Front page: Mogens Andersen, Denmark

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**International monitoring**

Monitoring the health and rehabilitation of torture survivors: A management information system for a rehabilitation and research unit for torture victims. København: IRTC 1992. By: Søren Bøjholm, MD; Anders Folds- spang, MD, PhD, DMSc; Marianne Juhrer, MD, DMSc; Marianne Karstrup, MD, PhD; Grethe Sky1v MD, MA; Finn Sønnier, MD.

A system for stringent registration of torture, its effects, and their treatment is needed. RCT in Copenhagen, Denmark, has developed a monitoring system based on ICD trauma classification and DSM-IIIIR posttraumatic stress classification. The system is designed to record and compare effect of treatment/treatments, to allow international/interinstitutional exchange, and to aid management priority in decisions on resource allocation. It is the hope that it could also be an important part of preventive work against torture.

Price: $8 or DKK 40.
SEEKING JUSTICE

New barbaric war methods have been exposed in the Yugoslav civil war, new endeavours to seek justice developed. The Cold War world of peace in Europe, though in parts through suppression, is today challenged by scarcely imaginable sufferings and crimes in rump Yugoslavia. How should the international society react?

The outrageous practices of Communism, the prisons and camps, the torture, the misery, seem to be surpassed by the atrocities in the Yugoslav civil war that even shape two new crimes against humanity: ethnic cleansing and mass rape. Both were already known - were not the Jews of Europe being exposed to ethnic cleansing during Nazism’s attempt to remove them from the earth? And were not a huge number of German women (some say two million) raped when the Red Army conquered the Third Reich?

Revenge, soaked in hatred and lust may be the motive during some of the most terrifying cruelties of our century, but sometimes there is no other “reason” than precipitous contempt for people of another nationality. How could you otherwise explain the rape and often murder of ten thousand Chinese women by the Japanese in Nanjing in 1937? Or the rape of more than 250,000 women and girls by Pakistani troops in Bangladesh in 1971? Far back in history there were rules according to which the female population of a besieged city would be spared being raped if the city surrendered in timely fashion. Armies in civilized countries instruct their men in decent behaviour, explaining the conditions for being court-martialled.

The endeavours to create mechanisms within the United Nations to deal with the guilty ones warrant attention, though they will hardly stop continuous rape, torture, and murder. However, there is as yet no legal basis to punish the new types of hostis humani generis, enemies of mankind. This category already includes terrorists, torturers, and pirates, all supposed to be condemned in national courts. The present conflict between different nationalities requires the use of an international body, however difficult it may be to find out where to set it up, and where to put those who are convicted, assuming that the death penalty, if allowed, is not carried out.

The Romans told us nulla poene sine lege, no punishment without a law, and this goes for enemies of mankind as well. Few wars have ended with judgments by international tribunals of those responsible for initiating the war or of the belligerents who have violated the rules of war. Many traitors and spies have been convicted, and some executed, after prosecution in their own courts, that is courts of a new regime that has succeeded the one during the war.

Yes, there are rules of war, the four Red Cross Geneva Conventions of 1949 being the most important. They are, generally speaking, referred to as instruments of humanitarian law. They entitle the victims of war to certain rights, whereas other conventions try to give some rules for the belligerents. The International Committee of Red Cross (ICRC) is given the authority to be the (moral) guardian of these rights, alleviating the suffering of prisoners of war and of the populations in war-torn countries.

But now Slobodan Milosević and his supporters – how should they be dealt with? Preparations for prosecuting the Serbian President, politicians, and officers responsible for war crimes have started and developed to an extent, as if the war was already over. Witnesses are giving their personal accounts to hundreds of volunteers, as a contribution to composing a true picture of events.

Yet many ifs and buts are attached to this process. The statute of Nuremberg, according to which outstanding personalities in Nazi Germany were convicted and sentenced, cannot be used because it referred only to the specific Nuremberg court, whose judges were chosen from representatives of the victors, the Allies in the Second World War - the United States, the Soviet Union, France, and Great Britain.

But international law started a new chapter when the Security Council of the United Nations passed a resolution in February whereby a new international court should be established to punish the violators of humanitarian law in the civil wars of former Yugoslavia. The wilful killing of civilians and prisoners, often after torture, can all be termed gross violations of the above mentioned Geneva Conventions and their protocols of 1977 (the latter referring specifically to civil wars).

Many of the crimes, whether against people, real property, or monuments, are crimes according to the law of any country, whence a general legal principle may be applied. Serbian, Bosnian, or Croatian penal law may also be used against the accused. Another big problem is that many Muslim women are reticent about being witnesses, for example when rape is involved. An EC delegation that visited Bosnia some months ago was able to obtain only eight such testimonies.

The immunity that normally applies to heads of state will hardly be available at the new UN court. At least the UN Genocide Convention of 1948 did not make any exception here. On the other hand, there is no precedent. The Japanese emperor, Hirohito, was never prosecuted, unlike his generals, in the special Tokyo Process after the Second World War. Hitler took his own life, while Mussolini was executed out of court. To date only the former head of state of the Central African Republic, Jean Bédel Bokassa, was convicted by a national court in his own country (life imprisonment). That happened because he returned voluntarily from exile.

Apart from the legal considerations and obstacles, there are the weighty political and military aspects. There are many parties to the conflict in Bosnia-Hercegovina - Muslims, Serbs, Croats, the government of what remains of Yugoslavia, the White Eagles, the White Tigers, etc - and God alone knows what the reactions to setting up a court will be. To prevent being caught, some parties may even escalate the war crimes, so that the peace talks in Geneva may be postponed indefinitely.

Documentation is piling up with respect to the thousands of victims of rape, torture, and murder. Accounts are also documented of the appalling conditions in the camps, of destroyed houses in the villages, where human beings have tried to survive in the winter cold. It is an immense task for the world inside and outside what was once Yugoslavia to help the desperate women, many of them seeking abortions, and try to give them the will to shape a new life. Seeking justice is worthwhile, bringing effective humanity to the victims is perhaps even more important...
Phrenic-like state, to which the theme is pleasurable, hypervigilance, sleep disturbance. In most of the cases, there is a certain degree of numbing situation, a certain degree of numbness, inability to find pleasure in activities that were formerly pleasurable, hypervigilance, sleep disturbances, survival guilt, etc. Among those tortured, there are some who seem to heal with or without psychiatric help; but after a while they develop a depressive or schizophrenic-like state, to which the theme of the torture experience is central. This takes place often after the patient and the relatives think there has been complete resolution of the trauma.

The Chilean researchers in this field, Lira and Weinstein, insist on a feature regularly observed in persons who suffered the torture experience: "general impoverishment manifests itself concretely as a major lowering of the capacity to work and of the capacity to cope with usual life situations, particularly interpersonal relationships." We are in complete agreement with these authors' observations. In addition to the reaction immediately following the experience of torture, described as acute posttraumatic disorder, one finds a deep personality change in a high proportion of the cases.

Global change in personality and behavior, which we have observed in this and in other patients, greatly resembles what has been described by Venzlaff and Baeyer as "reactive change of personality" among many victims of Nazism. The subject not only reacts to torture with tiredness lasting days, weeks, or months, but remains as a tired human being, relatively uninterested and unable to concentrate. We have also observed chronic post-traumatic syndromes that take a depressive form.

There are also some cases that present neither a schizophrenic-like nor a depressive-like picture. These cases are characterized by only the change of personality with a general impoverishment, particularly of emotions and affective life.

What in torture makes possible a change of such nature that it appears similar to psychotic processes and to disorders of organic origin? We may be able to help to answer this question if we determine the essential features of the torture situation in comparison with other circumstances that are also called stressf ul by North American psychiatrists, or limit situations by the Germans. Toward this end, we will try to suggest a phenomenological description of the situation of torture.

Phenomenology of the torture situation

Absolute asymmetry

One of the fundamental traits of the interpersonal encounter as described by Baeyer and Buber is its asymmetry. A true encounter can take place in the framework of equality and of respect. The first feature characterizing the situation of torture is, in turn, the absolute asymmetry of the torturer/tortured relationship. The torturer holds complete power, while the latter says in a condition of total or near total defenslessness. There is nothing he or she can do to defend himself or herself, or to strengthen his or her position by using intelligence or physical power. Handcuffed and blindfolded, he or she cannot even confront the torturer with his or her eyes, unveiling boundless misery. The power of the tormentor is oriented toward inflicting harm and, eventually, obtaining the involuntary change or destruction of the subject being tortured. The inflicted damage is not only physical but also psychological. "The breakdown techniques... aimed at the transformation of all time and all place, including the prisoner's cell, in a constant torment that does not allow the subject to recover from his sensation of defenslessness."

Anonymity

The second feature peculiar to the situation of torture is its anonymity. Torturer and tortured did not know each other up to that moment. The victim does not even know the name of his or her tormentor, and the latter is frequently misled by his superiors regarding the victim's true identity. They both represent a collective entity in front of the other. For the torturer, the victim is not a specific human being but a terrorist or a communist, the representative of an enemy group, who has to be destroyed because of the instructions and training that the tormentor has had; for the victim, the tormentor is a symbol of all the totalitarian state that has disrupted his or her life and that now keeps him or her on the verge of death. This loss of the personalized element within the torturer/tortured relationship partially explains the excesses of violence that can be reached by the former, and also the extreme degree of defenslessness that can be achieved by the latter. In an earlier work, "The phenomenology of violent behavior," we reached the conclusion that, as in the literature on wartime propaganda, one of the factors that allow and stimulate aggressiveness in man is the depersonalization of the other person. The proximity of the loser.
is, in contrast, an element that in animals and in man inhibits aggression. The torturer may be a partial sad exception to this atavistic rule, since his violence may become exacerbated not just by depersonalization but also by some aspects of this close intimacy with the victim.

Double bind
The third element peculiar to the situation of torture is the double bind in which the tortured one is caught. It is an awful alternative: Either suffer to the limit of pain, or denounce the political comrade, the belief or cause, the friend or relative. In the first case, pain can be so intense that the subject is unable to resist: his or her only way out is confession and/or denunciation, which could eventually save his or her physical life, but which represents a serious threat for his or her psychological balance. By denouncing, the victim is going to destroy parts of his or her own self, of his or her identity, as she or he is betraying the collective bonds that give meaning to existence. Denunciation "indirectly transforms the tortured one into the torturer of his or her companions..."14. In a way, the whole social and political situation that surrounds the tortured one has a double-bind character, because totalitarian systems widely impose upon their opponents traps and conflicts from which escape is not possible. This situation generates a constant level of anticipatory anguish: in the most thoroughly set traps and double binds, the only way of overcoming this anguish would be the renunciation of values, friends, life projects. In other words, the subject harassed because of political ideas, who is arrested and tortured, is exposed, relatively defenseless, to a series of cruel choices that are marked by the character of a double bind. He has to choose between his or her own life and that of a comrade, between his or her physical integrity or his or her values and beliefs, between the integrity of his or her family and that of his or her political organization, etc.; and all this within a framework of the most absolute lack of confidence.

Falsehood
The act of torturing is surrounded by falsehood, by lies. Its scope is the opposite of truth in the sense of the Greek concept aletheia, that is to say, of discovery in common with the other person, of revealing senses, which gives meaning and plenitude to the subject and to the other person. The charges that lead to arrest and imprisonment are often or usually false, and false is the route that will take the victim to the place where he or she will be tortured. The different disguises with which the tormentors hide their identities represent other forms of the deceit inherent in torture. The victims are kept in places that are either dark or brightly artificially lit. Natural light, closely related to the concept of truth as aletheia, is banned from those spaces, where lies reign. Generally at least some of the threats are also false. It is not the wife that is hollering while being raped in the next room but another person, or a simulated voice. It is often not true either that the subject submitted to torture has been denounced by his or her best friend, or that his or her children have been kidnapped. The horrible practice of mock executions, recounted by the majority of freed prisoners, is an extreme form of falsehood, imprinted on one psychological bedrock for human beings: our own life and death. The temporospacial sensory disorientation that this is aimed at represents a kind of twilight of consciousness, that is to say, a state of consciousness contrary to and undermining the only one able to discover truths and meanings: alertness, wakefulness, clarity, sense of self. Such processes often end with the signing of a document in which the tortured, without being allowed to read the text, acknowledges that he or she has been treated correctly and agrees to blame himself or herself for various terrorist acts (also fake), thus, for example, seeming to make him or her deserve a prison term, justifying further repression by the government against him or her, or others, etc.

Spaciality
In torture, space and spacial objects and substances are deeply altered. We have already seen how the route to the site of torture is concealed and faked; how the cells are very small, emptied of all personalizing contents, either dark or lit by a persistent and exhausting artificial light. In this space, objects appear distorted, their natural sense distorted. The bed, traditionally made for resting, or for loving encounters, is specifically transformed into an instrument of torture by electrical wiring. Water, that usually quenches thirst or cleans, is transformed into an abominable substance, source of a form of suffering difficult to surpass - the immersion of the head into the water, to the point of choking. The cell itself, the place where even the poorest and most abandoned of the human beings might expect at least rest in sleep, becomes another cause of suffering when filled with noises or light, or by constant arousals of the prisoner during those endless day-nights and night-days. Further, one's own body is transformed through the torture process into something spiteful or betraying (because it hurts and complains in spite of one's will), or alien (at times the only way of bearing pain is perceiving the body as not one's own) or even repellant (e.g. when it has been sexually assaulted). The body of another person, normally perceived as potential company and warmth, object of aesthetic admiration and/or sexual attraction, is transformed by the torture situation into a perverted and refined instrument of hurt, by pain, humiliation, rape. And not rarely, a dog, man's traditional guardian and friend, is trained to menace and to carry out a twisted function such as acting sexually upon a human being.

If, as we have developed in another context15, the spaciality of love is characterized by overcoming the principle of the vital space in the sense of Bollnow16, acceding existence to a space without limits that allows the reciprocal enrichment of the lovers, the spaciality of torture's aggressive behaviour represents exactly the contrary: displacement, trapping, narrowness and destruction. The spaciality of torture is an extreme version of the spaciality of aggression, because in it there is not only displacement and narrowness but invasion of the body itself by another person, through the instrument of torture or sexual aggression. The intimacy that is produced between torturer and tortured is comparable with the one of love, but with the opposite sign: love exalts, while torture diminishes; love dignifies, while torture represents the maximum indignity that a human being can suffer; love is life and in a certain degree eternal life, while torture has qualities of incessant death.

Temporality
Time is also deeply altered in torture. Unlike usual rhythms of life, advancing from the past toward the future through rhythms and periods, crises and stages, interwoven with seasonal cycles, the time of torture is characterized by some unpredictability and much circularity, having no end. This feeling of endlessness has little to do with the eternal character typical of the temporality of love17,18. Torture is carried out at erratic times to suit the schedule of the torturer and to confuse and disorient that of the victim. The victim never
knows when the process will begin again. The majority of patients personally examined by one of us (O.D-Z.) insisted that what most tormented was not so much the physical pain in itself as the feeling that it had no knowable end, that perhaps it would never end. In torture, existence is withdrawn from usual interaction between present, past and future, and reduced to a pure unbearable present. There seems to be no other future than a new torture session, or perhaps death, with which the victim is threatened again and again. The past knows when the process will begin, that perhaps it would never end.

The feeling that it had no knowable end, that perhaps it would never end.

As the feeling that it had no knowable end, that perhaps it would never end.

The past knows when the process will begin, that perhaps it would never end.

Both certainly interfere with a coherent sense of self. The first leads more to a temporality of torture, existence is withdrawn from the development of late and/or chronic psychiatric states following torture: the features described undermine basic human structures, which can probably not be affected without seriously altering the person as a whole. Asymmetry and anonymity of the relationship between torturer and tortured create a significant threat to the interpersonal encounter in the sense of Heidegger’s Miteinandersein and Martin Buber’s I-You relationship, that is, threats to essential interpersonal human structure, to fundamental personal and reciprocal qualities. Then Bateson’s double binds, though rarely now thought centrally caused in schizophrenia, retain a significant place as a clinical organizing and psychopathology-fostering principle in psychiatry and family therapy. It would be parsimonious and consistent with many data to think that the loss of identity and self-esteem observed in the chronic sequels of torture have to do with the forceful double-bind element characterizing the communication style between torturer and tortured. Some evidence from the rehabilitation of torture victims trends to confirm this.

The falsehood surrounding the torture situation seems to us particularly related to that deep mistrust that characterizes the persons who have survived torture. Trust and truth are etymologically related, and trust is only possible within the framework of truth as aetheiea, as clearing (Lichtung) in the sense of Martin Heidegger. And finally, as we noted, torture also causes destruction and distortion of major aspects of temporalita and spacialita. Both certainly interfere with a coherent sense of self. The first leads more to a loss of motivation, while the second - the break in ‘lived space’, as Erwin Straus would say - severely damages tortured people’s sense of their own place in the world, of home and hearth and community. The tortured person becomes something of a psychologically homeless person.

References

Acknowledgement

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Call for papers

Jerusalem, Israel
August 28 - September 1, 1994
World Association for Medical Law: The 10th World Congress on Medical Law.

All enquiries should be directed to:
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In this congress RCT will hold a session on medical and legal aspects of torture. Interested potential participants are invited to send their abstracts for consideration to:

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Evidence of torture

Polical repression and human rights abuses in South Africa

By
Leslie London, MB BSc (hons)*
Terence L. Dowdall, MA (Clin Psych)#

“Everyone has the right to life, liberty and the security of person.”

“No one shall be subject to arbitrary arrest, detention or exile.”

“Everyone is entitled in full equality to a fair and public hearing by an independent and impartial tribunal, in the determination of his rights and obligations, and of any criminal charges against him.”

Millions of South Africans still await the day when these 3 articles of the Universal Declaration of Human Rights become a reality in our country.

The death in detention of Mr Steve Biko – after being injured during interrogation by South African security police in 1977 – catapulted South Africa and the South African medical profession into the international Human Rights' limelight.

Deaths in police custody represent only the extreme manifestation of a systematised strategy developed by the Apartheid government to curb widespread political opposition to its iniquitous political ideology. Detention without trial has been the mainstay of political repression in South Africa for many years.1,2

However, during the period 1985 to 1990, with the imposition of successive states of emergency by the South African government, unprecedented numbers of South Africans were subjected to arbitrary detention and arrest on a scale never encountered previously; particularly children, who constituted anything between 10 and 25% of persons detained under emergency regulations1,3.

The Human Rights Commission estimates that at least 73,000 detentions have taken place since 1960, of which 70% occurred since 1984.4 These detentions were not simply of political leadership but of community members at all levels, and they had a profound impact on the social fabric of South Africa's oppressed communities1,3-5. It was virtually impossible to encounter ordinary people in the communities who did not have some experience of the effects of detention, either of themselves, family members or friends.

At the same time, allegations of assaults, beatings and torture during this period of unlimited police powers were rampant.6-9. These abuses were not restricted only to detainees, but affected entire communities6,7.

83% of detainees report on physical torture

The evidence of torture of South Africa's political prisoners was particularly embarrassing to the South African government, which sought at all costs to prevent such information being publicised through repressive laws and banning of human rights organisations.1,3. However, a number of studies conducted with ex-detainees and political prisoners have confirmed that torture has been systematically practised in South Africa.6-10. Foster and Sandler found that 83% of a sample of people detained between 1974 and 1984 reported that they had been physically tortured during their detention (Table I).8

A study with 131 ex-detainees, described at the 1987 NAMDA conference, found that 72% alleged that they had been physically tortured during their detention, and, of this group, 75% at the time of their release still had physical evidence on examination that was consistent with the history of torture. Psychological abuse was reported by 79% of ex-detainees, and 63% had

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psychological disorders related to their detention (Table 1)\(^5\).

These findings are similar to those in a recent study of the detention experiences reported by prisoners released from Robben Island in 1990-91\(^10\). These allegations of torture are corroborated by the contents of an affidavit submitted by Dr Wendy Orr, who, while working as a district surgeon in Port Elizabeth in 1985, saw accumulating evidence in her work of assaults and torture of political prisoners.

She found that, out of 286 detainees who complained of assault, 153 had evidence on examination of unlawful injury.

This included 60 with facial injuries, 8 with perforated eardrums, and 26 with wheals and blisters consistent with being struck with a quilt\(^11\).

A crucial feature of South Africa’s security laws has been the use of indefinite solitary confinement\(^12,13\), recognised worldwide as a form of torture.\(^14\)

Section 29 of the Internal Security Act allows for indefinite detention in conditions of solitary confinement for purposes of interrogation until the detainee has satisfactorily answered all the questions put to him or her.\(^15\) Children held in detention have also frequently been subjected to solitary confinement\(^13,14\), and it is disturbing to note that section 29 is still in regular use in South Africa today\(^16\).

Confessions extracted under conditions of solitary confinement have been unquestioningly accepted by South Africa’s courts, thereby facilitating the ongoing use of this practice. It has usually been under conditions of solitary, where the prisoner or detainee is totally isolated, that the worst physical and psychological abuses have taken place.

Towards the end of the 1980s repression of political activists began to take on different forms, with the emergence of vigilante groups, assassinations and harassment, that have come to be termed informal repression.\(^12,16\)

This coincided with the implementation of a new state strategy of serving restriction orders on released detainees.\(^17\)

Many of these restrictees were then sitting targets for assassination by mysterious hit squads\(^17,18\). In many ways, the changing nature of repression in South Africa appeared to reflect an adaptation and refining of repression techniques used in other regimes, as well as a pioneering of new techniques which serve as a model for others to follow.\(^14\)

With the unbanning of political organisations announced by the Nationalist government in February 1990 and the general easing of space for political activity, vigilante and informal violence has escalated hideously out of all proportion to previous experiences. Assassinations, abductions, and mass killings have become almost everyday occurrences in South Africa’s already poverty-stricken urban and rural townships.

Allegations of police complicity and cooperation in these events lend credence to an argument that elements within the security forces are fermenting this violence to prevent the political organisations from mobilising and building themselves effectively in the process leading up to negotiations.\(^16\)

At the same time, while police detentions have declined in the past year, there is still ample evidence of ongoing use of detentions and, in particular, of solitary confinement, especially in the bantustans where assault and torture of detainees is a routine event.\(^1,16\)

What is even more worrying is the fact that persons taken into police custody continue to be tortured and continue to die whilst in detention,\(^16,19\) despite an apparent liberalisation in the security forces’ attitude to political organisation.

Second highest rate of judicial executions

Another area where South Africa holds notoriety is in its commitment to capital punishment. South Africa has the dubious honour of being the hanging capital of the world, with the second highest rate of judicial executions in the world (second only to Iran)\(^20\). Conditions of prisoners awaiting execution on Death Row are in many ways far more devastating than for ordinary prisoners.\(^21\)

Since 1984, a growing number of executions have been for “political” crimes unrecognized by the South African regime as legitimate actions of freedom fighters, but rather treated as criminal actions. In the past 5 years, intense public campaigns have focused on the plight of political prisoners on death row. This pressure has, in some measure, forced the State to suspend its executions.

The result is that some cadres have now been released after spending years on Death Row, watching while others less fortunate than themselves were executed. To return from a situation where one was waiting for one’s own execution is a torture that few can really appreciate adequately, and is one of the many sorts of stress-related problems that counselling services for expatriate prisoners and detainees are having to deal with.

References

18. Memorandum on Restrictions presented to the Minister of Law and Order by families of restrictees, August 1989.
The Argot of the victim

Explanation of expressions peculiar to the use of torture in Iran

By
Mohammad Beh, *

The cultural background of the Middle East torture victims, their individual experiences, and the torture to which they have been exposed are of course essentially different from what RCT is used to dealing with in victims under treatment, even though the purpose of torture is the same all over the world. Many of the torture methods were unknown at RCT. Some of these methods have a cultural, religious, or climatic background different from the better known ones.

Attached to these methods are naturally some new words and expressions that are used in the prisons by the torturers and their victims. The victim’s contact with the therapist at RCT takes place via the interpreter, and his role as go-between is therefore very important for the outcome of the treatment. To make the interpretation correct and avoid misunderstandings and/or misinterpretations, both the interpreter and the therapist must have a certain knowledge of the victim’s culture and situation, and of the methods of torture to which he has been exposed. An incorrect interpretation or a misunderstanding between the client, the interpreter, and the therapist may have serious consequences for the outcome of the treatment.

Since interpretation for torture victims is a new and very sensitive area, both the interpreter and the therapist must be as well prepared as possible. The torture victim’s vocabulary, and the way he uses the language, may cover – often using the characteristics of everyday language – concepts and meanings totally different from what is used in ordinary interpretation. It is therefore important for the therapist and the interpreter to be extremely aware of these words and concepts during the conversation.

The use of new words, sentences, or expressions by the victim when talking with the therapist can be taken for their ordinary primary meaning, but they may have a completely different secondary meaning which in the situation in reality is the primary. If the interpreter and/or the therapist do not know these expressions or sentences, which are therefore open to misinterpretation, it is necessary to ask the client about their meaning; one may at best get an explanation. It is sometimes difficult for the client to explain the meaning of each single word of prison jargon. A torture victim will often refrain from telling about previous horrors. The prisoners and their torturers create a language with new words and expressions so that they can talk about various things without being under-
stood by outsiders. Some torture methods have been given their name from certain things, situations, or procedures. If the client is under pressure to explain in detail the meaning of each word and expression, it may result in a situation of stress and confusion, involving victim, interpreter, and therapist, who may all be distracted from the main problem. The conversation and the treatment both suffer.

If only the interpreter knows the meaning of the words, the interpreter and the therapist will start a conversation without involving the client, i.e. two of the involved persons are in a treatment situation and discussing, giving the client the impression that the therapist is "far away from the situation in which he/she had been", and that "the therapist after all does not understand his/her cultural background", or that "the interpretation is not correct", and thus creating mistrust of the interpreter and his interpretation.

During the preparation of this article I came across some words which more or less expressed religious and cultural aspects. These words have been included in a glossery where they are also explained.

I have chosen to call the research The Argot of the victim, because many trades have their own jargon: the doctors, the mechanics, the butchers, etc. In the same way, the prisoners have developed their own jargon during their imprisonment. It is not slang, but a jargon peculiar to the prisoners: The Argot of the victim.

From the glossery:

3. ANTEN: Antenna (informer)
Client: All the cells had ANTEN
meaning: There were one or more informers in all the cells

25. ZIRE HASHT: Under eight (torture/torture chamber)
Client: They took him to ZIRE HASHT
meaning: They took him to the torture chamber

Refers to one of the prison’s departments, the function of which was to watch the prisoners. This department is allowed to torture (punish) the prisoners without special orders or permission from above.

From the methods:

1. APOLLO (after the spacecraft, the helmet)

The prisoner is placed on a metal chair with his legs stretched forward. His hands are tied to the arm rest. His head and face are covered by a metal helmet which rests on his shoulders.

a. Live electrodes are placed on the most sensitive areas of the body. The prisoner’s screams are amplified inside the helmet.

b. Various instruments are hammered against the helmet.

c. The helmet has inbuilt screws which can be tightened more and more against the skull of the prisoner.

11. GHAPANI (weight)

The right arm is twisted above the shoulder and the left arm behind the back, where the hands are fixed together with handcuffs. A stick is put through the angles formed by the bent elbows, and the prisoner is suspended from a metal pipe placed in the wall, so that only his big toe can reach the ground. A piece of rope is usually tied to the handcuffs, and its length can be adjusted to the height of the prisoner. This method is often combined with whipping.

The full text of The Argot of the victim can be obtained, by writing, from RCT/RCT
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* Interpreter Consultant, RCT, Copenhagen
Strong criticism by the European Committee for the Prevention of Torture

The European Committee for the Prevention of Torture (CPT) has published a ten-page report, strongly criticizing Turkey for continuing its extensive practice of torture. The torture takes place in police stations, against persons suspected of ordinary criminal acts and against those who are detained under the special anti-terrorist laws. The committee also found items, identified as instruments of torture, when it inspected two Turkish police stations.

The Committee, which was created according to the 1987 European convention for the prevention of torture and other inhuman or degrading treatment or punishment, has visited Turkish prisons and police stations three times – in 1990, 1991, and 1992. No other European country has had so many visits by the committee’s inspectors, doctors, lawyers, and police officers.

However, according to article 10 of the 1987 convention, the committee can go public on its own initiative if, after several requests, a country continuously fails to cooperate or refuses to make improvements.

Throughout 1991 and 1992 an ongoing dialogue was maintained between the Turkish authorities and the CPT on matters of concern, based on the reports drawn up by the Committee after its first and second visits and on the reports provided by the Turkish authorities in response. This dialogue culminated in a number of meetings between the Turkish authorities and a delegation of the CPT, held in Ankara from 22 to 24 September 1992.

Falanga, beating, and electrical torture

Subsequently, at its 14th meeting (28 September to 2 October 1992), the CPT reviewed the action taken by the Turkish authorities on the recommendations made by the Committee in its visit reports. The Committee concluded that the continuing failure of the Turkish authorities to improve the situation in the light of its recommendations concerning:

- the strengthening of legal safeguards against torture and other forms of ill-treatment in police (and gendarmerie) establishments, and
- the activities of the Anti-Terror Departments of the Ankara and Diyarbakir Police, justified a public statement from the Committee.

During the CPT visit in December 1992, it became evident that torture and other forms of ill-treatment of persons in police custody had not been abandoned, despite the importance which had been attached to this subject by the present government when it came to power at the end of 1991.

Subsequently, CPT in its meeting in December 1992 with the requiret two third majority decided to make a public statement, in accordance with the Convention’s Article 10(2).

The Committee’s delegation was inundated with allegations of such treatment, from both ordinary criminal suspects and persons detained under anti-terrorism provisions. Further, numerous persons who were examined by the delegation’s doctors displayed marks or conditions consistent with their allegations.

Three examples:

- several prisoners charged with offences against property, encountered in the reception unit of Bayrampasa Prison (Istanbul), whose fresh haematomas were consistent with their allegations that they had recently been subjected to falanga and to beating on the palms of the hands and the ventral aspects of the wrists;
- a prisoner charged with a drug-related offence being held for observation in a forensic section at Bakirköy Hospital (Istanbul), who had a fresh rounded mark on his penis (reddish-brown and slightly swollen edge, whitish centre without induration), consistent with his allegation that an electrode had been placed by the police on that part of his body some five days earlier in order to deliver electric shocks;
- a prisoner charged with smuggling examined at Adana Prison, who displayed haematomas on the soles of his feet and a series of vertical violet stripes (10 cm long/2 cm wide) across the upper part of his back, consistent with his allegation that he had recently been subjected to falanga and beaten on the back with a truncheon while in police custody.

How the torture instruments were found

Comparable cases in Ankara and Diyarbakir could also have been described, including persons who had been held by the Anti-Terror Departments of the police in the two cities (in particular, cases of motor paralysis of the arms and severe sensory loss consistent with allegations of suspension).

Of special interest was the highly incriminating material evidence found by CPT in police establishments in those cities. Acting in each case on concordant information independently received from several different sources, the Committee’s delegation carried out two impromptu visits to specific rooms situated on the top floors of both the Ankara Police Headquarters (new building) and the Diyarbakir Police Headquarters. The rooms in question were located within the areas occupied by the Law and Order Departments, which deal with ordinary criminal suspects. In the room at the Ankara Police Headquarters, the delegation discovered a low stretcher-type bed equipped with eight straps (four each side), fitting perfectly the description of the item of furniture to which persons had said they were secured when electric shocks were administered to them. No credible explanation could be proffered for the presence of this bed in what was indicated by a sign as being an “interrogation room”.

In Diyarbakir, the delegation found the equipment necessary for suspension by the arms in place and ready for use (i.e. a three metre long wooden
beam which was mounted on heavily-weighted filing cabinets on opposite sides of the room and fitted with a strap made of strong material securely tied to the middle). On both occasions, the delegation’s discoveries caused considerable consternation among police officers present; some expressed regret, others defiance.

In the light of all the information at its disposal, the CPT concluded that the practice of torture and other forms of severe ill-treatment of persons in police custody remains widespread in Turkey and that such methods are applied to both ordinary criminal suspects and persons held under anti-terrorism provisions. The words “persons in police custody” should be emphasized.

The Committee has heard very few allegations of ill-treatment by prison staff in the different prisons visited over the last two years, and practically none of torture. Certainly, there are problems which need to be addressed in Turkish prisons, but torture is not one of them. The CPT’s dialogue with the Turkish authorities on prison matters is on the whole progressing satisfactorily.

**Improved conditions for detainees**

As for the gendarmerie (which is responsible for police functions in rural areas), the CPT has heard allegations that suspects are frequently handled roughly and on occasions even beaten by members of the gendarmerie, in particular when apprehended. Further, the CPT has reason to believe that, from time to time, ill-treatment occurs in the course of the transport of prisoners (which is another task performed by the gendarmerie). However, the CPT has heard fewer allegations – and found less medical evidence – of torture or other forms of premeditated severe ill-treatment by members of the gendarmerie.

According to the CPT statement of December 1992, action is required on several fronts if this problem is to be addressed effectively. Legal safeguards against torture and other forms of ill-treatment need to be reinforced and new safeguards introduced. At the same time, education on human rights matters and professional training for law enforcement officials must be intensified. In this respect, the recent arrangements to send some 20 Turkish police officers to various other European countries in order to study police methods there are to be welcomed, and the CPT trusts that they represent part of an ongoing process.

Furthermore, public prosecutors must react expeditiously and effectively when confronted with complaints of torture and ill-treatment. On this point, the recent annulment by the Constitutional Court of section 15 (3) of the Law to Fight Terrorism of 12 April 1991 (which severely curtailed the possibilities for public prosecutors to proceed against police officers alleged to have ill-treated persons in the performance of duties relating to the suppression of terrorism) is a very positive development. In order to facilitate effective action by public prosecutors, the medical examinations of persons in police and gendarmerie custody carried out by the Forensic Institutes should be broadened in scope (medical certificates should contain a statement of allegations, a clinical description, and the corresponding conclusions). Further, appropriate steps should be taken to guarantee the independence of both Forensic Institute doctors and other doctors who perform forensic tasks, as well as to provide such doctors with specialized training.

Proper managerial control and supervision of law enforcement officials must also be ensured, including the institution of effective independent monitoring mechanisms possessing appropriate powers. Neither should the issue of the conditions of service of such officials be overlooked, since satisfactory conditions of service are indispensable to the development of a high-calibre police force.

Application of the recently drawn up Custody Regulations, which relate inter alia to material conditions of detention, must also be vigorously pursued throughout the whole of Turkey. Considerable progress in this area has been made in Ankara and Diyarbakir, in pursuance of the CPT’s recommendations. However, the situation found recently at Adana Police Headquarters (in particular in the Anti-Terror Department) suggests that, in other parts of the country, persons detained by the police or gendarmerie may still be held under totally unacceptable conditions.

**Safeguards with the extensive exceptions**

Particular reference must be made to the recently adopted Law amending some provisions of the Code of Criminal Procedure and of the Law relating to the organization and procedure of State Security Courts, which entered into force on 1 December 1992. This is a revised version of the text returned to the Grand National Assembly earlier in the year by the President of the Republic. The new Law inter alia clarifies the existence of certain fundamental safeguards against ill-treatment, such as the right to have a relative notified of one’s custody and the right of access to a lawyer (safeguards which had been provided for previously but which had been largely inoperative in practice), regulates in detail the mechanics of the interrogation process, introduces a right to apply to a judge for the immediate release of an apprehended person, and shortens the maximum periods of police/gendarmerie custody. The introduction of these provisions is a most welcome step forward. However, it is a matter of great regret to the CPT that their application to offences within the jurisdiction of State Security Courts has been specifically excluded. Admittedly, the number of offences under the jurisdiction of such courts has also been reduced by the new Law, but it remains considerable: crimes against the State; terrorist offences; drugs and arms-related offences, etc.

The CPT took the opportunity to underscore that it abhors terrorism, a crime which is all the more despicable in a democratic country such as Turkey. The Committee also deplores illicit drug and arms dealing. Further, it is fully conscious of the great difficulties facing security forces in their struggle against these destructive phenomena. Criminal activities of this kind rightly meet with a strong response from state institutions. However, under no circumstances must that response be allowed to degenerate into acts of torture or other forms of ill-treatment by law enforcement officials. Such acts are both outrageous violations of human rights and fundamentally flawed methods of obtaining evidence for combating crime. They are also degrading to the officials who inflict or authorize them. Worse still, they can ultimately undermine the very structure of a democratic state.

Unfortunately, Turkish law as it stands today does not offer adequate protection against the application of those methods to persons apprehended on suspicion of offences falling under the jurisdiction of State Security Courts; on the contrary, it facilitates the use of such methods. Suspects in relation to collectively committed crimes may be held for up to 15 days by the
police or gendarmerie (rising to 30 days in regions where a state of emergency has been declared), during which time they are routinely denied any contact with the outside world.

It is true that the provisions of section 13 of the new Law, concerning prohibited interrogation procedures, apply also to persons suspected of offences under the jurisdiction of State Security Courts. However, it would be unwise to believe that these provisions alone will be able to stem torture and ill-treatment. The methods described in section 13 have been illegal for many years under Turkish Law by virtue of the general prohibition of torture and ill-treatment in Article 17 (3) of the Constitution. Further, the stipulation that statements made as a consequence of such methods shall not have the value of evidence is merely a welcome reaffirmation of a principle already recognized by the Turkish legal system.

How to balance security and rights of the detainee

In reality, the long periods of incomunicado custody allow time for physical marks caused by torture and ill-treatment to heal and fade; countless prisoners have described to CPT delegations the treatment techniques applied by police officers. It should also be noted that certain methods of torture commonly used do not leave physical marks, or will not if carried out expertly. Consequently, it is often difficult to demonstrate that a statement has been made as a consequence of ill-treatment. The same point applies to the admissibility of other evidence obtained as a result of ill-treatment (cf. section 24 of the new Law).

The CPT does not contest that, exceptionally, specific legal procedures might be required to combat certain types of crime, in particular those of a terrorist nature. However, even taking into account the very difficult security conditions prevailing in several areas of Turkey, an incomunicado period of up to 15 days, let alone 30, is patently excessive. It is clear that a proper balance has not been struck between security considerations and the basic rights of detainees.

The CPT calls on the Turkish Government to take appropriate measures to reduce the maximum periods for which persons suspected of offences falling under the jurisdiction of State Security Courts can be held in police or gendarmerie custody, clearly to define the circumstances under which the right of such persons to notify their next of kin of their detention can be delayed and strictly limit in time the application of such a measure, and to guarantee to such persons, from the outset of their custody, a right of access to an independent lawyer (though not necessarily their own lawyer) and to a doctor other than one selected by the police.

As regards ordinary criminal suspects, the amendments introduced by the above-mentioned Law could deal a severe blow to the practice of torture and ill-treatment. However, much will depend on how the new provisions are applied in practice.

This is a matter that the CPT intends to follow carefully during the coming months, in close co-operation with the Turkish authorities. Nevertheless, a number of points should be raised now.

The maximum period of police custody for collective crimes (three or more persons), although reduced, remains quite high – up to eight days at the request of a public prosecutor and by decision of a judge. In this regard, the CPT wishes to emphasize that, in the interests of the prevention of ill-treatment, it is essential that the person in custody be brought physically before the judge to whom the request for an extension of the custody period is submitted. The new Law is not clear on this point.

How to abolish the mentality of torturing

Although the precise content of the right of access to a lawyer is impressive, a potential flaw lies in the fact that, with the exception of persons who are under the age of 18 or disabled, a lawyer will only be appointed if the person in custody so requests.

A fail-safe procedure will have to be found that ensures that detainees are (as the law requires) informed of their right to appoint a lawyer and are not subjected to pressure when considering the exercise of that right. The same point applies as regards the right of persons in custody to make known to a relative of their choice that they have been apprehended. Care will also have to be taken that the possibility offered to take a statement, in certain cases, in the absence of the lawyer appointed by the detained person is not abused.

Under the new provisions, public prosecutors are in an even better position to exercise considerable influence over the manner in which police officers perform their duties and, more specifically, treat persons in their custody. The CPT very much hopes that they will make effective use of the possibilities open to them, with a view to the prevention of ill-treatment.

The new law is silent on the question of the right of persons in police or gendarmerie custody to have access to a doctor. However, by a circular issued by the Ministry of the Interior on 21 September 1992, a right of access to a doctor in the form previously recommended by the CPT (i.e. a right for the detainee to be examined by a doctor chosen by him – if appropriate from among a list of doctors agreed with the relevant professional body– in addition to any examination carried out by a state-employed doctor) was recognized. The CPT welcomes this development, though the inclusion of this right in a law would be preferable. Previous circulars relating to important safeguards for detained persons have remained a dead letter.

Torture and other forms of ill-treatment by the police will not be eradicated by legislative fiat alone. It will always be possible for the impact of legal provisions to be diminished by ever more expertly applied techniques of ill-treatment.

The CPT felt convinced that it would have been counter-productive from the standpoint of the protection of human rights for it to have refrained – as it was requested to do by the Turkish authorities – from making the public statement. It is issued in a constructive spirit. The CPT hold that, far from creating an obstacle, it should facilitate the efforts of both parties – acting in cooperation – to strengthen the protection of persons deprived of their liberty through torture and inhuman or degrading treatment or punishment.

1) The report is available from: Secretariat of CPT, Council of Europe, F-67075 Strasbourg Cedex, France
2) The Editorial Board finds that the report is so important that the full text will be printed in the next issue of TORTURE.
Welcome
In his welcome to the participants to The V International Symposium on Torture and the Medical Profession, Yavaş Özen, President of Human Rights Foundation of Turkey (HRFT) remembered the Turkish mothers whose children are today under arrest or convicted or have disappeared following torture.

Pointing to the HRFT, he deplored the atmosphere of organized struggle for human rights, which necessarily developed in Turkey after 1986. HRFT has treated about 500 torture victims in two years, after organizing and institutionalizing itself with that aim. More than 200 psychologists and physicians were contacted, resulting in a great supportive contribution from these defenders of human rights – the voluntary and devoted efforts of physicians, psychologists, psychiatrists, and others.

Due to the imposition of states of emergency, democratic and social activities are gradually disappearing in a medium of fear and lack of confidence in some war-torn regions of Turkey. The Kurdish people, who have been forced into an armed struggle, are thus unable to use their most fundamental democratic rights.

For this reason, it is urgent to end the state of war, to create a medium which is based on the fraternity of Turkish and Kurdish people.

The present Turkish Government, however, does not keep its promises of democratization. All the antidemocratic laws that regulate democratic life must be amended in order to eliminate torture. The accused person must be allowed to talk to his/her lawyer from the moment of arrest.

Human Rights Foundation of Turkey
Mahmut Tali Ongören, General Secretary, HRFT, Ankara, Turkey.

The Human Rights Foundation of Turkey (HRFT) was established in 1990 by 32 founding members of the Human Rights Association (HHD), which is a non-governmental organization. HRFT was established in order to broaden the scope of HHD and for certain formal reasons. HRFT has based its work on all international Human Rights accords whether signed by Turkey or not.

The purpose of HRFT is to issue publications and documentation on Human Rights and freedoms; to carry out scientific research and education; to publish periodicals and irregular publications; to establish, run or delegate the management of research, education and health institutions concerned with all kinds of human rights and specified in international human rights accords and national legislation.

HRFT works on the principle of projects. Once the projects have gained support by non-governmental Human Rights organizations, they are implemented. The Treatment and Reference Centre Project was the first one designed by HRFT.

Within this project designed for torture victims, 40 persons were treated in 1990, 238 in 1991, and 190 persons in the first 6 months of 1992.

HRFT supports some activities of Human Rights organizations in Turkey with limited means. HRFT does not accept donations or support from government, institutions and persons violating Human Rights.

Characteristics of persons who applied to the treatment centers
Ökan Akkan, MD, Treatment and Rehabilitation Centre of HRFT, Ankara, Turkey.

The study describes certain demographic characteristics of the persons who applied to the Ankara, Istanbul, and Izmir Treatment Centres of HRFT (Human Rights Foundation of Turkey). The characteristics included age, sex, marital status, educational level, and occupation. Periods of detention and imprisonment, methods and place of torture, if any, and treatment methods are also described.

In all, 25 variables from the files of 439 subjects who applied to the Treatment Centres of HRFT from August 1990 to September 1992 were analyzed retrospectively. The findings are discussed.

Bone scintigraphy as a clue to previous torture
Veli Łok, MD, Human Rights Foundation, Izmir, Turkey.

In order to find objective and repeatable criteria for the existence of previous torture, we have been applying bone scintigraphy to our cases since 1985. We have evaluated 64 patients who claimed to have been victims of torture, mainly beating and falanga.

There were 18 acute cases (seen 1-30 days after torture), 10 subacute (seen 1-12 months after torture), and 36 chronic (seen 1-15 years after falanga). Acute cases had their bone scintigrams at their first visit, at 1, 3, and 6 months, and then twice yearly. Bone scintigraphy was repeated every 6 months in subacute and chronic cases.

Positive scintigraphic findings were recorded in 18 of 11 acute cases (61.3%), 7 of 10 subacute cases (70%), and 20 of 36 chronic cases (55.5%). The mean time lapse from torture to bone scintigraphy was 10.5 years in the chronic cases.

We followed 8 patients from very soon after the torture was applied periodically repeated bone scintigraphy; the positive scintigraphic findings persisted for 6-31 months in 6 cases. One case was normal scintigraphically at one month, the remaining one at 16 months. We conclude that bone scintigraphy may become a valuable additional tool combined with the history and psychiatric-physical findings of torture victims in their initial diagnostic work up, since the positive findings persist for a very long time, this procedure may become a legally useful clue.

Signs of falanga torture
Ole Vedel Rasmussen, DMSc, & Grethe Skyld, MD, PhD, Rehabilitation and Research Centre for Torture Victims (RCT), Copenhagen, Denmark.

Blows on the soles of the feet for the purposes of torture are called falanga. Sticks, chains, cables, or similar implements are used for the beating. During the past years, the Rehabilitation and Research Centre for Torture Victims in Copenhagen (RCT) has received many torture victims from the Middle East, where falanga torture is common.

Physical examination is an important tool in the diagnosis of the sequelae of falanga, and there is need for a prospective randomized study to establish the validity, the reproducibility, and the interobserver variation of such an examination.

X-ray examination after torture
Hermann Vogel, MD, Head of X-Ray Department, AK Ochsenzoll, Hamburg, Germany.

It is possible with X-ray examination to see fractures, foreign bodies, abdominal lesions, and lesions of soft tissues and ligaments.

Lesions of abdominal organs due to torture often lead to death of the victim, or they heal without demonstrable sequelae. Lesions of soft tissues and ligaments are more difficult to see by X-ray techniques.

Different questions arise when the age of a torture victim is to be determined. It is then important to differentiate between persons younger or older than 18 years. X-ray examination can give some additional clues.

New techniques such as MRT can show soft tissue changes far better than conventional X-rays. This is also valid for ultrasonography in some regions of the body.

An interesting new method is PET (position emission tomography), by which the cerebral metabolism can be analyzed. Publications on psychiatric patients show promising results. It is likely that this method would also show changes in torture victims.

Post-traumatic falling of the hair as a result of electric shocks
Maria Pinion-Kalli, MD, & Tsikolis Polis, MD, Medical Rehabilitation Center for Torture Victims, Athens, Greece.
A case is presented of a female who was subjected to vicious torture in an African country. The torture included electric shocks on the hairy scalp, administered through ribbon-like electrodes. Loss of hair later occurred from the area in a pattern quite different from normal loss of hair. The condition was diagnosed as post-traumatic loss of hair due to the use of electricity.

The problem was very serious because the hair follicles might have been destroyed completely. Despite the fact that a long period had passed since the torture episode, I started treatment, though without much hope of improvement.

After two months of medical treatment and applied massage, the result was very encouraging, as can be seen from the photographs before and after therapy.

Neurological complications of repeated hunger strike

I. Hakan Gürvit, MD, Department of Neurology, Faculty of Medicine, University of Istanbul, Turkey, et al.

Hunger strike is a widely used means of protest, particularly popular among political prisoners all around the world. It was used by thousands of political prisoners in Turkey following the military coup in 1980, and it led to many fatalities during the last decade. It is not an exaggeration to state that hunger strike, together with torture, is one of the major causes of morbidity and mortality in prison. Surprisingly, however, very little has been published on hunger strike, and almost nothing on its “Turkish epichromes”.

Here we report two cases, together with their 5-6 year follow up. They illustrate morbidity related to hunger strike.

The first, a 27-year-old male, presented with a clinical picture compatible with a diagnosis of Strachan’s syndrome, which is one of the main neurological entities reported in prisoners of war in World War II. It is related to malnutrition.

The second, a 23-year-old female, had undergone a “fasting to the death”, but this was ended on the 56th day after she had become unconscious. The clinical picture and the subsequent course were compatible with the diagnosis of the Wernicke-Korsakoff syndrome. While being major causes of disability, as in our patients, both conditions are preventable; this necessitates special medical insight on the part of the doctors who are to deal with this specific population.

Two hundred cases of alleged torture among asylum seekers in Sweden 1985-1991

Sten W. Jakobsson, Center for Torture Survivors (CTD), Karolinska Institute, Stockholm, Sweden.

During the last ten years, about 30,000 refugees have arrived yearly in Sweden. Our patients came from four continents and 30 different countries. Every patient was seen by a forensic clinician and about 30% also by a psychiatrist or a psychologist. In 25 cases consultations were made with specialists in surgery, orthopaedics, or dermatology. Colour photos were taken of all skin lesions, and X-ray documentation was done when needed.

The main findings were:

1. scars, from different causes according to the patients’ reports,
2. marks from probable burns and application of electrodes, and
3. bone abnormalities (missing sections and wrongly healed fractures).

A collaborative evaluation showed:

a. history and findings did not support alleged torture (55%),
b. history and findings probably consistent with torture (30%),
history and findings well consistent with torture (53%), and, d. findings conclusive (12%).

A multidisciplinary medical and psychological/psychiatric approach is necessary for the documentation of sequelae in survivors of torture.

Tinnitus in torture survivors

Sepp Grausser, MD, Behandlungszentrum für Folteropfer, Berlin, Germany.

Tinnitus affects not only torture survivors. It is a tormenting symptom for about every tenth citizen in Europe (German Tinnitus League).

Nearly every second torture survivor, especially from the Middle East, complains of tinnitus.

Two sequelae of tinnitus are important: the loss of silence, and the permanent memory of the trauma that caused the noises in the ear.

The causes of tinnitus in torture survivors have been systematically investigated. Beating on the head may cause tinnitus by disturbing the sacculus and the endolymphatic duct, as well as causing retrocochlear lesions.

Tinnitus may be caused by stress. Anxiety leads to an increase of catecholamines and cortisol: this may be followed by premature atherosclerosis or coronary stenoses, as was seen in survivors of the holocaust. It is possible that the arteries of the inner ear react in a similar way.

Diagnosis depends on the exclusion of tumours, arterial disease, and accompanying hypoaesthetic attempts must be made to make the noises audible in special tinnitus laboratories.

Management must take into consideration:

a. organic lesions – treat with hearing aids or, if necessary, surgery,
b. the influence and role of psychotherapists – the annoying character of tinnitus decreases with empathy therapy,
c. behaviouristic methods – modulating noises and silence in a soundproof laboratory,
d. acoustic masking of the noises – walkman and hearing aids.

Ethical considerations allow an approach to tinnitus only step by step, mainly through observations. Our patients are not a field for experiments, but we need specialists to help with the diagnosis and treatment of tinnitus.

Latvian forensic specialist’s role and help for tortured persons

Veiko Volkonsse, MD, Dept. of Forensic Medicine, Riga, Latvia.

Latvian forensic specialists dedicated to their country worked under very difficult conditions before Latvia gained independence. The activities of forensic specialists, who worked essentially independently and objectively, ran in two main directions:

1. To secure objective evaluations of corporal injuries to victims, e.g. deserters from the Red Army and freedom fighters, at the same time giving medical aid.
2. To examine returned soldiers’ corpses. Every year about 20 young Latvian men were called up for service in the Red Army. Often enough they were returned in zinc coffins. Their families were not allowed to open the coffins. Forensic specialists were subject to army institution control. Objective evaluations of the injuries and cause of death could be openly stated at the nation’s revival. These were often quite the opposite of those stated by the military.

Both above-mentioned activities could be illustrated by numerous examples.

Our work at present is directed to the organization of a rehabilitation centre in Latvia for persons who were physically and mentally tortured by the occupying forces. We want to improve the health of these victims so that they regain strength enough to work for the benefit of independent Latvia.

Prevention of torture and rehabilitation of survivors in Nepal

Bhogendra Sharma, MD, Centre for the Victims of Torture, (CVICT), Kathmandu, Nepal.

Rehabilitation of survivors of torture after the pro-democracy movement in Nepal started in December 1990. Due to a change in the political scenario, a new centre CVICT was founded. During the course of our work, the Nepalese people have experienced torture as it was before. Since none of the human rights violators are punished, and since no legal action is being taken against the present torturers, CVICT has launched an awareness programme to tell health professionals and other intellectuals how to prevent and fight torture. A new approach to concerned people could be a milestone in the prevention of torture.

The right to development: an urgent challenge

Mario Vidal, Professor of Psychiatry, Faculty of Medicine, University of Chile, Santiago, Chile.

The gravest violations of Human Rights (we refer to the physical and psychological damage caused to a group of people in a context of political repression) usually concern social injustice, especially in Third World countries. Moreover, social injustice leads to the non-satisfaction of the most essential human necessities, thus implying the violation of another group of rights, also included in the Universal Declaration of Human Rights.

In the paper we abridge the Declaration on the Right to Development adopted by the United Nations in 1986, and the present international discussion about the need for a new and more humane economic order.

The purpose of the paper is to analyse the matter from the mental health point of view. Dissimilar access to opportunities that tend to satisfy some essential necessities is the foundation of dissimilar maturation of certain capacities which could allow full development of the personality.

Treatment centre in Berlin: Establishment and working

Christian Press, MD, Behandlungszentrum für Folteropfer, Berlin, Germany.

Since the beginning of 1992, torture victims have been treated at the former University Hos-
Psychological effects of torture
Cem Kaplanoglu, MD, Department of Psychiatry, Medical Faculty, University of Ankara, Turkey.

In this study 28 torture victims who had been referred from the Ankara section of the Human Rights Organization of Turkey (HRFT) were questioned about the methods of torture they had undergone and the subsequent psychological difficulties. The symptom check list 90-revised (SCL-90-R) was used to determine the psychological profiles of the subjects.

Family and torture—a systematic analysis
Antonio Martinez, PhD, Coordination, Marjorie Kovler Center for the Treatment of Survivors of Torture, Chicago, Illinois, USA.

Torture is the systematic destruction of personality in order to strip the survivors of their capacity to exercise power. There are devastating effects of torture in the family system. This paper will address these effects. Special emphasis will be given to the dysfunctional patterns developed vis-a-vis family hierarchy, family boundaries, the management of torture, and key transitions in the family developmental cycle. Strategies will be provided.

Psychological consequences of torture with and without a sexual component
Ozgün Tasdemir Paker, MD, MA, Istanbul, Turkey et al.

According to the theoretical framework, the types of sexual torture were expected to differ between the sexes with respect to their gender roles. In addition, due to the effects of the subordinate position of women on their psychology, women were expected to have more psychological problems after exposure to sexual and general torture.

In this controlled study of 55 tortured and 55 control participants (30 men and 25 women in each group), only one male and one female tortured participant had not been tortured sexually. So the tortured group could not be divided into sexually and non-sexually tortured sub-groups. The sexes were compared with respect to the following; the number exposed to each type of objectively defined sexual torture, the number of exposures to these types, the number exposed to each type of subjectively defined sexual torture, and the number of exposures to these types perceived as sexual torture. The gender differences were also examined with respect to the objective and subjective severity of general and sexual torture. After comparing the sexes on the psychological problems, including problematic sexual behaviour, depression, anxiety, PTSD, and low self-esteem due to exposure to torture, the predictive power of torture, the predictive powers of the objective and subjective intensity of general and sexual torture and sex on these problems were investigated.

Sexual abuse
Lambros Vazeeos, MD, & Maria Pinou-Kalli, MD, Medical Rehabilitation Center for Torture Victims, Athens, Greece.

The sexual abuses hold a conspicuous position in the long list of torture methods; they include all kinds of violence against the genitals or their sexual function. Sexual abuse is probably the only form of torture for which the victim does not reveal his/her suffering. The authorities admit that they commit such extreme violations in order to appear powerful and unhesitant. The mere threat of rape also has effects on the psychological endurance of the victim; it is considered to be the supreme means of compulsion. The abused persons are characterized as being fragile.

The abuses can be categorized as follows:

a. Direct torture of the urinary and genital systems.
b. Torture in connection with rape.
c. Threat of rape.

The victims must be treated with extreme care because there are due to the special psychological sequelae are particular difficulties in the treatment approach.

A discussion of atypical psychological phenomena after trauma
Pakize Cevatgül Geyran, MD, Bakırköy State Mental Hospital, Istanbul, Turkey Şahika Yuksel, Professor, Department of Psychiatry, University of Istanbul, Turkey.

Various psychological disorders were identified after trauma. While some of them could be classified as anxiety disorder, particularly under the heading of PTSD in the DSM-III-R classification, there was difficulty in classifying others, and in making a differentiation between psychosis and neurosis.

There is little in the literature that indicates the difficulties in the diagnosis and treatment of these phenomena with apparent psychotic properties. Our work discusses the symptomatology, prognosis, and treatment of the phenomena that were difficult to diagnose, comparing and contrasting similar cases.

Failure or success of subconscious defense mechanisms
Marie-Hélène Beauloin, Psychotherapist, AVRE, Paris, France.

The torture victims we treat owe their survival to various factors: First, chance, which in spite of everything has placed them on the survivors side. Second, the stage of life (age, physical condition, emotional situation, militant involvement, etc.) at the time when such a major breaking-in of their being takes place, which determines the strength or weakness of their identity at that moment. Third, their former personality structure, as well as the more or less efficient way in which the subconscious defense mechanisms will re-develop in a borderline situation.

The presentation will focus on one point which should encourage clinical exchange: which situations most favour activation of subconscious survival mechanisms? What is the weight conveyed by situations such as: solitary confinement, multiple transfers, group links, threats against relatives, mock executions, transgression of taboos?—(non exhaustive list). And of course the impact of pain and physical oppression whenever they occur. As we shall see, certain situations may at times prove destructive or reconstructive.

Cognitive behaviour treatment strategy for Post Traumatic Stress Disorder

During the last few years, new developments
in the theory of learning came up with a useful heuristic model which can be applied in cognitive behavioural therapy. The model proved of practical use in the diagnostic process and treatment of trauma-related disorders.

The model proceeds from a cognitive view of classical conditioning. Central to it are meaningful associations between situations. The referential situation in particular evokes the memory of another. The latter situation is emotionally loaded (cognitive representation). Part of the practical application is a search schedule, to be used in the diagnostic and therapeutic process.

This search schedule is used together with psychiatric diagnostic tools (e.g., DSM-III-R). Patients with PTSD frequently have a diagnosis of co-morbidity (e.g., PTSD + Mood disorder, or PTSD + Panic disorder). A model for dealing with the diagnostic process will be presented.

Psychiatric symptoms of tortured persons

This presentation emphasizes the utility on the practical clinical use regarding assessment and diagnosis.

Psychiatric symptoms in tortured persons

Süle Daruwa, BSc, & Emin Önder, MD, Ankara Treatment Center, Ankara, Turkey.

The Human Rights Foundation of Turkey (HRFT) aims in this study to examine the psychiatric symptoms of the people who have alleged being tortured and have applied to the Ankara Treatment Center.

The study group comprised the first 50 subjects who applied to the Ankara Treatment Center between September 1991 and September 1992 because of physical complaints. 50 subjects who had not been tortured or imprisoned served as controls. The two groups were approximately equal with respect to age and sex. SCL-90 (Derogatis Symptom Check List) was used to score their symptoms, which were then assessed. The scores were analysed by means of a t-test, and the results were discussed in the light of the literature on this subject.

Psychological effects of torture: a comparison of torture with non-tortured


Turkish political activists who had been tortured (n=55) were compared with a closely matched group of activists who had not been tortured (n=55), using semi-structured instruments based on the DSM-III-R. The two groups of activists were similar with respect to age, sex, marital and socioeconomic status, political ideology, political involvement, non-torture stressful life events, and other features.

Torture survivors reported an average of 291 exposures to a mean of 25 forms of torture during 47 months of imprisonment. Compared with the controls, torture survivors had significantly more Post Traumatic Stress Disorder (PTSD) and anxiety/depression. PTSD symptoms were only moderately severe, and mood was normal. Despite the severity of their torture experience, the torture survivors had only a moderate level of psychopathology.

A controlled study on chronic PTSD in political torture survivors


The major aim of this study was to identify some of the factors that predict torture-related PTSD. It was hypothesized that PTSD would be more commonly encountered in torture survivors than controls and that torture survivors would be more depressed and anxious than controls. A series of factors expected to predict PTSD were also stated. The subject sample consisted of 55 tortured political ex-detainees/prisoners and 55 non-tortured political controls matched for age, sex, and educational level. Socio-demographic characteristics of the two groups were very similar. The two groups differed only in the diagnosis of PTSD among all DSM-III-R diagnoses. Although the tortured group scored higher on most of the depression and anxiety scales, all scores were within the normal range. A higher degree of perceived severity of torture, lower social/emotional support, more impact of other traumatic events, more intense torture, and higher political involvement were predictors of PTSD. The results show that:

1. torture has some psychological effects independent of the other forms of political repression and organized violence,
2. the impact of other traumatic experiences, cross-cultural differences, value differences, subjective meaning of the trauma, individual differences, and personality characteristics should be taken into account in order to develop a more holistic approach for understanding/explaining/treating (post-torture) traumatic stress, and
3. social/emotional support is the most important factor in preventing traumatic stress.

Revising the traumatic event-experience of the incident

Polly Taiskoll, MD, & Georgia Sotropouleou, Psychologist, Medical Rehabilitation Center for Torture Victims, Athens, Greece.

We depict the psychiatric-psychological side of the tasks performed by the Medical Center, as well as the events that have occurred and the difficulties that were confronted. We also present certain queries concerning the therapeutic target that we pursue, and the methods for its fulfillment, together with the interrelations of the above queries to the corresponding ones in the field of psycho-pathology and the trends of modern psycho-therapy.

Reference is made to the ethical problems that are created when medical science extends to the whole range of human activities (biological and social), trying to give answers without losing its objectivity. At the same time, an effort is made not to lose its subjective therapeutic goal, as well as the necessary enthusiasm of today's Asclepiades, so that common efforts such as these of our centre will flourish.

We also comment on particular situations that arise when a victim re-lives the torture event, and the various difficulties that result according to whether the event is expressed verbally or non-verbally. This revival of an event may become an obstacle to the formation of a stable therapeutic relationship with the survivor, or it may create strong negative factors in the treatment, not only for the follow-up of the therapy itself, but even for the continuation of any systematic effort by the survivor to lighten the dark background of his/her life.

Finally, concerning the therapeutic goal, our tasks merge with the deontological problems of our intervention, as they are put forth by the social, medical, and humanitarian reality of our times.

Psychosocial and clinical consequences of political repression and impunity

Dario Lagos, MD, EATIP, [Equipo Argentino de Trabajo e Investigación Psicosocial], Buenos Aires, Argentina.

In this presentation we analyse:

1. the consequences of the regime of State terrorism in Argentina from 1976 to 1983 and
2. the effects of the impunity sanctioned by the constitutional governments that followed, taking up 2 aspects:
   a. psychosocial consequences on the community as a whole
   b. psychological effects on the victims and their families, with special reference to the difficulties in describing the traumatic situation and the psychological effects on the second generation.

Monitoring health and rehabilitation of torture survivors

Marianne Juhr, MD, MDS, Science Research Consultant, RCT [Rehabilitation and Research Centre for Torture Victims], Copenhagen, Denmark.

Treatment of individual cases victimized by torture has become systematically established in many parts of the world. The work has produced an increasing recognition of torture as a societal problem nationally and internationally. Thus, a system for stringent registration of torture, its effects and their treatment, is needed. In order to be widely applicable, the system should feature exhaustive classification of torture methods (physical and psychological); and of symptoms/objective findings after torture. RCT in Copenhagen, Denmark, has developed a monitoring system based on ICD trauma classification and DSM-III-R posttraumatic stress classification.

The system is designed to record and compare effect of treatment/treatments, to allow international/institutional exchange, and to aid management. Priority in decisions on resource allocation. By facilitating international antitorure collaboration, it could also be an important part of preventive work against torture.

The book is now available from IRT (please see page 34).

Proposal for evaluation of rehabilitation of torture survivors

James M. Jarusson, MD, MA, MPH, Director, Center for Victims of Torture, Minneapolis, Minnesota, USA.

The Center for Victims of Torture, established in Minneapolis in 1983, was the first comprehensive treatment centre for torture victims in the United States. Since then, several hundred torture survivors and their family members have received the multidisciplinary services of psychiatry, primary medical care, psychology, social services, and legal assistance in seeking asylum.

While accumulating a significant client base and body of experience, the Center has had to rely...
on case-by-case clinical judgments to evaluate the effectiveness of treatment. In an attempt to develop a more systematic assessment of which treatment strategies have been most helpful, the center is proposing to evaluate the impact of the first five years of experience. The proposal also establishes the basis for defining the first multi-cultural/multi-centre evaluation of treatment strategies used to assist torture survivors.

The goals of this research are to establish the effectiveness of all individuals who have suffered torture, to establish common descriptive client information systems and treatment evaluation measures across centres, and to estimate the relative effectiveness of treatment strategies. The results of this evaluation research will assist providers in developing treatment approaches for individual patients and, with systematic multinational data, place treatment centres in a better position to advocate additional funding by government agencies.

Torture prevention and cultural context

Evgueni Guentchev, MD, National Neuroscience and Behaviour Research Programme, Sofia, Bulgaria

Why is torture more common nowadays in other parts of the world than in Western civilisations? There are many viewpoints to this problem, and one is the particular cultural context. Cultures in which the individuals are very much concerned with social power, perceiving physical punishment as a normal and necessary instrument of society, are torture-promoting cultures. A very important factor is the ability to put yourself in the position of the other (role-reversal ability) or the rigidity/ flexibility of your own role-set. In a study of post-traumatic stress disorder in victims of organized violence in Bulgaria (Tornov T, Guentchev E 1991), we discovered that social power was by far the most dominant dimension in human relations with which the political survivors in our cohort tended to be concerned. The roles of the victim and the perpetrator were rigidly defined, and no psychological role-reversal was possible. These traits seem to be characteristic of Bulgarian culture when organized violence was widely applied.

Prevention of torture should be seen in the broader perspective of prevention of culturally accepted violence or promotion of non-violent behaviour. A psychosocial approach is needed to elaborate a torture prevention strategy.

A new centre in Stockholm for torture survivors

Sten W. Jakobsson, MD, PhD, Centre for Torture Survivors (CTD), Karolinska Hospital, Stockholm, Sweden

Torture and persecution have accompanied humanity throughout history until the present time. As a reaction to atrocities experienced by millions of people during the Second World War, the United Nations adopted a general Declaration of Human Rights in 1948: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment". Torture and comparable degrading treatment generally causes grave physical and mental suffering. Everything points to improved chances for helping torture survivors to return to a normal existence when a proper diagnosis is made and early treatment started. The road back may start when the experience of the torture and the reality of the violence are understood as parts of a specific context. CTD addresses persons who are seeking political asylum and refugees who have experienced traumatic events such as torture and other forms of violence, persecution, and acts of war.

A comprehensive appraisal of torture injuries is important, not only for the individual. An accurate account of injurious effects complicates the denial of violence and counteracts the powerlessness that stems from ignorance. It is consequently important that we document and convey our experiences.

Rehabilitation activities in South Africa

Thabo E. Ramagala, MD, South Africa Health and Social Service Organization (SAHSSO), Johannesburg, South Africa

The South Africa Health and Social Service Organization (SAHSSO) has set up Emergency Services Groups (ESGs) to cooperate with various psychological service groups in training community members to cope with victims of physical and psychological torture.

A state pathologist, Dr J. Glickmann, dismissed in July 1992 that 70% of the postmortems he had carried out on detainees and prisoners during his professional lifetime had died as a result of torture by the police.

An important step towards rationalizing and aiding the anti-torture work took place in September 1992, when 11 organizations set up a working committee whose aim is to establish a Human Rights Foundation along the lines of such foundations in other countries.

Torture is rampant in South Africa. President F.W. de Klerk is bent on giving impunity and blanket amnesty to the perpetrators of torture, political violence, and genocide. SAHSSO intends to combat racism in health and sociopolitical welfare and ensure fairness and real democracy in South Africa.

Different dimensions of the work done in Pakistan

Mahboob Mehid, BSc., Medical Director, Rehabilitation and Health Aid Centre for Torture Victims (RAHAT) & Voice Against Torture (VAT), Islamabad, Pakistan

The different methods of torture used in Pakistan are mostly the same as those that have been standardized for use in other torture-practising countries.

In Pakistan, unfortunately, health professionals participate at very many levels in procedures of torture and cruel punishment. However, there is one example of the prevention of cruel punishment by doctors - their refusal to amputate limbs on the orders of the court.

Our analysis shows that the most important purpose of torture on an individual level is to destroy the personality of the individual, while on the societal level it is to inculcate a climate of generalized fear in the population.

VAT is an interdisciplinary organization for those returning from lengthy exile in forced labour camps, those forcefully detained in mental institutions because of their political views, those who are still in the former Soviet Army on Latvian territory and whose abuse continues, plus victims of the earlier Stalinist regime.

It is difficult to establish the number of victims who have significant post-traumatic stress symptoms. People are still afraid to talk and it is difficult to break the silence. And then there are the co-victims, family members of victims of torture who themselves often develop significant symptoms that are in need of attention.

On a small but significant scale, rehabilitation efforts have already been undertaken by such organizations as the Latvian Women's League and by dedicated physicians such as Dr. Volk sone. Dr. Volkstone organized hospitalization, treatment, and rehabilitation for OMOM victims, especially following the January 1991 OMOM attack in Riga. She has also collaborated in the past with the Latvian Women's League to help Latvian conscripts and deserters from the Soviet Army, especially in the late 1980s. She and Dr. Kirsentals are planning to provide a more organized administrative structure to expand the rehabilitation activity so that more victims of torture and abuse can receive the care they need.

Human rights abuses in Turkey

Ata Seyer, MD, Turkish Medical Association, Ankara, Turkey

Human rights abuses in Turkey, which intensified following the 1980 military coup, have continued in varying degrees. One sector which particularly confronts these abuses is the medical profession. Medical doctors and human rights abuses are therefore the main concern of the Turkish Medical Association. Since 1980-1984, during which period the Turkish Medical Associ-
development this paper around the description of the very reality we are confronting. First of all, we tried to evaluate what was written based on the following empirical criteria: 1. Recommendation for psychiatric examination. 2. General report of psychological problems. 3. Description of mental symptoms such as insomnia, frequent nightmares, memory disorder, short concentration span, hyperactivity, aggressive behaviour. 4. Description of physical disorders of probable psychogenic origin, such as intense headache, dizziness, urinary frequency, reports of pain that is uncontrollable by ordinary pain-killers and without organic basis. 5. Description of methods of torture that presumably caused brain damage or psychiatric syndromes (non-systematic beatings, blows to the head, electric torture to the head, sleep deprivation, induced asphyxiation, sexual or psychological torture, torture through sensory deprivation, the use of psychotropic drugs, neuromuscular inhibitors, or fever-inducing substances, not to mention all the rest). 6. Reported loss of consciousness subsequent to blows to the head.

We wish to expand on the last two criteria. All doctors in all specializations recognize that it is needless to look for that proportionate relationship of clinical syndrome to causal event. Even in branches of medicine such as orthopedics, traumatology, and infectious disease pathology, there is held in store a significant element of complex unforeseen factors for consideration. Of course, some causal relationship between pathogenic factors and manifest symptoms must always be investigated, but the above syllogism cannot be an excuse used by medicine in a formalistic way, particularly in our time, when the professed holistic trend of the bio-psycho-social model for illness is continually gaining ground.

Teaching of medical ethics and human rights in medical education
Katrine Sidenius, MD, Danish Medical Association (DMA), Copenhagen, Denmark.
Member countries of the United Nations have a special obligation to provide formalized education of doctors who are in particular danger of violating their ethical obligations because of their professional functions.

The DMA has taken initiatives regarding training of doctors with specific contractual engagements: “doctors at risk”. These are typically doctors who are sent to developing countries, military doctors, and prison doctors.

Education of doctors working in developing countries and paid by the Danish State: In cooperation with the Danish Foreign Ministry, DMA has developed a programme for education of Danish doctors on medico-ethical rules, principles of human rights, as well as torture and the consequences of torture. Danish doctors and other health professionals are not sent to developing countries without training in these matters prior to their departure.

Education of military doctors: The DMA and the Danish Ministry of Defence agreed to introduce formalized education in medical ethics and human rights over two and a half days from August 1991 for all doctors who are drafted for military service.

Education of prison doctors: The DMA is cooperating at present with the legal authorities in Denmark on the establishment of formalized education in medical ethics and human rights for doctors working in Danish prisons.

It is hoped that such education of all prison doctors will be realized during the course of 1993.

Providing medical care in conformity with Human Rights
Jilali Najib, MD, Assistant Professor, Casablanca University of Medicine, Member of the Moroccan Human Rights Association, Casablanca, Morocco.
Justified by certain complex and tragic events, our study was carried out on a sample of 100 students in their 6th year of medical studies. The survey consisted of questions about their opinions and knowledge. The questions were divided into three groups: the right to medical care, the rights of health professionals, and the rights of patients. The subsequent analysis allowed us to draw two conclusions. First, the students’ ignorance of medical ethics and human rights texts. Second, their spontaneous readiness to promote the right to “a better state of health”.

The bibliographic part concerns medical ethics and human rights texts of universal, regional, or national character.

The ideal goal is to treat “in conformity with human rights”, which necessarily implies promotion of teaching of medical ethics and a more human approach in all actions connected with health and welfare services.

Neurophysiological examination
E. Zeografos, MD, & Maria Pintou-Kalli, MD, Medical Rehabilitation Center for Torture Victims, Athens, Greece.
Can a neurophysiological examination become the means to complete the diagnosis of injuries in victims of torture?

We present for the first time, as far as we know, use of a neurophysiological examination, complete or partial, to ascertain and verify the extent of injury in humans.

Individuals who had been tortured in ex-Yugoslavia (mainly from Kosovo) came to Switzerland in mid-1991 and were given temporary work. Because they sought political asylum, they were examined in the neurophysiology department, where one of us (EZ) was working. We have also examined two torture victims who have lived in Greece for the last two years. The results and conclusions of these examinations will be presented.

With the use of neurophysiological examinations, we possess a powerful diagnostic method which will help in the specification or exclusion of various injuries resulting from torture.

Psychological approach to torture survivors in Greece
Polka Tiskolla, Psychiatrist, Medical Rehabilitation Center for Torture Victims, Athens, Greece, et al.
Our centre in Athens has helped approximately 100 individuals who were tortured in their own countries and then fled to Greece.

We must be very specific in psychiatry – and even more so when dealing with victims of torture. Despite the fact that it is unavoidable at sea in the chaos of fragmentary experience and journalistic coverage, the following paper has that aim. We presume that the most expedient way through the incoherent problems presented is to
Systematic sexual abuse in former Yugoslavia

Sexual abuse of women in Bosnia-Herzegovina has been widespread and sometimes systematic to such a degree that thousands of women have been raped. It seems to fit into the pattern of ethnic repression which has tragically characterized the Yugoslav civil war.

Amnesty International (AI) has documented cases in which women had been raped in houses by soldiers from the town or passing through, as well as in detention centres and during detention in hotels and other buildings.

Forces from all sides in the conflict have become rapists, and women from all backgrounds have been victims, although Muslim women have been the chief victims, at the hands of Serbian armed forces, AI said in the most recent report of January 1993.

In one such case, a 17-year-old Muslim girl told a doctor that Serbs took her and other women from her village to huts in nearby woods. She was held there for three months along with 23 other women — although she believes she saw about 100 women in total being unloaded. She was among 12 women who were raped repeatedly in the hut in front of the other women — when the women tried to defend her, they were beaten by the soldiers.

While it is open to question whether rape has been explicitly selected by military leaders as a weapon of war, it is clear that local officers must have known about the abuses — and condoned them. And that level of indifference is all too blatant across a frightening range of human rights abuses in Bosnia-Herzegovina, particularly as rape and other abuses can amount to a grave breach of the Geneva Conventions of 1949.

Amnesty International emphasizes, however, the extreme difficulty in assessing the full extent of the sexual abuses to which women in Bosnia-Herzegovina have been subjected. These include the shame and social stigma which discourage many women from speaking of the abuses they have suffered (please also see page 56-57). In addition, the administrative chaos that has accompanied armed conflicts in Bosnia-Herzegovina has rendered almost impossible the systematic collection of data, other than in a few centres. The temporary nature of some of the places used for detaining women has also made it difficult for international bodies seeking to monitor them.

Further, the issue of the rape of women (and of other atrocities committed in the conflict) has been widely used as a propaganda weapon, with all sides minimizing or denying the abuses committed by their own forces and maximizing those of their opponents. Amnesty International considers, therefore, that at present all estimates as to the number of women who have suffered rape or sexual abuse must be treated with caution.

In another document by Amnesty International, the organization reveals an insider's view of atrocities which happened in one town in Bosnia-Herzegovina between April and November 1992. The daily diary of intimidations, woundings, imprisonments, arrests, and killings is made more compelling still by the realization that these horrors were occurring even as the world was scrutinizing — and fiercely condemning — such violations, under the spotlight of the media.

The atrocities are illustrated in a diary written by a Muslim man in the town of Bosanski Petrovac; it documents the descent of the town from tension to terror. From initial reports of Muslims losing their jobs, the situation in the town deteriorated and the document relates how Serbian soldiers began firing into Muslim homes, how men were imprisoned, homes burned, civilians killed, and eventually thousands were left with no option but to flee, fearing for their lives.

The diary's writer describes the fear in which the Muslims lived, "The coming night is uncertain", he wrote; "one awaits it with fear and trepidation. The Muslims are utterly terrified, conscious that they are surrounded and left to the mercy of those whom no one can pacify... The time is ideal for murder, plunder, ill-treatment, rape, and arson".

All this was going on even as the world was first learning of violations elsewhere in Bosnia-Herzegovina. "People in countries around the world were being sickened by the horrors of detention camps in Bosnia-Herzegovina, but the armed forces themselves continued to violate human rights", said Amnesty International.

But while the forces and their leaders may seem not to care, hundreds of thousands of other people from around the world care passionately. When Amnesty International asked people to write in protesting about the violations in the former Yugoslavia, they did so in massive numbers — almost half a million, from scores of different countries and every region of the world.
The 1991-1992 aggression on Croatia was specific for various facets of brutality, which included maltreatment of civilians and prisoners-of-war. We had the opportunity of examining numerous prisoners-of-war immediately after their release from Serbian concentration camps. The present study of changes in their EEG is evidence of the conduct of their guards: the method reveals unique pathological features.

The subjects of this study were prisoners released from Serbian concentration camps. They were captured in the second half of 1991 during the war in Croatia.

Approximately 2000 released prisoners had arrived in Zagreb up to 20 May 1991. Every tenth was hospitalized because of impaired health. During a general medical examination, a neurological examination was indicated in many of them. This was indicated in those ex-prisoners who had received a blow on the head or neck during physical maltreatment in the camps, or in those with suspected neurological impairment. 107 of them were examined in our department.

Of those examined in the Neurological Department, 94 with a history of blows to the head and neck were further examined between 12 December 1991 and 20 May 1992. Their median age was 33.7 years (range 18-67). More than three-quarters were within the age range 20-26 years.

The average length of stay in the concentration camps was 88.2 days, ranging from 24 days (a prisoner from Sremska Mitrovica) to 179 days (a prisoner from Stara Gradiška). Men captured in eastern Croatia were put in camps at Stajičević, Begejcji, Sremska Mitrovica, Niš, and Belgrade; those captured in central and southern Croatia were put in camps in Stara Gradiška, Vojnić, Glika, and Knin.

All the subjects were male. Two-thirds were civilians and one-third Croatian National Guard forces. The examinations were carried out on average three days after release.

Various torture methods

According to the evidence of the prisoners, the maltreatment included being forced to stay in an unnatural position for several hours with rigorous punishment for every movement, staring at an intense light source for hours, subjection to hours of intense noise, electric shocks by the use of radio set wires attached to the fingers and toes, denial of liquid and food for several days, denial of rest and sleep during the night and day, hard physical work, and various forms of physical maltreatment.

An EEG was performed in each released prisoner with standard provocation by photoaudio stimulation and hyperventilation immediately on admission. The following EEG findings were considered pathological: slow cerebral activity in q (5-7 Hz) and d (0.5-4 Hz) spectra, the occurrence of spike, high voltage sharp wave and spike-slow wave complex.

Isolated occurrence of certain other characteristics in the EEG, such as microvoltage basic electrocortical activity, significant participation of moderately fast and fast b activity in the basic rhythm (25%) with poor or no blocking of the basic activity by psychosensory attention (eye-opening) was not considered pathological but was separately examined and discussed.

Psychological testing

Psychological testing was performed in every prisoner who had lost consciousness for any reason during his stay in the camp, or if he complained of impaired memory or concentration. The following tests were applied: Fechinger's memory scale, verbal fluency test, Benton's visual retention test (from D), Lütscher colour test. The Bender-Gestalt test was applied in some prisoners, as well as an examination of simple psychomotor reactions to sound and light.

A method of rank correlation coefficient was used in the statistical analysis of data, and the results were considered significant when the validity of the correlation coefficient was at the level of 0.05 or lower.

Pathological changes in the EEG

Of the 94 examined subjects, 34 had pathological changes in the EEG (36.2%). These changes were diffuse in 24 cases and focal in 10. With regard to the location of the focal changes, 8 were in the occipitotemporoparietal region and two frontotemporal. Specific graphoelements, such as spike-slow wave complexes, were not found.

Photo-stimulation elicited pathological changes in the EEG in three cases (spike, located occipitotemporoparietal without asymmetry).

Hyperventilation elicited 8 pathological changes in the EEG which consisted of diffuse θ activity, and two pathological changes of frontal high sharp waves, located unilaterally.

Regardless of the reported number of blows received on the head and neck, the percentage of pathological EEG findings was similar in all subjects, and ranged from 32-40% (Table I, page 55).

Pathological EEG findings were found in 59.1% of prisoners who had lost consciousness during the blows, and the number increased significantly with the increase in the number of reported unconscious states (Table II).

As the interval from the last blow to the head and neck increased, so did the number of pathological changes. This correlation was statistically significant (Table III).
The frequency of the EEG changes increased also with the length of stay in the camp (Table IV). Only 3.2% of the prisoners with pathological changes in the EEG reported having craniocerebral injury prior to physical maltreatment in the camps. The pathological changes in the EEG of the released prisoners did not show significant dependence on craniocerebral trauma prior to capture.

The EEG changes did not differ significantly between subjects from the different camps (Table V). However, according to the evidence of the released prisoners, it seems that the camp authorities exchanged or released only those prisoners in a better state of health, and that severely injured prisoners were held, or even killed in some cases, in order to avoid the state of health being used as evidence of the maltreatment. This was particularly the case in the camps at Stajicevo and Begejci.

Apart from the pathological changes in the EEG, changes were found in several cases which were not considered pathological. Low voltage basic cerebrac activity was found in 42 (45%) subjects (amplitude less than 15 mV) while in 39 (41.5%) more than 1/4 moderately fast, and fast β activity was present in the basic rhythm, and in 48 (51.1%) poor or no blocking of the basic rhythm was found by psychosensory attention (eye opening).

Psychological examination was carried out in 26 of the 94 prisoners (all the prisoners who had lost consciousness during imprisonment in the camp, or who complained of loss of memory or concentration). Changes indicating organic damage were found in 65%. Elements which indicated the existence of posttrauma stress impairment were found in 19 (73.1%) of these 26 prisoners. Only two of the 26 were able to concentrate satisfactorily.

Not allowed to move

According to the reports of the released prisoners, it can be concluded that the blows on the head and neck were carried out with police truncheons, hard objects such as electric cables (metal wires in a plastic sheath), wooden handles, etc., and with the open and closed hand and the feet, and occasionally by beating the head of the prisoner on a hard surface, particularly a wall. The prisoners were made to assume a forced body position from which they were not allowed to move (under the threat of more beating). Such positions usually entailed kneeling on a raised surface or standing with the head bent down and the hands behind the back. The cervico-occipito-parietal region was the most frequently beaten, and when the guard used his hands or feet, the face and temple region. Loss of consciousness occurred most frequently when the blows were unexpected and in the cervico-occipital region (19 of 32 cases).

Consciousness was also lost following blows to other parts of the head and when the prisoner was physically exhausted. Consciousness was lost in 4 of the 5 prisoners whose occipital head region was beaten against a wall.

From talks with released prisoners, it can be also be concluded that the blows were particularly vicious and connected with fearfulness; following electric shocks the blows to the neck and upper part of the thorax were relatively slight.

Although the clinical presumption was that the pathological changes in the EEG would be more frequent in prisoners with a greater number of craniocerebral traumas (blows to the head and neck), the results failed to confirm this. Thus, because the number of pathological EEG changes in the prisoners who had lost consciousness was statistically significant, it can be concluded that these changes are more likely to be a reflection of the severity of the craniocerebral injuries rather than their number.

It was also predicted that the number of pathological EEG changes would decrease with increasing lapse of time between the last blow on the head and neck and the EEG recording. However, the results did not confirm this.

In conclusion, the length of stay in the camps, and therefore of maltreatment, had the greatest influence on the EEG changes, indicating that factors other than the craniocerebral injuries were contributing to the pathological changes in the EEG. In this connection, the forced hyperextension of the head and neck as part of the maltreatment could be mentioned.

Acknowledgements

I would like to thank Professor Matko Marusic, Professor Anja Marusic, and my colleagues at the Institute for Medical Research and Occupational Health for their help in this study. I thank particularly Mrs. Joyce Cicin-Sain for her help in the preparation of the English text.

References

A seminar in Nepal

At a request from CVICT [Centre for Victims of Torture], Nepal, a seminar on general health perspectives of torture, addressed to local doctors, was held in Kathmandu 21-23 August 1992. The subjects were normally used methods of torture, health sequel of torture, assessment of health, declarations relevant to medical ethics, the attitude of doctors to these declarations, medical documentation of torture, and forensic medical aspects of torture.

69 Nepalese doctors participated in the seminar, coming from almost all districts of the country and representing nearly 7 per cent of the total number of medical doctors in Nepal.

The teachers were Dr. Bhogendra Sharma of CVICT, Professor Derrick Pounder; head of the Institute of Forensic Medicine, University of Dundee, and a member of Physicians for Human Rights, Allan Dorfelt, Morten Ekstrom, Hans Draminsky Petersen, and Ole Vedel Rasmussen of Physicians for Human Rights in Denmark (PHR/DK).

The seminar was sponsored by Danish through the Danish Embassy in Kathmandu. Dr. Sharma described the present conditions in Nepal, including the needs for treatment and rehabilitation; his paper was followed by those of the European doctors. Between the sessions there were a number of "private" contacts, and in this way we were informed that a Nepalese participant had made an investigation among police officers, asking them a series of questions. It appears that nearly all the officers complied with the examination and admitted that torture was commonly used in Nepal. The results were extremely interesting, but because the examined group of officers was rather small, we suggested that the material should be extended somewhat before attempting to publish.

It was suggested that a reporting system should be set up in Nepal, and one of the Nepalese doctors was willing to carry out some in depth examination of persons reported to have been subjected to torture.

The Nepalese participants expressed the need for further training, first of all in forensic medicine. Derrick Pounder offered to organize such a seminar in...
Prejudice expected
The sequelae of sexual abuse against women reach far beyond the actual abuse.

By Lizet Jørgensen, MD*

Most women think that rape is the worst possible abuse they could experience. This is compounded by the belief that even other women are influenced by the supremacy of the male and will join in the condemnation of a woman who has been exposed to sexual abuse.

In the Islamic world, for instance, a woman is considered a prostitute if she has had sexual contact with men other than her husband, and any man is then allowed to approach her sexually. It is among the rights of the husband to reject his wife if he learns that she has been abused sexually by her torturers during imprisonment. It doesn’t matter that the woman was not able to defend herself against her torturers. Rape is the greatest humiliation she can experience as a person, and the most serious threat to her personal integrity.

Throughout history, sexual abuse or the threat of it has been used to oppress women. In all violent or armed conflicts, women’s sexuality has been used by men as a weapon to suppress women. According to Jean Shinoba Bolen’s book *Godesses in everywoman*, man took on the power to misuse woman sexually at the same time as religion changed from worship of Mother Earth as the highest Goddess to worship of a male God, i.e. the shift from a matriarchal to today’s patriarchal culture. All the many qualities of the Mother Goddess were divided among a legion of goddesses, each of whom received only a small part of the power of the Mother Goddess, while the male god was given ultimate authority and in this way would always win over the woman. At the same time the reproductive ability of the woman became the property of the man, and in the course of time many large and small struggles have been fought to defend this.

Even today in the western hemisphere, we still witness the fight over the control of woman’s fertility, but not so in the Third World. There it is the man who owns the women from cradle to grave.

cooperation with Jørgen Lange Thomsen of PHR/DK.

During talks on the many (hitherto 65,000) refugees from Bhutan living in camps in Eastern Nepal, it was decided to try to establish an investigation consisting of two phases partly carried out by Nepalese and partly by members of PHR/DK and PHR/UK. The aim is to clarify how many of the inhabitants of the camps had been exposed to torture and other organized violence.

Following the seminar, Sharma, Ekstrom, Dorfert, and Draminsky Petersen went to these camps to get a direct impression of the possibilities of carrying out such an investigation. The conclusion of the visit was that CVICT, PHR/UK, and PHR/DK should continue preparations for this work. A draft proposal for this investigation is available on request.

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work only with female psychotherapists and interpreters.

We see the same pattern of symptoms during psychotherapy as in western European victims of rape and incest. The feeling of having to keep the abuses secret, of not being understood or taken seriously, and the fear of being told that they themselves were partly to blame for what happened, are the first barriers to overcome.

Methods of rape
Apart from "normal" sexual intercourse with one of the prison staff, sexual abuse can be carried out in other ways, for example by dogs specially trained to copulate with women, small creatures (spiders, mice) inserted into the vagina, or by various instruments more or less in the shape of a penis (e.g. truncheons or bottles).

The abusers can also use electrical apparatus (see next page). Here the woman is humiliated in various ways. She is naked, tied down, blindfold, exposed to the eyes of several torturers and to their comments. Furthermore, she has to put up with the pain caused by the electric probe inserted into her vagina. This method causes very painful spasms, not only in the sexual organs, but in the whole body. The torturer in the background of the picture controls the strength of the electric current, while the man in white seated at the victim’s head is probably a doctor, seeing to it that she does not die, as the torturers do not want the victim to die. Their aim is rather to give her a psychological trauma which she will carry as a dreadful secret for the rest of her life.

Sexual torture is thus a life sentence.

The anger is turned inwards
Psychotherapists at RCT share the impression that the vast majority of the women under treatment at RCT have been victims of sexual abuse in prison. Discussion of the subject is taboo, extremely sensitive, and therefore seldom raised by the victims themselves. Consequently, it takes a long time to approach it, and it is for the therapist to judge when the woman is ready to face talking about this form of torture.

All over the world women have been brought up to turn their feelings inwards to avoid an accusation of being hysterical. So these abused women hide all their anger, powerlessness, sadness, fear, and bitterness, while they pretend to be able to cope with everyday life as normally as possible. They confide in no one, everyone shuns them, and their feelings about these abuses are thus encapsulated; they try by all means to forget or deny this part of their torture.

In an attempt to help these women to overcome their of condemnation, (also by the therapists at RCT), all of them

“It is visible to all”
From our experience with physiotherapy, we know that women who have survived sexual torture complain of special pains and muscular tensions in the lower back and in both thighs. Therefore, before the topic is mentioned, her psychotherapist will suspect sexual abuse. The women have been told that the sexual torture make it im-

continued from page 55.
possible for them to have healthy children, or even to become pregnant. Therefore, the very first step at RCT is to have the tortured women examined by a female gynaecologist in order to refute the above threats of the torturers and to assure the women that they can function normally, and that there is nothing to prevent them from having healthy children. Their symptoms correspond to those of victims of rape and incest who live in a Christian culture. The most important symptoms for the therapist to deal with are the woman’s shame of what has happened, together with the cultural taboo, the feeling that the shame is visible to everyone, the disgust with sexual contact, also with her husband, the fear of being impregnated during the rape, and a feeling of being unclean, contaminated, of having broken one of the basic Islamic rules so totally that she will never be forgiven.

As with all religions, the rules of Islam are interpreted differently in different countries. One woman said that in her country a victim of rape would not see the face of Muhammad on the last day. The meaning was that she would never enter Paradise, but would be condemned to the flames of Hell for eternity.

Helping to regain self-respect
At RCT psychotherapy focuses on helping the victim to understand that she is not to blame for what happened, that there is absolutely no excuse for torture and the trespassing of her natural private limits so grossly, as she experienced during sexual torture. Her feelings are natural and understandable. Any woman exposed to sexual abuse has the same feelings, and there is no reason to feel shame. Everything she says will remain a secret between her and the therapist. Nobody can come and ask for information, not even her husband. These women’s torturers have often told them that nobody will believe them if they recount their abuses from prison. The immediate reaction of the victim is therefore that the therapist not will believe her either.

The starting point for the therapist is always to believe what a client says. Why should she lie? What could she gain by lying? What she recounts is what happened to her in prison, and that is the focus of basic importance during the treatment of her traumas.

The aim of the treatment is to help the woman accept her own feelings as normal, that it is natural to turn them outwards against the torturers where they belong, and not inwards towards herself as anger, hatred, and depression. She was in a situation where there was no choice and therefore she cannot be responsible for what happened. Nobody at RCT would dream of condemning her. We know that sexual abuse takes place and we are here to help her as much as possible to overcome the after-effects.

As Christian psychotherapists we can only use ourselves and our view of life, based on mercy and forgiveness, as models in treatment. We do not see God as one who punishes or takes revenge, but as one who loves us and forgives us without limits. This is the attitude the torture survivor will meet in her new country. Our respect for her as a human being and woman is unchanged despite what happened, and to be a refugee in a Christian country is therefore also a chance for her to build a new life.

Normal reactions
The therapist should be prepared, for different reactions among their women clients, including obstinate denial, violent crying, or expressions of anger against the torturers, acute depression, sometimes thoughts of suicide, or various degrees of apparent apathy. All these reactions serve to hide the chaotic state of the women’s feelings. Their reactions may be so violent that they require admission to hospital to protect the woman against the inner chaos which has been opened up. At RCT, we always choose admission to a non-psychiatric ward. We consider these women’s reactions as normal, the result of an extremely abnormal situation, and therefore we do not want to label the client as a psychiatric case. We must also stress that admission to hospital has been necessary only very rarely.

Professional tact
At RCT, sexual problems are mainly problems of women from Third World cultures. But even there, among themselves, they are difficult to talk about — in some countries impossible. And torture victims have already mental blocks about their experiences in prison. Extreme tact is required from the therapists when they start to work on sexual torture. Furthermore, an extremely professional attitude is required so that the therapist does not become carried away by the atrocities she hears. No woman can avoid being affected by such stories from a sister. The reward for having dared to deal with the problem is the joy of seeing the victim blossom and to feel her extreme relief in finding another human being who will listen to her and believe her, and who is prepared to share her feelings with her.

References

Also recommended

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Watercolour by Latin American artist.
Visits to prisoners

By Dr. Hernán Reyes*

The International Committee of the Red Cross (ICRC) has a clear mandate, as stipulated in the Red Cross Geneva Conventions of 1949, to visit Prisoners of War (POWs). But the ICRC also visits thousands of so-called political prisoners every year, in over 50 countries around the world – in countries with situations of internal strife, troubles, or disturbances. In most cases, these persons are in custody for reasons relating to the conflict, and are therefore in a category apart from “common-law” prisoners.

The ICRC main objectives when visiting prisoners

1. Attempts to prevent forced disappearances
   In situations of internal strife, people are sometimes arrested or abducted by governmental or other forces. Subjected to interrogation and kept in custody without any acknowledgement that they are imprisoned, these persons are particularly vulnerable. They may be summarily executed or left for months or years without anyone knowing of their existence. They often have no contacts with their families.

2. Attempts to prevent torture
   The ICRC endeavours to visit all prisoners who may have been submitted to any kind of ill-treatment or torture. By getting first-hand information from the victims themselves, it makes a global assessment of the situation. With such information to hand, the ICRC submits its findings to the highest authorities of the country in question, and demands that all such practices cease at once.

   The ICRC also tries to protect those prisoners who have given their accounts from any sort of retaliation. Finally, through its direct contact with the prisoners, it can hope to give some comfort to the victims who are in need of medical care or advice.

3. Improvement of conditions of detention
   Living conditions in places of detention can in some cases amount to cruel, inhuman and degrading treatment. This may be due either to deliberate infliction of such conditions on prisoners by malevolent authorities, or to extreme poverty, neglect, or other non-deliberate causes. In either case, the ICRC strives to bring about improvements.

Preliminary criteria for ICRC visits

ICRC delegates, and ICRC physicians in particular, have a specific role to play as outside, neutral intermediaries in the assessment of the situation and bringing about positive changes.

However, before even considering visiting prisoners in conflict situations, the ICRC has to ascertain that it can work according to its criteria. Three main conditions are considered sine qua non:

1. The ICRC must be guaranteed access to all prisoners, wherever they may be kept in custody. The ICRC defines at the beginning which prisoners are within its term of reference. Once this is done, it insists that all prisoners so defined must be visited. This may involve seeking permission from different ministries, different armed forces, and various intermediary authorities. If the ICRC comes across a prisoner not duly notified by the authorities, but within the terms stated, this prisoner comes automatically under the protection of the ICRC.

2. The ICRC demands the right to talk to any prisoner it chooses to see, in private and in a place duly chosen by the ICRC delegates—not by the authorities. In private also means that prisoners can speak up without group pressures within the prison itself. These talks in private are the keystone of the visit, which enables the ICRC team to obtain information on all the topics mentioned.

3. The ICRC has to be able to repeat the visit when it itself decides that it is necessary, and not necessarily at a date proposed by the detaining authorities. This repetition of the visit, and in fact an on-going presence and working relationship with the authorities, ensure protection for the persons and follow-up of what is undertaken to better the conditions. A single visit may be worse than no visit at all.

The role of the doctor

The ICRC physician has two distinct roles, both related to his/her unique position as a neutral doctor from outside.

First, the doctor is responsible for the objective assessment of the health of the prisoners, and all aspects related to it, i.e. food, sanitary conditions, medical services, etc. This requires a detailed assessment of the various systems providing such services, discussions with the detaining personnel responsible for their implementation, and, of course, examining a certain percentage of the prison population in order to have not only the prisoner’s point of view but also the clinical facts.

Second, the physician has a crucial role to play whenever prisoners have been submitted to torture or other forms of cruel, inhuman or degrading treatment. In such cases, the role of neutral medical intermediaries is again important, because the doctor from outside can provide specific counsel in many cases. Often, even when good medical services are provided, prisoners will be reluctant to seek help from a service they see as “part of the system”. Moreover, the ICRC physician can also often help prisoners who are suffering from psychological disturbances after their ordeal. Finally, documentation of torture also warrants expertise from a physician, as well as documentation of cases of medical participation in torture. In the latter case, the ICRC physician will take up the appropriate action with the local Medical Association, when necessary.

All ICRC visits to prisoners have a set pattern, to ensure that all sources of information are tapped, and thereby guarantee conclusions that are unbiased and objective. All visits begin and end with an interview with those in charge of the prisoners. In between are the all-important interviews with the prisoners. ICRC physicians in particular have a specific role to play as outside, neutral intermediaries, both in the medical assessment and in the context of working with victims of torture.

The fact that ICRC reports to the government are confidential is not a sign of complacency or timidity. On the contrary, the confidentiality allows the reports to be explicit and sometimes even “tough”. The aim is to be able to have an active presence in situ, and to achieve results, not to denounce publicly what others already do.

ICRC visits are therefore an essential, effective and unique complement to all other efforts that are being made worldwide to improve the lot of all persons being held in custody in situations of conflict.

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The Nazi doctors and the Nuremberg Code

Human Rights in human experimentation


This remarkable historical book, which makes us think about the SS physicians' behaviour in the concentration camps during World War II, is very moving and sensitive.

Having myself been a victim of the Gestapo and a prisoner in the concentration camps, the last one of which I was an inmate being Buchenwald, the book took possession of me in such a way that I couldn't stop reading before its end.

The winter 1944-45 was the most difficult to bear because it was not only very hard and cold, but the camps situated in the centre of Germany — Buchenwald was located 6 miles from Weimar — were overcrowded due to huge arrivals of prisoners evacuated in tragic circumstances from the Eastern camps before the advance of the Russian army.

In these indescribable conditions, the Nazi doctors were continuing their experimentation on inmates, some of whom didn't hide that, by being selected as guinea pigs, they hoped to escape faster from suffering, slow death, cold, hunger, crowding, tiredness and forced work, which were the fate of those detained in the camps during the last year of their existence.

In my capacity as The World Medical Association Secretary General, and involved in its activity since 1964, the year when its General Assembly unanimously adopted the Helsinki Declaration in its first version, I learned in this exciting and provoking book historical data concerning the drafting of this Declaration and especially its overall ripening.

The book highlights in particular the philosophical, moral and intellectual links between the Code of Nuremberg and this important document of medical ethics which is used as a reference and guideline in all the countries where medical research and experimentation are performed.

I would like to point out however that the Nuremberg Code as well as The World Medical Association Helsinki Declaration need to be used only when the first medical ethics principles and the basic patients' rights are respected, i.e. the free choice of his doctor by the patient, and his right to accept or to refuse the proposed treatment.

As to the physician's duty, it is to meet his patient's confidence by a total obligation to defend only the latter's interests.

The patient's right of free choice covers also that of changing his doctor without pressure or interference, and without the necessity to justify his decision if he has lost confidence in his doctor. The reason to select another physician does not have to be explained.

In other words, if this ethical rule, which is a fundamental right of the patient, is respected, then there is no need to apply the Nuremberg Code or the Helsinki Medical Association Declaration.

The patient's informed consent is also implicitly included in the free choice which is his best defensive weapon.

Where this principle no longer exists, all deviations are possible and the ethical rules needed to remedy the situation are circumstantial and unfortunately often interpreted abusively.

If the whole world was deeply shocked by the totally reprobat behaviour of the Nazi doctors who were prosecuted and condemned in Nuremberg, it also seems that voices had arisen to insinuate that the German medical profession as a whole was indirectly involved in that crime against medical ethics and that its silence during the 12 years of Nazi power was a kind of tacit agreement.

I want to be witness here to two indisputable historical facts which explain these serious accusations, not confirming them, but on the contrary in order to understand with the best possible objectivity the behaviour of our German colleagues during the Nazi era and to justify the decision of the world medical profession which accepted to reintegrate them in its family after the war. Indeed, they are today appreciated as the strictest and the most "orthodox" in the field of medical ethics, especially in sensitive circumstances and in basic problems encountered at the present time, such as euthanasia. They are considered as an example of strictness and faithfulness to the principles which were taught to the physician by Hippocrates 2500 years ago. It is perhaps because of the tragic experience made by our German colleagues during the Nazi time, which generated such horror of the consequences of that inhuman philosophy which led to the Holocaust, that they have today become the best and the most efficient advocates of medical ethics.

When in 1939 Hitler signed the law initiating active euthanasia against the mental patients called incurable, "the empty envelopes", as he called them, papers of doctrine were published in the German medical journals mainly to obtain the agreement and the cooperation of the German medical profession.

One of the most famous authors of the editorials annexed to the official documents used at the trial pleaded before the court of Nuremberg was Professor Conrad Lorenz, who was teaching at the University of Vienna. The main argument he used was the failure of natural selection, well described by Darwin, because of the success of the medical sciences.

The conclusion of the papers was aimed at convincing the medical profession to replace nature in order to eliminate from human society its "rubbish", dangerous for the race. It was the first step towards eugenism.

When Conrad Lorenz, awarded the Nobel Prize, went to Scandinavia to receive it, the press interviewed him about the editorials he signed in the 1940s. When some journalists asked him clearly if he was still defending the same ideas as he had at the time of Nazism, he completely and radically disapproved them.

He even confessed that he bitterly regretted what he had written on that matter. He emphasized that he sincer-
ely believed at that time that Nazism would bring serious improvement to humanity, but if he had known that its philosophy would lead to Auschwitz he would never have adhered to it.

If Conrad Lorenz was forgiven by the world, to the point of being honoured by the Nobel Prize, it should be admitted that the German medical profession as a whole could have made the same mistake with the same philosophical enthusiasm, and therefore deserves the same "indulgence" as the one granted to Conrad Lorenz by the whole world. The second fact which has more than just historical significance, is this: when the Nazis took over power in 1933, they abolished the established and democratically based organizational structures and, in 1935, installed a Reich Medical Association according to National Socialist ideals. The Reich Medical Association was subordinated to the Reich Medical Führer, who was not elected democratically, but appointed on the recommendation of the Reich Minister of the Interior, in agreement with the deputy of the Führer himself.

The Reich Medical Association was installed strictly on the basis of Nationalist Socialist principles, far removed from all democratic guidelines of a free medical profession. A German Medical Assembly, as an organ of the Reich Medical Association, continued to exist formally, even if it was never convened in the 12 years of National Socialist rule.

If the Nazis had not considered the Deutsche Arztetag as a dangerous enemy, they would have colonized, Nazified and used it for political and ideological purposes, as they did with many other cooperative organizations, rather than to disband it and create a completely new organization.

These two unquestioned facts deserve to be added to the ones already mentioned in this remarkable book.

They enable us not only to keep our respect for our German colleagues, but also to consider them, because they were directly traumatized by the Nazi horrors, as the most motivated in medical ethics, and, thanks to their knowledge of what happened, as the most able to prevent the world from lapsing again into such moral deviations as the ones experienced during 12 years, amid the most dramatic ones ever known by humanity.

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**BOOK REVIEWS**

**Good booklet on trade in torture instruments**

Repression trade UK Limited – how Britain makes torture & death its business. £2.50.
Available from Amnesty International British Section, 99-119 Rosebery Avenue, London EC1R 4RE, UK.

While the sale of major weapons systems to Third World countries has slowed down in recent years, a new trade has emerged in weapons, technology, and training which has been designed specifically to quell internal dissent. This booklet covers this repression trade, which is now being rapidly as many highly militarized states operate national security and state of siege regimes. Most wars now fought are not Gulf War type conflicts between states, but counter-insurgency or counter-revolutionary, low intensity conflicts within individual nations. Within such conflicts, these technologies of political control enable the industrialization of repression and human rights violation.

This booklet, published by the British Section of Amnesty International, spells out some examples of UK involvement, together with the intense secrecy which allows this trade to continue, in supplying repression to regimes where terror may be the only government service. Amnesty is demanding that all exports of repressive technology ad training should be disclosed publicly in advance, and that the human rights record of the receiving country should be taken into account before export licences are granted. AI says that any equipment or training which can reasonably be assumed to contribute to human rights violations and extrajudicial executions should be prevented from being exported.

The pamphlet explores specific cases in which British equipment and the exchange of personnel have contributed to gross human rights violations, including the export of leg irons to South Africa, the supply of pulsed stroscopic light and white noise generators for torture purposes to the United Arab Emirates, telecommunications equipment to Uganda, counterinsurgency training to the Philippines, and secret training to Cambodia, including courses on mine laying and sabotage. It also explores the need for new controls on weapons such as the Frag 12, a pre-fragmented bullet filled with high explosive, which, designed for police use, can only be used for extrajudicial killings.

Very little is published on the repression trade because hard information is difficult and dangerous to obtain. This campaigning pamphlet therefore makes a powerful contribution to public debate. In the wake of disturbing revelations about British involvement in the Saddamgate arms to Iraq scandal, there has never been a more appropriate time to question the adequacy of current European arms controls and policies.

The pamphlet proposes an alternative way of monitoring and preventing exports of such military, security, and police equipment and training, as well as identifying ways in which individuals and groups can build a more powerful campaign against the repression trade. This initiative is particularly important given the growing number of specialized security firms selling this technology to those countries on Amnesty's list of torturing states. These cater for the burgeoning number of companies looking for new markets at the end of the cold war.

A new European sales policy is demanded in the light of new EC legislation which seeks to lay down and apply common controls on the export of defence equipment. The key question is how these EC proposals would be framed to control the repression trade since much of this technology is cheap and as a result may slip through any net of controls crudely configured around monetary values of each sale. Joint action is urgently required by all European organizations working for Human Rights to ensure the appearance of adequate controls that are powerful enough to encompass the repression trade – particularly the emergence of multinational merchants of repression. The booklet is a useful start to that campaign, and at £2.50 it is a must for anyone wishing to be kept seriously informed about these issues.

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TORTURE Volume 3, Number 2 1993
Randall GR, Lutz E. Serving Survivors of Torture: A Practical Manual for Health Professionals and Other Service Providers. Washington, D.C.: American Association for the Advancement of Science [AAAS], 1991. 199 pp. Copies of the manual can be purchased for $22 (U.S.), including postage and handling, from AAAS Books, P.O. Box 753, Waldorf, MD 20604, U.S.A.

"If the torturer’s purpose is to destroy solidarity, then the community’s goal must be to rebuild and reclaim those links”. Douglas Johnson, Executive Director of The Center for Victims of Torture in Minneapolis, Minnesota, in his Foreword (p. xi).

Why do survivors of torture who were politically active in the countries from which they come often avoid involvement in political or solidarity activities in the countries where they find refuge? (p. 33). Why might survivors of torture make poor witnesses in judicial inquiries aimed at helping them gain compensation from their torturers or refugee status in a host country and how might professionals help tribunals and judges understand why this is so? (p. 37). What are the common defences that survivors of torture use to cope with their trauma and how might these different coping mechanisms affect treatment or diagnosis? (p. 37 et seq.). What pre-trauma factors might be expected to reduce the intensity of post-traumatic sequelae in survivors of torture? (p. 107). What are the typical cognitive patterns that aggravate post-traumatic sequelae in survivors of torture and how might survivors be taught to correct them? (p. 118-9). Why might pain medicine for crippling migraine or tension headaches or sleep medication for persistent insomnia due to intrusive thoughts not be in the best long-term interests of torture survivors who suffer from these symptoms? (p. 129). Why do many survivors of torture feel uncomfortable with civil suits against their former torturers or with accepting compensation that such suits might award them? (p. 142). What are the most important variables that determine the extent of post-traumatic sequelae in children who have experienced or witnessed traumatic human rights abuses? (p. 148-151). Why are North American health professionals less comfortable with primary prevention than those who live in countries where traumatic human rights abuses are common and what might North American health professionals do to become more involved? (p. 156-7).

These are but some of the questions that are raised (see pages in brackets) — and answered — in the 1991 manual published by the AAAS Committee on Scientific Freedom and Responsibility in its series of Reports on Health and Human Rights. The genesis of the manual is interesting in itself, symptomatic as it is of the problems that many professionals face in combating human rights abuses and helping its survivors to cope. The manual was born out of the failure of the two authors to attract sufficient funding for a service centre for torture survivors in Los Angeles. In their preface to the manual, the authors describe what went wrong:

Nearly everyone we approached was unfamiliar with or sceptical about the problems survivors face, and unprepared to recognize the serious public health problem posed by failing to prevent human rights abuses or failing to alleviate post-traumatic consequences. Some found it difficult to listen to or believe the details of the sequelae of traumatic human rights abuses and thus doubted the need for a centre. Others contended that because such abuses most commonly happen outside the United States, they had no local relevance or impact. Several foundations told us that because the problem was not adequately studied, funding for a program to assist survivors was premature (p. xiii).

Here we see four obstacles to progress in the combat against gross human rights violations: scepticism and lack of knowledge about the extent or seriousness of the problem; disbelief or denial that a problem exists; parochialism and failure to recognize the international or transnational scope of the problem; and paucity of adequately funded research programmes that could provide the testable hypotheses and reliable data that funding agencies like to see before they commit themselves to long-term projects.

This manual is an excellent antidote to all four problems and goes a long way to addressing issues that surround each. In their first three chapters, Randall and Lutz address scepticism and lack of knowledge by outlining the state of the art, surveying areas of consensus and controversy, and cataloguing the physical and psychological sequelae of traumatic human rights abuses. The authors deliberately use a broad definition of trauma and their use of terminology is carefully tailored to their main goal of helping people cope with and move beyond their previous trauma by restoring trust and rebuilding community solidarity: using the term survivors rather than victims emphasizes the future over the past; serving rather than treating emphasizes the helping relationship and shifts control from the professional to the survivor. The emphasis throughout is on treating the whole person and the context within which she or he lives; survivors, their families, those who help them. The discussion is even-handed, informative, and clearly written. There is not a lot of jargon or technical language, though there is adequate information for informed professionals as well as the more general reader.

The manual not only sensitizes the reader to the wide range of sequelae experienced by survivors, but also to the kinds of problems that those who help them might be expected to encounter.

These include reactions of disbelief and denial, referred to above, as well as the need to create a support system for helpers, the issue of interpreters, the issue of cross-cultural and political differences between helper and survivor (chapter 4). Chapter 5 deals with the important issue of documenting the trauma story and the kinds of problem that might be encountered due to the very sequelae that one is trying to document. The authors also discuss the various contexts other than therapeutic in which documentation might be necessary, such as legal and investigatory proceedings. It is in their detailed advice that the authors provide a compelling picture both of the sequelae themselves and of the practical problems that these sequelae might cause.
both for the survivor and for those who help them. They warn professionals not to scold their clients for late or missed appointments since these are symptoms of continuing mistrust or apprehension that can only be exacerbated by impatience or annoyance. They highlight the importance of providing expert testimony at asylum hearings on the tendency of traumatized individuals to narrate their trauma without any sign of affect or to be reluctant to talk about their trauma for fear of reliving it, lest they be refused asylum and returned to their home country on the grounds of lacking credibility.

The manual also addresses the parochialism referred to earlier by describing the many ways in which post-traumatic sequelae permeate daily and bureaucratic life. Chapters 6 to 9 deal with physical treatment, psychological treatment and self-help therapy, while chapter 10 focuses on children. The ripple effect of torture and human rights abuses is immense. Refugee populations are on the increase as mass migrations in the face of war and human rights abuses grow ever larger. Survivors of torture are everywhere. It is not something that is distant, "over there". A serious public health problem exists precisely because we do not know the extent of survivor populations in our communities and the problems that they face. It is important to know, for example, that some families "blame the survivor for what occurred or label him or her weak, stupid, or unlucky" (p. 126) or that adults who were traumatized as children "may harbour thoughts and feelings relating to the trauma that are expected in a child but not in an adult" (p. 153). The dimensions of victimization and traumatization are complex and permeate everywhere. While this book is aimed specifically at health professionals in the United States and the particular problems that characterize health care in that country, it also has relevance for treatment programmes everywhere. For example, the manual discusses the differences between treatment for refugee populations in Western countries, with or without well-developed national health care systems, and treatment in the countries where human rights abuses are going on.

In the final chapter (11), the authors discuss prevention. It is here that they most explicitly address the question of research and what is necessary to improve knowledge, such as standardized diagnostic criteria and cross-culturally valid research instruments. They contribute to this end by providing in appendices a sample consent form for an examination as well as a fictional sample of a health professional's declaration and medical and psychological report. Two additional appendices provide a list of information sources and a list of selected centres and clinics in North America that offer health and social services to survivors of torture. Each chapter is followed by references and notes that point the reader to other sources and elaborate on specific points in the text. The manual also includes some photographic examples of physical sequelae and an index. Anyone involved in or concerned about combating human rights abuses - clinical practitioners and researchers, educators and students - would do well to obtain a copy.

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Selected list of publications received in the IRCT-International Documentation Centre


Berit Backer
Albania expert murdered

The 45-year-old social anthropologist Berit Backer was brutally murdered in her home in Oslo, Norway, on 7 March 1993.

Berit Backer was on leave from her job as senior executive officer in the reception and integration department of the Norwegian Directorate for Foreigners. Her knowledge of the whole Balkan area was first rate, and she was known as an Albania expert. She was the project leader of Aksjon Norge Albania [Action Norway-Albania] when the murder abruptly stopped her work.

I had the pleasure of collaborating with her during RCT's work in creating a centre for the treatment of torture victims in Tirana, Albania. It is a great tragedy that she should die in this brutal way. Her knowledge, expertise, and uniting energy were an inspiration for all of us. The work in Albania will continue, but it will not be the same without her. She leaves behind a six-year-old adopted daughter.

We at RCT are deeply moved by Berit Backer's death, but we shall continue to hold her in our thoughts as we work on our common task.

Peter Vesti
RCT Consultant
Canada
Compensating victims of brainwashing experiments
The Canadian government has announced its wish to compensate victims of brainwashing experiments conducted in the 1950s with funding by the US Central Intelligence Agency (CIA).
The deprogramming experiments were carried out on about 80 people who were drugged and subjected to electroshocks and other experiments to wipe their brains clear.
The experiments, conducted at Montreal’s Allan Memorial Institute by psychiatrist Ewen Cameron between 1950 and 1965, were jointly funded by the Canadian government and the CIA.
Justice Minister Kim Campbell announced that victims who were still alive would receive CS 100,000 (US$ 79,000) on compassionate and humanitarian grounds.
The US Justice Department reached an out-of-court settlement in 1988 that gave similar compensation to nine Canadians who sued the Canadian government and the CIA.

Chile
More than 2,000 opponents killed
Chile’s President Patricio Aylwin has called a report by the International Commission of Jurists (ICJ), which urged Chile to prosecute military and police officials accused of torture and murder, flippant and unreliable.
A 1990 report commissioned by Aylwin’s civilian administration said that the military abducted, tortured and killed more than 2,025 of its opponents between 1973 and 1990.
The administration’s initial commitment to try human rights violators has become progressively modified and diluted during the period of transition, the report said.

Burma (Myanmar)
Torture and repression
After General Saw Maung, Army Chief of Staff of Myanmar, and his colleagues staged a coup d’état, declared martial law, and formed the State Law and Order Restoration Council (SLORC) in 1988, the troops of Myanmar inhumanly have gunned down peaceful demonstrators and have killed, injured and tortured thousands of people.
Both physical and psychological torture methods were commonly applied in centres of the different intelligence agencies, of which there are at least six. Beating, slapping, punching the face or body, kicking with combat boots, and blows with the knees against the sides, chest, or back are the consistent methods of physical torture. Beatings were carried out repeatedly in many cases after protecting the body with several rice bags in order to reduce external marks, but there was no protection against external injuries. Wooden sticks, rifle butts, or truncheons were also used to strike the face, chest, and back.
Ordinary beatings were sometimes followed by beatings with a truncheon while the victim was in the motorcycle position (being forced to maintain a crouching rider’s position). Some victims were subjected to the iron road – an iron bar is rolled up and down their shins with increasing pressure.

Some underwent walking on the seashore – walking on the knees on sharp gravel, and some motorcycle riding – squatting for long periods in the position of driving a motorcycle. One victim was nearly suffocated by having a large plastic bag placed over the head and trunk.
Other torture methods included:
- prolonged standing in water
- prolonged exposure to sun or intense cold
- burning with cigarettes
- rolling of iron or bamboo rods or bottles along the shin bones
- near drowning through immersion in water
- hanging by the feet from the ceiling
- beating with a whip or club while suspended
- putting salt, salty water, urine, or curry powder in open wounds after cutting the skin or whipping
- electric shocks applied to fingertips, toes, ear lobes, penis, or testicles
- submersion of the head in water until near suffocation
- rape and sexual assaults
- deprivation of sleep, food, and water
- solitary confinement in dark cells for long periods
- continuous exposure to powerful light or constant noise
- intimidation with a pistol
- humiliation while stripped naked for interrogation

Apart from physical torture, psychological pressure has been used to break the prisoner’s will and force a confession. Several prisoners were interrogated continuously for many days by a shifting team of interrogators. This technique has sometimes been combined with deprivation of food, water, and sleep, false accusation, witnessing others being tortured, threat of torture to self and relatives, and sham execution.
As a result of severe beatings or untreated gunshot wounds during demonstrations or after arrest, many deaths occurred. Some prisoners reportedly died as a consequence of torture, e.g. from fractures after beating, cardiac arrest, and neurogenic shock due to intense pain. All these methods of torture affect not only the bodies, but also the minds of the victims.

Dr. Myint Cho
Rangoon
Myanmar (Burma)
Córdoba, Argentina
May 6-7, 1993
All enquiries should be directed to:
Centro de Asistencia a la Víctima del Delito
Pasaje Santa Catalina 66
C.P. 5000
Córdoba
Argentina
Tel: (54) 51 21 20 57
Fax: (54) 51 24 14 05

York, Canada
May 9-11, 1993
Centre for Refugee Studies and York Centre for Feminist Research: Gender Issues and Refugees: Development Implications.
All enquiries should be directed to:
Farhana Mather, Conference Coordinator
Centre for Refugee Studies
Suite 322, York Lanes, York University
4700 Keele Street,
North York
Ontario
Canada M3J 1P3
Tel: (416) 736-5663
Fax: (416) 736-5837

Durban, South Africa
May 13-16, 1993
All enquiries should be directed to:
Forensic Congress Secretary
Department of Forensic Medicine
University of Natal
P.O. Box 1015
Durban 4000
South Africa
Tel: (27) 031 215141
Fax: (27) 031 216258

Brisbane, Queensland, Australia
June 6-11, 1993
All enquiries should be directed to:
Conference Secretariat
P.O. Box 177
Red Hill Qld 4059
Australia
Tel: (617) 368 2644
Fax: (617) 369 3731

St Giles, Oxford, UK
August 9-14, 1993
All enquiries should be directed to:
The In-Service Training Office
Refugee Studies Programme
Queen Elizabeth House
21 St Giles,
Oxford OX1 3LA
UK
Tel: (44) 865 270722
Fax: (44) 865 270721

Hamburg, Germany
September 26-29, 1993
Department of Children and Adolescent Psychiatry in the Medical Faculty of Hamburg University: Children – War and Persecution.
All enquiries should be directed to:
Conference Secretariat
Children – War and Persecution
C/O Congress Centrum Hamburg
Congress Organisation
P.O. Box 30 24 80
W-2000 Hamburg 36
Germany
Tel: (4940) 35 69 22 44
Fax: (4940) 35 69 23 43

Budapest, Hungary
August 22-27, 1993
All enquiries should be directed to:
Prof. Dr. Hans Joachim Schneider
Department of Criminology
University of Westfalia
Biszpinghod 24/25
4400 Münster/Westfalia
Germany

Düsseldorf, Germany
August 22-28, 1993
International Association of Forensic Sciences: The 13th Meeting.
All enquiries should be directed to:
Institut für Rechtsmedizin
Congress Secretariat
Moorenstr. 5
D-4000 Düsseldorf
Germany
Tel: (49) 211 311 2385
Fax: (49) 211 311 2366

Gaza
September 13-15, 1993
Gaza Community Mental Health Programme: International Conference on Mental Health and the "Challenge of Peace".
All enquiries should be directed to:
Gaza Community Mental Health Programme
P.O. Box 1049
Gaza
Tel: (972) 7 863684
Fax: (972) 7 822534

Havana, Cuba
October 11-16, 1993
The FORENSE' 93
All enquiries should be directed to:
Prof. Dr. Jorge González Pérez
Chairman, Organizing Committee
Palacio de las Convenciones
Apartado 16046
Havana
Cuba
Fax: (537) 22-8382 or 33-1657

Argentina, Buenos Aires
20-22 October
VI International Symposium on Torture and the Medical Profession.
All enquiries should be directed to:
Professor Erik Holst, MD
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