human beings. When the Minister of Health at the symposium toyed with the idea that all prisons ought to be closed, or when the Prime Minister said in 1991 that “in a new Turkey the walls of all police stations will be made of glass”, one may laugh – if it was not such a serious matter.

It should be remembered that President Türğut Özal blocked a package of tentative reforms, whose general aim was to protect detainees from ill-treatment and torture, on the grounds that it might be prejudicial to national security. Political detainees were then excluded from this for the next two years.

Amnesty International in its November report advised the Turkish government radically to change the practice of investigation used by the police, to fulfil its legally-binding obligations under the UN Convention against Torture (articles 7, 12, and 13), and to ensure prompt investigation by an independent and impartial authority when accusations of torture are made.

Detainees should also have the right to be examined medically by a doctor of their own choice, and to have access to the results of the medical examination. It is indeed horrible that Turkey continues with its promises when thousands of Turks are being beaten, exposed to electric torture, and hung by their arms in order to force confessions or simply to weaken them.

Most striking was perhaps that the Council of Europe Committee for the Prevention of Torture went public on its own for the first time in reporting the widespread use of torture by the Turkish authorities, despite as many as three visits by the Committee, in 1990, 91, and 92. The Committee can make a public statement only if a party to the Convention fails to cooperate or refuses to improve the situation after having received recommendations.

The Committee in 1992 made surprise visits to interrogation rooms in the Ankara and Diyarbakır police headquarters. They saw a stretcher with straps and a beam, which were as good as proof that people were given electric torture and hung by their arms. The description of these instruments by released torture victims fitted with what the inspectors saw.
THE ISTANBUL DECLARATION
of the International Rehabilitation Council for Torture Victims

A global appeal for the abolition of torture

- Notwithstanding that the United Nations Universal Declaration of Human Rights adopted in 1948 included the right to freedom from torture by specifying that "no one shall be subjected to torture or to cruel, inhuman or degrading treatment"
- notwithstanding that this Universal Declaration of Human Rights clearly indicates that this provision constitutes a prohibition to use of torture to which no exception can be tolerated
- notwithstanding that the United Nations International Covenant of Civil and Political Rights underlines that "even in time of public emergency which threatens the life of the nation", "no derogations to the prohibition of torture and cruel, inhuman or degrading treatment or punishment can be made"

still torture continues to be a fact of life being perpetuated and tolerated by a large number of governments and other authorities in countries being members of United Nations in contradiction to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment adopted in 1984.

This is especially the case in dictatorships and in other repressive forms of government which rely on torture and the threat of torture for their continued suppression of their populations.

But also in many countries where democratically elected governments have succeeded such repressive form of government, torture continues to be practised in parts of the system which have not been affected by the political change. There is ample evidence to suggest that medical doctors and other health professionals are directly or indirectly, actively or passively, involved in these inhuman practices thereby acting in contradiction to the World Medical Associations Declaration of Tokyo from 1975 and the United Nations Principles of Medical Ethics adopted in 1982.

Against this tragic background the V International Symposium on Torture and the Medical Profession organized in Istanbul October 22-24, 1992 by the International Rehabilitation Council for Torture Victims in collaboration with the Human Rights Foundation of Turkey and the Turkish Medical Association appeal to the United Nations and its responsible constituent member countries:

- to live up to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment;
- to make a serious effort to remove the practice of government or government inspired torture as part of political repression as well as interrogation or for any other purposes;
- to give the right to a detained or arrested person to demand a medical examination by an independent doctor of his own choice before and after interrogation. The official report must include in detail the history and the findings of the physical examination of the case. The detained or arrested person must be permitted to read this report and the examination must be conducted outside the influences of the police or security forces;
- similarly the family of a person alleged or suspected of having died as a result of torture should have the right to demand an independent post mortem examination of the body;
- to prosecute with diligence and effectiveness all cases of alleged or suspected torture and enact provisions for free legal aid for the victims;
- to establish the right to compensation to victims of torture and their dependents;
- to repeal all laws establishing impunity for torturers if these laws have been established by a non-democratic government;
- to protect by law and confirm by international, national or local laws the right to freedom from torture and cruel, inhuman or degrading treatment or punishment;
- to include in the curriculum of all health professionals and as part of the training of lawyers, police and the military, specific training programs in ethical obligations and international and national law governing the behaviour of each professional group in relation to the practice of torture;
- to support the establishment of special independent centres offering treatment to torture victims;
- and finally, as a matter of urgency


(Short of making contributions to United Nations Voluntary Fund for Torture Victims obligatory, which would be natural given the United Nations Universal Declaration of Human Rights, this could be done by setting each year minimum target sums for each country indicating what ought to be the contribution according to the usual distribution of financial contributions to United Nations activities). With collective good will and political determination the practice of torture could be eradicated by the year 2000.

However, the sad legacy of torture – the scars in the bodies and souls of the torture survivors – will remain with us and require professional care and social attention for many years to come.

Adopted by the IRCT Council and Bureau in Istanbul on October 24, 1992.

1) In countries where doctors are not easily available they may be substituted by other authorized health professionals.
This glimpse into the world of the torturer, based on material from about ten countries, begins with an interrogator’s manual from the central prison-execution facility of the Cambodian Khmer Rouge, a place called S-21 or Tuol Sleng.

The S-21 Interrogator’s Manual contains the following description of torture, under the heading The Question of Doing Torture:

The purpose of torture is to get their responses. It’s not something we do for the fun of it. Thus, we must make them hurt so that they will respond quickly. Another purpose is to break them (psychologically) and to make them lose their will. It’s not something that’s done out of individual anger, or for self-satisfaction. Thus we beat them to make them afraid but absolutely not to kill them. When torturing it is necessary to examine their state of health first and necessary to examine the whip. Don’t greedily want to quickly kill them — bring them to death.

This chilling glimpse into the Khmer Rouge’s “bureaucracy of death” highlights the principal features of the torturer’s world: first, the torturer is doing a job, he is “doing torture”; second, he is supposed to do it well, “mastering torture”; third, he is supposed to achieve certain results, (“make them talk”), i.e. obtaining confessions, breaking the enemy’s will; fourth, the central method used to achieve these results is inflicting pain (“make them hurt”) on people defined as “enemies”.

The Khmer Rouge says,

At the same time it is necessary to avoid any question of hesitancy or half-heartedness of not daring to do torture, which makes it impossible to get answers to our questions from our enemies, which slows down and delays our work. In sum, whether doing propaganda or torturing or bringing up questions to ask them or accusing them of something, it is necessary to hold steadfastly to a stance of not being half-hearted or hesitant. We must be absolute. Only thus can we work to good effect.

The purpose of torture

While the torture situation appears to resolve around interrogation — a series of questions and answers that can presumably be ended if all the questions are answered — it is more complex than this. Ask ex-torturers directly why they torture and the results usually focus on the information and confession aspects. A Uruguayan officer: “to extort confessions”; a Namibian soldier: “to detect guerrillas”; a Peruvian police officer: “to force someone to talk, you had to interrogate with violence. People were sought and we as police agents had to handle the investigation... The investigation was necessary and so we also had to torture”.

Even General Hugo Medina, head of the Uruguayan army during the defeat of the Tupamaros, used the standard line in an interview with the New Yorker: “in many instances, the life of one of our comrades was in danger, and it was necessary to get information quickly. That is what made it necessary to compel them” [read “torture them”].

Listen to an ex-torturer who was active in Rhodesia, before independence, and who was tortured himself when captured by guerrillas:

If you are torturing somebody you concentrate on your victim, you try to understand the point of resistance, how strong he is, can he take the pain, or do you have to work on him psychologically... They first inflict pain on you and that type of thing, for a long time, and then they give you a cigarette, good food, well, something to eat. So that you get confidence in them. If you get confidence you will confide in them and tell them everything. They will for a certain time pose as friends. And if that does not work the first time, they break you down again, and then it is psychological because you start, doubtfully, but still trusting them and then — flat again. It may destabilize you.

The Khmer Rouge:

a) Reassure them by giving them something, giving them something to eat; reassure them that the Party will be giving them back their posts.
b) Terrify them... and split them up in clever ways. Arrange little skits for them in order to make them give up hope that they will ever live again or ever be able to survive.
c) Draw them into some ordinary conversation but formulated so that it is of some use,
d) Bring them over to a sentiment of being caught up in thinking about their family, their wives, their children and their life.... Don’t make us torture you or torture you severely. It’s bad for your health and makes it difficult for us to deal with each other in the future....
e) Avoid propagandising them in such a way that they can grasp our weak points, such as they know that we want them to confess about someone or some activity.

As one ex-victim who spent 8 years and 45 days in Libertad prison in Uruguay stated:

All of us were tortured for days on end, without even being interrogated at first.... They weren’t really after any information — they knew everything already, had everybody’s name. It was all just part of the process’.

Andres Valenzuela, a Chilean ex-torturer, observed that “Every detainee was tortured, irrespective of age, sex or background.”

And again, the Khmer Rouge: “They cannot escape from torture. The only difference is in whether there will be a lot of it or a little of it. However, although we in this way consider torture to be a necessary measure, we must, nevertheless, strive to do politics to get them always and absolutely to confess to us”.

The ultimate purpose, then, is political, to impose the will of the regime even upon those condemned to die.

The interrogation is but the primary vehicle for this larger purpose; the confession the proof of the absolute power of the regime.
Classification methods

The language of torture is one that replaces the words of cruelty with euphemisms. There are also black humour, sick jokes, wisecracks, obscenities of the worst kind and cruel ironies.

One Brazilian victim paints the following picture of the torture process:

The torturers interspersed their shocks and beatings with a good deal of joking and horseplay among themselves. Or they would mock the United Nations declaration on human rights. “Time to apply the declaration again”, they would say, tying a prisoner back on the parrot’s perch and fastening the wires to his body. [The parrot’s perch or Pau de arara is a technique whereby the victim is strapped at his hands and feet and hung on a wooden stick, usually with the stick behind his knees].

Things and persons are not called by their real names. Torture, to begin with, is called interrogation, or tea party, or tea party with toast, depending on the variation. In the Philippines, for instance, a secret torture centre is called a safe house – they are safe for the torturers, but certainly not the victims. From their perspective, the name is cynical. The victims in Argentina had another name for ‘safe houses’ – chupaderos – places that suck people up.

For security reasons, the torturers often use fictitious names when talking to each other. The Monkey, Moustache, Don Pedro, Don Julio, El Tigre, El Suizida or Captain Gestapo. Clearly, the choice of name can convey a message as well. The torturer’s jargon, his vocabulary, sometimes refers to the world of medicine, or to the world of cooking or even to the world of history of ideas. Using metaphors of cooking we find, for instance, in Zaire that a torture session begins with le petit déjeuner [breakfast] (the prisoner has to drink his own urine), to be followed by le déjeuner [lunch] (he is beaten systematically on his shoulders) . When a prisoner is put on a diète noire, this means in Equatorial Guinea that he was not allowed food or water. When a victim’s head is submerged this is sometimes called in Columbia Bano de Maria. The same technique is also known as submarino mojado [wet submarine]. Then there is la parrilla [the grill], a metal bed on which the victim is strapped while being given electric shocks.

Torturers sometimes make use of the vocabulary of healing. They insist on being called ‘doctors’. In Chile, one technique of torture, whereby the victim’s lower half of the body is forced to lie on a table with the upper half of the body unsupported while the abdomen is beaten was called el quirofano or the operating table. Expressions not linked to one metaphor are el telefono whereby the victim is beaten simultaneously on both ears with the palm of the hand, causing great pain and sometimes deafness. In Brazil, a torture whereby the victim would be forced to stand on sharp objects with their bare feet while holding heavy objects in each hand with arms raised high was called ‘the Statue of Liberty’.

Blasphemy was also part of the vocabulary. One victim recalled the treatment they got from the Nicaraguan Contras: ‘While they were raping us, they were chanting slogans like ‘Christ yesterday, Christ today, Christ tomorrow’.

As for the auditory aspect of torture, none who has experienced the screams of torture victims can forget them and none who has not heard them can imagine them. Here is the description of an Israeli reservist whose job it was to stand guard over prisoners who were forced to stand in a cold room called the refrigerator while they were awaiting interrogation:

So this was the first day, and at that time I hadn’t heard the screaming yet. The screaming I heard on Saturday morning, there came interrogators from the Israeli police, also with Shabakniks [Israeli security service], and those were screams which until today, when I sleep at night, I hear them inside my ears all the time. It doesn’t leave me, I can’t get rid of it, all the time. They were horrible screams, really, someone who sees a Hitchcock movie, or hears an actress scream in terror, I think it’s nothing compared to how they were screaming then.

It has often been reported that screams of torture victims no longer sound human. The irony is that, to the torturer, this only reinforces their dehumanization. One Chilean victim, speaking of her own screams, recalled: ‘it’s much worse than a howl. The sound coming from within is just terrible. It’s the worst sound I’ve ever heard’.

The Brazilian project, Nunca Mals, that documented the systematic torture in Brazil was able to isolate 283 different types of torture: classified into moral/psychological, general physical, and physical specific. I shall not further enumerate the myriad, perverse and ingenious ways that have been and are to this day being used to torture victims; suffice it to say that the least of them is terrible beyond words for the sufferer. Many people die under torture. As one Columbian torturer says: “…it gets out of hand” . One Argentinian victim writes: “Some people die on their torturers, without a decision having been made to kill them; this is regarded as a professional failure.”

This is what the Khmer Rouge called a loss of mastery. Yet, not all deaths are regarded as unprofessional, as any member of a death squad would attest to. Consider what a Contra officer says: “The direct method [of interrogation] is to beat him until he speaks. But this pays only if the person has information. Interrogating persons who do not know anything means wasting time. They are killed immediately.”

For the victims, the torture chamber is a place of terror. But often the terror continues even after the interrogation, when they are imprisoned elsewhere. A Uruguayan psychologist described the Libertad prison in Montevideo in these words:

“The environment was totally unstable and unpredictable. The prisoner inhabited a crazy world filled with perils. Orders were to be followed absolutely but they changed diametrically, arbitrarily, and without any notice, from one day to the next (...). Violations were recorded with mock-scientific thoroughness, so that you were made to see that – on paper anyway – you had indeed now committed three violations, which had such-and-such consequences. But it was all double binds piled on more double binds.”

There was always the possibility that the prisoner would be sent back to the torture chamber for a “refreshing course”.

Recruitment of torturers

Many of these units where torture is carried out are elite units with exalted reputations within the military or the police command structure. If their existence is known to the public, they are often highly respected and/or feared. To be promoted or assigned to such units can be very rewarding for a career-oriented soldier or policeman.

The second route is direct conscription, either into the armed forces in general or directly into a specialized unit. Many of such conscripts are lower class, poorly educated, and come from
families that share the ideological orientation of the regime in power. In some cases, conscription is really akin to kidnapping, whereby youths are rounded up as they come out of a cinema and taken off to basic training. One youth who had been forced in this way to join the Contras fighting in Nicaragua describes how he felt: I admit that I had a chance to take off several times, but I didn't. It was more fun than going back to my family. It's true that once they've snatched you, you feel a little of their power. That makes an impression. I really felt excited.

This kind of recruit is usually very young – a teenager – very poor, and uneducated. The ages of the subjects of the ego-documents examined were rarely stated explicitly, but when they were, they were primarily in their teens: 17, 18, 19.

The third route to torture is serendipitous and can often be quite ironic. One Honduran torturer first worked in surveillance and was then moved into kidnapping. But the night work kept him from his family and he requested a day job, so he was transferred to the torture unit. One torturer who worked for the Polish Secret Police had previously worked with the military police and with the rail police, but wanted to live closer to his home town. The only organization to have an opening, at the level of inspector, was the secret police. He knew nothing of the organization, but took the job.

A Peruvian torturer joined the police to be able to play on their second soccer team. Placed in Cajabamba, where terrorists had killed a colleague, he wanted to be somewhere safer, so he took a course in interrogation in Ayacucho. That's how he got into torture.

Training
How is one trained to become a torturer? The process is not an instantaneous one. Few people, if any, take it with gusto and even the most sadistic torturer has to be trained to retain 'mas­tery' and not lose a victim too soon. The process already begins with basic training and the induction into the hierarchi­cal structure within which torture units operate. As one observer has noted: There is little difference between the training of soldiers in general and the training of torturers in particular. More often than not, the second part is a byproduct of the first, with the act of torture becoming an integral part of one's duty; a duty that requires you to "be a man".

During basic training, an internal selection process occurs whereby command­ers identify not only those who are particularly suited to their needs, but also those who are unsuited. "In the War Academy, Valenzuela [a Chilean ex-torturer] learned how to detain, interrogate, and exploit the fears of prisoners – while psychologists looked for weakness in the young draftees and weeded out those, who seemed sentiential." In similar fashion, one of the Greek KESA graduates was given a clerical job because he couldn't stomach the torture. One ex-torturer whom we inter­viewed described how recruits had to hang from a rope by their fingertips to learn how to withstand pain. This and similar training techniques serve to weed out those who cannot take it, so to speak.

Just as training is designed to condition recruits to endure pain and suffering, techniques are also used to overcome the recruit's natural aversion to inflicting pain and suffering on others. One such technique that has been described is "the forced watching of films that get progressively more gruesome, during which the trainee must concentrate on small details such as the motif on the handle of a knife. A steady diet of this desensitizes the soldier so that he can dissociate his feelings from the act of killing and inflicting pain". According to a Chilean ex-torturer, "the con­script did not attend torture personally, but he found his natural aversion to mistreating a defenceless person gradually being eroded. The prisoners in the basement were dehumanized, blindfolded, anonymous 'subversives'".

Along with what is learned in basic training, there is special training that goes on for those assigned to torture units.

Ricardo Gamez Mazuera (Colombia):
they mustn't be hit in the face, but in the stomach, in parts where there's not much of a mark left or where they can be explained as falls. Now they are using wet surgeons' gloves, which means they hit twice as hard. Apart from the strength they have, a wet glove hits much harder. And the torture is done with batteries with cables to the testicles, the ears – these are very sensitive to that.

Special classes are given where new torturers are shown what torture looks like, either in filmed demonstrations or even live demonstrations on actual prisoners. One Brazilian victim, who was himself a guinea pig in such a class, describes the scene: "He recognized the voice of Lieutenant Aylton, an of­ficer who had greatly impressed Murillo over the weeks he had spent at Vila Militar. As Aylton oversaw the beatings and shocks, he displayed a calm and control that a less assured college student could only envy. Setting up the tortures, Aylton always seemed so – odd description but true – serene."

The parrot's perch seemed to be Aylton's favourite, and he explained its advantages to the crowd [of around eighty young soldiers, seated in groups of six around tables as in a cabaret]. "It begins to work...when the prisoner can't keep his neck strong and still. When his neck bends, it means he's suffering." As Aylton spoke, the prisoner in the perch let his head fall backward. Aylton laughed and went to his side. "Not like that. He's only fak­ing the condition. Look" – Aylton grabbed the prisoner's head and shook it soundly – "his neck is still firm. He's only shamming now. He's not tired, and he's not ready to talk." There were other refinements. Use the electricity where and when you like, Aylton said, but mind the voltage. You want to extract information from the prisoner. You don't want to kill him. He then read out numbers – a voltage reading and the length of time a human body could withstand it. At one point during this same class, one prisoner, who was strung between two wires and sub­jected to increasing voltage – this was done in order to demonstrate the effects of giving too much voltage – suddenly fell forward onto the nearest table. There was a roar of laughter from the men as they pushed him off the table, kicking and hitting him while laughing and cracking jokes. The prisoner who narrated this scene realized at that point that the men's laughter and wisecrack­ing had formed a continual counterpoint to the demonstration, now forty minutes long. "I am suffering", he thought, "and these men are having the time of their lives".

Despite all the training, both basic and specialized, those who finally begin torturing "on the job", so to speak, can still find it very difficult. But
then other factors play their part, not the least of which is habituation. Listen to a Chilean ex-torturer who defected from his job with Air Force Intelligence:

I can only say that when you first start doing this job, it is hard... you hide yourself and cry, so nobody can see you. Later on you don't cry, you only feel sad. You feel a knot in your throat but you can hold back the tears. After that... not wanting to... but wanting to, you start getting used to it. Yes, definitely, there comes a moment when you feel nothing about what you are doing".

The routine of torture
Torture is often justified as a means to extract as much information as quickly as possible. This urgency to obtain information is captured in the following statement by an ex-torturer and death squad leader active in Rhode Island before independence: "When you do it [torture], you are in that condition of 'conscience narrowing' and strangely obsessed to get information. So you inflict pain, maim and kill to get what you want". Here we see the phenomenon of narrowing of awareness to a specific goal- or task-oriented frame of mind. The fact that one is only feeling sad. You feel a knot in your throat but you can hold back the tears. After that... not wanting to... but wanting to, you start getting used to it. Yes, definitely, there comes a moment when you feel nothing about what you are doing".

One of the most revealing testimonies comes from Colombian, Ricardo Gamez Mazuera, who reveals some of the less obvious reasons why victim selection is so often indiscriminate.

Q: Working as an army informer, did you feel under pressure to bring in results? When you penetrated the University but found that in fact there weren't any such subversive activities, what did you do?

A: If you came with nothing, the head of the S-2 unit you were working with would say: 'Son of a b... you have to bring me a daily report. Go and look for some dirt!' There is rivalry between group officers - which is the best group and [which is] to be singled out? Then there are more funds, more money for this group.

Types of torturers
Now we turn to the question of who the torturers are, what kinds of torturers are there.

One who has already been arrested. Here is the testimony of a Turkish woman who, along with her husband, was picked up in Ankara in early 1981 and was detained and tortured for 47 days and imprisoned under cruel and degrading conditions for 14 months:

...my husband and I went to visit some friends at their home... Our friend had been captured and the police had staked out their flat to apprehend and question visitors. When they learned that I was still a student and that my husband had graduated from the Middle East Technical University, they said: You must have engaged in political activity, we are bound to find out something when we get there. So they blindfolded us and put us in a car.

Another victim, a renowned Argentinian pianist who was arrested and tortured in Uruguay, describes how his torturers directed their torture specifically at his hands and his arms: 'They were like sadists... After two days of torture I hurt all over, and had no sensation whatsoever left in my hands. I touched things and didn't feel anything. They kept making like they were going to chop off my hands. The last time they even had an electric saw going. They'd pull on my finger and ask, 'Which is the finger you use most in playing the piano?...Is it maybe the thumb?' They pulled on the fingers and made like they were going to slice them off with the electric saw". Here we see how the cruelty is specifically tailored to the victim, so to speak, to maximize the terror and suffering.

Much of what we know about the different kinds of torturers comes from ex-victims. Here is what a Greek victim, K. Alavanos, had to say about two of his torturers".

The two 'super-stars', at all events, were Tzelingas and Petrou. I and Petrou, the other hand, was a very intelligent man... Often he was against what he did, although fully aware of what he was doing. He gave you the professional impression of a man who serves a cause to obtain certain advantages.

The routine of torture
Torture is often justified as a means to extract as much information as quickly as possible. This urgency to obtain information is captured in the following statement by an ex-torturer and death squad leader active in Rhode Island before independence: "When you do it [torture], you are in that condition of 'conscience narrowing' and strangely obsessed to get information. So you inflict pain, maim and kill to get what you want". Here we see the phenomenon of narrowing of awareness to a specific goal- or task-oriented frame of mind. The fact that one is only feeling sad. You feel a knot in your throat but you can hold back the tears. After that... not wanting to... but wanting to, you start getting used to it. Yes, definitely, there comes a moment when you feel nothing about what you are doing".
Yet another Brazilian victim was surprised to find that the men who tortured him wore their hair long, went to the same night spots he had known, and would even occasionally come to his cell to confide their troubles with women. He realized that they had been trained to hate him: "You are the son of a whore!" a man would shout, while his face clenched in hatred. Then someone would call, 'Dr. Paulo, telephone!' As he crossed the room and picked up the receiver, his face would open up again, and he would be smiling and smoothing his hair and murmuring endearments. Here we see how the face of the torturer changes when a loved one intrudes into his world.

If we try and summarize these various descriptions, it appears that there are basically three types of torturer. First, there is the zealot who seems to be detached from what he is doing, like the instructor, Aylton, or the Greek, Tzelingas. They are unflinching, cruel, and totally controlled in their emotions. These are the true believers, the crusaders. They believe totally in what they are doing, in the rightness of their cause. As in the Greek case, they are not necessarily well educated nor very refined.

Second, there is the professional, the careerist, like the Greek, Petrou, who is career oriented and wants to do a good job (for a soldier, it is very important). He ultimately defected from the Argentinean pianist's hands could just as easily be zealots, coolly tailoring their torture to gain maximum advantage, or professionals using threats that exert maximum pressure. In any case, a sadist would be a bad torturer, torturing "for the fun of it" and liable to "lose mastery", to echo the Khmer Rouge.

The torturers rarely act alone and they are certainly not trained alone. So different types will interact and influence one another. A Brazilian corporal expressed his doubts to a prisoner when they were alone and retreated when the other's arguments made sense, indicating to what extent peer pressure can be internalized. Torture and the process of becoming a torturer are, as we have seen, group phenomena. Good guy-bad guy routines can pair a professional with a sadist, for example, or a zealot with a professional. No typology is clear-cut; they only point the way to useful distinctions.

Conclusion: to obey or disobey

The social nature of the torturer's world explains why it is so difficult for individuals to exit from the group. The pressure is usually to stay in. Probably all ex-torturers who have spoken out about their experience have at one time or another feared being killed by their former colleagues. The difficulty of exit is related to the larger question of obedience and disobedience, obeying and refusing orders. Military or police superiors usually demand total obedience. Why do torturers obey their superiors? What happens to them if they disobey?

Consider the testimony of a Chilean torturer, a DINA agent who was formerly a member of the revolutionary group, MIR, but was 'turned' by his captors:

I was trained in interrogation and counterintelligence work. I was then given the job of hunting people down and interrogating, torturing and killing them. Because ... of the situation in which I was living and what I had to do, I reacted and tried repeatedly to leave, but this was impossible, because once you are in you cannot get out. [...]
leave was the Greek torturer, Petrou, the professional. He was convicted during the first trial of torturers and was interviewed after he was released:

Q.: Are there methods of torture which you on no account would have used? Then? At the time?
A.: At the time? No, I don’t think so. We would have been able to do everything....
Q.: Even the worst forms of torture? A.: Yes, regardless.
Q.: Even, let us say... if they ordered you...to torture [a victim’s] children before his eyes?
A.: Yes
Q.: Would you have done it?
A.: Yes, definitely

When asked whether a torturer can refuse an order, the death squad leader active in Rhodesia was more reflective:

That point in time when you strike somebody, you can refuse to strike or you can strike. That is not objective at that point in time. Now I can say, then I had a choice. In that situation you don’t even realize that you had a choice. And sometimes you don’t. It’s so difficult to formulate. Do you have a choice or don’t you? You always have a choice if you know what the consequences are.

One Salvadoran torturer told his interviewer, in general, the prisoners are killed – based on the fundamental assumption that they have no right of life. If we have to pass them on to the judge, we are freed and we have to capture them perhaps again. If there is strong pressure from Amnesty International or from abroad, we possibly leave them to the court; without the pressure, they are doomed.

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2. “Statement on torture in Uruguay made by First Lieutenant J. C. Cooper to Amnesty International, June 1979”.
4. Interview by Alex Schmid with Raul.
6. Weschler, 125
8. “Greek torturers on trial”, as quoted by H.V. Kempen, (Leiden, Student paper, 1991: 8).

TORTURE WORLDWIDE

EL SALVADOR

42 corpses found

El Salvadoran authorities and foreign anthropologists have found the remains of 42 corpses in a village in which the El Salvadoran army is accused of having killed more than 1,000 people in 1991. They were found in the town of El Mozote, 225 km east of the capital, San Salvador. Most of the skulls were of children, all shot through the head. Adult skeletal remains showed signs of extensive torture before execution.

The country was in a state of civil war at the start of the 1980s, between the government and the army on one side, and on the other the leftist partisan movement FMLN, with which the army accused the EL Mozote inhabitants of collaborating.

30. Guest I, op. cit. (Interview with Andres Valenzuela).
31. Langguth, 218; cf. also Wechsler, 40, for a similar incident although the first names of the victim are different.
32. Langguth, 221
35. Langguth, 221.
38. Wescsher, 51-52.
40. From a transcript of the film, Your Neighbour’s Son, a film about Greek torturers and their victims, distributed by Amnesty International.
41. Wescsher, 126.
42. Langguth, 201.
43. Langguth, 199.
44. Plate & Darvi, 133: (Juan Munoz Alarcon).
45. Ibid., 141-142.
46. Der Spiegel, 7 May 1984, taken from the Progressive Testimony of Rene Hurtado.

Acknowledgement

PIOOM’s Research Director, A.P. Schmid, collaborated on the larger paper from which this abridged version is taken.

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Falanga – diagnosis and treatment of late sequelae

By
Grethe Skytv, MD, MA*

Physical maltreatment of particular parts of the body leads to specific injuries, depending on the structure and function of the tissues in the area concerned. A typical example is falanga.

Falanga, or bastonade, is a form of torture that is used particularly in the Middle East, but also in other parts of the world. It is still used in certain parts of the Middle East as punishment in the upbringing of children, though naturally in a far milder form than is practised in torture.

During falanga, the torturers beat the soles of the victim’s feet with cables, iron bars, sticks, or other wooden or metal implements. The victim is usually tied with elevated feet. The blows may be given on the bare soles, or through the victim’s shoes or boots. Sometimes the victim is forced to put on his shoes immediately after the beating.

After the torture he may be forced to walk barefoot on small stones or fragments of glass, or suchlike, or on a wet floor. Or to jump on the spot while holding a heavy weight, a torturer for example. All these variations greatly increase the acuteness of the pain, but they also influence the severity of the sequelae.

The immediate effects of falanga are pain, bleeding, and tissue swelling/oedema in and around the different structures in the feet, spreading up the legs to the knees. The oedema does not reach above the knee because of the tight fascial attachments just below the knee. The swelling and extravasation of blood resolve during the following weeks, but some of the sequelae cannot heal spontaneously, or only poorly. This means that the victim is left with a permanent malfunction of gait, unless treatment is given. However, treatment can be initiated at any stage. In other words: it is never too late to start treatment of a falanga victim.

Feet with swelling and haematoma shortly after falanga torture.

Diagnosis:
The late sequelae of falanga can give the following symptoms:

- Pain in the calves and feet, particularly deep in the calves and near the joints. The pain is described as stabbing, cutting or burning. It may be continuous, but is usually intermittent. It intensifies during the day and is not always relieved by rest; indeed, warmth in bed sometimes makes it worse. In those cases there may be short-lived relief on getting up and walking barefoot on a cold floor. There is often a direct relationship between the pain and weight-bearing, so that it worsens during walking or running. Sometimes the victim experiences temporary relief while jogging, but the pain will return later with renewed force. Standing for long periods, and going up and down stairs, make the pain worse. Walking speed is reduced, as is walking distance. The victim has sometimes to stand still in the street, or sit down, before he can continue. He cannot sit cross-legged, cannot squat without pain, and it may be impossible to kneel for any length of time. The pain is worse in cold, damp, windy weather. It is accompanied by tingling or prickling in the calves and sometimes in the feet also.

- Other symptoms include feelings of tiredness and heaviness in the thigh and lower leg, and a feeling that the knee and ankle joints are loose, as if they are falling apart. The victim has often noticed that the gait has changed, as for example that the unwinding of the foot from the ground has changed, or that he has to put more weight on the inner or on the outer arch of the feet to avoid pain.

- Cramps in the legs and feet are not common, but when they occur they are either provoked by exertion, thus resembling the closed compartment syndrome(1), or they come on at night, provoked by the warmth under the bedclothes.

- Lumbar pain on standing, and more particularly on walking, is frequent, but without radiation to the legs such as is characteristic of sciatica. There is little or no swelling of the ankles or feet.

On examination, there are many changes, not all of which are pathognomic for falanga, but which together paint a recognizable picture of a syndrome:

1. ‘Smashed’ heel and forefoot pads:
A normal foot has elastic adipose pads under the calcaneum (the heel pad) and the bases of the proximal phalanges (the forefoot pads). These pads consist of a matrix of elastic connective tissue arranged in septa containing vessels and nerves. The septa divide the pad in small compartments containing closely packed fat cells, and the whole structure functions as a biological shock absorber that reduces the impact from the foot striking the ground during walking and running(2).

Following falanga, these pads may be found to be ‘smashed’. The extent to which they are destroyed depends on the amount of swelling present immediately after the torture. Presence of this sign indicates that the swelling of the soles provoked by the beating has torn the septa that tie the skin to the bones. The fatty tissue, now deprived of its blood supply, atrophies, making the foot less able to absorb the sudden im-
pact from the ground up through the joints and the long bones of the lower limbs to the back. This in turn increases the predisposition to low back pain.

The diagnosis of the 'smashed' heel pads is made by means of a few easy clinical examination procedures:

1) On direct inspection from behind, with the patient standing on a hard surface (he can stand on a stool or low table, or the observer can kneel down behind him): a normal heel pad will have a rounded contour, while a 'smashed' pad is compressed, flat, and wide.

2) On palpation, the normal elasticity is lacking when the heel pad is 'smashed'. With finger pressure at right angles to the underlying tuber calcanei, the bony surface can easily be felt through the skin, and the elastic resistance of the fat compartments of the pad is partly or totally lacking.

The same condition may occur in long-distance runners, but only in the heel pads. Damaged forefoot pads can be taken as pathognomonic for falanga. It should be stressed, however, that normal foot pads do not rule out exposure to falanga. The degree of damage probably depends on the extent of the post-traumatic oedema; the torturers may limit this, as part of the torture, by putting on shoes immediately after the torture to falanga. The degree of damage to the feet often present hard, rough scars after falanga-inflicted wounds. They can be felt at 20 degrees’ dorsiflexion of the toes while palpating the aponeurosis; in the normal foot, tension in the aponeurosis can be felt at 20 degrees’ dorsiflexion, and the maximum possible dorsiflexion is 60-70 degrees. Further dorsiflexion is a sign of damaged fixation of the aponeurosis.

Overloading of normal feet can cause a condition called plantar fasciitis with tenderness and irritation of the proximal attachment of the aponeurosis to the tuber calcanei. In falanga victims such irritation is present throughout the length of the aponeurosis and is thus called aponeurosis. It is diagnosed by palpation of the aponeurosis while it is tightened by 20 degrees’ passive dorsiflexion of the toes. In this way it is also assured that the tenderness registered is not localized in deeper tissues. With practice, the uneven coating of the aponeurosis can be felt, as also occurs in tennis elbow following incorrect use of the arm.

4. Muscles:

By dissection of the feet of 6 torture victims, supplemented with injection experiments, Bro-Rasmussen and Rasmussen in 1978 showed that the plantar muscles of the feet are arranged in tight compartments, leading to a risk of the closed compartment syndrome, which is also known from sports injuries. When the muscles are supplied with blood during activity, e.g. walking, the pressure rises inside the muscle sheet, and chemical changes occur locally, involving increased lactate concentration and interstitial oedema, leading to cramps. As mentioned above, our clients seldom complain of cramps. It may be that they have got into the habit of walking abnormally without using
the muscles of the foot and the leg, thus leading to muscular atrophy and consequently decreased pressure inside the compartments.

5. Blood supply and autonomic reaction:
The pulse in the arteries of the foot and leg is normal, and there is no increased tendency to varicose veins. There is, however, a tendency for the feet to alternate between being hot and cold and for increased sweating of the feet. These signs may remind one of Reflex Sympathetic Dystrophy (RSD). Corresponding to RSD, dysesthesia is often present after falanga in parts of the sole or in the whole foot without any segmental pattern, but other signs of RSD are usually absent, such as change in the distribution of the hairs, change in nail growth, pointed toes, etc. We have not yet had the opportunity to perform thermography of the legs of falanga victims, but would expect to find pathological changes in the direction of either hot or cold, depending on the degree of the trauma.6

6. Bones:
Fractures of foot bones, with their sequelae, can occur in falanga victims.7,8 However, they are rare, probably because the flexible structure of the foot makes it able to absorb most of the force of the blows. In the few patients in whom we have seen sequelae of fractures, once or twice with osteitis, the feet had been exposed to other forms of torture as well, e.g. they had been crushed against the ground with the heel of a boot.

A case of aseptic bone necrosis of a toe was probably secondary to a falanga-provoked closed compartment syndrome.

7. Joints:
On examination of the passive movements of the tarsus and metatarsus, there is often a change of "joint play", and decreased movements in many joints. Treatment, however, often reveals a hidden hypermobility/instability in several joints as a result of damage to ligaments and joint capsules during falanga, and from the subsequent oedema as well. The ability of the foot to function as a dynamic spring during walking is thus also affected at this level.

8. The lower leg and interosseous membrane:
During falanga the talus is forced up within the ankle joint, as in landing heavily on the heels. This trauma and the subsequent oedema lead to overstretching of the stabilizing ligaments around the ankle, so that the normal shock-absorbing and stabilizing function of the connection between the fibula and tibia is affected. In a falanga victim, the normal tightening of the interosseous membrane does not occur when the foot strikes the ground during walking. Also, there is little or no activity in the Tibialis Posterior, the only muscle to support this tightening with its attachment to the tibia, the fibula, and to the intervening membrane, whose fibres stretch obliquely downwards and laterally.

On palpation, there is tenderness of the superior and inferior tibio-fibular joints, as well as indirect tenderness of these joints when light pressure is applied to the tuber calcanei from below. Furthermore, instability of the joint constructions of the lower leg can be diagnosed by pushing the fibula backwards and forwards in relation to the tibia.

9. The musculature of the lower leg:
Various patterns of muscular imbalance in the lower extremities are seen, depending on which compensating pattern of gait the individual has adopted in order to diminish the pain. In general, though, there are increased tension and active trigger-points in the Tibialis Anterior, Biceps Femoris, Tensor Fasciae Latae, and in the Ilio-tibial Tract, as well as inactivity (but not paresis) of Tibialis Posterior, Peroneus Longus and Brevis, and Popliteus. The fasciae surrounding all the muscle compartments feel tight on palpation. This muscular imbalance can lead to musculo tendinous inflammatory conditions similar to the "medial tibial stress syndrome", but with various localizations depending on which groups of muscles are overworked during the relieving gait pattern.

10. Proprioception, balance:
The various structures of the foot are richly supplied with proprioceptors, i.e. nerve endings with sensitive organs to provide us with information about ourselves: about the positions and movements of the foot, the forces generated by the muscles, and our attitude and motion relative to the earth. They register impulses of importance for our balance and space orientation. They are found in the cuts, subcutis, joint membranes, tendons, muscles, and joints, and to a large extent their function has been affected by the sequelae of falanga.

Treatment
The treatment of the sequelae of falanga is a puzzle consisting of the following pieces: relief of pain, treatment of soft tissue, mobilization, stabilization, training of inhibited/inactive muscles, self-training, training of balance, proprioception and orientation in space, supply of aid-appliances, rehabilitation, and instruction in how to maintain the improvement. These pieces must be put together paying due attention to the fact that many physiotherapeutic practices can remind a torture victim of the torture itself. A detailed review of the necessary precautions in the treatment of torture victims will be published in a later issue.

Relief of pain:
If the victim can accept soft massage of the feet and lower legs, this is a good pain-relieving measure which probably works via the mechanoreceptors. Furthermore, thermotherapy is another
mild, but efficient pain-relieving treatment. Heat should be the primary choice, but in some cases alternating heat and cold will prove more effective. Later in the course of the treatment, electrical therapy may be introduced in the form of ultrasound for tendinitis, and laser treatment, first and foremost to the trigger points. However, this requires very careful preparation of the victim, if he has been exposed to electrical torture.

Various other appliances may be pain-relieving: an elastic bandage to support the anterior transverse arch of the foot, a figure-of-8 bandage to stabilize the ankle, taping of the ‘smashed’ heel pad with sports-tape, a pair of palliative orthotic devices with heel cushioning to redistribute pressure away from the tuber calcanei and to support what is left of the heel pad, and a pair of shoes with inbuilt shock-absorption, such as a pair of good running shoes.

Soft tissue treatment:
The primary aim of soft tissue treatment is to remodel the connective tissue in all the structures of the foot and lower leg, in order to make room for the muscle fibres to function freely, and to remove any pathological pressure on vessels or nerves. Any soft tissue technique which does not provoke pain can be used.

Mobilization:
The locked joints of the tarsus and lower leg must be mobilized using manual techniques, but carefully, because of a possible underlying hidden hypermobility, as mentioned above. The Functional Techniques which work away from the barrier instead of trying to break it, are well suited for this.

Before training of endurance is commenced, the tight connective tissue in and around the muscles, and the tight fasciae, must be stretched, using techniques such as the Soft Tissue Technique or the Myofascial Release Technique, in order to avoid development of the compartment syndrome.

Stabilization:
The stabilization that was started passively by supportive appliances should be replaced little by little by active muscular training. This can preferably be done as rhythmic contractions and co-contractions, at first without weight-bearing, but facilitated by distal fixation with the foot in its normal position of function.

Tibialis Posterior plays a key role in the stabilization of both the lower leg and the foot. As mentioned, it arises from the tibia, the interosseous membrane, and the fibula, and it is inserted on all the tarsal bones, apart from the talus and calcaneum. Thus, it is not only responsible for the stability of the tibia and fibula, but also, together with Flexor Hallucis Longus, for the posterior transverse arch of the foot. The lateral longitudinal arch is mainly supported by the peroneus muscles, which must therefore be exercised when there is instability around the cuboid bone. The anterior transverse arch is primarily stabilized by Abductor Hallucis. Quadratus Plantaris serves to stabilize the foot at the medial longitudinal arch. Training of Quadratus Plantaris will at the same time facilitate the stability of the ankle, knee, and hip.

The importance of the function of the clivus for the stability of the foot should be mentioned here. The clivus is the cleft along the axis between the medial and the lateral part of the foot. Medial to the clivus are the talus, the navicular bone, the three cuneiform bones, and the three medial toes. Lateral to the clivus are the calcaneum, the cuboid, and the two lateral toes. The construction of this axis, with all the ligaments crossing transversely, and none going longitudinally, makes it possible for the medial and lateral parts of the foot to slide forward and backward in relation to each other, forming a built-in, elastic, springing ‘orthosis’. If the ligaments are too tight, the foot will become stiff; if they are too loose after the oedema, the Quadratus Plantaris should be trained to take over part of their lost, stabilizing function.

Self-training:
Instruction in self-training should avoid unnecessary weight-bearing for the joints of the feet and legs, but it will add to the purpose to combine the exercises with facilitation of the proprioceptors of the sole of the foot.

Balance training:
The structures of the foot play an important role in the body balance and the stability of all the joints of the body by having a large number of proprioceptors and thus a large afferent input. Therefore, training of balance in the standing position is an important part of the rehabilitation of falanga victims. A rocking board is useful for this purpose, or a flat foam rubber pillow or other yielding surface.

Supporting appliances:
The most important appliances for late sequelae of falanga have already been mentioned: elastic stabilizing bandages on forefoot and ankle, supporting heel orthoses, and shoes with built-in shock absorption and a solid heel cap. But another ‘appliance’ should be mentioned here: long under-pants or perhaps leggings made of angora fleece. They are thought to be effective at two physiological levels:

1. Connective tissue when cooled becomes firm and hard. Since torture victims have large amounts of cicatricial adhesive connective tissue within and between the musculo-skeletal structures, cooling will exert increased pressure on the surrounding tissues, including the nociceptors (‘pain receptors’) so that the brain receives a pain signal. This pain impulse can be avoided if the tissue is kept warm and soft.

2. As mentioned above, it is probable that torture victims have some degree of RSD, and it is therefore im-

Torture Volume 3, Number 1 1993
Most victims can become symptom-free
It is rewarding to treat the sequelae of falanga torture. Most victims can become symptom-free, and all can be much improved, by traditional physiotherapeutic techniques directed against the above-mentioned specific changes, supplemented by supporting and shock-absorbing appliances, elastic bandages and/or taping, and, not least, explanation and advice.

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: 3197-3202.

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Signs of falanga torture

By Ole Vedel Rasmussen, MD, DMSc & Grethe Skyll, MD, MA

Falanga torture is a form of physical torture in which the soles of the feet are beaten with sticks, chains, cables or similar implements. This form of torture is particularly practised in the Middle East.

Previous studies have described an acute closed compartment syndrome of the foot, caused by the beating. Acute as well as longer lasting symptoms and signs have been described in torture victims, including necrosis of the bones. Scintigraphy of the bones of the foot has shown changes of longer duration.

The Rehabilitation and Research Centre for Torture Victims (RCT) has received an increasing number of falanga victims from the Middle East during the past years, and we have observed several clinical changes related to this form of torture. These changes have not previously been described, but they are considered of importance for the diagnosis of the sequelae of falanga torture.

Material

All new referrals of clients to RCT between 1 January 1990 and 30 June 1991 who claimed exposure to falanga torture (30 persons) were studied consecutively.

Methods

Physical examination of all the clients was performed by the same rheumatologist (GS). 18 persons were examined in 1990 and the remaining 12 in 1991.

The following clinical data were registered:

1. ‘Smashed’ foot pads:
The padding of the balls of the heels and of the medial and lateral parts of the anterior balls, respectively, were examined. A ball was registered as ‘smashed’ when at palpation with one finger, at a right angle to the skin of the balls, loss of tissue was noticed between the skin and the underlying bones, i.e. the tuber of the calcaneus and the bases of the first and fifth proximal phalanges.

2. Aponeurosis:
Tenderness on palpation and an uneven, grainy surface corresponding to the plantar aponeurosis throughout its course were registered as aponeurosis.

3. Lesion of plantar aponeurosis:
A passive dorsal flexion of more than 70 degrees of the metatarso-phalangeal joint of the big toe was interpreted as a lesion of the distal attachment of the aponeurosis and the skin to the deep transverse ligament.

4. Fixation or instability of the tarsus:
This sign was studied according to Maitland by evaluating the passive translatory movement in each joint separately.

5. Instability of the inferior tibio-fibular joint and of the interosseous ligaments:
At the clinical examination this sign was evaluated by the translatory movement in the tibio-fibular joints and by the elasticity of the interosseous ligaments when the fibula is moved anterior and posterior in relation to the tibia.

It would have been useful to correlate the sequelae of falanga with the intensity of the exposure to it, but this was impossible; several of the victims were blindfolded during the torture, others lost consciousness several times, various instruments were used for the beating, and the victims were sometimes allowed to keep their shoes on. Finally, it should be noted that not all the alleged cases of falanga torture could be clinically verified.

Results

Thirty clients (25 men and 5 women), who claimed to have been exposed to falanga torture, were examined. The mean age was 33 years (range 21-55 years). 11 persons came from Iran, 8 from Iraq, 3 from Lebanon, 3 from Turkey, 1 from Syria, 1 from Egypt, and there were 3 Palestinians. The median time interval between exposure to torture and the physical examination was 11 months (range 2-144 months). The findings at the physical examination are shown in Table I. In 4 persons, no abnormal physical signs were noted.

13 persons had no signs of ‘smashed’ balls of the feet; findings with respect to the balls of the feet in the other 17 persons are shown in Table II.

Clinical signs of aponeurosis were diagnosed in 22 persons, and of these 19 were bilateral.

Passive dorsi flexion of more than 70 degrees in the metatarso-phalangeal joint of the big toe was found in 16 persons, bilateral in 8 of them.

The tarsus was affected in 25 persons, 12 of whom had bilateral fixation of the tarsus, 7 others had bilateral instability, 4 had fixation of one tarsus, and 2 had fixation of one tarsus and instability of the other.

Instability in the tibio-fibular joint and/or of the interosseous ligaments was diagnosed in 19 persons. 13 per-

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sons had bilateral instability both in the joints and in the interosseal ligaments, 5 persons had unilateral instability, and one person had bilateral instability of the interosseus ligaments.

There were no characteristic changes in the patterns of gait. The changes were first and foremost related to the scars on the soles. There were no signs of trophic disturbances, including atrophy of the skin.

Discussion

It has been shown in sports medicine that trauma to the heel during jumping or running can harm the ball of the heel. Experiments on cadavers have confirmed these clinical findings. In falanga, the soles of the feet, including the heel, are exposed to trauma of the same character, only repeatedly and with extreme force. The acute changes are oedema and bleeding in the soft tissues of the feet, possibly leading to the closed compartment syndrome. Falanga torture can damage both the anterior and the posterior padded balls of the feet. In the present study we found such damage in 57% (17/30) of the victims. All were examined by the same physician, but she was aware of the exposure to falanga. Thus, there is a need to study the validity of the examination, the reproducibility, and the inter-observer variation. Such a study is already planned.

Since only half of the victims had ‘smashed’ feet balls, the absence of this sign cannot be used as an exclusion criterion in cases requiring legal documentation. However, we have not been able to find descriptions of ‘smashed’ anterior feet balls, and this sign may therefore be specific for falanga.

Fascitis plantaris, with inflammation corresponding to the posterior attachment of the aponeurosis to the tuber calcanei, is well documented. In persons exposed to falanga, however, the clinical signs of tendinitis (tenderness and localized swellings) were present all along the aponeurosis. This sign was found in 73% (22/30).

Tearing of the fibres which fix the aponeurosis, partly in the skin, partly to the heads of the metatarsal bones via the deep transverse ligament, is a possible patho-physiological sequela of the oedema following falanga, leading to decreased fixation of the aponeurosis in dorsal flexion of the big toe. We found this sign in 51% (16/30), bilateral in half of them.

Blows to the soles can damage the tarsus and the joint between the tibia and the fibula, leading to instability similar to other dysfunctions of the foot and ankle. The present study revealed involvement of the tarsus in 25 persons (83%), and of the tibia-fibular joint in 19 (63%).

Conclusion

Our study shows a high incidence of pathological findings at the clinical examination of victims who claimed exposure to falanga torture.

A correct clinical examination makes the diagnosis of falanga sequelae possible. However, it must be stressed that the lack of pathological conditions does not exclude exposure to falanga. 4 persons had none of the described findings. There is a need for a prospective randomized study to establish the validity, the inter-observer variation, and the reproducibility of the physical examination.

References


Acknowledgement

A shorter version of this article has been published as: Rasmussen OV, Skyll G. Signs of falanga torture. The Lancet 1992; 340: 725 (letter).

* & # Rehabilitation and Research Centre for Torture Victims (RCT)

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DK-2100 Copenhagen Ø, Denmark

Table II. ‘Smashing’ of the various foot pads.

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A world organisation against torture: OMCT/SOS-Torture

The World Organisation Against Torture (OMCT/SOS-Torture), based in Geneva, became fully operational in February 1986. It grew out of the direct need voiced by non-governmental organisations (NGOs), particularly from the Third World, to have a more rapid transmission of information and for more efficient action on torture. These NGOs saw the necessity of having a clearing house for information where they could raise the alarm about cases of torture, summary executions, and forced disappearances. These needs were first expressed during a symposium organised under the auspices of the Swiss Committee Against Torture (CSCT) in 1983.

OMCT/SOS-Torture is the largest network of organisations dealing with torture.

How is it organised?
OMCT/SOS-TORTURE is an international association which comes under Swiss laws governing non-profit associations. The organisation has a network of over 160 non-governmental human rights organisations throughout the world which have the struggle against torture as one of their objectives. The General Assembly is the supreme organ of the organisation and convenes every four years.

The first General Assembly met in Geneva in February 1988, and the second in Manila in December 1991. The Executive Council, which consists of 21 members from all continents, meets every year, while the Bureau of the Council, consisting of 6 members, meets every month. In addition, the organisation has an Advisory Board, made up of human rights activists and experts from all over the world. The Director is empowered to implement programmes proposed by the General Assembly.

The organisation has consultative status with the Economic and Social Council of the UN (ECOSOC), the ILO, and the African Commission on Human and People’s Rights, and participates regularly in the meetings of these organs, in particular the UN Human Rights Commission and Sub-Commission, the ILO Conference, and the UN Committee Against Torture.

What are the objectives and mandate?
The mandate of the organisation is the struggle against torture, forced disappearances, and summary executions. It is responsible for encouraging cooperation among the members of the network, and in particular cooperation between NGOs from the South. The primary objectives of the organisation are to encourage the rapid circulation of information to NGOs and other inter-governmental and regional organisations susceptible of taking action and intervening in a situation; to give legal assistance to those NGOs which wish to make use of international procedures and instruments; to give financial support to the victims of torture. It regularly puts pressure on governments to cease torture and other human rights violations.

How does it operate?
The organisation circulates information as rapidly as possible to its network, to government missions (by the intermediary of their representatives to the United Nations in Geneva), to the relevant United Nations bodies, regional intergovernmental organisations, and the Parliamentary Commissions responsible for human rights – to as many as 1,000 recipients at the end of 1991, using telex, fax, and electronic mailing.

It is the responsibility of the members of the network to circulate accurate information and to verify it at its source. In this way, the information reaching the secretariat does not require any further research and can be acted upon immediately.

In view of the importance of the accuracy of the information, NGOs are screened before being accepted in the network and must fulfil three criteria:

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The Manila Declaration

On December 10, 1948, the General Assembly of the United Nations adopted the Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations. Amongst these fundamental rights is:

- the right not to be subjected to torture or to cruel, or inhuman, or degrading treatment or punishment.

This principle was reaffirmed by and embodied in the United Nations Convention against Torture (1984).

The General Assembly of the World Organization Against Torture, gathering in Manila, taking into account the experiences of its 160 Non Governmental Organisation members, and after hearing the reports of international high-level experts, hereby states that:

- there exists a correlation between development and a genuine democratization process based on human rights;
- torture, enforced disappearances, and summary executions spring from and develop in situations of grave socioeconomic and cultural inequalities; and,
- even in societies with democratic institutions, the exacerbation of socioeconomic conflicts engendered by structural disequilibriums give rise to the development of grave and massive violations of human rights.

The work of the General Assembly emphasised evidence that some measures of structural adjustment by the international financial and monetary institutions and economical policies of industrialised countries, all of whom proclaim adherence to the defence of human rights, can aggravate these inequalities and imbalances and even lead to a social breakdown.

In consequence, the General Assembly of the World Organisation Against Torture brings to the attention of the international institutions and member-states of the United Nations the urgent necessity to implement strategies of economical development and to promote policies for the protection of human rights which are consistent.

Manila, Geneva, 10 December 1991
By

Esther Bron*
and ill-treated by the police, the sole reason being that they sleep in the street. The fact that a child can be arrested simply for having a 'suspicious attitude' is sufficient evidence of the arbitrary nature of police action against street children.

Institutionalised torture
Torture is endemic in Brazil, and, while largely known about, it solicits little reaction. Indeed, torture is a more or less institutionalised practice. In the absence of modern and civilised interrogation techniques, and training of the police force, torture is the standard practice for obtaining confessions from suspects.

It is also used against minors in order to intimidate them and to prevent them from witnessing against the ill-treatment by the police force of which they are very often victims, as well as of the participation of the latter in criminal activities.

In Sao Paulo, on 18 July 1989, a young boy of 14 was arrested and subjected to electric shock treatment by police from the ROTA (special battalion of the military police, inherited from the dictatorship), for having been the witness to the death of another minor, Andre, aged 13, during an attack.

The case of Sidnei is a perfect example of this. Wounded in the back by a bullet, and rushed to hospital, Sidnei was taken away by the police for interrogation before his operation, despite the objections of the doctor. When the police brought him back four hours later, his condition had deteriorated considerably, and the marks on his body showed that he had been tortured. Sidnei died the next day.

Thus, two young people, aged 18 and 20, were arrested and tortured by the police in Belo Horizonte in order to draw confessions from them. One was tortured to death, while the other was released and subsequently murdered to prevent him from witnessing.

Furthermore, it would appear that some units of the state military police even receive special training in torture.

Murder of children
The murder of children in Brazil is taking on very serious and disquieting proportions. A real extermination war is being waged against street children. According to a study carried out by IBASE (Instituto Brasileiro de Analises Sociais e Economicas), 457 children were murdered in the streets of Recife, Rio, and Sao Paulo between March and October 1990. During the same year, 140 children were apparently murdered in the State of Sergipe (Nordeste) and 67 more in Salvador. Murder would appear to be on the increase. Statistics for the first three months of 1991 indicate that about 300 children were killed in the eleven major towns of Brazil. Most of these murders have been carried out by the 'death squads', groups of hired killers paid by shop-keepers and hotel owners, amongst others, to rid them of the children who threaten them with their petty plundering.

It is very rare for a member of the police force to be taken to court, and even more rare for him to be condemned, even if he has murdered a perfectly innocent person. The judicial system is always slow in dealing with cases in which police officers are involved, and during this time the culprits are not arrested or suspended from their jobs, not even deprived of their arms.

Furthermore, falsification of evidence and intimidation of witnesses are common practices when the police are involved. A climate of intimidation reigns in the court and throughout the trial, with the aim of preventing witnesses from lodging complaints or of ridiculing them and destroying their credibility.

Human rights activists who have denounced the use of torture by the police have been taken to court for slander and defamation.

Hundreds of names of torturers are known, but until now none have been condemned or even taken to court. There is still no legislation for introducing more severe measures in the legal system for dealing with torture, while a new law, prolonging the duration of provisional detention to ten days, facilitates the practice of torture.

A chief of police, responsible for numerous abuses and violations of human rights, was, however, sacked, but no criminal charges were held against him and soon afterwards he was promoted to the post of chief disciplinary officer, responsible for supervising and disciplining civil police officers.

Impunity also extends to the members of the death squads. Despite government declarations, proclaiming their determination to put an end to arbitrary assassinations of children, the judges responsible for matters concerning the death squads continue to release the principal suspects. Of all the assassinations for which the squads have been identified as responsible, only 23 minor condemnations have been pronounced, compared with a great number of absolutions and cases that have not even been heard.

The phenomenon of impunity for the members of death squads is partly due to the obvious implication of the police in their activities. Indeed, many extermination groups are led by off-duty policemen. But impunity is above all reinforced by the popular support of police violence and the death squads.

Some local representatives have pronounced themselves in favour of reinforcing police autonomy; against the dismantling of the ROTA; and in favour of the creation of concentration camps in Brazil. Some even participate in the activities of the death squads. The election of such representatives bears witness to the increased popular support for institutionalised police violence and for groups of assassins who murder children.

Arresting children and detaining them are not effective solutions to the problem of vagrancy: on the contrary, such practices tend to encourage crime and juvenile delinquency.

Nor is it enough simply to put an end to the ill-treatment of children or to protest against their murder. It is important to seek a solution to the problem of street children by offering them an alternative life-style, for example in homes which could give them support, attention, education, and training.

Action by the international community should therefore consist of effective pressure applied to the Brazilian state in order to bring about a reform of its budget and public spending so that they benefit the poorest layers of society. International financial organisations should also give subsidies directly to local projects whose aim is to reduce poverty and help children.

Acknowledgement

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The principal sins of psychiatry

Psychiatry as a repressive force under the totalitarian system in former Czechoslovakia

By
Radkin Honzák, MD, PhD*

There were two principal sins of psychiatry during the four decades of totalitarian Communist authority in Czechoslovakia. The first was abuse of psychiatry, using it as a repressive force against people with a different political opinion. The second was the direct subordination of a scientific medical discipline—psychiatry—to the pseudosophical political doctrine of Marxism-Leninism.

The Yalta Conference in 1945 divided Europe into two parts and put the countries of Central and Eastern Europe into the arms of Big Brother, the Soviet Union. In 1948 Czechoslovakia became a satellite of the USSR, and in fact a lot of Czech and Slovak people went there of their own free will. Some of them became disillusioned within a few years, some took part in power and helped to maintain that—at first revolutionary, later bureaucratic—monstrous totalitarian system even in times when the majority of our society tried to reach for freedom.

The first years of Communist rule were years of 'class struggle', i.e. a time of consistent liquidation of all democratic principles and their replacement with the Communist Party dictatorship. An article referring to the "leading role of the Communist Party" was eventually incorporated in the Czechoslovak Constitution. A functioning legal system was destroyed and replaced by a doctrine of class antagonism under which the rights of the working class and its vanguard—the Communist Party—had to be given absolute priority.

Uniform health doctrine
All the health-care system was nationalized, put under strictly centralized state administration, and a "uniform health doctrine" was declared. Private practice was allowed only for some academic personalities. Czechoslovakia was divided into small districts, and people living in each district were obliged in all cases of need, except emergencies, to visit their particular district health centres. The general practitioner was the first instance, and he/she had to decide if he/she was competent enough to handle the case, or if the patient should be referred to a specialist. Direct access to a specialist was impossible for the patient except for gynaecological and dental care.

The entire insurance system was abolished and all health care became free of charge for all state and state-run agricultural cooperatives' employees; 'class enemies', i.e. the few people remaining in the private sector, had to pay for health care, thereby accelerating their assimilation into the nationalized sphere, because their real income did not permit such a luxury. Remuneration in the health care system was provided by the district executive, with all the consequences of such a routine. Patients, as well as all citizens, were divided into Communist bosses, ordinary people, and class enemies who had no right even to a health pension. Mental illness was claimed as the consequence of capitalistic exploitation of the working class. Yet, in 1984, psychosomatic medicine was labelled as reactionary dilettantism from the position of official ideology.

The 1950s saw the beginning of political trials of the "inner enemies within the Communist party", and the preparatory part of this work took place under the guidance and supervision of the NKVD (later the KGB). The methods, later known as 'brainwashing', were employed against defendants and were eventually crowned by incredible confessions by absolutely innocent people, which was shocking for the majority of our society.

It seems obvious that, in a system in which ethics was replaced by Marxist ideology, tailored for each particular occasion, not a single scientific and/or practical discipline could have clean hands. This rule holds also for psychiatry, which, instead of being a domain of humanity, became a domain of politics and of ideology.

Pavlovian mythology
The Pavlovian mythology, consisting of mechanical application of laboratory experiments to clinical practice, became the substantial part of the compulsory official doctrine for several years. Other approaches were strictly condemned. The system became suspicious of any different ideas, whose dissemination was in fact impossible across the East-West communication barrier, made up of soldiers, minefields, jamming of radio broadcasts, and later symbolized by the Berlin Wall. There arose strong tendencies towards centralized regulation and medicalization of social problems (delinquency, alcoholism, ageing) under the Communist regime. This fact led to growing disagreement among medical professionals, as well as among those involved; but there was no substantial antipsychiatrist movement comparable with that existing in Western countries, probably due to the fact that psychiatry was perceived as a suppressed discipline rather than as a cause of such conditions. The social status of physicians, which used to be really high (with a negative aspect being a strongly paternalistic approach), were eroded in the 1950s, and gradually reached the level hardly ever seen. On the other hand, the fact that the patients had no free choice of their doctors sometimes led to a peculiar relationship with mutual hostility.
However, there were no doubts in the first decades of Communist reign about any unqualified acts, except of omission, in general psychiatric practice.

An entirely different situation could be assumed in some special areas, especially in forensic psychiatry and in cooperation of psychiatrists with state police. As far as capital punishment is concerned, the last word indisputably belongs to the court, but psychiatric examination is the inevitable basis for the final decision. There are well-known experts, known for their attitude of neglecting psychopathological symptomatology in cases of murderers. An current official report written by workers of the Institute of Criminology and Social Prevention is dealing with executed persons from 1952 to 1989. The authors studied the protocols of 173 executed persons. The cases of political trials were excluded.

Another problem is the participation in the preparatory phases of political trials in the late 1950s. In 1969, I had the opportunity to participate in developing psychological and psychiatric assessments in the case of Mr. Cuhra, who made his confession in 1958 under obvious inhuman psychological pressure, evidently facilitated by the interrogators’ intimate knowledge of these methods. No physical violence was used during his interrogation. He was accused of illegally establishing a political movement aimed at seizing power in Czechoslovakia. The accusation was obviously senseless, but after several months of interrogation the man confessed to all the crimes of which he had been accused.

System of brainwashing

The system of brainwashing was simple and efficient: it consisted of absolute isolation in a dark cell (even the presence of the defendant’s lawyer was forbidden) and sleep deprivation (the interrogations would begin consistently one hour after the end of the preceding one, mainly during the night hours), and the interrogators had their opposite roles of ‘bad man’ and ‘good man’. The script of Mr. Cuhra’s eventual psychological failure was sentimental and cruel.

It was July 26, the name day of Anne, a popular and common Czech first name. That evening the interrogator, a Major Kadiku (after 1966, he became Deputy Minister of the Interior) summoned Mr. Cuhra, offered him the typical Czech cake and coffee, and told him: ‘Your wife is Anna, my wife is also Anna. She is sending you this cake and the message: ‘Don’t make your wife worry, she is longing for you. When you make your confession, you will be home – with your wife – as soon as possible. In the opposite case, you will never meet her again.’’ And Mr. Cuhra, the hard man who endured five years in a Nazi prison and six years in a Communist prison after 1948, started to cry and signed all that was put in front of him.

There was a department of ‘psychological consultants’ in the Ministry of the Interior which collaborated with the state secret police. Presumably consisting of psychologists and psychiatrists, it was abolished officially at the beginning of the Prague Spring in 1968. Leaked information told about the composition of interrogation methods, training of Czech spies to beat lie detectors (if necessary), manipulating public opinion, and other activities.

The majority of psychiatrists remained on the right side, also after the Soviet-led invasion and during the ensuing 21 years. The Communist government knew this and it did not trust them at all; as a result of this fact, we can see the enormous number of psychiatrists and psychologists in leading positions in our contemporary public life. Nevertheless, the USSR remained our ideal, and the totalitarian system in Czechoslovakia tried to use its methods. Since 1970, a secret regulation of the Ministry of the Interior and the Ministry of Health ordered the preventive detention of suspected persons in mental health hospitals on important anniversary days (e.g. August 21, the anniversary of the Soviet-led invasion, October 28, the Independence Day of the Czechoslovak Republic in 1918, etc.).

Police staff in mental hospitals

These acts were enforced and executed by policemen, who also operated as staff in mental hospitals in those days. The psychiatrists were asked to write an ‘order for admission’ in several cases; most detainees were released the next day without any explanation. Despite the fact that this way of treating inconvenient citizens (the detained persons repeatedly included hospitalized psychotics, socially marginal people, members of unlicensed churches, unorthodox artists and musicians, members of dissident groups, etc.) seemed to be easy for the Communist government, this practice survived for only a few years.

The Brezhnev doctrine asserting that there was no need for political trials if the same job could be elegantly done by psychiatry failed to succeed in our country. Even our withdrawal from the World Psychiatric Association after the Hawaii meeting was ordered by the Central Committee and the Government.

The attempt to graft the Russian diagnostic system, including the diagnosis ‘chronic latent schizophrenia’, to our psychiatry failed completely. In spite of the eventual ineffectiveness of preventive detention, repeated analogous regulations were ordered by the Ministry of Health, even in 1988 when the USSR stopped being our ideal due to Gorbachev’s reforms when a decree was issued in the USSR opening the doors of madhouses to members of Amnesty International.

A resistant attitude was adopted by Czech psychiatry as a whole to the efforts of the Communist government to ‘psychiatrize’ political activities. After the revolution of November 1989, several major psychiatric hospitals issued an appeal to all citizens who might have the impression that they had been held in psychiatric hospitals unlawfully, and that psychiatry had been abused in their particular cases against their human rights. A review of several dozen suits by independent commissions revealed only several offenses of administrative nature, but not a single case of deliberate abuse. The majority of those filing their suits were indubitably psychotics, and their suits were indeed part of the paranoid condition.

Only three cases of violation of ethics and abuse of psychiatry surfaced throughout the years of totalitarian rule. These cases were known at the time, when they started to unfold; they received considerable publicity and were criticized by dissident organizations, and there was also a response from abroad. We were most grateful for this because such support was encouraging at a time when the pressure of injustice, in anticipation of the system’s demise, was escalating substantially.

As has been said, the efforts to abuse psychiatry failed. This was why the truncheon law was passed in 1989, enabling police to detain, as prevention, persons suspected of political activities against the Communist regime.

The Communist government failed to manipulate psychiatry, and, on the contrary, it continued to regard it, quite justly, as an unreliable and often even
hostile discipline, with the exception of several humble servants.

Transgression of ethics?
A number of us treated prominent personalities of the dissident movement during the years of the totalitarian system. Their social status was indeed very low, and so, after their informed consent, a psychiatric diagnosis was often established to make them eligible for a health pension. The most frequent diagnosis was chronic depression with exhaustion and psychosomatic symptomatology. A number of arguments in support of this diagnosis were always available, even though the data had to be appropriately exaggerated. There were dozens of such cases in our country.

British colleagues disapprove of our procedures. They have even asserted that if psychiatrists had examined Jan Hus (the Czech religious reformer burned to death in 1415 – his martyr’s death triggered a mighty reform movement), he would never have been burned to death and would have ended up as a health pensioner. While I agree that this boosted unhealthy attitudes of physicians, these radical views make me believe that some experiences from totalitarian systems simply cannot be shared.

It would be fair to say that the overwhelming majority of Czech psychiatrists defied the pressure of totalitarianism with integrity and clean hands. They were less radical than the community of psychologists, and their pragmatic attitudes occasionally made them seek compromises that bordered on transgression of ethics. This will presumably be the most formidable legacy we are taking with us into the present time.

Acknowledgement
This article is a shortened version of a speech, held at the APA Annual Meeting, May 1992, Washington DC.

The atrocities of the civil war in former Yugoslavia brought into daylight

The civil war in the remains of Yugoslavia has gradually revealed so many atrocities that it is difficult to take them all in. Pressure from the international community, from the UN and the EC, has not been able to stop the shocking destruction and bloodshed. Torture, also practised as part of the war, is partly different in type from the torture that is usually described in this journal.

It is a question of horrors and inhuman behaviour as part of the war which Serbia has waged against other republics of ex-Yugoslavia, of torture on prisoners of war, of torture before execution, or of a particularly barbaric type of execution. Only few torture victims from Croatia and Bosnia-Hercegovina have yet reached the European centres for rehabilitation. Thousands ought to be treated after months of torture and starvation in concentration camps.

These atrocities are gradually being brought into the light, not least because in 1992 the medical faculty of the University of Zagreb published two supplements of its journal, in which the many violations of the laws and rules of war are described in detail.

It has often been said that the first victim of war is the truth. One shall therefore not take sides here with respect to the extent of violations committed by Serbian forces, compared with those of the Croatian or Bosnian forces. But we know that thousands of Croatians and Bosnians have been beaten, raped, forced to see other prisoners being tortured, or molested in other ways.

More than 300 pages of documentation of this kind of inhumanity have been published by the Zagreb Faculty of Medicine. Much more is to come. Thus, the Zagreb Medical report concerns just the start of the Yugoslav civil war, when it raged in Croatia. The Danish forensic pathologist Professor Jørn Simonsen describes the presented material as being of high quality, very detailed and supplemented with many gruesome colour photos of the victims.

It can be taken for granted that the UN Commission on the Examination of War Crimes in the Yugoslav Area will get a lot of basic information from these two supplements. "The many photos and accounts of close-range bullet lesions are striking and difficult to accept as due to normal war injuries", says Professor Simonsen to TORTURE. As stated in the second supplement, medical institutions have been attacked in nearly every area of fighting – hospitals damaged, if not destroyed, so that many of the wounded could not be treated. It was thus a question of a systematic annihilation of many of the facilities for relief of unimaginable war-provoked sufferings.

There is no obvious explanation for the intentional bombardments of medical institutions by the Yugoslav army or the Serbian paramilitary forces. As is stated in the journal, the Serbian soldiers were often treated there. One might ask whether such acts were in retaliation for similar acts by the Croatian forces? The intentional destruction of civilian targets was also a gross violation of Red Cross Geneva conventions of 1949.

No wonder that the Croatians express the wish that the international community will punish these violators of humanitarian law, those rules that were made in the 1940s to alleviate the brutality of war. They suggest using the model of the August 1945 London Convention that established the legal basis for the later Nuremberg trials of war crimes and crimes against humanity during the Second World War.

The United Nations are working on this. But the situation is much more complicated than at that time.

So far, there are no real victors in this war...

H. D. 1)

1) Please also see p. 26.
A true humanitarian

Czech-Norwegian doctor Leo Eitinger is 80 years old

Many personalities of this century have experienced and suffered so much that people born just after the Second World War can hardly believe it. They represent history,—well, they are the history of our time.

The activists against inhumanity, against the destruction of freedom fighters, against imprisonment of defenders of democracy, are many. But for the circle of doctors and Human Rights believers of this journal, Leo Eitinger’s name has a special sound.

Many medical doctors around the world paid him tribute when he turned 80 in December 1992. Born a Jew in the old Austro-Hungarian Empire, but active as a physician with Norwegian nationality, he, among many others, may be regarded as an internationalist. But Eitinger is more than that. He is a true humanitarian.

He was born on 12 December 1912 in the town Lomnice in what until the New Year was Czechoslovakia. He graduated as a medical doctor in 1937, was drafted into the Czech army, but was barred from practising as a doctor because he was a Jew. Later he was refused an exit visa because he was a doctor!

But he arrived in Norway as an emigrant in 1939 thanks to the assistance of Fridtjof Nansen, the great Norwegian humanitarian, after whom a whole aid programme was named Nansenhjælpen. In his new home country Eitinger was allowed to practise as a doctor, but after the Nazi occupation of Norway in 1940 he was denied this right for the second time, again because of his Jewish origin. He was arrested in March 1942 and spent time in various prisons and concentration camps.

He treated his Jewish fellow prisoners in the camp because they were not entitled to any medical aid; at the same time he had to work in a quarry, where most prisoners were exposed to the sadism of the Nazis. In 1943 he was sent to the Auschwitz KZ-camp, where he worked as a doctor. During this stay he helped some of his fellow prisoners to escape the gas chamber by falsifying their papers. In January 1945 he was sent to Buchenwald KZ-camp where he stayed until the end of the war.

Leo Eitinger was among the founders of medical victimology, the study of the sequelae of violence in its victims. As such he was one of the important inspirers of the Rehabilitation and Research Centre for Torture Victims in Copenhagen.

He has received many awards for his work at home and abroad. He is still a highly praised lecturer.

A distinguished prize bears Leo Eitinger’s name: List and Leo Eitinger’s Fund. The fund was created in 1984, and the yields of this fund are used for a prize in connection with a lecture. The topic of the lecture must be in accordance with the scientific questions which preoccupied the donors and/or the humanitarian goals they worked for. In 1992 the prize was awarded to Elizabeth Marcelino, Director of the Children’s Rehabilitation Center, the Philippines, and June Lopez, MD, Medical Action Group and Philippine Action Group Against Torture.

The prize has earlier been given to—among others—Inge Genefke, Medical Director, RCT, Denmark, and the Nobel peace prize winner and author Elie Wiesel.

A lecture room at RCT is named after Leo Eitinger, the Leo Eitinger Room.

H. D.
Acoustic shocks used on unarmed people

After-effects of acoustic shocks used by the Soviet Army on unarmed civilians Vilnius, Lithuania Jan 11-13, 1991.

On blank charge hazard
If powerful and close enough, such charges may produce shock-waves of air-pressure and heat that 'blow down' a man and leave him in a state of instantaneous shock/disorientation with perforated eardrums and hearing loss. Exceeding one atmosphere peak over-pressure, the air pressure from the shock wave may produce air emboli (gas bubbles in the blood that obstruct blood supply to vital organs), and/or diffuse bleeding from inner organs, leading to incapacitation or death within seconds or days. Survivors would most likely experience long-term after-effects such as permanent noise-induced hearing loss and Post Traumatic Stress Disorder (PTSD), and in severe cases permanent neurological and inner organ dysfunction. (This information, given by the reviewer, is only partly included in the report.)

The PHR mission
One year after the event, a team of three medical doctors from PHR/UK and PHR/DK (one UK audiologist and two DK psychiatrists) went to Vilnius and during one week examined 19 of the civilians present during the actions – focusing on the detection of hearing loss and psychological after-effects. Pathological findings and subjective complaints were assessed according to internationally acknowledged procedures. Inconsistent responses and subjective aggravation of symptoms were taken into account, and one person was excluded from the study for reasons of inconsistency between the medical evaluation and his self assessment report. Gross findings are summarized in writing and in one table without statistics. Extensive case reports are given for each of the remaining 18 subjects, followed by general conclusions, recommendations, and a glossary with definitions.

The report concluded that all were in need of audiological and mental counselling, half of them needing psychotherapy.

Some critical remarks
The mental assessment procedures and results are described best. Audiograms and the definitions of mild/moderate/severe hearing loss are lacking. The sound pressure levels of the T72 tank and the 'parcel' blank charges are unfortunately not given, but the descriptions in several of the case reports make permanent hearing losses and psychological after-effects likely indeed. The findings for the excluded person should have been reported.

The study claims that the findings 'must be taken as representative of what may be true of the several hundreds of people who were exposed to the same trauma...'. This statement represents a problem, and for several reasons. In general, the subjects seeking medical aid would most likely belong to the more seriously affected part of the exposed population. If so, the trauma incidence is overestimated. On the other hand, torture victims are claimed to refrain from reporting their horrifying experiences, leading to underestimation of the incidence of trauma.

Unfortunately, the criteria for patient selection are not given. In this study the primary contact in Vilnius was Head of Otolaryngology at a Vilnius hospital, where the patients also were examined. To be polemic: if the examined patients were only those of the Vilnius actionists referred to this department and who were found to have a hearing loss, it is not amazing that 'all were in need of audiological counselling'. If so, corresponding hearing losses would not be expected in 'the several hundreds of people who were exposed to the same trauma'. The risk of hearing loss decreases with the distance from the sound source. Conversely, a number of people with psychological after-effects – especially those without hearing loss – would most likely be under represented in a patient sample referred to an otolaryngology unit. Combined with the tendency for not reporting their horrifying experience, the study might thus seriously underestimate the incidence and severity of psychological after-effects.

Of the report's detailed recommendations I would question the effects of short study tours to the West for single doctors, and favour the proposed 'updating of technical equipment' and courses for Lithuanian doctors on treatment of post traumatic stress disorder (PTSD) – and corresponding updating initiatives 'on the spot'.

Based on the sample of case reports, this study provides more than enough evidence to support its final recommendation: 'that authorities internationally desist in the use of explosive devices – in whatever form – on unarmed people at close range as a method of 'crowd dispersal'.

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Valuable report on Serbian atrocities

Croatian Medical Journal – Volume 33 – War Supplement 2 1992. Eds. in Chief: M Granic and M Marusic. Publisher: University of Zagreb, School of Medicine, Salata 3 B, 41000 Zagreb, CROATIA. Price (full calendar year) 200 DEM.

This volume, the second War Supplement produced by the Croatian Medical Journal is a larger publication than the first War Supplement published earlier in 1992. Although the general outline and range of papers is similar, the second supplement amplifies and enlarges on the issues discussed in the first supplement.

The overall design and lay out of the supplement is similar to a standard medical journal having an editorial and invited paper followed by reports and papers from a variety of sources on a number of subjects related to the conflict in Croatia as well as a selection of letters to the Editor.

The journal starts with a number of contributions from psychologists and psychiatrists outlining a number of theories to explain the origins and development of the conflict in Croatia and of its psychological sequelae on the general population and certain subgroups, including the mentally handicapped and children. The journal contains many reports of deaths within both the military and civilian population, including detailed descriptions of the autopsy findings. Reports of Serbian attacks on hospitals and similar institutions, Red Cross vehicles and media personnel reporting the conflict are documented. The journal also contains a variety of papers illustrating the responses of medical specialties, including Mobile Surgical Teams, Orthopaedics, Neurosurgery, Anaesthesia and Toxicology in dealing with the casualties of the conflict.

The papers describing autopsy findings and those detailing treatment of the living describe a variety of injuries resulting from artillery attacks, air bombardment, explosions and gunfire affecting both military personnel and civilians. It is interesting to note that some of these reports include the authors’ interpretations of the findings and their comments and views regarding the origins and development of the conflict whilst others, perhaps more eloquently, confine themselves to documenting the facts and findings leaving the reader to draw their own, sometimes disturbing, conclusions regarding the events. The publication of the Croatian Medical Journal is supported in part by the Croatian Ministry of Science Technology and Informatics and this may be reflected in the political views expressed by some authors.

The second War Supplement contains a good range of articles of interest to doctors from many specialities and fields and of particular interest to those involved in forensic pathology, traumatology, surgery and orthopaedics. The overall lay out and organisation of the journal makes it easy to read or to dip into for individual viewpoints and articles. The standard of English is excellent throughout, as are the range and quality of the illustrations which include numerous colour photographs, video stills and diagrams.

Although many of the articles make harrowing reading this supplement represents a valuable addition to the sparse literature on the medical aspects of international conflict and warfare and as such would be a useful addition to the library of many medical schools and larger hospitals, if not deserving of an even wider publication amongst those interested in international conflicts and human rights issues.

Diana Cox
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Theoretical understanding and practical experiences


The theoretical understanding and psychological clinical practical experiences of the psychological problems of victims of war, torture, and organized violence, and of refugees in exile, have been the subject of increasing scientific research since the middle of the 1970s, leading to a wealth of literature.

This book, written by Gius van der Veer, psychologist at the Social Psychiatric Services for Refugees in Amsterdam, with contributions from Victor Vladar Rivero, psychiatrist, and Mia Groenenberg, psychologist, is a valuable addition to this development.

The book, in 3 parts, contains 13 chapters; the lay-out is very clear and logical.

The first part describes the general problems of refugees based on various levels of analysis, theoretical models, and perspectives: the psychodynamic approach, the family-therapy approach, the learning-theory approach, the cognitive approach, and the approach of psychiatric classification. This introduction ends with the critical remark: “Diagnostic hypotheses that do not generate therapeutic intervention are useless and blame the victim” (p. 96).

The second part deals with “the use of psychotherapeutic techniques” and describes various special aspects of the work with refugees, such as overcoming cultural differences, language problems, the establishment of a therapeutic relationship, and the use of psychother-
Useful booklet for relatives to torture survivors

Now we are free... A handbook for ex-political prisoners and their families. Published by E.S.G. Black Sash & OASSSA, University of Cape Town, South Africa, 1991. Editing, illustrations and design: Bridget Pitt. ISBN 0-620-15461-6, 29 p.

The booklet is a mixture of short statements from both female and male ex-prisoners in South Africa. As far as can be seen from the illustrations, the prisoners are all coloured. The booklet is meant to inform the families to which they return about the problems of the prisoners, their dreams and visions about the future while in prison, their reactions to being set free and to returning to their families, and their disappointment and surprise when they discover that it is much more difficult than expected to take up the threads of their previous lives.

The booklet is divided into sections about the difficulties in re-establishing family relations, relations to their group or political organization, their present problems, and finally some suggestions on how to make their present situation easier. Each section consists of short statements from individually named prisoners, illustrated by a portrait drawing. In between these statements are drawings, in which the same ex-prisoners or their nearest relatives are seen in groups of various sizes, thus allowing not only the ex-prisoners, but also their wives and husbands, to express their difficulties.

All these statements, whether from prisoners or their families, are short and precise, characterized by mutual warmth, intensity, and understanding for each other's difficulties. It explains in a very instructive way several of the ex-prisoners' symptoms, some of which are difficult to explain to the families. At the same time it gives such a precise understanding of the ex-prisoner's situation that it opens the door for questions from the relatives, leading in turn to a better understanding of this situation. The many cartoon-like illustrations make the reading easier for less literary-minded clients.

The booklet ends with a very beautiful poem called The touch, describing in a fine way the difference between the touch of the torturers and the one the ex-prisoner is longing for, the touch of his family, which at the same time is difficult for him to accept.

The booklet, with its 50 pages, could be a valuable aid for 'torture families', because it answers many of the questions that are usually kept secret in these families. Thus, it can help the torture survivor to overcome some of his shame resulting from his experiences in prison. At the same time he discovers that he is not alone in the world with these problems, but that they are common to many - if not all - torture survivors, and in this way it may give him a feeling of belonging to a community of equals.

Lizet Jørgensen
Psychiatrist RCT

Sometimes it may seem as if nothing is going right...

...but with the support of comrades, family and friends, things will get easier in time!
A work in progress


This 40 page booklet describes the range of activities open to scientists in their day to day work which may assist in the protection of basic human rights and the prevention of human rights abuses. It is described by its author as "a work in progress".

The chapters, which are clearly laid out with useful footnotes, briefly introduce a number of different areas in which scientists may be involved in human rights issues. Each chapter also contains a list of references and useful addresses of organisations and bodies involved in human rights issues.

Amongst the topics covered are the ways in which forensic scientists, the medical profession and other scientific disciplines may be involved both in the upholding of human rights and in individual campaigns, regardless of their country of origin or field of expertise. A number of open ended questions concerning scientific ethics are raised, for example with regard to the location of international conferences and research links between scientists and medical, educational and scientific organisations, issues which until recently may not have been considered as relevant in these fields.

If the prime role of this book is to make scientists stop and think about ways in which they may inadvertently be supporting or lending credibility to regimes, governments or countries where human rights are not respected it is likely to succeed. As a discussion document and a resource document it deserves wide distribution. Its short length and well organised lay out mean that it may be read quickly and retained for future reference. Although it seems to be written primarily for Americans and Europeans, the comments and suggestions made are universal in their application. Its appeal lies not just amongst the scientific community, but would be a valuable addition to many libraries serving the disciplines of law, education and business.

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LETTER TO THE EDITOR

Torture victims have low self esteem

In an article "The Stasi Prosecution Syndrome" (TORTURE, Volume 1, Number 2 1991) my attention was caught by a phrase of Dr. Graessner's, from Behandlungszentrum für Volteropfer, Berlin - "the coexistence of torturers and victims is unacceptable".

This phrase reminds me of my own experience as an ex-prisoner doctor. I was condemned because of my sincerity. Personally, I was against the policy of imprisonment, and so fell to it as a victim. To speak openly was very dangerous in an ex-communist country.

I do agree with Dr. Graessner, and I stress that it is very true. We cannot live with our former torturers.

I think that Albania, now a small ex-communist country, suffered much more than any of the other eastern European communist countries. The reason is that the former leader of Albania had a paranoid character, like that of Hitler and Stalin, etc. Profiting from the cold war between east and west, this monster could do anything with his people. The number of persecuted and tortured men in my country was too high in relation to the general population. The situation now is that two groups of people are confronting each other - the survivors and the torturers. This is a dilemma for the future.

Will time be able to appease the spirits of such poor human beings?

I think that the persecuted and tortured men suffer from two things. First, their low self-esteem, which gives them feelings of depression and depression. Their personality has been wounded for a long time, in Dr. Graessner's words. Second, these men suffer from feelings of revenge. The object of their revenge is the group of torturers.

How can this dilemma be resolved? Can our consciences permit feelings of revenge now that we have become a democracy? Or should we be hypocrites and submit to living in peace with our former torturers?

These are highly debatable matters.

There are now two problems that distress Albanian society - namely, economic and spiritual. They march in parallel. I think that we psychiatrists in eastern Europe have a heavy responsibility to help these poor human beings to regain their place in society.

It is impossible to help them with medicine alone. Perhaps the coming time of economic and social improvement will be the best healer.

Dr. Afrim Dangëlia
Psychiatrist
Tirana
Albania

TORTURE Volume 3, Number 1 1993
Almost a million children now suffering mentally from the Yugoslav wars

By Edith Simmons-Richner*

It is estimated that at least 900,000 children in the former Yugoslavia have been psychologically traumatised by the wars in Bosnia and Croatia — 150,000 of them and their parents have been directly exposed to terror over prolonged periods. The United Nations, especially UNICEF, and various non-governmental organisations (NGOs) now try to help them as best they can.

For 13-year-old Kazimir, living now with his mother, his 10-year-old brother and his cousin in temporary crowded accommodation in Zagreb, the worst event was when a grenade fell into their shelter. Looking drawn and blinking nervously, Kazimir explains: When we managed to run away, we had to climb over corpses while snipers were shooting at us. My father was wounded and taken to hospital. We have not seen him since, but I hope that he is in one of those detention camps we have heard about and seen on television. I try not to talk about it, but I get very upset, and I very often dream about it.

For 13-year-old Alik, sitting close to Kazimir, hard to look through the heavy black curtain that the war has drawn between him and his vision of a future. After a long pause, he straightens his body and tries to smile in spite of his tears: “I shall tell my son not to go to the war”, he replies softly.

One hour’s drive from Zagreb, in Karlovac, over 500 refugees, men, women, and children, are packed in a makeshift camp in the town sports stadium. The majority are Muslims who have been uprooted from the neighbouring republic of Bosnia-Hercegovina by war and the infamous policy of ‘ethnic cleansing’. 

13-year-old Alik says: After the soldiers ordered us out of our house, they immediately burnt it. I saw it. Then they took us to the train. There they ordered the men to lie down on the ground. They selected some men to kill. They chose my uncle and a neighbour and shot them with a machine gun.

Alik’s eyes fill with tears and he tries bravely, like the men, not to cry. He swallows hard before continuing: After that, the soldiers put the women in the front part of the train, and the men at the back. As the train started, they disconnected the carriages, and took the men to the camps. I cannot sleep any more. I try to forget, but it does not work. Sometimes I cannot feel any more.

Huge risks to provide water and food

According to figures available in September 1992 from the Crisis Committee and the Health Institute of Bosnia-Hercegovina, 1,417 children have been killed and 29,169 wounded in Bosnia-Hercegovina since the war started in March 1992. In the besieged city of Sarajevo alone, 274 children have been killed and 6,096 wounded.

“Many families live in their cellars”, explains one paediatrician at Sarajevo’s main hospital. “But parents cannot ask young boys, especially teenagers, to remain confined day and night. Boys need to go out and meet their friends to play. That is when they get hit by shrapnel or even shot at by snipers”.

“Often, too, they are children, mainly boys, who leave their shelters to fetch water and food for their families. These are desperate situations and these boys take huge risks to help their families”, adds Rune Stuvland, the psychologist from the Norwegian Centre for Crisis, also working with UNICEF in former Yugoslavia.

Two months ago, the paediatric and obstetric units were bombed and completely destroyed. This event was very traumatic for the young patients, such as 8-year-old Ivana, a girl from the town of Mostar, who was transferred to the main Sarajevo hospital 2 weeks before the war started to undergo treatment for acute leukaemia. She does not complain about her loss of hair or about her illness because she knows that she is getting the best treatment here.

But she is very sad because she does not know what has happened to her parents; she has had no news from them since the war started. “I am alone and I am very worried about the situation at home”, she explains. “The worst moment was when the paediatric unit was bombed. The nurses told us to run and hurry because snipers were shooting at us from across the street. I was very scared because I want to live”.

Sitting on the bed with Ivana and two of her friends, 13-year-old Anka and 14-year-old Admir, also leukaemia patients, Professor Raundalen asks them which is worse, their illness or the war? They reply without hesitation “The war”.

In the next ward, 9-year-old Admir is slowly recovering from a severe skull and brain injury after a grenade exploded on the garage where he and his friends were playing. The injury has left him blind in the left eye and with his left arm paralysed. Although Admir wants to talk about the event, it is very painful for him to describe what he remembers of the explosion, and his parents weep silently as he bravely tries to make sense of the war.

“I feel very sad about the war. It has destroyed my life, but I guess it is my destiny ... Sometimes, I think I will go mad because of this war. I try to hope, but they are still bombing and shooting, you know ...”.

As Admir falls silent, mortar shells shake the windows of the hospital. Admir gets hold of his parents’ hands and shivers as he closes his eyes tightly to shut out from his shell-shocked mind.

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the insanity that continues to destroy everything around him.

In the tented camp of Stobrec, hosting 1,000 refugees close to the ancient seaside resort of Split, a 9-year-old girl sits with Tihomila Becker, the lady psychologist whom she considers as one of her friends:

I saw my house being burned. I felt terrible and had goose pimples all over my body. Then we ran away in the forest and walked from one village to another. I was terrible hungry. After 2 months, we reached a town where we saw people making halva [a sweet of Arabian origin made from honey] – but they did not offer us any.

**Many children want revenge**

Up in the mountains of Bosnia, the policy of ‘ethnic cleansing’ continues to uproot fresh loads of Muslim families who have gathered in the school grounds of the small town of Travnik. They are waiting for the buses which will take them to refugee camps hours away from the front line. Sitting on their hurriedly packed belongings, the grandmother and the mother of two small children weep uncontrollably.

Despite the intense summer heat, the little boy and his sister are wearing light blue fluffy duffle coats with two jumpers underneath. A neighbour explains that the little boy saw soldiers cut people’s throats, including his father’s. The boy is frozen with fear and, on hearing the woman’s words, tears stream down his face.

Children who have experienced and witnessed, first hand, such terror – the slaughter, the shooting, their fathers beaten and humiliated and no longer able to protect and provide for them, their mothers abused and often raped – will probably want revenge when old enough.

When children go back to school, reading and writing may have to take a back seat to allow teachers and children to work together on a *Story of my Life*, trying to rebuild the threads of shattered lives, talking about the war, the events that took place, drawing, writing essays, poems, and even songs about this traumatic period of their lives, using group activities and the creative process to start the healing.

**Mothers and children often war targets**

Knowledge about war trauma is relatively new and training for psychiatrists, psychologists, social workers, teachers, and health workers needs also to be provided as soon as possible, as well as raising public awareness about the psycho-social problems of war-traumatised families so that every child and every family which needs help in surmounting their trauma can have access to psychosocial support and counselling services without delay.

According to Professor Raundalen, each war, seen from the perspective of children, is different. The war in ex-Yugoslavia has two very disturbing features:

First, it is the closeness of the war and the fact that, in many homes, the soldiers lived upstairs while the families lived in the cellars of their houses, sometimes for months. The families were constantly threatened; they were beating their fathers and raping their mothers, and often they were shooting in the kitchens and in the bathrooms upstairs. That closeness has never been seen before, at least not in contemporary wars.

Second, this war is extraordinarily cruel, because the mothers and the children are often targeted – those who are defending the cities with their bodies; we witness weapons against defenceless bodies and weapons against children. That goes for cities like Bihać, Gorazde, and Sarajevo.

Nobody can be unhurt by this terrible war in our Europe.

It is also our war.

*Journalist and photographer, associated with UNICEF for many years.

200,000 Yugoslav children have received UNICEF aid

UNICEF has distributed food and clothing to some 200,000 child victims of the Yugoslav civil war. During a so-called Week of Silence, UNICEF in the autumn of 1992 made a massive effort to help the children of the war.

Before the start of the operation, UNICEF calculated that almost one million children were in need of aid, but that it would only be able to help about 150,000 with food and clothing.

Fighting continued in the war-torn republic of Bosnia-Hercegovina during the aid operation, even though UNICEF had requested the warring parties to stop shooting for the sake of the children.

At the same time, UNICEF had to return supplies to Belgrade in Serbia because the Muslim authorities in Sarajevo, capital of Bosnia, refused to accept Serbian goods for the city’s children.

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**Distinguished order for IRCT’s president**

The IRCT President, Professor Ole Espersen, MP (Denmark), has been awarded the prestigious Chilean Bernard O’Higgins Order for his long and much respected work for victims of Human Rights violations in Chile. He has visited Chile 14 times since 1973, and Professor Espersen could almost be referred to as a globetrotter for the good cause of Human Rights.

As a civil servant in the Danish Ministry of Justice, he was also a member of the expert committee of legal affairs of the Council of Europe in Strasbourg from 1965 to 1970, and was thereby engaged in the important work of protecting Human Rights within the European Convention of Human Rights of 1950.

He was the legal representative of the Danish Government in its case, together with some other countries, against Greece at the European Human Rights Court in Strasbourg, which established gross violations of Human Rights by the Greek junta.

He taught law, including international law, for about 20 years at Copenhagen University, was appointed professor, and became involved in a var-
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In 1993 the United Nations Voluntary Fund for Victims of Torture has to limit its recommendations for grants by the Secretary-General to less than half of the amounts requested in approximately 60 applications for assistance to torture victims.

The Voluntary Fund provides practical help to relieve the suffering of the tens of thousands of victims by obtaining for them medical or psychological support, opportunities for social or economic reintegration, and legal or financial assistance. But more and more torture victims are asking for professional help. In 1991/1992 the Fund supported some 100 projects all over the world to assist them in coping with the consequences of torture and cruel, degrading or inhuman treatment or punishment.

Thousands of others are still in need of medical, psychological, social, or financial help. During the eleventh session in 1992, the Board assessed the operation of the projects subsidized by the Fund and heard 13 persons responsible for 36 projects, and examined 25 new projects submitted to the Fund for support. The Board recommended to the Secretary-General the funding of, or continued support for, some 70 projects either currently in progress or planned for 1992 and 1993, involving expenditure of approximately $1.6 million.

Since its creation in 1981, the Fund has collaborated with nearly 100 organizations on approximately 160 projects in about 40 countries. These projects fall essentially into the following fields: psychotherapy; medical care; social rehabilitation; and training of professionals and volunteers (doctors, psychologists, physiotherapists, paramedical personnel, social workers, etc.) for the specialized treatment of torture victims. In addition to helping torture victims directly, the Fund has also been able to assist the relatives of victims with their psychological, economic, and social problems, and has contributed to the development and application of suitable forms of treatment.

The Fund is administered by the Secretary-General, assisted by a Board of Trustees, composed of a Chairman and four members who have wide experience in the field of human rights and serve in their individual capacity. The current members of the Board of Trustees are: Elizabeth Odio-Benito (Costa Rica), Ribot Hatan o (Japan), Ivan Tosovsky (Yugoslavia), Amos Wako (Kenya), and Jaap Walkate (The Netherlands), Chairman.

Since its establishment, the Fund has received contributions from several individuals and non-government organizations as well as from the governments of the following countries: Argentina, Australia, Austria, Belgium, Brazil, Cameroon, Canada, Cyprus, Denmark, Eire, Finland, France, Germany, Greece, Haiti, Holy See, Iceland, Indonesia, Italy, Japan, Jordan, Kenya, Libya, Liechtenstein, Luxembourg, Malta, the Netherlands, New Zealand, Norway, San Marino, Senegal, South Korea, Spain, Sri Lanka, Sweden, Switzerland, Togo, Tunisia, United Kingdom, and United States.
Workshop on Torture

Prof. R.D. Crelinsten and Prof. A.P. Schmid are soliciting proposals for papers to be delivered at a workshop on torture at the World Congress of Criminology in Budapest, Hungary. The Congress will take place from August 22-27, 1993 and the one-day workshop is tentatively scheduled for the 25th. The following themes will receive preferential consideration though others are welcome:

- perpetrator accounts and testimonies;
- post-traumatic sequelae of torture and perpetrators, bystanders & victims;
- criminal investigation & interrogation: moderate physical pressure or torture?
- the link between torture and disappearances;
- torture in the former Yugoslavia;
- torture under Communism;
- torture by opposition movements or non-state actors;
- torture in ethnic conflicts;
- impact of human rights campaigns against torture;
- training of police & security forces: safeguards against torture.

Abstracts should be sent no later than April 1st, 1993 to:

PIOOM/LISWO, Leiden University,
Wassenaarseweg 52, 2333 AK Leiden
The Netherlands
Fax: +31 71 273 619 Phone: +31 71 273 848
E-mail: CRELIN@RULFSW.LEIDEN-UNIV.NL or SCHMID@RULFSW.LEIDEN-UNIV.NL

VI International Symposium on Torture and the Medical Profession
Buenos Aires, Argentina
20-22 October 1993

The plenary sessions, workshops, panels and seminars will focus on:

1. Diagnosis and Treatment of Physical Torture Sequelae
2. Diagnosis and Treatment of Psychological Torture Sequelae
3. National and International Experience with Provision of Assistance and Rehabilitation Services to People Suffering from Physical and Psychological Consequences of Torture
4. Psychological and Social Consequences of Impunity

If you would like to contribute to this symposium, please write to:
Professor Erik Holst, MD
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Fax: (+45) 31 39 50 20

Abstracts are to be submitted no later than May 1st, 1993.

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 1985 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.